Holistic Pelvic Care

NEW CLIENT INFORMATION & HISTORY

Name _____ Date of Birth ____/____/____ Today's Date ____/____/____

Home address _____

Phone _____ Email _____

Emergency Contact _____Relation_____ Phone _____

Occupation _____

Source of Referral _____

What major concern, symptom, or problem brings you here? _____

_____

When and how did this begin? _____

_____

What tests and/or treatments have you received for this concern? _____

_____

What are your goals for treatment? _____

_____

Health History

Please share details of your overall health history (hospitalizations, longterm health struggles, musculoskeletal symptoms, etc.)_____

_____

_____

Please share details of your menstrual history (monthly symptoms, regularity, menopause symptoms, etc.)

_____

_____

Please share details of your gynecological history (persistent infections, positive PAP results, STI's, procedures, etc.)

_____

_____

Please share details of your sexual history (birth control history, pain with intercourse, difficulty orgasming, sexual abuse, etc.)_____

_____

Please share details of your reproductive / birth history (number of pregnancies, abortions, miscarriages, relevant birth details, etc.)_____

_____

_____

NEW CLIENT INFORMATION & HISTORY CONTINUED

Please share details of your digestive health (constipation, diarrhea, gas, bloating, etc.)_____

_____

_____

Please share details of your urinary system health (stress incontinence, urge incontinence, UTI's, etc.)

_____

_____

Describe your diet (allergies, restrictions, cravings, etc.)_____

_____

Please list current medications & supplements:_____

_____

Describe your weekly exercise regimen:_____

_____

What are your self-care practices?_____

_____

Anything else you'd like to share?_____

_____

CONSENT

PELVIC FLOOR EVALUATION AND TREATMENT

If you are receiving a pelvic floor assessment, this assessment includes an internal vaginal exam to assess pelvic health. Treatment of findings may include internal vaginal massage, instructions on pelvic muscle and breathing exercises, rectal assessment, and other techniques as needed. I understand and consent to these services, to be provided at the discretion of therapist. I also understand there is no guarantee of outcome of any treatment. Patients may experience a range of effects as a result of treatment including many benefits, but also physical effects such as soreness or bleeding, as well as emotional responses to treatment. I understand and agree that if at any time I experience symptoms that concern me or difficulty integrating a pelvic session, I will promptly consult my treatment provider (primary care physician or counselor, as applicable).

By signing below, I consent to evaluation and/or treatment of my condition by Kate Coletti. I understand the nature and purpose of the procedures, evaluation and course of treatment. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction. I certify that I have read, fully understand, and agree to the terms of this consent form.

Client Signature: _____ Date: _____

If the recipient is a minor: I, _____ as the ____ parent or ____ guardian, authorize Kate Coletti to provide treatment.