



Date: _____

Client Name: _____

Diagnosis:

- | | | |
|---|--|---|
| <input type="checkbox"/> Stress Incontinence | <input type="checkbox"/> Urge Incontinence | <input type="checkbox"/> Mixed Incontinence |
| <input type="checkbox"/> Post-prostatectomy Incontinence | <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> Pelvic Organ Prolapse |
| <input type="checkbox"/> Dyspareunia | <input type="checkbox"/> Vestibulodynia | <input type="checkbox"/> Vulvodynia/
Vaginismus |
| <input type="checkbox"/> Interstitial Cystitis/
Painful Bladder Syndrome | <input type="checkbox"/> Chronic Pelvic Pain
Syndrome | <input type="checkbox"/> Chronic Non-Bacterial
Prostatitis |
| <input type="checkbox"/> Levator Myalgia/
Hypertonicity | <input type="checkbox"/> Pudendal Neuralgia | <input type="checkbox"/> Dysynergia |
| <input type="checkbox"/> Pelvic Girdle Pain | <input type="checkbox"/> Postpartum Assessment | <input type="checkbox"/> Painful Scar |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Coccydynia | <input type="checkbox"/> Fertility |
| <input type="checkbox"/> Other: _____ | | |

Treatment Required:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Pelvic Physiotherapy at Therapist's Discretion | <input type="checkbox"/> Trigger Point Release/
Manual Therapy | |
| <input type="checkbox"/> Scar Mobilization | <input type="checkbox"/> Dilators | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Electrical Stimulation, TENS | <input type="checkbox"/> Acupuncture & Chinese Medicine | |
| <input type="checkbox"/> Registered Massage Therapy | <input type="checkbox"/> Mindfulness Meditation | |
| <input type="checkbox"/> Sex Therapy/Psychotherapy | <input type="checkbox"/> Nutrition Counselling | |

Referrer: _____ **Tel:** _____

-Other pertinent medical information may be included on the back of this form-



Other Relevant Information:

