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### CONSENT FORM INTERNAL PELVIC FLOOR EVALUATION

Name:	Date of Birth:
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In order to fully understand the scope of your individual diagnosis, there is important information your physical therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? \_\_\_\_\_ YES \_\_\_\_\_ NO  
     If "No", have you been in the past? \_\_\_\_\_ YES \_\_\_\_\_ NO
2. Do you have any communicable diseases? \_\_\_\_\_ YES \_\_\_\_\_ NO  
     If "Yes", please explain: \_\_\_\_\_
3. Has there been any sexual abuse in your past? \_\_\_\_\_ YES \_\_\_\_\_ NO
4. Have you had difficulty in the past with vaginal exams? \_\_\_\_\_ YES \_\_\_\_\_ NO

I give / deny (circle one) my consent for the physical therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and giving therapeutic treatment.

1. I understand I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of bringing a second person to be in the room with me during the procedure, and I refuse / choose (circle one) this option.
4. I have read this consent form and understand its terms.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date