



We would like to welcome you to the Creekside Performance Center, Sheboygan's Premier Chiropractic and Sports Rehab Facility. Voted Best Of Sheboygan in the Sheboygan Press in '19, '20, '21, '22, '23, and 2024 including: best chiropractic office, best sports rehab facility, acupuncture (dry needling), and best massage therapy. To help us assist you, please complete the following form to the best of your ability. This will speed up our on-boarding process for your first appointment. We appreciate you choosing us to help. Thank you and welcome to Creekside! -The Creekside Team

**PERSONAL INFORMATION**

Full Name :

Preferred Name/Nickname : \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Cell Phone Provider : \_\_\_\_\_

E-Mail : \_\_\_\_\_ OK to receive texts?  Yes  No

Occupation : \_\_\_\_\_ Employer : \_\_\_\_\_

Marital Status : \_\_\_\_\_ Spouse's Name (if applicable): \_\_\_\_\_

Emergency Contact Name : \_\_\_\_\_ Relation : \_\_\_\_\_

Emergency Contact Phone Number : \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**BRIEFLY EXPLAIN WHY YOU ARE SEEKING TREATMENT**

\_\_\_\_\_

\_\_\_\_\_

Date Symptoms Appeared: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Have you had this issue in the past?  Yes  No

Have you seen anyone else for this condition? If yes, who?  Yes  No \_\_\_\_\_

What treatments were performed? \_\_\_\_\_

Who is your OBGYN? \_\_\_\_\_

What are your goals of treatment?

---

---

## PELVIC FLOOR MEDICAL HISTORY

### Urinary Symptoms

Yes  No Do you experience urinary leakage? If yes, how long? \_\_\_\_\_ months/years

Do you experience leaking during the following times? Check all that apply:

Coughing/Sneezing/Laughing  Walking/Running  With Intercourse

On The Way To The Bathroom  Minimal Activity  Laying Down

What amount of leakage do you experience?

Drops  More than Drops  Flood

Yes  No Do you use a pad for leakage? If yes, how many pads in a day? \_\_\_\_\_

Yes  No After emptying your bladder do you feel like you have completely finished?

Yes  No Do you find it hard to begin urinating?

Yes  No Any kidney infections (pyelonephritis)?

Yes  No Any history of kidney stones?

How many times do you urinate during the day? \_\_\_\_\_

How many times do you urinate during the night after you go to sleep? \_\_\_\_\_

Number of urinary tract infections in the last year? \_\_\_\_\_

### Bowel Symptoms

How often do you have a bowel movement? \_\_\_\_\_

Yes  No Do you strain to have a bowel movement?

Yes  No After emptying your bladder do you feel like you have completely finished?

Yes  No Do you push with a finger in the vagina to assist with a bowel movement?

Yes  No Do you have any constipation?

Yes  No Do you use any laxatives?

Yes  No Do you have diarrhea/loose stools?

Yes  No Do you have fecal urgency and do not make it to the bathroom in time?

Yes  No Do you have fecal seepage or staining on your underwear?

Yes  No Do you usually lose stool beyond your control if your stool is loose?

Yes  No Do you have difficulty controlling formed stool?

## Prolapse Symptoms

Yes  No Do you feel any vaginal or lower abdominal pressure?

Yes  No Do you see or feel a bulge or something falling out in the vaginal area?

Yes  No Do you see or feel a bulge or something falling out in the rectal area?

## Sexual Symptoms

Yes  No Have you ever had sexual relations?

Yes  No If yes, do you have pain with sex?

Yes  No If yes, are you satisfied with your sex life?

Yes  No Are you currently having sexual relations?

## GENERAL MEDICAL HISTORY

Please list any current health conditions (i.e. hypertension, diabetes, hypothyroidism, etc.):

---

---

Please list all prior surgeries, procedures, and/or injections (include body area, procedure type, and date):

---

---

Please list any current medications, vitamins, or supplements (name, dosage, frequency, what it is taken for):

---

---

Please list any allergies (i.e. latex, seasonal, medications, etc.):

---

---

Are there any notable diseases in your family history? (i.e. hypertension, diabetes, stroke)

Please also list family member relationship for each disease (i.e. mother):

---

---

Yes  No Do you use tobacco products?

If so, what type? (cigarette, vape, etc.) and amount? \_\_\_\_\_

Yes  No Do you consume alcohol?

If so, how many drinks per week? \_\_\_\_\_

Yes  No Do you exercise regularly?

If so, what type of exercise & frequency? \_\_\_\_\_

Yes  No Do you consider your diet healthy?

## PREGNANCY HISTORY

How many times have you ever been pregnant? \_\_\_\_\_

Of these pregnancies, how many were:

Full Term Deliveries: \_\_\_\_\_ Preterm deliveries: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

Of these pregnancies, how many were:

Vaginal delivery: \_\_\_\_\_ Vaginal delivery with forceps assistance: \_\_\_\_\_

Cesarean: \_\_\_\_\_ Vaginal delivery with vacuum assistance: \_\_\_\_\_

Yes  No For the vaginal deliveries, did you have any vaginal tearing?

Degree of tear(s): \_\_\_\_\_

What is the weight of your largest baby? \_\_\_\_\_

## MENSTRUAL HISTORY

When was the first day of your last period? \_\_\_\_\_

How often do you have your period? \_\_\_\_\_

How long does your period last? \_\_\_\_\_

Have you ever had an abnormal pap test? \_\_\_\_\_

Have you ever had a pelvic infection (i.e. gonorrhea, chlamydia, herpes)? \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

Yes  No  Unsure Have you gone through menopause?

If you answered "No" above:

Are you using any contraception? \_\_\_\_\_

Have you completed your family? \_\_\_\_\_

If you answered "Yes" above:

After menopause, did you use hormone replacement therapy?  Never  Past  Currently

After menopause, did you use vaginal hormone therapy?  Never  Past  Currently

Notes:

---

---

---

---

---

---

---

---

# INFORMED CONSENT TO PELVIC FLOOR EVALUATION AND TREATMENT

I hereby request and consent to pelvic floor therapy and other procedures including various modes of physiotherapies, and/or testing by Creekside Performance Center who now or in the future treat me while a patient at this office. I will discuss with my provider the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that there are some risks to treatment, including but not limited to: soreness and increased pain. I do not expect the provider to be able to anticipate and explain all risks and complications, and will rely on the provider to exercise judgment during the course of any procedure which the provider feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had the opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any further conditions for which I seek treatment by this clinic and/or employed staff.

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, sacroiliac conditions, sexual dysfunction, and/or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the perineal region, including the vagina and/or rectum externally and /or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region. I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my provider and the procedure will be discontinued and alternatives will be discussed with me.

Treatment may include, but is not limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization, relaxation techniques, use of vaginal weights and several manual techniques including massage, as well as educational instruction. Treatment may also include the use of vaginal dilators. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan.

## Potential risks:

I may experience an increase in my current level of pain or discomfort, emotional distress, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my provider.

## Potential benefits:

I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

## Alternatives:

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

## Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or OBGYN.

## Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home exercise program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my provider.

## No warranty:

I understand that the provider cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my provider will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

**Based on the information I have received, I voluntarily consent to pelvic floor therapy evaluation and treatment. I understand that I may withdraw at any time.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OFFICE POLICIES

### Cancellation Policy:

Our goal is to provide quality services to all our patients in a timely manner. When scheduling your pelvic floor therapy, we do require a credit card to be kept in our secure file. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other clients as well. Please be aware we do have a 24 hour cancellation policy. If you need to reschedule an appointment please allow at least 24 hours notice to avoid any fees. Cancellations within 24 hours will be charged half of the service price to the credit card on file. No call/no show missed appointments will result in full service price being charged.

Initial: \_\_\_\_\_

### HIPPA:

I acknowledge that I have, if requested, received a copy of The Notice of Privacy Practices for Protected Health Information, and I understand the authorizations listed.

Initial: \_\_\_\_\_

### Billing of Services:

I acknowledge that the pelvic floor services provided will not be billed to my insurance. Creekside Performance Center will not be submitting any insurance claims on my behalf. Payment is expected at time of service.

Initial: \_\_\_\_\_

## NOTICE OF PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

### USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. Your provider or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health care condition.
2. Your provider and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

For more details on HIPAA Privacy Policies and Procedures, copies are available upon request from the front desk.

### APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your provider and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person who answers the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with the individuals at your home and/or place of employment.

### MARKETING AUTHORIZATION

From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing would most likely occur in a newsletter that our office sends with the monthly statements. Your provider and members of the practice staff may need to use your health information, including your name, address, phone number, and your clinical records for the purpose of marketing products and services from Creekside Performance Center to you. Our office also utilizes website and social media platforms. I consent to the use of my photos with verbal permission on all platforms.

**By signing below, I acknowledge that I have read and understand the above stated information. Any questions have been answered satisfactorily, and I agree to the above stated policies. I acknowledge that I may request a copy of The Notice of Privacy Practices for Protected Health Information from the front desk and I understand the authorizations listed above.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_