Matrix Therapy, LLC
678-520-0986
carrie.matrixtherapy@gmail.com

Name: _____ Date of Birth:_____
Address:_____ Phone Number: Cell: _____

_____ Home: _____

Email: _____

Medical History:

- ☐ heart disease
- ☐ high blood pressure
- ☐ malignancy
- ☐ auto immune disorder
  Please list:_____
- ☐ mental illness
  Please list: _____
- ☐ DVT
- ☐ Hemmorage
- ☐ Stomach ulcers
- ☐ Diabetes
- ☐ Fractures
  Please list: _____
- ☐ Stroke
- ☐ TBI
- ☐ Chronic Fatigue Disorder
- ☐ Cancer

Type:_____
Location:_____

- ☐ Cerebral palsy
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ Vascular disease
- ☐ Insomnia
- ☐ Depression
- ☐ Thyroid imbalances
- ☐ Metabolic disorders
- ☐ Hormonal irregularities
  Please list:_____
- ☐ Other:_____
  _____
  _____

Allergies: _____
Medications:_____
Please list all previous injuries/accidents that have occurred: _____

_____
_____
Please list all surgeries: _____
_____

Reason for therapy/what do you hope to gain from therapy: _____
_____
_____
Please list areas of the body that are sore/painful; _____

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List any other sensations you have been experiencing: _____

On a scale of one to ten, what is your pain level, on average: _____
at best: _____ at worse: _____
What activities aggravate this problem? _____
_____
Are there activities that ease the symptoms? _____

Do your symptoms vary with your menstrual cycle? _____
Are symptoms relieved by voiding urine? _____
Do you have pain with sexual activity? _____
If yes, since your first partner or with your current partner? _____
Do you have a history of unpleasant or unwanted sex? _____
Do you have pain with a pelvic exam? _____
Are you able to use a tampon? _____

Bladder Habits

What is your daily fluid intake?

- Water: _____
- Coffee/tea: _____
- Soda: _____
- Alcohol: _____

How often do you urinate everyday? _____
How often do you get up at night to urinate? _____
Do you have urinary urgency? _____
Do you have urinary leakage? _____
Do you have pain when you urinate? _____

Bowel Habits

Do you have leakage? _____
Do you have difficulty defecating? _____
Do you have constipation? _____
Do you have diarrhea? _____
Do you have pain with defecation? _____

OB/GYN History

At what age did you start your menstrual cycle? _____
Are your cycles regular? _____
Do you usually have cramping or pain with your menses? _____
Do you have a history or sexually transmitted diseases? _____
How many pregnancies have you had? _____
Of those, how many deliveries have you had?_____

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How many c-sections? _____
How many vaginal? _____
Were there complications? _____
How many abortions have you had? _____
How many miscarriages have you had? _____
How many tubal pregnancies do you have? _____

General Health

Do you smoke? _____ How many packs/day? _____
Do you exercise? _____ How often? _____
What do you do for exercise? _____
What is your occupation? _____
What activities do you have difficulty with do to this problem? _____

_____

Contraindications: Please check off all contraindications, as they could have negative affects to treatment, if therapist does not know about them:

- ☐ Aneurysm
- ☐ Acute rheumatoid arthritis
- ☐ Celluitis
- ☐ Systemic or local infection
- ☐ DVT
- ☐ Osteomyelitis
- ☐ Obstructive edema
- ☐ Open wounds
- ☐ Sutures
- ☐ Hematoma
- ☐ Fracture
- ☐ Osteoporosis
- ☐ Anticoagulant therapy
- ☐ Advanced diabetes
- ☐ Hypersensitivity to skin
- ☐ Pregnant (or possibility you are pregnant)

I, _____, consent to receive physical therapy treatment from Matrix Therapy, LLC. I understand that these techniques will be explained to me beforehand, and I have the right to refuse treatment at any time. I understand that the risk for injury during treatment is low, but temporary soreness is a common side effect for treatment.

Patient signature

Legal Guardian (if under 18)

Date

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Acknowledgement of HIPAA Notice

I, _____, acknowledge that I have received the Notice of Privacy Practices from Matrix Therapy, LLC.

_____ _____

Signature Date

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Informed Consent for Assessment and Treatment of the Pelvic Floor

Internal examination of the pelvic floor muscles is consistent with physical therapy practice. It complies with national physical therapy policies requiring the performance of test and measurements of neuromuscular function as an aid to the evaluation and treatment of a specific medical condition.

-this statement was adopted by the executive committee of the Section of Obstetrics and Gynecology of the American Physical Therapy Association
-San Antonio, Texas, February 1993

I understand that it may be beneficial for my therapist to perform soft tissue assessment and treatment of the pelvic floor. Palpation of this area is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary or fecal incontinence, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis, or other similar conditions. Restrictions in this area may also be contributing to symptoms in other areas of the body.

I understand that the benefits of this procedure will be explained. I understand that, if I am uncomfortable with participating in this treatment procedure AT ANY TIME, I will inform the therapist and the procedure will be discontinued and alternatives will be discussed with me.

This Direct pelvic floor release procedure utilizes Myofascial Release principles entailing the relaxation and lengthening of muscles, fascia and other soft tissue structures within the areas of the pelvic floor, sacrum, coccyx, and the sacroiliac, hip and pubic joints. The procedure also requires pressure and/or distraction directly to the coccyx bone. This technique is an accepted physical therapy technique, as indicated above. Our experience has demonstrated that this direct pelvic floor release is helpful, often facilitating consistent therapeutic results. As with any area of the body, most people require a series of these specific treatments. This is determined by evaluation and treatment findings.

I have read and understand fully and consent to the above procedure being performed by the therapists at the Matrix Therapy.

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____

Witness or Therapist's Signature: _____