Integrative Physical Therapy
Pelvic Floor – Men's Health

SportsCare
Integrative Physical Therapy

Name: _____ **Date of Birth:** _____

	Never		Moderate		Severe
Pain in the rectum	0	1	2	3	4
Pain in the groin or lower abdomen	0	1	2	3	4
Pain in the buttocks	0	1	2	3	4
Pain in the testicles	0	1	2	3	4
Pain in the penis	0	1	2	3	4
Prostate pain	0	1	2	3	4
Pain in the sacrum or low back	0	1	2	3	4
Pain during or following intercourse	0	1	2	3	4
Pain when sitting	0	1	2	3	4
Pain with urination	0	1	2	3	4

List any other activities that increase your pain in the pelvic region: _____

_____

_____

_____

Do you have difficulty getting or maintaining an erection? NO YES

Do you experience urinary incontinence? NO YES

Are you wearing pads/diapers for protection? NO YES

If so, how many do you wear a day? _____

Do you use any other form of protection? NO YES

If so, what? _____

Do you experience urinary urgency? NO YES

On average, how many times do you urinate during the day? _____

On average, how many times do you urinate at night? _____

Do you have difficulty stopping the urine flow? NO YES

Do you have difficulty starting the flow of urine? NO YES

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In order to fully understand your individual diagnosis, we ask you answer the following questions.

Please be brief in your answers. If needed, your physical therapist will ask you to expand on your answer.

Are you currently sexually active? **NO YES**

If "no", have you been sexually active in the past? **NO YES**

Do you have any communicable diseases? **NO YES**

If "yes", please describe: _____

Has there been any sexual abuse in your past? **NO YES**

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

I understand I can terminate the procedure at any time.

I understand I am responsible for immediately telling my physical therapist if I am having any discomfort or unusual symptoms during the procedure.

I have the option of having a second person present in the room during this procedure and I refuse /choose this option. (please circle one)

I have read this consent form and understand its terms.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____