ART OF HEALING PHYSICAL THERAPY, LLC

119 N. Commercial Street, Suite 1100B
Bellingham, WA 98225
360-303-8353
stacey@artofhealingphysicaltherapy.com

INFORMED CONSENT
FOR
ASSESSMENT AND TREATMENT FOR 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 tests 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 on Obstetrics and Gynecology of the American Physical Therapy Association

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 to me. 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.

The 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 traction 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 therapist at Art of Healing Physical Therapy.

Patient's Printed Name _____ Date: _____

Patient's Signature _____

Witness or Therapist's Signature _____

IF YOU ARE PREGNANT, HAVE INFECTIONS OF ANY KIND, HAVE VAGINAL DRYNESS, ARE LESS THAN 6 WEEKS POST PARTUM OR POST SURGERY, HAVE SEVERE PELVIC PAIN, USING ANY IUD, SENSITIVITY TO KY JELLY, VAGINAL CREAMS OR LATEX, PLEASE INFORM THE THERAPIST PRIOR TO THIS PROCEDURE.