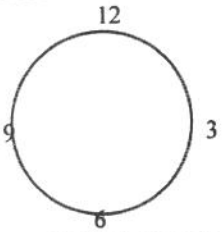
MEMORIAL HEALTHCARE SYSTEM

PELVIC REHABILITATION EVALUATION FORM

Name:_____ Date:_____
Physician's Name:_____ Diagnosis:_____
Subjective Complaint: _____
Onset of complaint:_____
Aggravated by: _____
Eased by:_____
Past Medical History summary: _____
_____
_____
ALLERGIES:_____
MEDICATIONS:_____

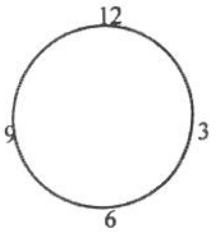
MUSCULOSKELETAL EXAMINATION:
Posture:_____
_____
Pelvic Alignment:_____
_____
Muscle Guarding/Spasm:_____
_____
Skin Condition/Scarring:_____
ROM:_____
Muscle Strength: RUE _____
RLE_____
LUE_____
LLE_____
Trunk _____
ABDOMINALS:
Diastasis Recti: _____
Functional Stability:_____
PELVIC FLOOR
Perineal Descent:_____
Introitus:_____
Skin condition:_____

EXTERNAL PELVIC CLOCK EXAM:



Resting position:_____
Response to cough: ❑ Lift ❑ Bulge ❑ None
Response to contraction ❑ Lift ❑ Bulge ❑ None
Skin integrity/scar:_____
Reflex: anal wink _____ Bulbocavernosus _____
Pain: _____
[+++ = SCAR //// = NUMB X = PAIN ~~ = SPASM]

INTERNAL PELVIC CLOCK EXAM:



Sensation:_____
Vaginal vault: ❑ Loose ❑ Tight ❑ Symmetric ❑Asymmetric
Muscle Bulk:_____
PF Muscle strength: 0 1 2 3 4 5
Symmetry:_____
Hold time:_____ Repetitions:_____
Quick Flicks:_____
Quality of contraction:_____
Specificity:_____

Coordination:_____
Other:_____

ASSESSMENT/PROBLEM LIST: _____

SHORT TERM GOALS:

LONG TERM GOALS:

PLAN OF CARE:

LEARNING BARRIERS IDENTIFIED: ❑ **NONE** ❑Decreased ability/unable to read

- ❑ Non- English speaking
- ❑Unable to comprehend
- ❑ Cognitive/mentally challenged
- ❑Ineffective listening skills
- ❑Poor body awareness
- ❑Cultural/religious norms _____
- ❑Physically challenged _____
- ❑Extremely anxious
- ❑Resistant to self-management ❑Lacking motivation
- ❑Other _____

Methods to overcome barriers:

- ❑ Provide interpreter
- ❑ Speak slowly/clearly facing patient
- ❑ Provide oral instructions/read material to patient
- ❑ Instructions to family member/caregiver/significant other
- ❑Age appropriate instructions
- ❑ Recommend further instructions to reinforce learning _____
- ❑Referral to another discipline _____
- ❑ Other: _____

Pt. learns best through: ❑Reading ❑Demonstration ❑Video/Audiotape ❑Discussion ❑ Don't Know

I, the patient/parent/guardian, understand and agree with the goals of the treatment and plan of care for my treatment. I understand it is my responsibility to advise the therapist of any unexpected changes in the patient's condition, changes in medication, or additional treatments the patient is receiving. I will actively participate in the decision-making process and be involved in the treatments and will express any concerns to the therapist. I acknowledge that I am responsible for the outcome, if the patient/parent/guardian does not comply with the treatment plan.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Charges: _____

Memorial Healthcare System

Patient label