
**Patient Consent for Holistic Pelvic Care™**

Patient Name: _____ Date of Birth:__/___/___
Address:_____
City: _____ State: _____ Zip Code: _____

Home Phone:_____Cell Phone:
_____
Email:_____

What is the primary reason for your visit today?_____
_____
Approx. when did this begin? Month _____ Year _____

How did this begin?_____
_____
Have you received any other treatments or tests for this condition? (If so, please list)_____
_____
What are your goals for treatment today?_____
_____
Please list any other associated medical diagnoses (please also list any treatments for those conditions): _____

**Medical History:**
Primary Care Provider (Midwife or Doctor):_____
Date of last pelvic exam PAP:_____Results:_____
Any past positive PAP? Y / N (please circle one)
Birth History: # of pregnancies_____ # of live births_____ # of miscarriages _____
# of abortions _____
Date/Type of birth (vaginal/cesarean)_____
_____
Please list any pelvic or abdominal surgeries (including DNC due to miscarriage or abortion):_____
Please list types of birth control used/length of time utilized:_____
_____

Please check if you have had any (past or present) and please give a brief description

__ Low back pain_____
__ Pelvic/Abdominal Pain_____
__ Menstrual Pain/PMS_____
__ Prolonged Bleeding/Altered Cycles_____
__ Pain During Sex_____
__ Sexually Transmitted Infections_____
__ Fibroids/Cysts_____
__ UTI/Bladder Infections_____
__ Hemorrhoids _____
__ Constipation/Irritable Bowel Syndrome/Disorder_____
__ Tearing with Birth _____
__ Pregnancy/Childbirth Complications_____
__ Sexual Abuse_____
__ Physical/Other Abuse_____
__ Depression_____
__ Cancer_____
__ Drug Use/Abuse_____
__ Tobacco Use (include # per day) _____
__ Eating Disorder _____
__ Other pertinent information_____

**Patient Consent:**

Payment Information: Payment is due at the time of service.
Cancellation and No Show Policies: There is a 24-hour cancellation notice for all appointments and patient will be charged full appointment price if less notice is given or if patient does not come to appointment. If more then one appointment is cancelled.

Holistic Pelvic Care ™ Treatment: This treatment includes internal vaginal work to assess pelvic musculature health, internal vaginal massage, instruction in pelvic muscle and breathing exercises and other techniques as needed. I understand and consent to these services, to be provided at the discretion of Dr. Kate Smith or Annie Adamson (Holistic Pelvic Care practitioner). I understand there is no guarantee of outcome of any treatment. Clients may experience a range of physical effects such as soreness or bleeding, as well as emotional responses to treatment.

I _____, understand that Dr. Kate Smith is a board certified Doctor of Naturopathy, Holistic Pelvic Care ™ certified, and certified yoga instructor; Annie Adamson is certified in Anusara, Power Vinyasa, haha yoga and Holistic Pelvic Care ™; Winter Pemberton has a bachelor of science degree in Exercise and Movement Science, massage license, Holistic Yoga Therapist™ license, and Holistic Pelvic Care ™ certified.

By signing below, I consent to evaluation and/or treatment of my condition from Dr. Kate Smith, Annie Adamson, or Winter Pemberton (circle the practitioner with which you made your appointment). I understand the nature and purpose of the procedures, evaluation, and course of treatment. I certify that I have read, fully understand and agree to the terms of this consent form.

Client signature:_____Today's Date:_____