



proaxistherapy™
women's health

Patient Name: _____ Date: _____ Dx/ICD9: _____

Phone: (HOME) _____ (CELL) _____ (WORK) _____

Specific Comments: _____

Diagnosis

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Coccydynia | <input type="checkbox"/> Voiding Dysfunction |
| <input type="checkbox"/> Incontinence, Urinary | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Incontinence, Fecal | <input type="checkbox"/> Vaginismus | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Prolapse | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Pre-op _____ | <input type="checkbox"/> Post-op _____ | <input type="checkbox"/> Date of Surgery _____ | <input type="checkbox"/> Other _____ |

Physical Therapy

- Evaluate & Treat Other _____

Physician: _____ Telephone: _____

Signature: _____ Date: _____