Brandi Robertson MSPT

Women's Health Physical Therapy Prescription

Patient Name:______________________**DOB:**____________ **Date:**_______________

Home Phone:____________**Work Phone:**______________**Cell Phone:**____________

Please circle one:
- **Evaluate and treat per therapist discretion**
- **Evaluate and discuss treatment program**
- **Evaluate and give specific treatments (please list below)**

Special Instructions/Diagnostic test results:___________________________________
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Frequency/Duration:_________________________**Date of Onset:**________________

Diagnosis (please circle all that apply):

Genitourinary Disorders:
Female stress incontinence
Female urge incontinence
Mixed incontinence
Fecal incontinence
Hypertonicity/Overactive bladder
Cystocele
Bladder/Detrusor instability
Incomplete Emptying/urinary retention

Pelvic Muscle Dysfunction:
Muscle Spasm
Muscle Weakness

Musculoskeletal Conditions:
Coccyx Hypermobility
Coccydynia
Diastasis Recti
Hip Joint/Pelvis/Thigh Pain
Low Back Pain
SI Dysfunction
Sciatica

Colorectal:
Constipation with muscular outlet obstruction
Proctalgia Fugax/Anal spasm

Pelvic Pain:
Dyspareunia, female
Endometriosis
Interstitial Cystitis
Painful Scar
Pelvic pain
Vaginismus
Vulvodynia/Vestibulitis

Other:___________________

Ordering Physician

Signature:______________________________________**Date:**_________________
Printed Name:____
Office:_______________________ **Phone:**_____________ **Fax** ______________

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