PINNACLE
PHYSICAL THERAPY
SPINE & SPORT

PELVIC REHABILITATION

Patient Name: _____ **DOB:** _____

Patient Phone Number: _____

Special Instructions: _____

_____

☐ Normal Scheduling ☐ Pregnancy

☐ Post-Op

Frequency: _____ *time(s) per week for* _____ *week(s)*

- ☐ **M25.55** Pain In Hip
- ☐ **M35.7** Hypermobility Syndrome
- ☐ **M53.3** Sacrococcygeal Disorders
- ☐ **M54.3** Sciatica
- ☐ **M54.5** Low Back Pain
- ☐ **N39.3** Stress Incontinence
- ☐ **N39.41** Urge Incontinence
- ☐ **N39.46** Mixed Incontinence
- ☐ **N81.84** Pelvic Muscle Wasting
- ☐ **N81.89** Female Genital Prolapse
- ☐ **N94.1** Dyspareunia
- ☐ **N94.2** Vaginismus
- ☐ **N94.6** Dysmenorrhea
- ☐ **N94.819** Vulvodynia
- ☐ **R10.2** Pelvic & Perineal Pain
- ☐ **R15.02** Constipation
- ☐ **R15.1** Fecal Smearing
- ☐ **R15.9** Full Incontinence of Feces
- ☐ Post-Surgical Pain / Rehab
- ☐ Post Cancer Rehab
- ☐ Pregnancy Related Pain
- ☐ Other: _____

_____ _____ _____

Referring Provider Name *Referring Provider Signature* *Date*

LOCATIONS:

☐ *4025 Cherry Ave. N.E. Keizer, OR 97303* **Phone:** 503-390-9009 **Fax:** 503-393-0834

☐ *210 W. Ellendale Ave. Suite 100 Dallas, OR 97338* **Phone:** 503-623-2433 **Fax:** 503-623-2196