HEALTHY CORE
WELLNESS & REHAB, LTD.

PHYSICAL THERAPY WOMEN'S HEALTH REFERRAL

Patient Name: _____

Patient Daytime Phone: _____

Referring Physician Name: _____

Physician Signature: _____

Physician Phone: _____

Diagnosis

Incontinence/Pelvic Pain

- ☐ Pelvic Muscle Weakness
- ☐ Pelvic Muscle Dysfunction/Dyspareunia
- ☐ Pelvic Organ Prolapse:_____
- ☐ Muscle Atrophy
- ☐ Muscle Spasm
- ☐ Stress Incontinence
- ☐ Urge Incontinence
- ☐ Mixed Urinary Incontinence
- ☐ Myofascial Pelvic Pain
- ☐ Scar Adhesions
- ☐ Other: _____

Pregnancy/Postpartum

- ☐ Back Pain
- ☐ Pelvic Pain
- ☐ Diastasis Recti
- ☐ Muscle Weakness
- ☐ Muscle Spasm:_____
- ☐ Scar Restriction - Site:_____
- ☐ Other: _____

Osteoporosis/Osteopenia

- ☐ Bone Building/Fracture Prevention
- ☐ Status Post-Fracture:_____

Other:_____

Physical Therapy Evaluation and Treatment Recommendations

- ☐ Core Strengthening
- ☐ Manual Therapy
- ☐ Other: _____

Patient First Visit Instructions

- ☐ Please complete the Health History Form before your first appointment.
- ☐ Please wear comfortable, loose-fitting clothing.

For An Appointment, Contact:

Healthy Core Wellness & Rehab **Phone:** 330.528.0034 ▪ **Fax:** 330.528.3149

www.healthycorewellness.com