

**Mercier Therapy and Pelvic Nation Informed Consent and Release Form**

I understand that Mercier Therapy is a soft tissue visceral manipulation therapy technique used to help and restore the health and general well-being of the female pelvis. I understand the goal of Mercier Therapy pelvic treatment is to decrease adhesions in and around organs, ligaments, muscles, joints, and support structures of the pelvis, abdomen, hips, and low back. I understand that if I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or application may be adjusted to my level of comfort. I understand that Mercier Therapy or my treatment from a pelvic floor physical therapist should not be construed as a substitute for a medical examination, diagnosis, or prescription. I should see a Gynecologist, Reproductive Endocrinologist, or other qualified medical specialist for any physical ailment or suspected condition I might have. I understand that Mercier Therapy is not intended to take the place of medical/surgical intervention, and my practitioner, Elizabeth Maskell, PT, DPT shall not bear any responsibility for any ill effects should I choose to NOT adhere to my primary doctor’s advice. I understand that the practitioner is not qualified to diagnose, prescribe, or treat any emotional or mental distress, and nothing said in the course of the session (s) given should be construed as such. Because Mercier Therapy is contraindicated (should not be done) under certain medical conditions (IUD, Essure, any present cancer cells),

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there will be no liability on the practitioner, Elizabeth Maskell, PT, DPT should I forget. Supplements recommended or suggested to me are taken/ingested by my choice/decision. I will not hold the practitioner, Elizabeth Maskell, PT, DPT, responsible or liable should I have an adverse or allergic reaction. I understand all supplements should be discontinued at the first determination of pregnancy. I will honor all office policies, including but not limited to payment, cancellation notice, tardiness, and conduct. I understand refunds are not given for any reason. I understand that compliance is necessary for successful treatment progress and results. I understand there is no guarantee of pelvic pain relief or pregnancy. I have read, fully understand, and agree to the above terms and conditions.

PrintName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

Practitioner Name: Elizabeth Maskell, PT, DPT

**Mercier Therapy History and Evaluation**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menarche\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LMP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of periods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of menses \_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Supplements\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past history of oral contraceptive or IUD use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Gynecological Ultrasounds done?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any abnormalities seen on ultrasound?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current complaints of pelvic pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When during cycle is pain noted?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past pelvic or vaginal infections: (if yes, how was it treated)

History of miscarriage or elective abortion: (give dates of occurrences)

Obstetric History- G P ( ) vaginal ( ) c-section

Reported birth trauma:

Gynecological surgical history:

History of sexual abuse:

Abdominal surgical history: (give dates and details)

Urinary surgical history: (give dates and details)

Intestinal problems:

Frequency of bowel movements:  
Any blood noted in BM? ( ) yes ( ) no

History of IVF: (give dates and type of drug used, how many eggs retrieved, how many embryos transferred, outcome)

History of medically assisted fertility cycles: (dates, type of cycle, outcome)

***(For Doctor Use Only):***

Evaluation of general pelvic movement:

Position and mobility of uterus and ovaries:

Comments:

Plan:

Supplements:

Practitioner Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_