PELVIC FLOOR PHYSICAL THERAPY
INITIAL EVALUATION FORM

Caroline Feig, DPT, GCFP | Please complete what feels relevant to you. You may leave any optional item blank.

Name: _____ Date: _____

Date of Birth: _____ Pronouns (optional): _____

1 REASON FOR VISIT

What brings you in for pelvic floor physical therapy?

Was there anything that seemed to coincide with the onset of your symptoms?

Which concerns are you experiencing? Check all that apply.

☐ Urinary leakage
☐ Frequent urination
☐ Incomplete bladder emptying
☐ Constipation
☐ Incomplete bowel emptying
☐ Vaginal/vulvar pain
☐ Abdominal pain
☐ Pelvic heaviness/pressure
☐ Low-back pain
☐ Tailbone pain
☐ Other: _____
☐ Urinary urgency
☐ Difficulty starting urination
☐ Bowel urgency
☐ Straining
☐ Pelvic pain
☐ Rectal pain
☐ Pain with sexual activity
☐ Bulging/prolapse sensation
☐ Hip pain
☐ Abdominal weakness/separation

2 BLADDER

How often do you urinate during the day?

How many times do you typically wake at night to urinate?

Do you experience urinary leakage?

☐ Yes ☐ No

If you experience leakage, when does it occur? Check all that apply.

☐ Coughing/sneezing
☐ Jumping
☐ Walking
☐ Laughing
☐ Lifting
☐ On the way to the bathroom
☐ Running
☐ Exercise
☐ Other: _____

Do you experience a sudden or difficult-to-control urge to urinate?

☐ Yes ☐ No

3 BOWEL

How often do you typically have a bowel movement?

Do you experience any of the following? Check all that apply.

☐ Constipation
☐ Pain with bowel movements
☐ Gas leakage
☐ Incomplete emptying
☐ Straining
☐ Fecal leakage
☐ Bowel urgency

Do you regularly use laxatives, stool softeners, fiber supplements, or other strategies to have a bowel movement?

☐ Yes ☐ No

If yes, please describe (optional).

4 PAIN & PELVIC SYMPTOMS

Do you experience pelvic, genital, abdominal, rectal, hip, low-back, or tailbone pain?

☐ Yes ☐ No

How would you describe the sensation? Check all that apply.

☐ Aching
☐ Sharp
☐ Heaviness
☐ Pulling
☐ Burning
☐ Pressure
☐ Tightness
☐ Other: _____

Do you experience pelvic pressure, heaviness, or a sensation of bulging?

☐ Yes ☐ No

If yes, when is it most noticeable?

5 SEXUAL HEALTH

Do you experience pain or discomfort with sexual activity?

☐ Yes ☐ No

If you would like, please describe anything that may be helpful for your care (optional).

6 PREGNANCY & BIRTH HISTORY

If applicable, please describe any significant pregnancy or birth history.

Examples: tearing, episiotomy, prolonged labor, assisted delivery, Cesarean complications, postpartum concerns.

7 MEDICAL / SURGICAL & HORMONAL HISTORY

Have you had pelvic or abdominal surgery?

☐ Yes ☐ No

If yes, please describe.

Have hormonal changes appeared to affect your symptoms?

☐ Yes ☐ No

If yes or unsure, please describe anything you have noticed (optional).

8 ADDITIONAL INFORMATION

Is there anything else you would like me to know before we meet?