David Stevenson Physical Therapy Inc.
Personal and Professional Care for
Pelvic Floor Rehabilitation

Pelvic Evaluation Form

This assessment form is intended to assist the clinician with the initial patient evaluation and is not meant to be used diagnostically. Please answer the questions thoroughly in order to have efficient time for the PT examination and evaluation.

If you are presenting with pelvic pain symptoms, please answer the following:

- WHAT do you think caused your pain? WHEN did it begin?

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- WHERE did the pain begin? Has it changed or spread?

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- Describe your symptoms? Intermittent or constant symptoms?

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- What makes your symptoms better?

❒Meditation ❒Relaxation ❒Lying Down ❒Laxatives/Enema
❒Bowel Movement ❒Massage ❒Ice ❒ Heat
❒ Walking/Standing ❒Sitting ❒Pain meds ❒ TENS unit
❒ Emptying bladder ❒Stretching ❒ Music ❒ Other_______

___

- What makes your symptoms worse?

❒Intercourse ❒Orgasm ❒Stress ❒Full Meal
❒Bowel Movement ❒Full Bladder ❒Urination ❒ Sitting
❒ Walking ❒Standing ❒Time of Day ❒ Weather
❒ Clothing contact ❒Cough ❒Sneezing ❒ Certain Foods

___

- Rate your average pain levels on a scale of 1-10: ____ / 10
- Are you taking any medications/creams for pain? ___________________
- What activities do your symptoms limit? ___________________

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- Does sitting affect your symptoms? ❒ Yes ❒ No
- How long are able to sit without symptoms? ❒ <10 minutes ❒ 15-30minutes ❒ >30min
- Has walking become painful or difficult due to your symptoms? ❒ Yes ❒ No
- Are you able to walk 1 mile without pain? ❒ Yes ❒ No
- What concerns you the most currently, your limited function or increased pain?

- Any past trauma to your body? (Ex: Fall on tailbone, MVA, sporting accident…)

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- Long-standing orthopedic issues: ____

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- Please list ALL Surgeries and Dates:

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- What past treatments have you had? What has helped, what has not?

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- What physicians or health care providers have evaluated or treated you for your current pelvic condition?

____

- Who is your primary care provider?____
- Do you have any objections to me contacting these healthcare providers? ❒ Yes ❒ No

Urinary:

- Do you leak urine when you cough, sneeze, laugh?
- Do you leak urine when you feel the urge to void/urinate?
- Do you leak urine without realizing it?
- Do you wear pads or panty liners? How many a day?
- Are you able to delay the urge to urinate?
- Difficulty initiating urinary stream?
- Is the stream weak or interrupted?
- How many times/day do you urinate? ❒ 8 or less ❒ 9-15 ❒ > 16
- How many times/night do you urinate? ❒ 0 ❒ 1 ❒ 2 or more
- Pain or burning before, during, or after urinating?
- Do certain foods, beverages, positions, or activities change your urinary function?

Bowel:

- Has the shape or quality of your bowel movements changed recently?
- Do you have a history of constipation and/or IBS?
  If yes, it is currently controlled?
- History of anal fissures or hemorrhoids?
- Any blood present after BM?
- How often do you have a bowel movement?
- Do you strain or push with effort to have a bowel movement?
- Do you experience pain or burning before, during, or after a bowel movement?

Health Habits:

- Do you get regular exercise? ❒ Yes ❒ No
- Would you say you have a healthy and well-balanced diet? ❒ Yes ❒ No
- How many cups of caffeine do you intake a day? (Coffee/tea/soda) ______________________
- Do you smoke? ❒ Yes ❒ No

Women Only:

Number of pregnancies:
C-section or vaginal delivery?
Any complications with pregnancy?
Episiotomy? ❒Yes ❒ No Painful scar tissue? ❒Yes ❒ No
Menopause: ❒Yes ❒ No
Hormone replacement therapy / supplement?

Sexual/Genital:

Are you currently sexually active? ❒Yes ❒ No
Do you have a history of sexual abuse or trauma? ❒Yes ❒ No

- Women:
  - Pain with penetration?
  - Pain w/ deep thrusting or certain positions?
  - Painful or irregular menstrual period?
  - Are you able to achieve orgasm?
  - Pain before, during, after sex/orgasm?
  - Vaginal dryness?
  - Genital or pelvic itching?
  - Frequent UTIs?
  - History of yeast infections?
  - Do you feel a presence of a foreign body in the vagina or as if things are falling out of the vagina?

- Men:
  - Are you able to obtain an erection?
  - Able to ejaculate?
  - Pain before, during, after ejaculation?
  - Change in the quality of your erection and/or ejaculate?
  - Genital or pelvic itching?
  - Tingling/numbness with an erection?
  - History of UTIs?

Additional Comments:____
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