Women's Health Physical Therapy Evaluation Form

Name

Date of Birth

Evaluation Date

Referral Source

Primary Complaint/Reason for Visit

Occupation

Handedness

Relevant Medical/Surgical History

Other Current/Past Medical Conditions

Obstetric History (if applicable)

Gynecologic History

Menstrual History

Sexual History

Current Medications

Pain Description (location, intensity, type)

Symptom Aggravating Factors

Symptom Easing Factors

Bladder Function

Bowel Function

Activities Impacted (functional limitations)

Observation/Posture

Palpation Findings

Range of Motion

Strength

Special Tests

Pelvic Floor Muscle Assessment

Assessment / Impression

Goals

Plan of Care / Recommendations

Therapist Name

Signature

Date