

# Pelvic Floor Exercise Guide

## Step 1: How to find the pelvic floor muscles

**Female:** Imagine the gentle lift you might use to stop the flow of urine. This is only a mental cue to help you find the muscles, not something to practice during bathroom use. The feeling should be light, like lifting upward from the inside.

**Male:** Imagine the subtle lift you might use to prevent passing gas. Think of gently lifting and shortening through the base of the pelvis. This should feel controlled and internal, not like a hard clench.

### Tips for how it should feel:

- ✓ Gentle and controlled, not forceful
- ✓ Breathing stays relaxed
- ✓ Your glutes, thighs, and stomach stay relaxed
- ✓ Less effort is better. If you're unsure, reduce intensity
- ✗ No squeezing, bearing down, or holding your breath

## Step 2: How often and how many

Practicing daily may help support pelvic floor strength.

Begin with gentle contractions, holding for 1-2 seconds, and gradually progress toward a longer hold of up to 10 seconds.

Aim for 8-10 repetitions (reps), and up to 3 sets spread throughout the day.

Start with a gentle lift, fully relax between each repetition, and record your progress. Continue practicing regularly.

## Step 3: Practice log and track your progress

Choose one type of hold for each session: Short (1-2 seconds), Building (3-7 seconds), Long (8-10 seconds).

### Sunday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Monday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Tuesday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Wednesday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Thursday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Friday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Saturday

**Hold Type:** ☐ Short ☐ Building ☐ Long  
**Reps:** \_\_\_\_\_ **Sets:** \_\_\_\_\_

### Always talk to your doctor before starting an exercise program.

Sources: Centers for Disease Control and Prevention (CDC) <https://www.nia.nih.gov/> This material is for general educational purposes only and is not a substitute for medical advice, diagnosis, or treatment. Participants should consult a licensed healthcare provider for personalized assessment or care.

<https://www.niddk.nih.gov/health-information/urologic-diseases/kegel-exercises?>

<https://www.nia.nih.gov/health/bladder-health-and-incontinence/15-tips-keep-your-bladder-healthy>

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# Pelvic Health Checklist & Log



**Share your results with your healthcare provider and let them know you are participating in the SilverSneakers® Pelvic Health program.**

**How to Use this Checklist:** Review each section and check off the habits you already practice. Choose 1-2 new habits to focus on this week.

## Hydration and nutrition

- ☐ Drink water regularly throughout the day
- ☐ Space fluids out instead of drinking large amounts at once
- ☐ Notice how caffeine, alcohol, or acidic foods affect you
- ☐ Eat fiber-rich foods to support digestion

## Lifestyle and movement

- ☐ Stay physically active most days of the week
- ☐ Practice pelvic floor exercises with breathing
- ☐ Maintain a healthy weight
- ☐ Avoid smoking

## Bathroom habits

- ☐ Respond to urges without rushing or delaying
- ☐ Sit comfortably and relax when using the toilet
- ☐ Allow time to empty the bladder fully
- ☐ Avoid pushing or straining

## When to talk with a healthcare provider

- ☐ Ongoing discomfort or pain
- ☐ Changes in bladder control
- ☐ Questions or concerns about symptoms

Healthy habits may support comfort, confidence, and overall well-being. Staying hydrated, following healthy bathroom routines, and maintaining an active lifestyle may help support normal bladder function and reduce common concerns. Progress takes time and looks different for everyone.

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<https://www.niddk.nih.gov/health-information/urologic-diseases/kegel-exercises?>

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# Pelvic Health Checklist & Log

**How to Use this Log:** Track your fluid intake, bathroom visits, urges, and activities over seven days. Tracking may help you better understand your habits and identify patterns you may want to discuss with your healthcare provider.

|       | Time of Day    | Drinks<br>(what and how much) | Bathroom Trip?                                           | Strong Urge?                                             | What were you doing at the time?<br>(walking, sitting, lifting, bending, coughing, getting up from a chair) |
|-------|----------------|-------------------------------|----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| DAY 1 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
| DAY 2 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
| DAY 3 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
| DAY 4 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |

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# Pelvic Health Checklist & Log

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|-------|----------------|-------------------------------|----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| DAY 5 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
| DAY 6 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
| DAY 7 | Morning        |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Morning   |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Afternoon      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Late Afternoon |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |
|       | Sleep Time     |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                             |

Based on tracking, one topic I would like to discuss with my healthcare provider is:

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