

# in Touch

## Physical Therapy Pelvic Floor Therapy Questionnaire

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What brings you here for treatment today? \_\_\_\_\_

When did this begin? \_\_\_\_\_

Please fill in the following questionnaire to the best of your ability. Your therapist will review the answers with you, and help you answer any questions that are confusing. Thanks for taking time to fill out this questionnaire!

### History

Number of Pregnancies: \_\_\_\_\_

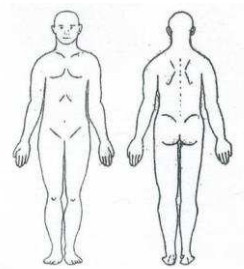
Number of Live Births: \_\_\_\_\_

### Birth History:

    Date         2<sup>nd</sup> Stage/Pushing duration         C-Section/Vaginal         Baby weight         Maternal/ Baby Trauma    

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Did you have any trouble healing after a delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular periods/menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N
Do you have a history of endometriosis, fibroids, cysts?	Y	N

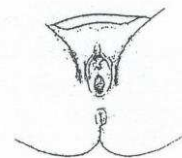


### Pain

Rate your pain with each activity on the Pain Scale 0-10:  
(0 = no pain, 10 = need to seek urgent medical attention)

Do you have pain with :			<b>0</b>		<b>10</b>
Sexual intercourse	Y	N	I-----I		
Pelvic Exam	Y	N	I-----I		
Tampon Use	Y	N	I-----I		
Other _____	Y	N	I-----I		
Do you have back, leg, groin, abdominal pain? (Circle One)			I-----I		

Indicate area of pain on figure above and below.



### Test results

Urodynamics test	Y	N	~date/results: _____
Cystoscopy	Y	N	~date/results: _____
Urine tests	Y	N	~date/results: _____
Bowel tests	Y	N	~date/results: _____
X-Ray, MRI, CT Scan	Y	N	~date/results: _____

### Bladder Symptoms:

Do you wet the bed?	Y	N	Do you have a "falling out feeling?"	Y	N
Have burning/pain with urination?	Y	N	Feel unable to empty bladder?	Y	N
Strain to empty your bladder?	Y	N	Difficulty starting stream of urine?	Y	N
Have a frequent, strong urge to urinate?	Y	N	Have pain with a full bladder?	Y	N
~Number of times you urinate during day: _____			~Number of times you urinate at night: _____		
~If you leak, how much do you leak?					
_____ droplets			_____ need to change underwear		
			_____ need to change pad.		

Do you lose urine when you:

Cough/sneeze/laugh?	Y	N	Feel nervous or anxious?	Y	N
Have intercourse?	Y	N	Lift/exercise/dance/jump?	Y	N
Walk to the bathroom?	Y	N	Hear running water?	Y	N
Enter your home/key in the door?	Y	N	Running?	Y	N
Other _____					

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## Physical Therapy

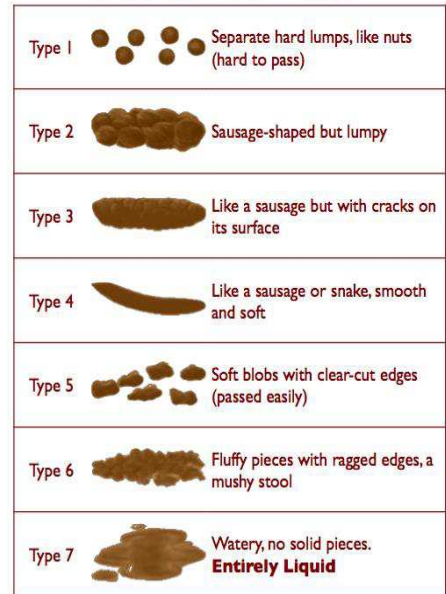
### Bowel Symptoms

Leak/stain feces? Y N  
Leak gas by accident? Y N  
Strain to have a bowel movement? Y N  
Have pain with bowel movement? Y N  
Have frequent, strong urges to move bowels? Y N  
Take laxatives/enema regularly? Y N  
How often do you move your bowels: \_\_\_\_\_ per day, week  
Most common stool consistency:  
(circle on Bristol Stool Chart at right)

What makes your symptoms (bladder, bowel or pain) better?

\_\_\_\_ Heat/Ice                      \_\_\_\_ Medication  
\_\_\_\_ Nighttime                      \_\_\_\_ Position Changes  
\_\_\_\_ Resting                              \_\_\_\_ Sitting  
\_\_\_\_ Standing                              \_\_\_\_ Walking  
Other: \_\_\_\_\_

### Bristol Stool Chart



### General Health History

Have you had any of the following in the past 2 weeks?

Sleep disturbance                      Night sweats                      Night pain                      Weakness  
Numbness                                  Dizziness                              Tingling                              Fatigue  
Headaches                                  Swelling                                  Vomiting                              Abdominal pain  
Nausea    Fever    Chills                                      Unexplained weight loss/gain

Have you ever been diagnosed with any of the following conditions?

Diabetes    Y      N      Smoking Habit    Y      N  
Osteoporosis                                      Y      N      Cancer:    Y      N  
Heart Problems                                      Y      N      Type \_\_\_\_\_ Date \_\_\_\_\_  
Fibromyalgia    Y      N      Treatment Type(s): \_\_\_\_\_  
Stroke    Y      N      \_\_\_\_\_

List **ALL** SURGERIES/INJURIES/MEDICAL CONDITIONS

**Date:**                      **Injury/Surgery/Medical Conditions:**                      **Reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which of the following **Over-the-Counter** and **Prescription** medications have you taken in the past **3-4 weeks**?  
Please list how many.

**Prescription Medications** \_\_\_\_\_

**Over-The-Counter Medications/Supplements** \_\_\_\_\_

**Do you have any product allergies?** ie. Latex etc. *please list* \_\_\_\_\_

**How would you rate your general health?**                      Poor / Fair / Good / Excellent

What do you hope to achieve when you are finished with physical therapy?

\_\_\_\_\_  
**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_