Pelvic Floor Questionnaire

Name______________________________________ Age________ Date______________

1. Was there a specific trigger/event associated with your symptoms? __________________
   If so, please describe the incident ____
   ____

2. Since then, your symptoms have: stayed the same ___________ worsened ___________
   improved _________ (check/circle one). If worsened or improved, how? ______________
   ____

3. If applicable, please describe any previous treatments you have received: ___________
   ____
   ____

4. Activities/events that cause or aggravate your symptoms. Check/circle all that apply:
   ____ Sitting greater than ______ minutes
   ____ Walking greater than ______ minutes
   ____ Standing greater than ______ minutes
   ____ Changing positions (i.e. sit ←→ stand)
   ____ Light activity (i.e. regular chores)
   ____ Vigorous activity/exercise (running, jumping, etc.)
   ____ Sexual activity
   ____ With cough/sneeze/straining
   ____ With laughing/yelling
   ____ With lifting/bending
   ____ With cold weather
   ____ With triggers (i.e. running water)
   ____ With nervousness/anxiety
   ____ Nothing affects the problem
   ____ Other, please specify: ____

5. How has your lifestyle/quality of life been altered/changed because of this problem?
   Social activities (exclude physical activities), specify ___________________________
   ____
   Diet /Fluid intake, specify ____
   Physical activity, specify ____
   Work, specify ____
   Other ____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling
Y/N Other /describe ____
____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____
Y/N Episiotomy #_____
Y/N C-Section #_____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _________
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Other: ____

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other: ____

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other: ____

1. Frequency of urination: awake hour's times per day, sleep hours times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ______ minutes, ______ hours, ______ not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements times per day, times per week, or _______________.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? ______ minutes, ______ hours, ______ not at all.
6. If constipation is present describe management techniques ___________________________
7. Average fluid intake (one glass is 8 oz or one cup) glasses per day.
   - Of this total how many glasses are caffeinated? ______ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for minutes or hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

10b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying

11. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other: ____
On average, how many pad/protection changes are required in 24 hours? _______ # of pads

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PELVIC FLOOR EXAMINATION AND TREATMENT CONSENT FORM

I, ______________________________ do / do not (circle one) consent to receiving **external** pelvic floor examination/treatment which may include, but is not limited to*:

- Visual Assessment
- Skin Assessment
- Palpation
- Pelvic Floor Reflex Test
- Muscle Strength Testing

I, ______________________________ do / do not (circle one) consent to receiving **internal** pelvic floor examination/treatment which may include, but is not limited to*:

- Palpation
- Muscle Strength Testing
- Prolapse Assessment

I, ______________________________, for **internal** examination/treatment would like/ would not like (circle one) a second person in the room. If you choose to have a seconds person, you consent to bringing second persons for your sessions:

____*

(name and relation)

*AMA recommends that the second person be a non-family member.

*Upon signing this form, you are consenting to any examination/treatment listed here, as well as any examination/ treatment that the therapist has deemed necessary.

Sign: ____ Date: ________________________