PEDIATRIC PELVIC FLOOR HEALTH QUESTIONNAIRE

Child's Legal Name: ___________________________ Preferred name: ______________ Date: _______________
DOB: ________________ Age: ___________ Grade: ______________ Height: _________ Weight: _________
Primary physician: ____________________________ Referring physician: __________________________________
Name of person completing this form: ___________________________ Relationship to child: _______________

Describe the reason for your child's appointment (your main complaint/problem): _________________________
____

How would your child rate his/her feelings as to the severity of this problem? With 0 being "Not a problem" and 10 being "Major problem"? _______________

When did the problem begin? _________________ Is it better, worse, or staying the same? ________________

Has there been prior treatment or tests for the condition for which your child is coming to therapy? YES or NO
If yes, please describe and be sure to list tests and results? ____
____

Date of child's last doctor visit :_______________________ Date of last urinalysis: _________________________

Has your child stopped or been unable to do certain activities because of their condition? (For example: embarrassed to play with friends, can't go to sleepovers, feels ashamed about leakage and avoids play dates)
____
____

Rate the following statement: My child's bladder/bowel condition is controlling his or her life. With 0 being "Not true at all" and 10 being "Completely true"? _______________

What are you currently doing to manage your child's condition? ____
____

MEDICAL HISTORY (Place a check mark next to any your child now has or has had):

__ Pelvic pain	__ Kidney infections	__ Asthma	__ Sexual abuse
__ Low back pain	__ Diabetes	__ Seizures	__ Neurologic issues
__ Blood in urine	__ Bladder infections	__ Physical abuse	__ Vesicoureteral reflux Grade ____
__ Other ____________			

**Explain any of the check marked conditions above & include dates: ____________________________________
____

Does your child need to be catheterized? YES NO If yes, how often? ______________________________

ALLERGIES: Does your child have any allergies? YES NO If yes, please list what they are allergic to and the reaction(s) they have had: ____
____

MEDICATIONS: Please list all of your child's present medications/vitamins/supplements (include date medication was started & reason for taking).____
____

SURGICAL HISTORY: Have you ever had any operations? YES NO

If yes, please list the TYPE of surgery, REASON for surgery, and DATE of surgery

____

____

SECTION A: BLADDER HABITS and SYMPTOMS

1. How often does your child urinate during the day? ___________times per day, every ________ hours.
2. How often does your child wake up to urinate after going to bed? ___________times
3. Does your child awaken wet in the morning? YES NO If yes, ___________days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? YES NO
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)
   NOT AT ALL 1-2 MINUTES 3-10 MINUTES 11-30 MINUTES 31-60 MINUTES HOURS
6. Does your child take time to go to the toilet and empty their bladder? YES NO
7. Does your child have difficulty initiating the urine stream? YES NO
8. Does your child strain to pass urine? YES NO
9. Does your child have a slow, stop/start, or hesitant urinary stream? YES NO
10. Is the volume of urine passed usually (circle one): LARGE AVERAGE SMALL VERY SMALL
11. Does your child have the feeling their bladder is still full after urinating? YES NO
12. Does your child have any dribbling after urination (ie: once they stand up from the toilet)? YES NO
13. What is your child's fluid intake (one glass is 8 oz or one cup)
    ____ of glasses per day (all types of fluid) ____ of caffeinated glasses per day
    What are the typical types of drinks your child consumes? ____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet (ie: running water, etc)? YES NO Please explain ____
15. Does your child experience bladder leakage (circle all that applies)?
    NEVER WHEN PLAYING WHILE WATCHING TV/PLAYING VIDEO GAMES WITH STRONG URGE TO GO
    WITH STRONG COUGH/SNEEZE/PHYSICAL EXERCISE NIGHTTIME SLEEP WETTING
16. What is the frequency of your child's urinary leakage (answer in number of episodes)?
    ___ # PER MONTH ___ # PER WEEK ___ # PER DAY ___CONSTANT LEAKAGE
17. What is the severity of the leakage (circle one)?
    NO LEAKAGE FEW DROPS WETS UNDERWEAR WETS OUTER CLOTHING
18. Does your child wear any protection for the leakage (circle all that apply)?
    NONE TISSUE PAPER PAPER TOWEL DIAPER PULL-UPS

SECTION B: BOWEL HABITS and SYMPTOMS

1. What is your child's frequency of bowel movements? ___ per day ___ per week
2. What is the consistency of your child's stools (circle one)? LOOSE NORMAL HARD
3. Does your child currently strain to go? YES NO
4. Does your child ignore the urge to defecate? YES NO
5. Does your child have fecal staining on his/her underwear? YES NO If yes, how often? ______________
6. Does your child have a history of constipation? YES NO
   If yes, how long has it been a problem? ____
7. Does your child experience bowel leakage (circle all that applies)?
   NEVER WHEN PLAYING WHILE WATCHING TV/PLAYING VIDEO GAMES WITH STRONG URGE TO GO
   WITH STRONG COUGH/SNEEZE/PHYSICAL EXERCISE
8. What is the frequency of your child's bowel leakage (answer in number of episodes)?
   ___ # PER MONTH ___ # PER WEEK ___ # PER DAY
9. What is the severity of the leakage (circle one)?
   NO LEAKAGE STOOL STAINING SMALL AMOUNT IN UNDERWEAR COMPLETE EMPTYING
10. Does your child wear any protection for the leakage (circle all that apply)?
    NONE TISSUE PAPER PAPER TOWEL DIAPER PULL-UPS