

Pediatric Pelvic Floor Health Questionnaire



Date: _____ Date of Birth: _____

Patient's Name: _____

School Grade: _____ Height: _____ Weight: _____

Father's Name: _____ Mother's Name: _____

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? (*0 being not a problem and 10 being a 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 your child is coming to therapy for? YES / 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? (*Embarrassed to play with friends, can't go to sleepovers, feels ashamed about leakage*): YES / NO

If yes, please explain: _____

Rate the following statement: "My child's bladder/bowel condition is controlling his/her life." (*0 being not true at all and 10 being completely true*): _____

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

Medical History: *Please check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic Issues |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Vesicoureteral reflux |
| <input type="checkbox"/> Other: _____ | | | |

Explain any of the check marked conditions above: _____

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 current medications/vitamins/supplements (*include start date and reason for taking*): _____

Surgical History:

Has your child ever had any operations? YES / NO - If yes, please list the type, reason, 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. Usual size/volume of urine passed: *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 (*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.*) And # ____ of caffeinated glasses per day.

14. Does your child have “triggers” that make him/her feel like he/she can’t wait to go to the toilet (*running water, etc.*)? YES / NO - If yes, please explain: _____

15. Does your child experience bladder leakage? YES / NO - If yes, *please check all that apply*

- While exercising
- When playing
- Nighttime (sleep wetting)
- With strong urge to go
- With strong cough/sneeze
- While watching TV/Playing video games
- Other: _____

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? YES / NO - If yes, *please check all that apply*

- While exercising
- When playing
- Nighttime (sleep wetting)
- With strong urge to go
- With strong cough/sneeze
- While watching TV/Playing video games
- Other: _____

8. What is the frequency of your child's bowel leakage? (Answer in number of episodes)
___ # PER MONTH ___ # PER WEEK ___ # PER DAY ___ CONSTANT LEAKAGE

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