PEACEFUL PELVIS
PHYSICAL THERAPY

Pelvic Floor Therapy Questionnaire

Patient name _____ Date _____

Please fill in the following questionnaire to the best of your ability.

History:

- Number of pregnancies _____ Number of vaginal deliveries _____
- Dates of delivery: _____
- Birth weight of largest baby _____ Number of cesarean deliveries _____
- Number of episiotomies/tears _____ Date of last pap smear _____
- Are you currently sexually active? YES/ NO
    - Partner: Male/ Female
- Did you have any trouble healing after delivery? YES/ NO
    - If yes: from a vaginal delivery or C-section? (circle one)
- Do you have a history of sexual abuse or trauma? YES/ NO
- Do you have a history of falls on your tailbone? YES/ NO
- Are you having regular periods/ menstrual cycles? YES/ NO
- Are your periods painful? YES/ NO
    - Date of last menstrual period _____
    - General length of cycle_____
- Do you have frequent urinary tract infections? YES/ NO
- Previous surgeries:
- Other medical history:
    - Cardiac
    - Endocrine
    - Pulmonary
    - Cancer

Pain

Do you have...

- Pain with vaginal penetration? YES/ NO
- Pain with pelvic exams? YES/ NO
- Pain with tampon use? YES/ NO
- Pain in the back, leg, groin, abdomen, elsewhere? YES/ NO

Test results

- Urodynamics test_____
- Cystoscope_____
- Urine test_____
- Bowel test_____

Thank you for taking the time to fill out this questionnaire.

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Bladder symptoms

Do you lose urine when you...

- Cough/ sneeze/ laugh? YES/ NO
- Lift/ exercise/ dance/ jump? YES/ NO
- On the way to the bathroom? YES/ NO
- Have a strong urge to urinate ? YES/ NO
- Hear running water? YES/ NO
    - Other triggers_____ YES/ NO

Do you have...

- Burning/ pain with urination? YES/ NO
- Difficulty starting a stream of urine? YES/ NO
- Spraying instead of a stream of urine? YES/ NO
- Straining to empty your bladder? YES/ NO
- Inability to empty bladder fully? YES/ NO
- A feeling like your "organs falling out" of you? YES/ NO
- Pain with a full bladder? YES/ NO
- Urgency of urination (a strong urge to urinate)? YES/ NO
- The need to urinate more than 7 times/day? YES/ NO
- Incidents of bed wetting? YES/ NO

Bowel symptoms

Do you have...

- Straining to have a bowel movement? YES/ NO
- Leakage or staining of feces? YES/ NO
- Frequent diarrhea? YES/ NO
- Accidental leakage of gas? YES/ NO
- Pain with bowel movements? YES/ NO
- Bleeding with bowel movements? YES/ NO
- A very strong urge to move your bowels? YES/ NO

Do you include fiber in your diet? YES/ NO

Do you take laxatives / enemas regularly? YES/ NO

How often do you move your bowels?

- _____ per day/ week (circle one)

Most common stool consistency

- ____ liquid ___ soft ___ firm ___ pellets ___ other _____

Thank you for taking the time to fill out this questionnaire.