



## Pelvic Floor Therapy Questionnaire

Patient name \_\_\_\_\_ Date \_\_\_\_\_

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

### History:

- Approximate date the current problem began \_\_\_\_\_
- Medical history:
  - Cardiac
  - Endocrine
  - Pulmonary
  - Cancer
- Previous surgeries: \_\_\_\_\_
- Do you have frequent urinary tract infections? YES/ NO
- Do you have a history of falls on your tailbone? YES/ NO
- Are you currently sexually active? YES/ NO
  - Partner: Male/ Female
- Do you have a history of sexual abuse or trauma? YES/ NO

### Pain

Do you have...

- Pain in the back, leg, groin, abdomen, elsewhere? YES/ NO

### Test results

- Urodynamics test \_\_\_\_\_
- Urine test \_\_\_\_\_
- Cystoscope \_\_\_\_\_
- Bowel test \_\_\_\_\_

### 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

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



Do you have...

- Burning/ pain with urination? YES/ NO
- Difficulty starting a stream of urine? YES/ NO
- Spraying of urine instead of a stream? 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
- A very strong urge to move your bowels? YES/ NO
- Bleeding with bowel movements? 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

Most common stool consistency

- \_\_\_\_ liquid \_\_\_\_ soft \_\_\_\_ firm \_\_\_\_ pellets \_\_\_\_ other \_\_\_\_\_

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