PELVIC FLOOR QUESTIONNAIRE

Date:________________________

Name of referring MD: ________________________________________________________________

May we leave a phone message regarding your therapy? ______________________________________

Pain Check all that apply □ Not applicable (skip to next section)

Location of pain: _________________________________________________________________

Activities/events that cause or aggravate your symptoms.

□ Sitting greater than ______ Minutes
□ Walking greater than ______ Minutes
□ Standing greater than ______ Minutes
□ Changing positions (i.e., sit/stand)
□ Light activity (light housework)
□ Vigorous activity/exercise (run/weigh lifting/jumping)
□ Other, please list _______________________________________________________________

Pelvic Symptoms

Voiding Habits
1. Number of times urinating in a 24 hour period? _______________
2. Number of times getting up at night to urinate? _______________
3. Number of times bowel movement? ___________ per day/week

Urinary Symptoms □ Not applicable Bowel Symptoms □ Not applicable

□ Urgency with or preceding urination
□ Trouble initiating urine stream
□ Urinary intermittent/slow stream
□ Trouble emptying bladder
□ Dribbling after urination leakage
□ Constant urine leakage
□ Blood in urine
□ Painful urination
□ Trouble feeling bladder urge/fullness
□ Recurrent bladder infections

Do you sense when you’ve lost urine? Yes □ No □
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Bladder leakage-number of episodes
☐ No leakage
☐ Only with physical exertion/cough
Times per day ________
Times per week ________
Times per month ________

Bowel leakage-number of episodes
☐ No leakage
☐ Stool straining
☐ Small amount in underwear
☐ Complete

On Average, how much urine do you leak?
☐ No leakage
☐ Just a few drops
☐ Wets underwear
☐ Wets outerwear
☐ Wets floor

What form of protection do you wear? (Check all that apply)
☐ None
☐ Minimal protection (Tissue paper/paper towel/panty liner)
☐ Moderate protection (Absorbent product, maxi pad)
☐ Maximum protection (Speciality product/diaper)

Sexual symptoms
☐ Not applicable
☐ Currently sexually active
☐ Pain associated with sex

What are your treatment goals? ________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Fluid Intake
# of 8 oz glasses of water per day?______________________________________
# of cups of caffeinated drinks per day? _________________________________
Amount of alcohol consumed in a typical week? __________________________
General History

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
Yes □ No □

During the past month have you been feeling down, depressed, or hopeless?
________________________________________________________________________________________

During the past month, have you been bothered by having little interest or pleasure in doing things?

Current level of stress? □ High □ Med □ Low

(Females Only)
Last date of last pelvic exam? _______________________________________________________________
□ Children by vaginal deliveries # ___________________________________________________________
□ Episiotomy # ____________________________________________________________
□ C-Section # ____________________________________________________________
□ Abdominal or pelvic surgeries # ________________________________________________________
□ Vaginal dryness
□ Painful periods
□ Menopause-when? _________________________________________________________________

(Males only)
Last date of prostate exam? _____________________________________________________________
□ Prostate disorders
□ Erectile dysfunction
□ Painful ejaculation
□ Abdominal or pelvic surgeries? ________________________________________________________