Bedford Orthopaedic Health Centre-Physiotherapy – Maria Radelich, PT

PELVIC FLOOR PHYSIOTHERAPY

200-1093 Bedford Highway
Bedford, NS B4A 1B7
Tel # 902.835.1932 Fax # 902.832.1374 Email: mariaradelich@gmail.com

SYMPTOMS QUESTIONNAIRE

Name: _____ Date: _____ Describe the reason for your appointment: _____

When did this problem begin?: _____ Is it getting better (circle) Yes or No, Worse? _____

Staying the same? _____ List activities or thins that you cannot do because of this problem: _____

1. **Bladder leakage, frequency – number (#) of episodes:** ***(check one)***
   a. ____ Never
   b. ____ Only with strong cough/sneeze
   c. ____ Only premenstrual
   d. ____ # per month
   e. ____ # per week
   f. ____ # per day
   g. ____ Constant leakage

2. **Severity of leakage** ***(check one)***
   a. ____ No leakage
   b. ____ Few drops
   c. ____ Wets underwear
   d. ____ Wets outerwear

3. **Protection Worn** ***(check one)***
   a. ____ None
   b. ____ Tissue paper / paper towel
   c. ____ Pantishields
   d. ____ Minipads
   e. ____ Maxipads
   f. ____ Diaper
   g. Specialty product name: _____

4. **Leakage caused or increased by** ***(check all that apply)***
   a. ____ Vigorous activity or exercise (running, weight lifting)
   b. ____ Light activity (walking, light housework)
   c. ____ Changing positions (sit to stand)
   d. ____ Walking to the toilet
   e. ____ Strong urge "to-go"
   f. ____ Intercourse or sexual activity
   g. ____ No activity changes leakage (constant despite activity)
   h. Other, please list: _____

5. **Position or activity with leakage** ***(check all that apply)***
   a. ____ Lying down
   b. ____ Sitting
   c. ____ Standing

6. **How long can you delay the need to urinate?** ***(check one)***
   a. ____ Not at all
   b. ____ 1-2 Minutes
   c. ____ 3-10 Minutes
   d. ____ 11-30 Minutes
   e. ____ 31-60 Minutes
   f. ____ How many hours

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Name: _____ Date: _____

7. **Rate a feeling of "falling out" or pelvic heaviness/pressure**
   a. ____ None present
   b. ____ Times per month
   c. ____ Only with menstruation
   d. ____ With standing
   e. ____ With exertion or straining
   f. ____ At the end of each day
   g. ____ Present all day

8. **Fluid intake (one glass is 8 oz. or one cup)**
   a. ____ Glasses per day
   b. ____ Number of caffeinated glasses per day
   c. ____ Number of alcoholic glasses per day

9. **Rate your feelings as to the severity of this problem from 0-10 with 10 being the worst:** _____ **(0-10)**

10. **Rate the following statement as it applies to you today: My bladder is controlling my life:** _____ **(0-10)**

BLADDER HABITS

1. How often do you urinate during the day? _____ *(# of times)*
2. How often do you urinate after going to bed? _____ *(# of times)*
3. Do you take the time to go to the toilet and empty your bladder? _____ *(yes or no)*
4. Number of bladder infections in the last year? _____
5. Can you stop the flow of urine when on the toilet? _____ (yes or no)
6. Is the volume of urine passed usually: _____ Small _____ Large _____ Average _____ Very Small *(check one)*
7. Do you have the sensation that you need to go to the toilet? _____ *(yes or no)*
8. Do you strain to pass urine? _____ *(yes or no)*
9. Do you empty your bladder frequently, before your experience the urge to pass urine? _____ *(yes or no)*
10. Do you have the feeling your bladder is still full after urinating? _____ *(yes or no)*
11. Do you have a slow or hesitant urinary stream? _____ *(yes or no)*
12. Do you have difficulty initiating the urine stream? _____ *(yes or no)*
13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.)
    _____ *(yes or no, please list)*

BOWEL HABITS

14. Frequency of bowel movements: _____ per day, _____ per week *(# of times)*
15. Consistency of stool: _____ loose, _____normal, _____hard_____ *(check one)*
16. History of constipation? _____ *(yes or no)*
17. Do you currently strain to go? _____ *(yes or no)*
18. Do you ignore the urge to defecate? _____ *(yes or no)*
19. Do you have trouble making it to the toilet on time when you have an urge to go? _____ *(yes or no)*

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INCONTINENCE SCREENING QUESTIONAIRE

Answering the following questionnaire will help us to manage your care better. Please complete all pages prior to your appointment.

Name: _____ Date: _____ Age: _____ Height: _____ Weight: _____
Date of last Doctors visit: _____ Last Pelvic Exam: _____ Last Urinalysis: _____ Previous tests for the condition for which you are coming to physical therapy?: _____ Please list test: _____

Do you know how or have you had a history of the following: Explain yes responses and include dates.
(Circle Y-yes or N-no)

Y / N - Bladder infections
Y / N - Pelvic pain
Y / N - Low back pain/sciatica
Y / N - Diabetes
Y / N - Multiple Sclerosis
Y / N - Stroke
Y / N - Allergies
Y / N - Asthma
Y / N - Childhood bladder problems
Y / N - Trouble holding back gas
Y / N - Trouble initiating urine stream
Y / N - Vaginal dryness
Y / N - Trouble emptying bladder
Y / N - Constant dribbling of urine
Y / N - Other *(please list):* _____

Y / N - Constipation
Y / N - Joint problems
Y / N - Abdominal pain
Y / N - Broken bones
Y / N - Heart disease
Y / N - Emphysema/Bronchitis
Y / N - High blood pressure
Y / N - Sexually transmitted disease
Y / N - HIV/Aids
Y / N - Fecal incontinence
Y / N - Smoking habit
Y / N - Blood in urine
Y / N - Trouble feeling bladder fullness
Y / N - Bladder cancer

Explanation of the above responses:

_____
_____
_____
_____

Surgical History

Y / N - Surgery of your back/spine
Y / N - Surgery of your brain
Y / N - Surgery of your female organs
Y / N - Other type please describe: _____

Y / N - Surgery of bladder
Y / N - Surgery for prostate
Y / N - Surgery for abdominal organs

Ob/Gyn History (females only)

Y / N - Painful periods
Y / N - Painful penetration
Y / N - Vaginal deliveries # _____
Y / N - Prolapse or falling out feeling

Y / N - Menopause, Date of last period: _____
Y / N - C-Section # _____
Y / N - Episiotomy # _____
Y / N - Difficult childbirth

Explain yes responses: _____
_____

Medications *(List)*	Start Date	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____