Integrated Physical Therapy of Colorado, P.C.

Pelvic Floor Screening Questionnaire

Name: _____Date:_____

Do you have or have you had a history of the following?

Y/N Bladder infections
Y/N Pelvic Pain
Y/N Painful intercourse
Y/N Low back pain
Y/N Received/receiving radiation
Y/N Menopause
Y/N Abdominal pain
Y/N Cancer
Y/N Sexually transmitted disease
Other_____
_____
Please explain your "yes" responses and provide dates:_____

Bladder Habits:

Have you experienced any of the following **bladder/bowel** problems?

Y/N Trouble initiating urination
Y/N Intermittent or slow urinary stream
Y/N Difficulty emptying bladder
Y/N Strain or push to empty bladder
Y/N Constipation/straining to empty
Y/N Loss of bowel control
Y/N Painful urination
Y/N Dribbling after urination
Y/N Difficulty sensing urinary urge
Y/N Blood in urine
Y/N Difficulty holding back gas

1. Do you lose urine with any of the following:

	Always	Sometimes	Amount
• Coughing, sneezing, laughing	_____	_____	_____
• Light exercise (walking, housework)	_____	_____	_____
• Active exercise (running, aerobics, etc.)	_____	_____	_____
• When you have a strong urge	_____	_____	_____
• Hear running water, see a bathroom, putting the key in the door, etc.	_____	_____	_____
• Nervousness or anxiety	_____	_____	_____
• Without cause	_____	_____	_____

2. Do you use protective pads?_____ What type?_____ Number per day?_____
3. How often do you urinate each day?_____Frequency?_____
   At night?_____

4. Do you urinate before you feel the urge in order to stay dry?_____
5. How many glasses of fluid do you drink each day?_____Type? (i.e. citrus juice, soda, water, etc.)_____ How many are caffeinated?_____
6. Do you rush to the bathroom when you have an urge to urinate?_____

Bowel Habits:
1. How often do you have a bowel movement?_____
2. If you have constipation how do you manage it?_____
4. Is your stool consistency: loose_____normal_____hard_____

Pelvic Pain (Male and female):
1. What activities increase your pain? (i.e. intercourse, sitting, bowel movements, constipation, urination, etc.)

_____

2. How would you describe your pain? (i.e. shooting, throbbing, sharp, burning, cramping, stabbing, etc.) _____

_____

3. Do you have other concerns or problems?_____

_____

OB-GYN History:
1. # of pregnancies_____ # of births_____ # vaginal deliveries _____
   # C-sections_____
2. Were there any complications? (i.e. episiotomy, suction, forceps, breech, etc)

_____

3. Do you experience a sensation of "falling out" or pressure vaginally?_____
4. Have you ever been physically_____ sexually_____ emotionally abused?_____

Please mark an "X" along the line at the point that best represents the **overall severity of your problem** (how much it bothers or hurts you).

0 (no problem) 5 10

5. Please list the history of your problem, including dates, treatments, and medications you have used and if they were helpful or not.

_____

_____

_____

6. What was the date of your last pelvic exam? _____
7. What are your current exercise programs and hobbies?

_____

_____

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