Integrated Physical Therapy of Colorado, P.C.

Pelvic Floor Screening Questionnaire

Name: _____ Date:_____

Please mark an "X" along the line at the point that best represents the **overall severity of your problem**. In other words, how much does your problem bother or hurt you:

0 ---------- 5 ---------- 10

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

Yes No Low back pain
Yes No Pelvic pain
Yes No Painful intercourse
Yes No Emotional Abuse
Yes No Sexual Abuse
Yes No Physical Abuse
Yes No Menopause
Yes No Abdominal pain
Yes No Cancer
Yes No Sexually transmitted disease
Yes No Bladder infections
Yes No Received/receiving radiation
Other: _____

Please explain your "yes" responses and provide dates: _____
_____

Bladder Habits:
Have you experienced any of the following **bladder** problems?

Yes No Trouble initiating urination
Yes No Intermittent or slow urinary stream
Yes No Difficulty emptying bladder
Yes No Strain or push to empty bladder
Yes No Rushing to bathroom to urinate with urge
Yes No Painful urination
Yes No Dribbling after urination
Yes No Difficulty sensing urinary urge
Yes No Blood in urine

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

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

2. Do you use protective pads? _____ What type? _____ Number per day? _____

3. How many times do you urinate each day? _____ How often? _____
4. How many times do you urinate at night? _____
4. Do you urinate before you feel the urge in order to avoid leaking? _____
5. How much and what types fluid do you drink each day (e.g. juice, soda, water, tea, coffee)?

_____

Bowel Habits:

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

Yes No Unusually strong fecal urgency
Yes No Constipation or strain to empty bowels
Yes No Difficulty holding back gas
Yes No Loss of bowel control

1. How often do you have a bowel movement? _____
2. If you have constipation how do you manage it? _____
3. Is your stool consistency normally: loose _____ normal _____ hard _____

Pelvic Pain:

1. What activities increase your pain? (e.g. intercourse, sitting, bowel movements, stress, pelvic exam)

_____

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

_____

_____

3. Do you have other concerns or problems we haven't addressed? _____

_____

OB-GYN History:

1. # of pregnancies: _____ # of births: _____
   # vaginal deliveries: _____ # C-sections: _____
2. Were there any complications? (e.g. episiotomy, suction, forceps, breech, tearing)

_____

3. Do you experience a sensation of "falling out" or pressure vaginally? _____
4. Please give a brief history of your problem, including dates, treatments, and medications you have used and if they were helpful or not:

_____

_____

5. What was the date of your last pelvic exam? _____

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