Rehabilitation Associates, Inc.

PELVIC FLOOR PHYSICAL THERAPY QUESTIONNAIRE

BLADDER:

Was there an event associated with onset of urinary complaints? □ None
□ Yes. Please describe:_____
Urine Stream: □ Easy to start □ Strong □ Weak □ Starts & Stops □ Deflects to one side
Emptying: □ Complete □ Incomplete □ Pushing or straining needed □ Other
Frequency of Urination: During awake hours? □ No □ Yes → # times per day:_____
During sleep hours? □ No □ Yes → # times per night:____
Urinary Sensation Present: □ Yes □ No □ Variable
Can you hold back your urine if no bathroom is available?: □ No
□ Yes → minutes_____ hours_____
What is the average length of urination: □ 5 seconds □ 10 seconds □ 15 seconds or greater
Fluid Intake: # of 8oz glasses per day_____
How many ounces per day is water?_____ How many cups of tea/coffee per day?_____
Can you stop your urine once started? □ Complete □ Deflects □ Unable
Pain with urination?: □ Yes □ No
Any dribbling after urination? □ Yes □ No

BOWEL:

Was there an event associated with onset of bowel complaints?: □ None
□ Yes. Please describe:_____
Bowel sensation present: □ Yes □ No □ Variable
Can you hold back your feces if no bathroom is available?: □ No
□ Yes → minutes_____ hours_____
Frequency of bowel movements: # of times per day_____, # of times per week_____
Evacuation Habits: □ None □ Straining □ Splinting □ Other: Explain:_____
Laxative use: □ None □ Yes: How often per week?_____
Any blood on tissue after bowel movement? □ Yes □ No

URINARY INCONTINENCE SYMPTOMS:

Urinary Leakage: □ No □ Yes → _____# of episodes per □ day □ week □ month
Cause of leakage: □ None □ Yes:
explain:_____
Urine leakage amount: □ None □ few drops □ wets pad □ wets underwear □ wets outerwear
Do you wear a pad? □ No □ Yes: What kind?_____
pad changes required in 24hrs:_____

(TURN OVER)

FECAL INCONTINENCE SYMPTOMS:

Fecal leakage: □ No □ Yes → _____# of episodes per □ day □ week □ month
Cause of leakage: □ None □ Yes: explain:_____
Fecal leakage amount: □ None □ Smear □ Diarrhea □ Few 'pepples' □ Full stool
Form of protection: □ None □ Yes: What kind of pad?_____
pad changes required in 24hrs:_____

PAIN: Abdomen/Pelvis/Vaginal/Rectal (circle one)

Description: □ None
□ Yes → □ Stabbing □ Aching □ Tender □ Sore □ Burning □ Prickling □ Sharp
How is pain affected by the following:
Movement: □ Unaffected □ Increase→ Type of movement?_____
□ Decrease→ Type of movement?_____
Rest: □ Unaffected □ Increase → Type?_____
□ Decrease → Type?_____
Time of day: □ Unaffected Morning: □ Increase □ Decrease
Afternoon: □ Increase □ Decrease
Evening: □ Increase □ Decrease
Nighttime: □ Increase □ Decrease
Full bladder: □ Unaffected □ Increase □ Decrease
Urination: □ Unaffected □ Increase □ Decrease
Bowel urge: □ Unaffected □ Increase □ Decrease
Bowel movement: □ Unaffected □ Increase □ Decrease
After a bowel movement: □ Unaffected □ Increase→ duration:_____
□ Decrease→duration:_____
Vaginal penetration: □N/A □ Unaffected □ Increase □ Decrease
Initial penetration: □N/A □ Unaffected □ Increase □ Decrease
Deep penetration: □N/A □ Unaffected □ Increase □ Decrease
Following penetration: □N/A □ Unaffected □ Increase → duration:_____
□ Decrease → duration:_____
Marinoff Scale – description scale of intercourse: □ N/A
□ 0 – no problems
□ 1 – discomfort that does not affect completion
□ 2 – pain interrupts/prevents completion
□ 3 – pain preventing any attempts at intercourse
Menstruation: □ N/A □ Unaffected □ Increase→ duration:_____
□Decrease→duration:_____
Bending: □ N/A □ Unaffected □ Increase □ Decrease
Lifting: □ N/A □ Unaffected □ Increase □ Decrease
Exercise: □ N/A □ Unaffected □ Increase □ Decrease
Contact with clothing: □ Unaffected □ Increase □ Decrease
How bad is your pain (10 being worst):
At best:___/10 At present:___/10 At worst:___/10

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PART TWO

WOMEN SPECIFIC HISTORY:

Please check if you have had: □ Dropped Bladder (cystocele)
□ Dropped uterus (uterine prolapse)
□ Hysterectomy (year:_____)
□ Rectocele (Rectal prolapse)

Pregnancies: □No
□ Yes→ How many?_____

Deliveries: Vaginal □ No
□ Yes →#_____
Episiotomy: □ No □ Yes →#_____
Tears: □ No □ Yes→#_____
C-Section □ No □ Yes →#_____

Have you had any hernia repair? □ No □ Yes (Year:_____)
Have you tried doing pelvic muscle exercises (Kegals)? □ Yes □ No

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MEN SPECIFIC HISTORY:

Please check if you have had: □ Prostatectomy (year:_____)
□ Pelvic Radiation
□ Hernia repair (year:_____)

Have you tried doing pelvic muscle exercises (Kegals)? □ Yes □ No