The Physical Therapy Effect

Pelvic Floor Physical Therapy Questionnaire

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

Y/N Yeast/ Bladder infections
Y/N Painful intercourse
Y/N Constipation
Y/N Smoking habit
Y/N Sexually transmitted disease
Y/N Depression
Y/N Pelvic pain
Y/N Low back pain
Y/N Abdominal pain
Y/N Neurological Muscle Disorders
Y/N Asthma
Y/N Cancer, please specify _____

Y/N Gastrointestinal or irritable bowel disease
Y/N Trauma to the pelvis (i.e. fall)
Y/N Other _____

Please explain and provide dates for any "yes" answers

_____
_____
_____
_____

Y/N Are you currently in menopause?
Y/N Are you currently pregnant?
Y/N Actively trying to conceive?
Y/N Have you ever been pregnant? Please list number, date(s) and outcome (i.e vaginal delivery, cesarean section, miscarriage, abortion) :

_____
_____
_____

If you had a vaginal delivery, did you have an episiotomy? Tearing?

_____
_____

Please list any past surgical procedures and date(s):

_____
_____
_____

Please list any current medications you are taking (prescription and over the counter) and for what reason:

What is your occupation? Do you work full or part time? What physical activity is required in this position?

Do you exercise? Please give description:

Urination history

1. Do you experience any urinary leakage: never ___ 1/week ___2-3/week ___1/month ___>1/day

Do you have trouble making it to the toilet in time? Y/N _____

Do you lose urine when you have a strong urge to urinate? Y/N _____

Do you lose urine with any of the following:

Coughing or sneezing Y/N

Laughing Y/N

Lifting Y/N

Active exercise (running, etc) Y/N

Minimal exercise (walking, light housework) Y/N

Sleeping Y/N

Nervousness/increased anxiety Y/N

Leakage unrelated to any specific cause Y/N

2. Do you ever experience leakage without feeling it? Y/N

3. What is the amount of urine leakage? None__ Small amount__moderate___Large___

4. Do you use any of the following: sanitary pads?___tissue paper?___diapers?____

5. If used, how many pads per day?____

6. How often do you urinate during the day?_____

7. How often do you urinate at night?_____

8. Do you experience any of the following urinary symptoms: incomplete emptying?_____ hesitancy?_____ slow stream?_____ difficulty initiating stream?____

9. Do you experience pain with urination?_____

10. Do you urinate frequently, before you experience the urge, just so you can stay dry? Y/N

11. How many glasses of fluid do you drink per day?_____

Bowel History

1. Do you experience stool leakage? Y/N

If yes, how often?_____ What causes leakage?_____

2. How often do you have bowel movements during the week?_____

3. Do you experience pain with bowel movements? Y/N

4. Do you have to use medications to have a bowel movement? Y/N

If yes, what do you use and how often? _____

5. Do you splint or use your fingers to assist with having a bowel movement? Y/N

6. Do you experience any other bowel problems? If so, please explain:

Sexual History

1. Are you currently sexually active? Y/N

If "no", have you been sexually active in the past? Y/N

If "yes", are you currently refraining from sexual activity because of the problem(s) that bring you to physical therapy? Y/N

2. Does your sexual practice (past or present) include any anal entry activities? Y/N

3. Do you experience/have you experienced painful intercourse (Dyspareunia)? Y/N

4. Do you experience/have you experienced painful sexual activity? Y/N

5. During a gynecological exam, do you have pain with the speculum? Y/N

6. Have you ever experienced physical, sexual, verbal or emotional abuse or trauma? Y/N

If "yes", is the abuse occurring currently? Y/N

Is this still a factor in your life physically, emotionally and/or psychologically? Y/N

Is there anything else you would like to comment on or add to the information on this form?