Pelvic Floor Therapy Questionnaire

Patient name ________________________________ **Date** ____________________

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies ______________ Number of vaginal deliveries ___________

Birth weight of largest baby __________ Number of cesarean deliveries __________

Number of episiotomies _____________ Date of last pap smear ________________

Did you have any trouble healing after delivery Y

Do you have a history of sexual abuse or trauma Y

Are you having regular periods/ menstrual cycles Y

Do you have frequent urinary tract infections Y

Pain

Do you have pain with:

Sexual intercourse Y

Pelvic exam Y

Tampon use Y

Back, leg, groin, abdominal pain Y

Test results

Urodynamics test Y Results: ______________________

Cystoscope Y Results: ______________________

Urine test Y Results: ______________________

Bowel test Y Results: ______________________

beyond exercise

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh	Y	Lift/ exercise/ dance/ jump	Y
On the way to the bathroom	Y	Have a strong urge to urinate	Y
Hear running water	Y	Other ________________	Y

Do you wet the bed Y

Have burning/ pain with urination Y

Difficulty starting a stream of urine Y

Strain to empty your bladder Y

Feel unable to empty bladder fully Y

Have a falling out feeling Y

Have pain with a full bladder Y

Have an urgency of urination
(a strong urge to urinate) Y

Urinate more than 7 times/day Y

Bowel symptoms

Strain to have a bowel movement	Y	Leak / stain feces	Y
Include fiber in your diet	Y	Have diarrhea often	Y
Take laxatives / enema regularly	Y	Leak gas by accident	Y
Have pain with bowel movement	Y		

Have a very strong urge to move your bowels

How often do you move your bowels: ____________ per day, week

Most common stool consistency

____ liquid ___ soft ___ firm ___ pellets ___ other ___________