VANITA'S REHAB
Website: www.vanitasrehab.com
Phone: 321-432-5573 Fax: 321-726-9938

Pelvic Floor Therapy Questionnaire

Patient Name: _____ Age: _____ Date: _____

What brings you here for treatment today? _____

When did this begin? _____

Please fill in the following questionnaire to the best of your ability. Your therapist will review the answers with you, and help you answer any questions that are confusing. Thanks for taking time to fill out this questionnaire!

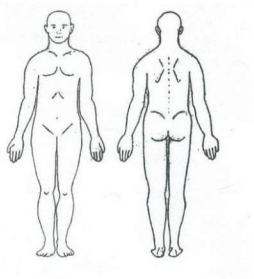
History

Number of Pregnancies: _____ Number of Live Births: _____

Birth History:

	Date	2nd stage duration	Delivery type	Weight	Trauma	Exercises
1.						
2.						
3.						

Did you have any trouble healing after a delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular periods/menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N
Do you have a history of endometriosis, fibroids, cysts?	Y	N

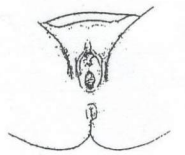


Pain

Rate your pain with each activity on the Pain Scale 0-10:
(0 = no pain, 10 = need to seek urgent medical attention)

Do you have pain with :			0 10
Sexual intercourse	Y	N	I----------I
Pelvic Exam	Y	N	I----------I
Tampon Use	Y	N	I----------I
Other _____	Y	N	I----------I
Do you have back, leg, groin, abdominal pain?	Y	N	I----------I

Indicate area of pain on figure above and below.



Test results

Urodynamics test	Y	N	~date/results: _____
Cystoscope	Y	N	~date/results: _____
Urine tests	Y	N	~date/results: _____
Bowel tests	Y	N	~date/results: _____
X-Ray, MRI, CT Scan	Y	N	~date/results: _____

Bladder Symptoms:

Do you wet the bed?	Y	N	Do you have a "falling out feeling?	Y	N
Have burning/pain with urination?	Y	N	Feel unable to empty bladder?	Y	N
Strain to empty your bladder?	Y	N	Difficulty starting stream of urine?	Y	N
Have a frequent, strong urge to urinate?	Y	N	Have pain with a full bladder?	Y	N

~Number of times you urinate during day: _____ ~Number of times you urinate at night: _____

When you leak, how much do you leak?

_____droplets _____need to change underwear _____need to change pad.

Do you lose urine when you:

Cough/sneeze/laugh?	Y	N	Feel nervous or anxious?	Y	N
Have intercourse?	Y	N	Lift/exercise/dance/jump?	Y	N
Walk to the bathroom?	Y	N	Hear running water?	Y	N
Enter your home/key in the door?	Y	N	Running?	Y	N

Other_____

(Turn Over)

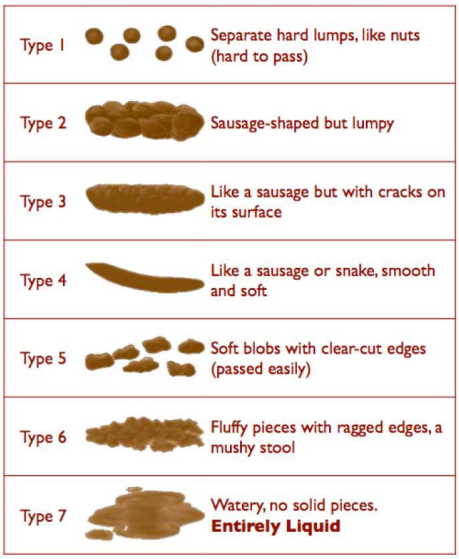
Bowel Symptoms

Strain to have a bowel movement?	Y	N	Leak/stain feces?	Y	N
Include fiber in your diet?	Y	N	Have diarrhea often?	Y	N
Take laxatives/enema regularly?	Y	N			
Leak gas by accident?	Y	N			
Have pain with bowel movement?	Y	N			
Have frequent, strong urges to move bowels?	Y	N			

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

Most common stool consistency:
(circle on Bristol Stool Chart at right)

Bristol Stool Chart



What makes your symptoms (bladder, bowel or pain) better?

_____Heat/Ice	_____Medication
_____Nighttime	_____Position Changes
_____Resting	_____Sitting
_____Standing	_____Walking

Other:_____

General Health History

Have you had any of the following in the past 2 weeks?

Sleep disturbance	Night sweats	Night pain	Weakness
Numbness	Dizziness	Tingling	Fatigue
Headaches	Swelling	Vomiting	Abdominal pain
Nausea	Fever	Chills	Unexplained weight loss/gain

Have you ever been *diagnosed* with any of the following conditions?

Diabetes	Y	N	Stroke	Y	N
Osteoporosis	Y	N	Smoking Habit	Y	N
Heart Problems	Y	N	Cancer:	Y	N
Fibromyalgia	Y	N	Type_____ Date_____		

List **ANY SURGERIES/INJURIES/MEDICAL CONDITIONS**

Date:	**Injury/Surgery/Medical Conditions:**	**Reason:**

_____

_____

Which of the following **Over-the-Counter** and **Prescription** medications have you taken in the past **3-4 weeks**? Please list how many.

Prescription Medications_____

Over-The-Counter Medications/Supplements_____

Do you have any product allergies? ie. Latex etc. *please list* _____

How would you rate your general health? Poor / Fair / Good / Excellent

What do you hope to achieve when you are finished with physical therapy?

_____

Patient signature: _____ **Date**: _____

Therapist signature: _____ Date: _____