Summit Therapy
Sports • Spine • Rehabilitation
Pullman Regional Hospital
1620 SE Summit Ct.
Pullman, WA 99163
509-332-5106 Fax: 509-334-5723

# Pelvic Floor Client Questionnaire

Date: _____

Name: _____

1. Describe the current problem that brought you here? _____
   _____

2. Check all activities that cause or aggravate your problems

   _____ Sitting greater than ___minutes
   _____ Standing greater than ___minutes
   _____ Light activity (light housework)
   _____ Sexual activity
   _____ With laughing/yelling
   _____ With nervousness/anxiety
   _____ Walking greater than ___minutes
   _____ Changing positions (sit to stand)
   _____ Vigorous activity/exercise (running/jumping)
   _____ With cough/sneeze/strain
   _____ With bending/lifting
   _____ With triggers (running water/key in door)
   _____ Other: _____
   _____ No activity affects the problem

3. How has your life been altered/changed because of this problem?

   Physical Activities: _____
   Work Activities: _____
   Social Activities: _____
   Diet/Fluid Intake: _____
   Other: _____

**Men**

Date and results of last physical exam: _____
Date and results of last prostate exam: _____
History of prostate cancer: _____
Are you taking any medications for prostate conditions (please list): _____
_____

**Continue on back*

**Women**

Date and results of last physical exam: _____
Date and results of last gynecological exam: _____
_____

Childbirth history (please check all that apply and indicate number of times each has occurred):

_____ Vaginal Deliveries _____ Episiotomy _____ C-Section
_____ Difficult Childbirth (describe): _____
_____ Other (describe): _____

Gynecological history (please check all that apply):

_____ Vaginal Dryness _____Painful Periods _____Painful Vaginal Penetration
_____ Pelvic Pain _____ Menopause (when): _____

If you have had a feeling of prolapse or organ "falling out" or heaviness/pressure, please check all that apply:

_____ Times per Month _____ With Standing _____ With Exertion/Straining
_____ Other (describe): _____

**Continue on back*

**<u>Bladder/Bowel</u> (check all that apply):**

_____ Difficulty Initiating Urine Stream
_____ Difficulty Stopping Urine Stream
_____ Dribbling After Urination
_____ Blood in Urine
_____ Difficulty Feeling Bladder Urge/Fullness
_____ Recurrent Bladder Infections
_____ Constipation
_____ Excessive Gas
_____ Difficulty Feeling Bowel Urge/Fullness
_____ Intermittent/Slow Stream
_____ Difficulty Emptying Bladder
_____ Constant Urine Leakage
_____ Painful Urination
_____ Urge with Inability to Urinate
_____ Recurrent UTI's
_____ Loose Stools/Diarrhea
_____ Difficulty Holding Back Feces
_____ Urge with Inability to Have Bowel Movement

1. Frequency of urination: _____ times per day _____ times per night
2. When you have a normal urge to urinate, how long can you delay before you must use the toilet?
   _____ Hours _____ Minutes _____ Not At All
3. Typical amount of urine passed: _____ Little _____ Moderate _____ Large

4. Frequency of bowel movements: _____times per day _____times per week _____ other
5. When you have a normal urge to have a bowel movement, how long can you delay before you must use the toilet? _____ Hours _____ Minutes _____ Not At All
6. If you are constipated, how do you manage it (ie medication, special foods): _____
   _____
7. Average fluid intake (one glass = 8 oz or 1 cup): _____ glasses per day
   How many of those glasses are caffeinated? _____ glasses per day

**<u>Incontinence/Leakage:</u>**

1. Bladder (indicate number of episodes):
   _____ times per day _____ times per week _____ time per month _____ only with cough/exertion
   How much on average do you leak?
   _____ a few drops _____ wets underwear _____ wets outerwear _____wets floor
2. Bowel (indicate number of episodes):
   _____ times per day _____ times per week _____ time per month _____ only with exertion/strong urge
   How much on average do you leak?
   _____ rectal staining _____ small amount in underwear _____ complete emptying
3. What protection do you wear?
   _____ none
   _____ Minimum (tissue paper, paper towel, pantie-shields)
   _____ Moderate (maxi-pad)
   _____ Maximum (adult diaper/underpants)
   _____ Other (describe): _____
   On average, how often do you change the protection in 24 hours? _____