

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.

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 push longer than 2 hours for any 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 pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominal pain Y N

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

Most common stool consistency

___ liquid ___ soft ___ firm ___ pellets ___ other _____

<p>How often do you leak?</p> <p>___ Never</p> <p>___ About once a week or less often</p> <p>___ Two or three times a week</p> <p>___ About once a day</p> <p>___ Several times per day</p> <p>___ All the time</p>	<p>How much do <u>you think</u> leak? How much do you <u>usually</u> leak (whether you wear protection or not)?</p> <p>___ None</p> <p>___ A small amount</p> <p>___ A moderate amount</p> <p>___ A large amount</p>
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Overall, how much does leaking interfere with your everyday life? Please circle on number.

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

Name _____ Date _____

Please answer all of the questions in the following survey. Answer these by putting an **X** in the appropriate box or boxes. While answering these questions, please consider your symptoms over the last 3 months.

1. Usually experience pressure in the lower abdomen?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
2. Usually experience heaviness or dullness in the pelvic area?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
3. Usually have a bulge or something falling out that you can see or feel in your vagina area?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
5. Usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
7. Feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
9. Usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
10. Usually lose stool beyond your control if your stool is loose?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

11. Usually lose gas from the rectum beyond your control?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
12. Usually have pain when you pass your stool?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
15. Usually experience frequent urination?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
16. Usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go to the bathroom?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
18. Usually experience small amounts of urine leakage (drops)?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
19. Usually experience difficulty emptying your bladder?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
20. Usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

Name _____ Date _____

For each question place an **X** in the response that best describes how much your activities, relationship, or feelings have been affected by your bladder, bowel, and vaginal symptoms or conditions over the past 3 months. Please make sure you mark and answer in all 3 columns for each question.

How do symptoms or conditions related to the following usually affect your	Bladder or urine	Bowel or rectum	Vagina or pelvis
1. Ability to do household chores (cooking, housekeeping, laundry)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
3. Entertainment activities such as going to a movie or concert?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
5. Participating in social activities outside of your home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
6. Emotional health nervousness, depression, etc?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
7. Feeling frustrated?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

Please circle any symptoms you have

PFM sensory: numbness, reduced feeling, decreased sensation, tingling, pins and needles, increased sensation, painful, tender, aching, burning, uncomfortable

PFM motor: loose, lax, gaping, sagging, open, weak, bulging, full, loss of control, tight, tense, narrow, constricted.

When do you leak? Name _____ Date _____

Please mark below based on the past one month.

Leave blank any section that does not apply

Use blank sections at bottom to add any other times you leak.

Do you leak with?	Not at all	Less than 1 in 5	Less than half the time	About half the time	More than half the time	Almost always
Coughing	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Laughing	0	1	2	3	4	5
Sleeping – occurs while sleeping	0	1	2	3	4	5
Sitting still	0	1	2	3	4	5
Moving from sit to stand	0	1	2	3	4	5
Getting out of chair, bed, car	0	1	2	3	4	5
Walking toward bathroom	0	1	2	3	4	5
Walking for exercise	0	1	2	3	4	5
Walking around the house	0	1	2	3	4	5
Bending down part way to floor	0	1	2	3	4	5
Bending down to the floor	0	1	2	3	4	5
Lifting off counter 8-10 lbs	0	1	2	3	4	5
Lifting from chair height 8-10 lbs	0	1	2	3	4	5
Lifting off floor 8-10 lbs	0	1	2	3	4	5
Lifting off counter 15-30 lbs	0	1	2	3	4	5
Lifting from chair 15-30 lbs	0	1	2	3	4	5
Lifting off floor 15-30 lbs	0	1	2	3	4	5
Lifting heavy objects from chair	0	1	2	3	4	5
Lifting heavy objects from floor	0	1	2	3	4	5
During exercise please specify type _____	0	1	2	3	4	5
	0	1	2	3	4	5
	0	1	2	3	4	5