Pelvic Floor Therapy Questionnaire

Beth Shelly PT

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 _____

How often do you leak?	How much do you think leak? How much do you usually leak (whether you wear protection or not)?
___Never ___ About once a week or less often ___ Two or three times a week ___ About once a day ___ Several times per day ___ All the time	___ None ___ A small amount ___ A moderate amount ___ A large amount

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

11. Usually lose gas from the rectum beyond your control?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
12. Usually have pain when you pass your stool?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
15. Usually experience frequent urination?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ 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?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
18. Usually experience small amounts of urine leakage (drops)?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
19. Usually experience difficulty empting your bladder?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ Quite a bit
20. Usually experience pain or discomfort in the lower abdomen or genital region?	□ No □ Yes →	□ Not at all □ Somewhat □ Moderately □ 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)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
3. Entertainment activities such as going to a movie or concert?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
5. Participating in social activities outside of your home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
6. Emotional health nervousness, depression, etc?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
7. Feeling frustrated?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit

Please circle any symptoms you have

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

Muscle: 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