Inspire Physical Therapy
and *Wellness*
Allison Ariail, Doctor of Physical Therapy
www.inspireptwellness.com
Phone: 303.944.6684 Fax: 720.389.8277

PELVIC HEALTH QUESTIONNAIRE

Answering the following questions will help us manage your health better. Please complete all four pages.
Name: ____ Date: __________________
Date of last doctor visit: ___________ Last pelvic/rectal exam: ____________ Last urinalysis: ____________
List previous tests for the condition for which you are coming to physical therapy:
____
____

Do you now have or have you had a history of any of the following? If yes, please explain in the space provided.

YES	NO		YES	NO	
		Bladder Infections			Pain with climbing stairs
		Yeast infections			Constipation
		Pelvic pain			Low back pain
		Sciatica			Sexually transmitted diseases
		Childhood bladder problems			Trouble with holding back gas
		Fecal incontinence			Trouble initiating urine
		Trouble emptying bladder			Trouble achieving orgasm
		Dribbling of urine			Vaginal dryness
		Erectile dysfunction			

Explanation of above responses:
____

SURGICAL HISTORY
Please list all pelvic or abdominal surgeries and their dates:
____
____

OB/GYN HISTORY (females only)
□ Yes □ No Painful penetration / intercourse
□ Yes □ No Painful menstrual cycles
□ Yes □ No Irregular menstrual cycles
□ Yes □ No Menopause: Date of last period ___________
□ Yes □ No Difficult childbirth
□ Yes □ No Pelvic infections / PID
□ Yes □ No Fibroids / Cysts

Number of pregnancies: __________________
Dates: ____________________________________
Number of vaginal deliveries: ________________
Dates & Birth weights: _______________________
Number of C-sections: _______________________
Dates & Birth weights: _______________________
Number of Episiotomy or tears: _______________

Other (please explain: ____
____

PROSTATE HISTORY (males only)
□ Yes □ No Elevated PSA levels
□ Yes □ No BPH

Procedures performed: _______________________
Dates: ____________________________________

Other (please explain):____

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Bladder Questionnaire

Name: ______________________________ Date: ______________

Describe the reason for your appointment: ______________________________

____

When did this problem begin? ______________________________

Is it □ getting better? □ getting worse? □ staying the same?

Does this problem cause you to change your schedule or life style? □ Yes □ No

If yes, please explain: ______________________________

____

List activities that you cannot do because of this problem: ______________________________

____

Please check the appropriate responses:

1. Bladder leakage frequency – number of episodes
   - □ Never
   - □ Only with exertion (strong cough/sneeze or when lifting heavy objects)
   - □ Only premenstrual
     - _____ # per month
     - _____ # per week
     - _____ # per day
   - □ Constant leakage
2. Severity of leakage
   - □ No leakage
   - □ Few drops
   - □ Wets underwear
   - □ Wets outerwear
3. Protection worn
   - □ None
   - □ Tissue paper / paper towel
   - □ Panti-liners
   - □ Minipad
   - □ Maxipad
   - □ Specialty product / Diaper Name: ______________________________

     Are they □ Damp? □ Wet? □ Saturated? ________# per day
4. Leakage caused or increased by (check all that apply)
   - □ Vigorous activity or exercise (running, heavy lifting)
   - □ Light activity (walking, light housework)
   - □ Sleeping
   - □ Changing positions (sit to stand)
   - □ Nervous / anxiety
   - □ Walking to toilet
   - □ Laughing
   - □ Strong urge to go
   - □ Cough / sneeze
   - □ Intercourse or sexual activity
   - □ No activity changes leakage (constant despite activity)

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5. Position or activity with leakage (check all that apply)
   - □ Lying down
   - □ Sitting
   - □ Standing
6. How long can you delay the need to urinate?
   - □ 1 – 2 minutes □ 31 – 60 minutes
   - □ 3 – 10 minutes □ _______ hours
   - □ 11 – 30 minutes □ Not at all
7. Rate a feeling of "falling out" or pelvic heaviness / pressure
   - □ None present
   - □ ________times per month
   - □ Only with menstruation
   - □ With standing
   - □ With exertion or straining
   - □ At the end of each day
   - □ Present all day

Please list your fluid intake (one glass is 8 oz. or one cup).

_______ glasses per day
# of caffeinated glasses per day _______
# of alcoholic beverages per day________

Rate your feeling as to the severity of this problem (from 1 – 10 with 10 being the worst ______)

0 - 5 - - - -- 10

Not a problem Average problem Major Problem

Rate the following statement as it applies to you today: "My bladder is controlling my life" _____

0 - 5 - - - -- 10

Not true at all Complete true

BLADDER HABITS

__________ How often do you urinate during the day?
__________ How often do you urinate after going to bed?
□ Yes □ No Do you take your time to go to the toilet and empty your bladder?
__________ Number of bladder infections in the last year?
□ Yes □ No Can you stop the flow of urine when on the toilet?
Is the volume of urine passed usually: □ Large □ Average □ Small □ Very Small
□ Yes □ No Do you always have the sensation that you need to go to the toilet?
□ Yes □ No Do you strain to pass urine?
□ Yes □ No Do you frequently empty your bladder before you experience the urge to go?
□ Yes □ No Do you have the feeling your bladder is still full after urinating?
□ Yes □ No Do you have a slow or hesitant urine stream?
□ Yes □ No Do you have difficulty initiating the urine stream?
□ Yes □ No Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.)
Please list: ____
□ Yes □ No Do you change your daily schedule to accommodate your bladder habits?

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BOWEL HABITS

Frequency of bowel movements: __________ per day ____________ per week
Consistency of stool: □ loose □ normal □ hard

□ Yes □ No Do you currently strain to go?
If yes, how often do you strain to have a bowel movement? _____________% of the time.
What effort of straining do you exert? _________________% effort.
□ Yes □ No Do you ignore the urge to defecate?
□ Yes □ No Do you have pain during or after a bowel movement?
□ Yes □ No Do you have leakage of feces? If yes, **X** __________ **per week / month**
□ Yes □ No Do you have leakage of gas? If yes, **X** __________ **per week / month**
□ Yes □ No Do you use laxatives or fiber**?** If yes, how often? **X** ______________**per week month**

SEXUAL ACTIVITY

□ Yes □ No Are you pregnant or attempting to get pregnant?
□ Yes □ No Are you sexually active?
□ Yes □ No Are you able to maintain erection? Please explain ____
□ Yes □ No Do you have pain with erection? Please explain ____
□ Yes □ No Are you able to climax?
□ Yes □ No Do you have any pain during or after climax? Please explain______________________
□ Yes □ No Do you have pain or problems with vaginal penetration or intercourse? **(circle which apply)**
Vaginal penetration, tampon, finger, other: ____

Please rate the following based on your pain
0- Pain does not interfere with intercourse at all
1- Pain causes discomfort but does not interfere with frequency of intercourse
2- Pain sometimes prevents intercourse
3- Pain completely prevents intercourse

List anything regarding your sex life, you would like to discuss with your provider _______________________________
____
____

OTHER

□ Yes □ No Have you ever been taught to do Kegel exercises? If so, how often do you do them?
___________ **per week / month**

Any problems / concerns not addressed?____
____
____

Patient Signature ____ Date:_________________________