AQUACARE Physical Therapy

Pelvic Floor Health History Questionnaire

Name:	Age:	Date:

PATIENT HISTORY

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

2. When did your problem first begin? _____ Months Ago _____ Years Ago

3. Was your first episode of the problem related to a specific incident? ☐ YES ☐ NO

   Please describe and specify the date: _____

4. Since that time is it: ☐ the same ☐ getting worse ☐ getting better

   Why or How? _____

5. If pain is present, rate the pain on a scale of 0 –10, with 0 being no pain and 10 being the worst: _____

   Describe the nature of the pain (i.e. constant burning, intermittent ache, etc.): _____

6. Describe previous treatment / exercises: _____

7. Activities or events that cause or aggravate your symptoms. Check or circle all that apply.

- ☐ Sitting greater than _____ minutes
- ☐ Walking greater than _____ minutes
- ☐ Standing greater than _____ minutes
- ☐ Changing positions (i.e. sit to stand)
- ☐ Light activity (light housework)
- ☐ Vigorous activity or exercise (run / weight lift / jump)
- ☐ Sexual activity
- ☐ Other, specify: _____
- ☐ Coughing / Sneezing / Straining
- ☐ Laughing / Yelling
- ☐ Lifting / Bending
- ☐ Cold weather
- ☐ Triggers: Running water / Key in door
- ☐ Nervousness / Anxiety
- ☐ No activity affects the problem

8. What relieves your symptoms? _____

9. How has your lifestyle / quality of life been altered / changed because of the problem?
   - Social activities (exclude physical activities), specify: _____
   - Diet / Fluid intake, specify: _____
   - Physical activity, specify: _____
   - Work, specify: _____
   - Other: _____

10. Rate the severity of this problem from 0 – 10 with 0 being no problem, and 10 being the worst: _____

11. What are your treatment goals / concerns? _____

Since the onset of your current symptoms have you had:

Y	N	Fever / Chills	Y	N	Malaise (unexplained tiredness)
Y	N	Unexplained weight change	Y	N	Unexplained muscle weakness
Y	N	Dizziness or fainting	Y	N	Night pain / Sweats
Y	N	Change in bowel or bladder functions	Y	N	Numbness / Tingling
Y	N	Other, specify:			

Name:	Age:	Date:

HEALTH HISTORY

Date of Last Physical Exam: _____ Test Performed: _____

General Health: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor Occupation: _____

Mental Health: Current Level of Stress: ☐ High ☐ Medium ☐ Low Current Psych Therapy? Y N

Activity / Exercise: ☐ None ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5+ days per week

Describe: _____

Have you ever had any of the following conditions or diagnoses? Check all that apply.

☐ Cancer	☐ Stroke	☐ Emphysema
☐ Heart Problems	☐ Epilepsy or Seizures	☐ Chronic Bronchitis
☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Asthma
☐ Ankle Swelling	☐ Head Injury	☐ Allergies (describe below)
☐ Anemia	☐ Osteoporosis	☐ Latex Sensitivity
☐ Low Back Pain	☐ Chronic Fatigue Syndrome	☐ Thyroid Problems: _____
☐ Sacroiliac / Tailbone Pain	☐ Fibromyalgia	☐
☐ Alcoholism	☐ Arthritic Conditions	☐ Diabetes
☐ Drug Problems	☐ Stress Fracture	☐ Kidney Disease
☐ Childhood Bladder Problems	☐ Rheumatoid Arthritis	☐ Irritable Bowel Syndrome
☐ Depression	☐ Joint Replacement: _____	☐ Hepatitis
☐ Eating Disorder: _____	☐ Bone Fracture	☐ AIDS / HIV
☐ Smoking History	☐ Sports Injuries	☐ Sexually Transmitted Disease
☐ Vision or Eye Problems	☐ TMJ	☐ Physical Abuse
☐ Hearing Loss or Problems	☐ Neck Pain	☐ Sexual Abuse
☐ Pelvic Pain	☐ Raynaud's (cold hands or feet)	☐ Other: _____

Surgical Procedure History

Surgery for:

Y	N	Back and/or spine
Y	N	Brain
Y	N	Female or Male organs
Y	N	Bladder / Prostate
Y	N	Bones / Joints
Y	N	Abdominal organs
Y	N	Other:

Females Only History

Y	N	Childbirth vaginal deliveries # _____
Y	N	Episiotomy # _____
Y	N	C-Section # _____
Y	N	Difficult childbirth # _____
Y	N	Prolapse or organ falling out
Y	N	Menopause, When? _____
Y	N	Painful vaginal penetration
Y	N	Pelvic pain
Y	N	Other:

Males Only History

Y	N	Prostate disorders
Y	N	Shy bladder
Y	N	Pelvic pain
Y	N	Erectile Dysfunction
Y	N	Painful ejaculation
Y	N	Other:

Prescription Medications

Name of Medication	*Start Date*	*Reason for Taking*

Over the Counter (Vitamins, etc.)

Name of Medication	*Start Date*	*Reason for Taking*

Name:	Age:	Date:

PELVIC SYMPTOM QUESTIONNAIRE

Bladder & Bowel Habits and/or Problems

Y	N	Trouble initiating urine stream	Y	N	Blood in urine
Y	N	Urinary intermittent / slow stream	Y	N	Painful urination
Y	N	Trouble emptying bladder	Y	N	Trouble feeling bladder urge / fullness
Y	N	Difficulty stopping the urine stream	Y	N	Current laxative use
Y	N	Trouble emptying bladder completely	Y	N	Trouble feeling bowel urge / fullness
Y	N	Straining or pushing to empty bladder	Y	N	Constipation / straining
Y	N	Dribbling after urination	Y	N	Trouble holding back gas / feces
Y	N	Constant urine leakage	Y	N	Recurrent bladder infections
Y	N	Other, specify:			

1. Frequency of urination: Awake Hour's _____ per day Sleep Hour's _____ per night

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
☐ Minutes: _____ ☐ Hours: _____ ☐ Not at All

3. The usual amount of urine passed is: ☐ Small ☐ Medium ☐ Large

4. Frequency of bowel movements: _____ times per day _____ times per week Other:

5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
☐ Minutes: _____ ☐ Hours: _____ ☐ Not at All

6. If constipation is present, describe management techniques: _____

7. Average fluid intake (one glass = 8 ounces): _____ glasses per day How many of these are caffeinated: _____

8. Rate a feeling of organ "falling out", prolapse or pelvic heaviness or pressure:
☐ None Present ☐ _____ Times per Month ☐ With Standing for _____ Minutes _____ Hours ☐ With Exertion or Standing ☐ Other:

9 a. Bladder Leakage – Number of Episodes (Skip if No Leakage Present)
☐ No Leakage ☐ _____Times per Day ☐ _____ Times per Week ☐ _____ Times per Month ☐ Only with Exertion or Cough

9 b. On average, how much urine do you leak?
☐ No Leakage ☐ Just a Few Drops ☐ Wets Underwear ☐ Wets Outerwear ☐ Wets Floor

10 a. Bowel Leakage – Number of Episodes (Skip if No Leakage Present)
☐ No Leakage ☐ _____Times per Day ☐ _____ Times per Week ☐ _____ Times per Month ☐ Only with Exertion or Cough

10 b. On average, how much stool do you lose?
☐ No Leakage ☐ Stool Staining ☐ Small Amount in Underwear ☐ Complete Emptying

11. What form of protection do you use?
☐ None ☐ Minimal Protection ☐ Moderate Protection ☐ Maximum Protection ☐ Other:

On average how many pad or protection changes are required in 24 hours? _____ # of pads

Signature: _____ Date:_____
□ Patient □ Legal Guardian □ Power of Attorney

Therapist Signature: _____ Date:_____