ORTHOPAEDICS PHYSICAL THERAPY plus

Pelvic Floor Questionnaire

*** = Required Information*

1) Describe your main concern, for which you are seeking treatment:**_____

2) List all pelvic and abdominal surgeries with dates of operations:**_____

3) List all pregnancies with date and method of delivery:**_____

4) Date of last pelvic examination:** _____

5) Date of last urinalysis:**_____

6) Have you had any special tests performed:** ☐Yes ☐No **If yes, please list:**_____

7) Have you had incontinence or leakage:** ☐Yes ☐No

8) Severity of incontinence or leakage:** ☐None ☐Few drops ☐Wet underwear ☐Wet outerwear

9) What position or activity is associated with the leakage(check all that apply):**

☐Lying down ☐Sitting ☐Standing ☐Changing positions ☐Sexual activity
☐Lifting weights/exercise ☐Laughing ☐Jumping ☐Other:_____

10) How many times do you urinate per day?:** ☐0-4 ☐5-8 ☐9+

11) How many times do you urinate during the night?:** ☐0 ☐1 ☐2+

12) How much fluid do you drink per day (# of 8oz glasses)?:** ☐9+ ☐6-8 ☐3-5 ☐1-2

13) How many of those glasses are caffeinated?:** ☐0 ☐1 ☐2+

14) How frequent are your bowel movements?:** ☐Less than daily ☐1x daily ☐2x daily ☐3x daily ☐4+ daily

15) Do you have trouble initiating a urine stream?:** ☐Yes ☐No

16) Are you sexually active?:** ☐Yes ☐No

17) Do you have pain during sexual activities?:** ☐Yes ☐No
If yes, how much (1-10):_____ *How consistently?:* ☐Infrequent ☐Occasionally ☐Moderately ☐Constantly

18) Do you have pain with tampon use?:** ☐Yes ☐No
If yes, how much (1-10):_____ *How consistently?:* ☐Infrequent ☐Occasionally ☐Moderately ☐Constantly

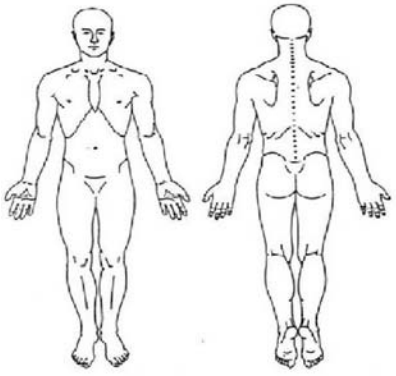
19) Do you have low back or sacral pain?:** ☐Yes ☐No
If yes, how much (1-10):_____ *With what activities?*: _____

20) Are you pregnant or attempting pregnancy?:** ☐Yes ☐No

21) Do you feel safe at home?:** ☐Yes ☐No

22) Do you have a history of sexual abuse or trauma?:** ☐Yes ☐No

On the diagram below, please mark where you are experiencing your symptoms:



On a scale of 1 to 10 (10 being emergency room pain) how painful is it (circle):

Today?	0	1	2	3	4	5	6	7	8	9	10
At its best?	0	1	2	3	4	5	6	7	8	9	10
At its worst?	0	1	2	3	4	5	6	7	8	9	10

Describe your symptoms (ie: achy, sharp, numbness, tingling...):_____

_____

What activities or positions do you have difficulty with, avoid, or are unable to do?

_____

What eases your symptoms?_____

~~~~~~~~~~~~~~~~PLEASE PROCEED TO OTHER SIDE~~~~~~~~~~~~~~~~