**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.

## History

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 have any trouble healing after 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

## Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominal pain Y N

## Test results

Urodynamics test Y N Results: __________________________

Cystoscope Y N Results: __________________________

Urine test Y N Results: __________________________

Bowel test Y N Results: __________________________

Resilience Physical Therapy

## Bladder symptoms

Do you lose urine when you:

| | | | | | |
|---|---|---|---|---|---|
| Cough/ sneeze/ laugh | Y | N | Lift/ exercise/ dance/ jump | Y | N |
| On the way to the bathroom | Y | N | Have a strong urge to urinate | Y | N |
| Hear running water | Y | N | Other ________________ | Y | N |

| | | |
|---|---|---|
| Do you wet the bed | Y | N |
| Have burning/ pain with urination | Y | N |
| Difficulty starting a stream of urine | Y | N |
| Strain to empty your bladder | Y | N |
| Feel unable to empty bladder fully | Y | N |
| Have a falling out feeling | Y | N |
| Have pain with a full bladder | Y | N |
| Have an urgency of urination (a strong urge to urinate) | Y | N |
| Urinate more than 7 times/day | Y | N |

## Bowel symptoms

| | | | | | |
|---|---|---|---|---|---|
| Strain to have a bowel movement | Y | N | Leak / stain feces | Y | N |
| Include fiber in your diet | Y | N | Have diarrhea often | Y | N |
| Take laxatives / enema regularly | Y | N | Leak gas by accident | Y | N |
| Have pain with bowel movement | Y | N | | | |

Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____________ per day, week

Most common stool consistency

_____ liquid ___ soft ___ firm ___ pellets ___ other ___________

Thank you for taking the time to fill out this questionnaire.