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Physical Therapy Screening Questionnaire

Name: _____ **Date:** _____

Answering the following questions will help us to better manage your care. Please complete questionnaire prior to your first appointment and give it quickly to your therapist during your evaluation.

Do you now or have you had a history of the following?					
	Y	**N**		**Y**	**N**
Bone / joint problems	☐	☐	Frequent yeast infections	☐	☐
Low back pain	☐	☐	Blood in urine	☐	☐
Abdominal pain	☐	☐	Constipation / IBS	☐	☐
Pelvic pain	☐	☐	Sexually Transmitted Disease	☐	☐
Painful intercourse	☐	☐	Multiple Sclerosis	☐	☐
Pain with tampon use	☐	☐	Allergies / respiratory problems	☐	☐
Bladder/kidney infections	☐	☐	Smoking Habit	☐	☐
Depression / Anxiety	☐	☐	Sleep problems	☐	☐
Bacterial vaginosis	☐	☐	Other:		
If you circled "Y" to any of the above choices, please briefly describe them below. Include dates.					

Bladder Health				
How many glasses of fluid do you drink per day?				
How many are caffeinated (coffee, tea, soda)?				
How often do you urinate each day?				
How often do you urinate each night?				
How often do you wet your bed each week?				
How is the volume of urine you usually pass?	Large ☐	Average ☐	Small ☐	Very Small ☐
Do you hover over the toilet in public restrooms?	Yes ☐	No ☐	Sometimes ☐	
Do you empty your bladder before you feel the need to urinate (just in case) to stay dry?	Yes ☐	No ☐	Sometimes ☐	
Is your clothing:	Dry Damp (a few drops) ☐	Wet (underwear) ☐	Very Wet (outer clothes) ☐	Saturated (floor) ☐
For your protection, which do you use:	Sanitary Pads ☐	Incontinence Pads ☐	Toilet Paper ☐	Diapers ☐	Nothing ☐
For each change, protection item is:	Damp ☐	Wet ☐	Saturated ☐	
Brand Name:	**Number used per day:**			

	Always	**Sometimes**	**Never**
Do you have trouble making it to the toilet?	☐	☐	☐
Do you find it hard to begin urination?	☐	☐	☐
Do you have to strain to pass urine?	☐	☐	☐
After you urinate, do you have dribbling or a full feeling?	☐	☐	☐
Do you have pain/discomfort when you urinate?	☐	☐	☐
Do you lose urine when you have a strong urge to urinate?	☐	☐	☐

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Do you lose urine with any of the following:	Always	Sometimes	Never
Coughing or sneezing	☐	☐	☐
Laughing	☐	☐	☐
Lifting	☐	☐	☐
Active Exercise (running, etc)	☐	☐	☐
Minimal Exercise (walking, light housework, etc)	☐	☐	☐
Sleeping	☐	☐	☐
Nervousness or increased anxiety	☐	☐	☐
Leakage unrelated to any specific cause	☐	☐	☐
Other (please explain below)	☐	☐	☐

Bowel Health		
How often do you have a bowel movement?	Per day:	Per week:
Do you strain to have a bowel movement?	Yes ☐	No ☐
Do you have difficulty holding back gas?	Yes ☐	No ☐
Do you lose stool on the way to the bathroom or with activity?	Yes ☐	No ☐

Pregnancy

Are you currently pregnant? ☐ Yes, my date is: ☐ No ☐ Not sure

Pregnancy #	Carried to Term	Delivery Type: Vaginal or Caesarian	Delivery Date	Birth Weight	Time Spent Pushing	Episiotomy or Tear
1	Y / N	V / C				
2	Y / N	V / C				
3	Y / N	V / C				
4	Y / N	V / C				
5	Y / N	V / C				

Surgical History

Please list any surgeries you have had below:	Date	Surgeon:

Sexual Health

Pelvic floor dysfunction can be very distressing to patients. Whether your symptoms are urinary incontinence, fecal incontinence, constipation, pelvic floor pain or painful intercourse, these issues are often times not discussed openly with family, friends or even doctors. In order to understand fully the scope of your individual diagnosis, there are some very important questions we need answered. Please feel free to be brief in your answers.

What is your gender identity?	Male ☐	Female ☐	Female to Male ☐	Male to Female ☐	Additional (please specify) ☐:_____
Do your current sexual practices include sexual intercourse or activities that involve vaginal penetration?	Yes ☐	No ☐	If no, have they in the past? Yes ☐	No ☐	
Does your sexual practice (past or present) involve anal entry activities?			Yes ☐	No ☐	
Are you currently sexually active?			Yes ☐	No ☐	
Are you sexually active with men, women or both?	I am not sexually active ☐	Men ☐	Women ☐	Both ☐	
Has there been any sexual abuse in your past or present?			Yes ☐	No ☐	
Do you have any communicable diseases? If yes, please describe:			Yes ☐	No ☐	

Are you satisfied with your sexual function?	☐ Yes → *(skip to Goals)*	☐ No → (continue with questions below)
How long have you been dissatisfied with your sexual function		
What is/are the problem(s) with your sexual function? Check all that apply. *Please also circle the problem that is <u>most</u> bothersome to you.*		
☐ Problem with little or no interest in sex		
☐ Problem with decreased genital sensation (feeling)		
☐ Problem with decreased vaginal lubrication (dryness)		
☐ Problem reaching orgasm		
☐ Problem with pain during sex		
☐ Other:		
Would you like to talk about this with your doctor or health care provider?	Yes ☐	No ☐

Goals	
Women have different goals for their pelvic care. Please list your **personal goals** for treatment of your pelvic problems in order of importance. Please also rate the level of importance of achieving this treatment goal on a scale from **0 (not important to me) to 10 (very important to me).**	
My personal goals for treatment are:	**Rating of level of achieving treatment goal**

PFPT – PFDI (short form 20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, Bladder or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last three months**.

	NO	**YES**			
		<u>If yes</u>, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Greatly**
Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)					
1. Do you usually experience <u>pressure</u> in the lower abdomen?	0	1	2	3	4
2. Do you usually experience <u>heaviness</u> or <u>dullness</u> in the pelvic area?	0	1	2	3	4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	0	1	2	3	4
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
5. Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
6. Do you usually have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4

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	NO	YES			
		If yes, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Greatly**
Colorectal-Anal Distress Inventory 8 (CRAD-8)					
7. Do you feel that you have to strain too hard to have a bowel movement?	0	1	2	3	4
8. Do you feel that you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9. Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10. Do you lose stool beyond your control if your stool is loose or liquid?	0	1	2	3	4
11. Do you usually lose gas from the rectum beyond your control?	0	1	2	3	4
12. Do you usually have pain when you pass your stool?	0	1	2	3	4
13. Do you usually experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4
Urinary Distress Inventory 6 (UDI-6)					
15. Do you usually experience frequent urination?	0	1	2	3	4
16. Do you usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1	2	3	4
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18. Do you usually experience small amounts of urine leakage? (this is, drops)?	0	1	2	3	4
19. Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

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Visual Analogue Pain Scale

Instructions: Please rate your pain on a scale from 0-10.