TOTAL BALANCE THERAPY

PHYSICAL THERAPY, PELVIC HEALTH, PILATES

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: _____

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

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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.

_____ _____

Patient Printed Name Guardian Signature (if applicable)

_____ _____

Patient Signature Date