OrthoRehab PHYSICAL THERAPY

# PELVIC FLOOR THERAPY QUESTIONNAIRE

Name _____ Date _____

## History

Number of:
Pregnancies_____ Vaginal deliveries _____ Cesarean deliveries _____ Episiotomies _____

Date of Last:
Pap smear _____ Menstrual cycle_____ Birth weight of largest baby _____

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 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 or abdominal Y☐ N☐

## Bladder Symptoms

Do you lose urine when you:
- Cough/sneeze/laugh Y☐N☐
- On the way to the bathroom Y☐N☐
- Hear running water Y☐N☐
- Lift/exercise/dance/jump Y☐N☐
- Have a strong urge to urinate Y☐N☐
- Other _____ Y☐N☐

Do you wet the bed Y☐N☐
Have burning/pain w/urination Y☐N☐
Strain to empty your bladder Y☐N☐
Have a falling out feeling Y☐N☐
Have an urgency of urination Y☐N☐
Difficulty starting a stream of urine Y☐N☐
Feel unable to empty bladder fully Y☐N☐
Have pain w/a full bladder Y☐N☐
Urinate more than 7 times daily Y☐N☐

## Bowel Symptoms

Strain to have a bowel movement Y☐N☐
Include fiber in your diet Y☐N☐
Take laxatives/enema regularly Y☐N☐
Have a very strong urge to move your bowels Y☐N☐
Leak/strain feces Y☐ N☐
Have diarrhea often Y☐ N☐
Leak gas by accident Y☐ N☐
Have pain w/bowel movement Y☐ N☐

How often do you move your bowels per day/week _____/_____
Most common stool consistency:
liquid ☐ soft ☐ firm ☐ pellets ☐ other _____