Female Incontinence/Pelvic Pain Questionnaire

Patient Name: ____________________ Date:_________________________

Briefly describe your current complaint:
____
____
When did this problem begin? ______ Is it getting better____ worse_____ same____
Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Do you now have or do you have a history of the following? Explain any checked responses and include dates when possible. ____

- ☐ Bladder infections
- ☐ Pelvic pain
- ☐ Low back pain/sciatica
- ☐ Multiple Sclerosis
- ☐ Childhood bladder problems
- ☐ Trouble holding back gas
- ☐ Vaginal dryness
- ☐ Constant dribbling of urine
- ☐ Interstitial Cystitis
- ☐ Constipation
- ☐ Joint problems
- ☐ Abdominal pain
- ☐ Emphysema/bronchitis
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS
- ☐ Fecal incontinence
- ☐ Smoking habit
- ☐ Blood in urine
- ☐ Trouble feeling bladder fullness
- ☐ Bladder cancer
- ☐ Other (please list)
- ☐ _________________________

<u>Ob/Gyn History</u>: Have you had a history of painful periods, painful penetration, prolapse or a falling out feeling, difficult childbirth? Y/N **If yes, please describe**:
____
____

<u>Childbirth history</u> :
Please describe: # vaginal deliveries: ______# C-sections _______ # Episiotomies _______
Menopause? Y / N Date of last period: ______________

<u>Bladder/Bowel Habits</u>:
Number of times you urinate during the day? 3-5 6-9 10-13 >13
Number of times you urinate after going to bed? 0 1-2 2-3 >3
# of bowel movements per day? 0-1 1-2 2-3 >3 per week? 1-3 3-5 5-9 9-12 >12
Consistency of stool: Loose Normal Hard

Y/N Do you take your time to empty your bladder?
Y/N Can you stop the flow of urine?
Y/N Do you strain to pass urine?
Y/N Do you strain to pass feces?
Y/N Do you empty your bladder frequently, before the urge?
Y/N Do you ignore the urge to defecate?
Y/N Does your bladder feel full after urination?
Y/N Do you have a slow, hesitant urine stream?
Y/N Do you have triggers that make you feel you can't wait to urinate or defecate?

Fluid Intake per day (one glass is 8 oz or one cup): 1-2 2-3 3-4 4-5 >5
Number of Caffeinated glasses per day: 0 1-2 2-3 3-4 4-5 >5
Number of Alcoholic glasses per day: 0 1-2 2-3 3-4 4-5 >5

Urine/Fecal Leakage Questions:

Number of urinary leakages daily: 1 2 3 4 5 >5

Number of fecal/bowel leakages daily: 1 2 3 4 5 >5

Severity of Leakage: None Few drops Wets underwear Wets outerwear

Protection worn: None Minipad Maxipad Full undergarment

Position or Activity with Leakage:

- Vigorous activity
- Light activity
- Changing positions
- Walking to toilet
- Strong urge to go
- Intercourse or sexual activity
- No activity changes leakage (constant)

Pelvic Pain Questions:

Circle appropriate answer(s): "I have pain with…"

- Sexual intercourse
- Urination
- Defecation
- Sitting
- Standing
- Tight clothes
- Menstruation
- Orgasm

Circle appropriate answer(s): "Pain is located…"

- Deep
- Surface
- Vagina
- Urethra
- Anus
- Rectum
- Tailbone / Coccyx
- Tailbone / Sacrum
- Pubic bone
- Right side / Left side /Both sides

Due to privacy regulations, we require your permission to leave messages (such as appointment reminders) on your answering machine or with any individual who answers the number you provide, identifying ourselves as "Sovereign Rehabilitation". Do we have your permission to leave such messages? → Yes → No Initials: __________

Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Sovereign Rehabilitation.

Patient Name (Please Print): ____

Patient Signature: ________________________________Date: _____________

Signature of parent or guardian (if applicable): __________________________

Cancellation & No Show Policy:

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. **It is your responsibility to make every effort to keep your scheduled appointment and to arrive promptly at the scheduled time**. We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least **24 hours before your schedule office visit to avoid paying a $20.00 fee**. This is **NOT** covered by your medical insurance or Workers Compensation benefits. This notice of 24 hours is necessary so that we may schedule other patients needing immediate appointments.

Notice for pelvic patients only: Your visits are scheduled so that no other patients may be seen during your appointment time. This form of scheduling allows for privacy and devoted one-on-one therapeutic interventions. Due to the individualized timing of these sessions, a missed appointment without notice means no other patients may be seen at that time either. For this reason, **the fee for not showing for or cancelling your appointment less than 24 hours prior to the scheduled visit is $50.00**.

This cancellation/ rescheduling fee must be paid on or before your next scheduled appointment.
Thank you for your attention to this matter.

Special Note: Worker's Compensation patients, please note that we will need to notify your adjuster and/or Nurse Case Manager in the event that you cancel/ reschedule your appointment.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree to abide by these guidelines.

__________________________________ ___________________________

Patient Signature Date