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INCONTINENCE SCREENING QUESTIONNAIRE

Answering the following questionnaires will help us to manage your care better.
 Please complete all pages prior to your appointment.

Name: _____ Date: _____
 Birth Date: _____ Age _____ Height _____ Weight _____
 Date of last doctor visit: _____ Last pelvic exam: _____ Last urinalysis: _____
 Previous tests for the condition for which you are coming to physical therapy? _____
 Please list tests: _____

Do you now have or have you had a history of the following? Explain your yes responses and include dates.

- | | |
|-------------------------------------|--------------------------------------|
| Y/N Bladder infections | Y/N Constipation |
| Y/N Pelvic pain | Y/N Joint problems |
| Y/N Low back pain/sciatica | Y/N Abdominal pain |
| Y/N Diabetes | Y/N Broken bones |
| Y/N Multiple Sclerosis | Y/N Heart disease |
| Y/N Stroke | Y/N Emphysema/Bronchitis |
| Y/N Allergies | Y/N High blood pressure |
| Y/N Asthma | Y/N Sexually transmitted diseases |
| Y/N Childhood bladder problems | Y/N HIV/AIDS |
| Y/N Trouble holding back gas | Y/N Fecal incontinence |
| Y/N Trouble initiating urine stream | Y/N Smoking habit |
| Y/N Vaginal dryness | Y/N Blood in urine |
| Y/N Trouble emptying bladder | Y/N Trouble feeling bladder fullness |
| Y/N Constant dribbling of urine | Y/N Bladder cancer |
| Y/N Other (please list) | |

Explanation of the above responses:

Surgical History

- | | |
|--------------------------------------|-----------------------------------|
| Y/N Surgery for your back/ spine? | Y/N Surgery for bladder? |
| Y/N Surgery for your brain? | Y/N Surgery for prostate? |
| Y/N Surgery for your female organs? | Y/N Surgery for abdominal organs? |
| Y/N Other type please describe _____ | |

Ob/Gyn History (females only)

- | | |
|-------------------------------------|---|
| Y/N Painful periods | Y/N Menopause Date of last period _____ |
| Y/N Painful penetration | Y/N C-Section # _____ |
| Y/N Vaginal deliveries # _____ | Y/N Episiotomy # _____ |
| Y/N Prolapse or falling out feeling | Y/N Difficult childbirth |

Explain YES responses _____

Medications

Start date

Reason for taking

_____	_____	_____
_____	_____	_____
_____	_____	_____

SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

Describe the reason for your appointment: _____

When did this problem begin? _____ Is it getting better? ___ worse? ___ staying the same? _____

List activities or things that you cannot do because of this problem: _____

1. Bladder leakage frequency -number (#) of episodes

Never

Only with strong cough/sneeze

Only premenstrual

___ # per month

___ # per week

___ # per day

Constant leakage

2. Severity of leakage (circle one)

No leakage

Few drops

Wets underwear

Wets outerwear

3. Protection worn (circle one)

None

Tissue paper / paper towel

Pantishields

Minipads

Maxipad

Specialty product name _____

Diaper

4. Leakage caused or increased by (circle all that apply)

Vigorous activity or exercise (running, weight lifting)

Light activity (walking, light housework)

Changing positions (sit to stand)

Walking to the toilet

Strong urge to go

Intercourse or sexual activity

No activity changes leakage (constant despite activity)

Other, please list _____

5. Position or activity with leakage. (circle all that apply)

Lying down

Sitting

Standing

6. How long can you delay the need to urinate? (circle one)

Not at all

1-2 minutes

3-10 minutes

11-30 minutes

31-60 minutes

_____ hours

SYMPTOM QUESTIONNAIRE CONTINUED

Name: _____ Date: _____

- 7. Rate a feeling of "falling out "or pelvic heaviness/pressure
 - None present
 - _____ times per month
 - Only with menstruation
 - With standing
 - With exertion or straining
 - At the end of each day
 - Present all day
- 8. Fluid intake (one glass is 8 oz or one cup)
 - _____ glasses per day
 - # of caffeinated glasses _____ per day
 - # of alcoholic beverages _____ per day
- 9. Rate your feelings as to the severity of this problem from 0-10 with 10 being the worst

0 _____ 10

not a problem _____ major problem
- 10. Rate the following statement as it applies to you today

My bladder/bowel is controlling my life.

0 _____ 10

not true at all _____ completely true

Bladder Habits

- 1. How often do you urinate during the day? _____# of times
- 2. How often do you urinate after going to bed? _____# of times
- 3. Do you take your time to go to the toilet and empty your bladder? _____ Y/N
- 4. Number of bladder infections in the last year? _____
- 5. Can you stop the flow of urine when on the toilet? Y/N
- 6. Is the volume of urine passed usually; Large Average Small Very small
- 7. Do you have the sensation that you need to go to the toilet? Y/N
- 8. Do you strain to pass urine? Y/N
- 9. Do you empty your bladder frequently, before your experience the urge to pass urine? Y/N
- 10. Do you have the feeling your bladder is still full after urinating? Y/N
- 11. Do you have a slow or hesitant urinary stream? Y/N
- 12. Do you have difficulty initiating the urine stream? Y/N
- 13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.) Y/N please list _____

Bowel Habits

- 14. Frequency of bowel movements ____ per day _____ per week
- 15. Consistency of stool loose__ normal____ hard__
- 16. History of constipation? Y/N
- 17. Do you currently strain to go? Y/N
- 18. Do you ignore the urge to defecate? Y/N
- 19. Do you have loss of sensation in or around your anus? Y/N
- 20. Do you have trouble making it to the toilet on time when you have an urge to go? Y/N
- 21. Do you soil your underwear? Y/N your outerwear? Y/N
- 22. Do you use a pad for this condition? Y/N