TherapySolutions

Female Pelvic Symptom Questionnaire

Welcome to Therapy*Solutions!* Please answer the following questions to the best of your ability. Check all boxes that apply.

Name: ________________________
Date:______________

Major Complaint:____________________
____
____
____

Bladder/Bowel Habits and Pelvic Floor Symptoms

- ☐ Trouble initiating urine stream
- ☐ Urinary intermittent/slow stream
- ☐ Trouble emptying bladder
- ☐ Difficulty stopping the urine stream
- ☐ Constant urine leakage
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Trouble feeling bladder urges/fullness
- ☐ Trouble feeling bowel urges/fullness
- ☐ Constipation/straining
- ☐ Trouble holding back gas/feces
- ☐ Recurrent bladder infections
- ☐ Straining or pushing to empty bladder
- ☐ Dribbling after urination
- ☐ Latex sensitivity or allergy
- ☐ Low back pain/sciatica
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS
- ☐ Pregnancies, if yes how many______
- ☐ Vaginal deliveries, if yes how many & what positions __________________ ______________________________
- ☐ C-Sections, if yes how many_______
- ☐ Difficult child birth, if yes how many______
- ☐ Pushing more than 2 hrs. during delivery
- ☐ Vaginal tearing**,** if yes # of births____
- ☐ Episiotomy, if yes how many_______
- ☐ Epidural, if yes how many & at what point in labor___________________ ______________________________
- ☐ Vaginal Dryness
- ☐ Painful Periods
- ☐ Menopause, if yes when___________
- ☐ Painful vaginal penetration
- ☐ Pelvic pain
- ☐ Childhood bladder problems
- ☐ Prolapsed organ/pelvic pressure
- ☐ Other:_________________________ ______________________________ ______________________________

Frequency of urination during waking hours? ___________________________
Frequency of urination during night/sleep hours?____________________________

When you have a normal urge to urinate, how long can you delay before you absolutely have to go to the restroom?

- ☐ Minutes
- ☐ Hours
- ☐ Cannot hold it at all

The usual amount of urine passed

- ☐ Small
- ☐ Medium
- ☐ Large

Frequency of bowel movements

______Times per day
______Times per week
______Times per________________

Average intake of fluid (one glass=8oz.)
______Glasses per day
Of this total how many are caffeinated?
_______Glasses per day

If experiencing pelvic pain, what would you rate your pain as today?
________(0=no pain 10=worst imaginable)
if it increases, to what rated level_____
During what activities?_____________
____

1455 Columbia Park Trail, Suite 102 Richland, WA 99352 || phone (509) 396-3707|| Fax (509) 396-3710
frontdesk@therapy-solutions.us

Therapy*Solutions*

Female Pelvic Symptom Questionnaire

CONTINUED ON OTHER SIDE

If experiencing pelvic pain, how would you describe it?______________________________
____
____
____

SKIP THE FOLLOWING QUESTIONS IF NO LEAKAGE OR INCONTINENCE.

Bladder leakage number of episodes
______None
______Times per day
______Times per week
______Times per month
______Only with physical exertion (including coughing/sneezing)

On average, how much urine do you leak?

- ☐ None
- ☐ Just a few drops
- ☐ Wets underwear
- ☐ Wets outerwear
- ☐ Wets the floor

Bowel Leakage number of episodes

______None

______Times per day

______Times per week

______Times per month

______Only with exertion/strong urge

How much do you lose?

- ☐ None
- ☐ Stool Staining
- ☐ Small amount in underwear
- ☐ Completely emptying

What form of protection do you wear? (Please chose only one)

- ☐ None
- ☐ Minimal protection (toilet tissue/paper/towel/panty liners)
- ☐ Moderate protection(absorbent products, maxi pads)
- ☐ Maximum protection (specialty products/ diaper)
- ☐ Other:____________________________

On average how many pad/protection changes are required in a 24 hr. period?

__________Number of pads

For office use only:

1455 Columbia Park Trail, Suite 102 Richland, WA 99352 || phone (509) 396-3707|| Fax (509) 396-3710
frontdesk@therapy-solutions.us