St. Luke's Rehabilitation Institute
INLAND NORTHWEST HEALTH SERVICES

PELVIC FLOOR QUESTIONAIRE

www.st-lukes.org

Describe the nature of your problem or reason for referral:___________________________________
____
When did your problem begin?____________ Have symptoms changed since onset? ☐Yes ☐No
Do you restrict or adjust any physical/social activities due to your problem? ☐Yes ☐No
Describe: ____

What prior treatments have you received for this problem? ☐Physical Therapy ☐Surgery ☐Medications
☐Other________________________

Are you currently sexually active? ☐Yes ☐No.
Do you have a history sexual abuse or negative sexual experiences? ☐Yes ☐No
Do you have any problems/restrictions with sexual activity? ☐Yes ☐No.
Please Describe:____

URINARY HABITS:

How many times do you urinate per day? ______ How long do you wait between trips to the toilet? _____
How many times during the night are you up to urinate? ______

Do you have: (Check all that apply)
☐Difficulty starting/maintaining your flow of urine ☐Urgency to get to the bathroom ☐Need to Strain with urination ☐Pain with urination ☐Blood in your urine

Do you feel you are able to fully empty your bladder? ☐Yes ☐No.
Do you have a history of urinary tract infections? ☐Yes ☐No. Date of last infection? _____________
Do you have Urinary leakage? ☐Yes ☐No. How often? Per Day_____Per Week______
Do you wear pads? ☐Yes ☐No. How many per day? ______
Type and size of pad? ☐Light ☐Medium ☐Large ☐Full Underpant.

Do you lose urine with: (Check all that apply)
☐Laughing/coughing/ sneezing ☐On the way to the bathroom ☐Without awareness
☐Immediately after urinating when standing up ☐During intercourse
☐Other activity____

BOWEL HABITS:

How often do you have a bowel movement? Per day _____ Per Week______ Per Month_______

Do you have: (Check all that apply)
☐Frequent constipation ☐Straining in order to empty your bowels ☐Frequent diarrhea ☐Hemorrhoids
☐Rectal Bleeding/Mucus

Do you feel as though you are unable to fully empty your bowels? ☐Yes ☐No
Explain: ____

What is the consistency of your stool? ☐Pellet ☐Firm ☐Soft ☐Liquid ☐other____________________

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Do you use any products to firm or soften your stool? ☐Stool softeners ☐Imodium ☐Laxatives ☐Suppositories ☐Enemas ☐Other ___________________________

Do you have leakage of stool from the bowels? ☐Yes ☐No How often? Per Day_____ Per Week______
What is the consistency of the leakage ☐Pellet ☐Firm ☐Soft ☐Liquid ☐Other:__________________

PAIN

Do you have any abdominal or pelvic pain/discomfort? ☐Yes ☐No. Where? ☐L eft abdomen ☐Rectum ☐Vagina ☐Tailbone ☐Other____
Describe the pain: ☐Sharp ☐Dull ☐Achy ☐Shooting ☐Other___________________________________
Frequency of the pain is: ☐Constant ☐Intermittent ☐Occurs with certain activities ☐Other___________________________________
What worsens your pain? ☐Sitting ☐Intercourse ☐Exercise ☐Other _____________________________
What relieves your pain?____
How would you rate your pain on a 0-10 scale (0=no pain, 10=worst imaginable)___________________

FOR WOMEN ONLY:

Number of vaginal births?_____ Number of C-Sections?_______
Any difficulty or trauma during childbirth? ☐Tearing ☐Episiotomy ☐Forceps ☐Vacuum ☐Other_______________________
Are you currently pregnant? ☐Yes ☐No. When was your last period? ________________________

Menopause? ☐Yes ☐No
Hysterectomy? ☐Yes ☐No. If yes, Did they take your ovaries? ☐Yes ☐No
Do you have a “falling out” feeling in your pelvic region? ☐Yes ☐No

Is there anything else your pelvic floor rehab therapist should know at this time?
____
____
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