ALPINE

PELVIC FLOOR QUESTIONNAIRE

NAME _____ F / M Sexual Orientation _____ Gender Identity _____

What activities are restricted because of your symptoms (*check all that apply*)

☐ Caregiving ☐ Sexual Activity ☐ Sports/Recreation ☐ Housework ☐ Walking
☐ Sleep ☐ Laughing ☐ Sneezing/coughing ☐ Work Activities ☐ Lifting
☐ Social Activities ☐ Yard work ☐ Other: _____

Do you experience any of the following issues:	Bladder	Bowel	0 Not at All	1 Slightly	2 Moderately	3 Greatly
Frequent toileting to avoid problems						
Leakage related to the feeling of urgency						
Difficulty initiating stream or movement						
No perception of bladder fullness						
Weak, slow or intermittent stream						
Pain or burning with emptying						
Difficulty or straining with emptying						
Not emptying completely						
Presence of blood						
Hemorrhoids						
Pain/discomfort in the lower abdominal region or genital area						
Bulging or protrusion you can see or feel in the genital region						
Other:						

INCONTINENCE HISTORY: *(if applicable)*

When do you leak? *(Please check all that apply)* ☐ Never

☐ Sitting, Standing or Lying down ☐ On the way to toilet ☐ Exercise/Physical Activity ☐ No obvious reason
☐ Coughing, Laughing or Sneezing ☐ After urinating ☐ Strong Urge ☐ Sexual Activity
☐ Changing positions ☐ When constipated ☐ Other _____

How ***often*** do you leak urine? *(choose one)* ☐ Never

☐ Once a week or less ☐ Two to three times a week ☐ Once a day ☐ Several times a day ☐ All the time

How ***much*** urine do you usually leak? *(whether you are wearing protection or not)* ☐ None

☐ A small amount ☐ A moderate amount ☐ A large amount

Protection used, and pads per day: ☐ None

☐ Panty liner _____ ☐ Medium flow pad _____ ☐ Heavy flow pad _____ ☐ Specialty pad/protective garment _____

How long can you delay the need to urinate? ☐ Not applicable

☐ Indefinitely ☐ 1+ hours ☐ ½ hour ☐ 15 minutes ☐ 1-2 minutes ☐ not at all

How long can you delay the need for bowel movement? ☐ Not applicable

☐ Indefinitely ☐ 1+ hours ☐ ½ hour ☐ 15 minutes ☐ 1-2 minutes ☐ not at all

Ability to stop urine flow

☐ Can stop completely ☐ Can maintain a deflection of the stream ☐ Can partially deflect the urine stream
☐ Unable to deflect or slow the stream ☐ Other: _____

Frequency of Urination: Daytime _____ Nighttime _____

Frequency of Bowel movements: ☐ 2+/day ☐ Daily ☐ Every other day ☐ Once every 4-7 days ☐ Weekly

(questions continue on second page)

Daily Fluid intake (*includes water and other beverages, serving size 8 oz*)

☐ 9+ glasses (72 oz) ☐ 6-8 glasses (48-64 oz) ☐ 3-5 glasses (24-40 oz) ☐ 1-2 glasses (8-16 oz)

How many servings per day contain caffeine? _____

Are you sexually active? ☐ No ☐ Yes If yes, number of partners _____

Pain or Problems with sexual activity? _____

FEMALE SPECIFIC QUESTIONS:

Any history or current complaints of pelvic heaviness, fibroids, cysts, endometriosis?_____

_____

List all pelvic and abdominal surgeries_____

_____

Date of last pelvic exam: _____ Date of last urinalysis _____

Menstrual History *(ie. Frequency, pain, flow*)_____

_____

Prolapse or any feeling of possible prolapse? ☐ Unknown

☐ Never ☐ Occasionally with menses ☐ Pressure at end of day ☐ Pressure with straining ☐ Pressure with standing

☐ Perineal pressure all day ☐ Other:_____

Pregnancy/Postpartum:

Are you currently pregnant/attempting pregnancy? ☐ No ☐ Yes

Number of: Pregnancies _____ Miscarriages _____ Vaginal births _____ Cesarean births _____

Episiotomies: ☐ No ☐ Yes Did you experience tearing or need stiches? ☐ No ☐ Yes

Birthdays and weight of babies:_____

_____

Did you have any complications from childbirth?_____

Any problems *(physical or other)* following deliveries? _____

_____

Are you breastfeeding and/or pumping? ☐ No ☐ Yes How Often? _____

How much sleep are you getting each night? _____

MALE SPECIFIC QUESTIONS:

Have you had a prostate exam in the last 12 months? ☐ No ☐ Yes

Do you have testicular pain? ☐ No ☐ Yes

Do you have erectile dysfunction? ☐ No ☐ Yes

Do you have prostate disease? ☐ No ☐ Yes

If yes, please describe_____

I understand that I have been referred to Alpine PT for evaluation and treatment of pelvic floor dysfunction and that all procedures will be carried out by a skilled physical therapist with specialized training in pelvic floor rehabilitation.

I understand the evaluation of my condition may include an internal pelvic floor muscle assessment, which will be used to determine pelvic floor muscle strength and length, scar mobility, and the source of the pain. Assessment and treatment may include observation, palpation, and mobilization of the structures in the pelvic floor region, exercise instruction, and biofeedback. Biofeedback may include the placement of electrodes internally or externally at locations around the pelvic floor region.

I understand that my therapist will provide me with alternative treatment options if I am not comfortable with the internal pelvic floor muscle assessment or treatment. By signing below you agree with the above assessment and terms of treatment.

_____ _____

Patient Signature *Date*