



PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE For Pelvic Floor

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better.
Please complete all pages **prior to** your child's appointment.

Name of parent or guardian completing this form _____

Child's name: _____ Prefers to be called _____

Date: _____

Age _____ Grade _____ Height _____ Weight _____

Describe the reason for your child's appointment _____

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

Name and date of child's last doctor visit _____ Date of last urinalysis _____

Previous tests for the condition for which your child is coming to therapy. *Please list tests and results* _____

<u>Medications</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, can't go on sleepovers. _____

Does your child now have or had a history of the following? Explain all "yes" responses below.

- | | |
|-------------------------------|--|
| Y/N Pelvic pain | Y/N Blood in urine |
| Y/N Low back pain | Y/N Kidney infections |
| Y/N Diabetes | Y/N Bladder infections |
| Y/N Latex sensitivity/allergy | Y/N Vesicoureteral reflux Grade ____ |
| Y/N Allergies | Y/N Neurologic (brain, nerve) problems |
| Y/N Asthma | Y/N Physical or sexual abuse |
| Y/N Surgeries | Y/N Other (please list) _____ |

Explain yes responses and include

dates: _____

Does your child need to be catheterized? Y N (if yes, how often)? _____

Bladder Habits

1. How often does your child urinate during the day? _____ times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____ times
3. Does your child awaken wet in the morning? Y N If yes _____ days per week.
4. Does your child have the sensation (*urge feeling*) that they need to go to the toilet? Y N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

- ___ Not at all
- ___ 1-2 minutes
- ___ 3-10 minutes
- ___ 11-30 minutes
- ___ 31-60 minutes
- ___ Hour(s)

6. Does your child take time to go to the toilet and empty their bladder? Y N
7. Does your child have difficulty initiating the urine stream? Y N
8. Does your child strain to pass urine? Y N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y N
10. Is the volume of urine passed usually: (circle one) *Large Average Small Very small*
11. Does your child have the feeling their bladder is still full after urinating? Y N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y N
13. Fluid intake (*one glass is 8 oz or one cup*) _____ of glasses per day (all types of fluid) _____ of caffeinated glasses per day
Typical types of drinks

14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.)

Y N please list

Bowel Habits

15. Frequency of movements: per day per week. Consistency: loose normal hard
16. Does your child currently strain to go? Y N Ignore the urge to defecate? Y N
17. Does your child have fecal staining on his/her underwear? Y N How often? _____
18. Does your child have a history of constipation? Y N How long has it been a problem _____
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SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
- Never
 - When playing
 - While watching TV or video games
 - With strong cough/sneeze/physical exercise
 - With a strong urge to go
 - Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
- # per month
 - # per week
 - # per day
 - Constant leakage
3. Severity of leakage (circle one)
- No leakage
 - Few drops
 - Wets underwear

 - Wets outer clothing
4. Bowel leakage (check all that apply)
- Never
 - When playing
 - While watching TV or video games
 - With strong cough/sneeze/physical exercise
 - With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
- # per month
 - # per week

___ # per day

6. Severity of leakage (circle one)

- No leakage
- Stool staining
- Small amount in underwear

- Complete emptying

7. Protection worn (circle all that apply)

- None
- Tissue paper / paper towel
- Diaper
- Pull-ups

8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0 _____ 10
Not a problem Major problem

9. Rate the following statement as it applies to your child's life today My child's bladder is controlling his/her life.

0 _____ 10
Not true at all Completely true