MARATHON

PHYSICAL THERAPY AND SPORTS MEDICINE www.MarathonPhysicalTherapy.com

425 CENTRE STREET, NEWTON, MA 02458 ● 617-244-1990 ● FAX 617-244-1811

PELVIC FLOOR PHYSICAL THERAPY QUESTIONNAIRE

NAME:_____ **DATE:**_____

Answering the following questions will help us to manage your care better.
Do you now have or have you had a history of the following?

Y/N	Yeast/ Bladder infections	Y/N	Pelvic Pain
Y/N	Painful intercourse	Y/N	Low back pain
Y/N	Constipation	Y/N	Arthritis/ Rheumatoid arthritis
Y/N	Diabetes	Y/N	Abdominal pain
Y/N	Neurological Muscle Disorders	Y/N	Stroke
Y/N	Asthma	Y/N	Heart disease/ Pacemaker
Y/N	Allergies	Y/N	Emphysema/ Bronchitis/ Lung disease
Y/N	Smoking habit	Y/N	Circulatory problems
Y/N	Sexually transmitted disease or other communicable disease	Y/N	Cancer, please specify _____
		Y/N	Gastrointestinal or irritable bowel disease
Y/N	Depression	Y/N	Trauma to the pelvis (i.e. fall)
Y/N	Thyroid dysfunction	Y/N	Other_____

For female patients:

Y/N Menopause
Y/N Are you currently pregnant?
Y/N Actively trying to conceive?
Y/N Have you ever been pregnant? Please list number, date(s) and delivery method below:

_____
_____
_____

Did you have an episiotomy? Tearing and stitching? _____
_____

During a gynecological exam, do you experience pain with the speculum? Yes No

For male patients:

Y/N Testicular pain?
Y/N Erectile dynfunction?
Y/N Prostate disease? Please specify disease and treatment below:

_____
_____
_____

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For all patients:

Please explain and provide dates for any additional "yes" answers:

_____
_____
_____
_____

Please list any past surgical procedures: _____
_____
_____
_____

Please list any current medications you are taking (prescription and over the counter) and for what reason:

_____
_____
_____

What is your work status? Is physical activity required in this position? _____
_____

Do you exercise? Please give description: _____
_____

	Always	Sometimes	Never
Do you have trouble making it to the toilet in time?	_____	_____	_____
Do you lose urine when you have a strong urge to urinate?	_____	_____	_____
Do you lose urine with any of the following:			
Coughing or sneezing	_____	_____	_____
Laughing	_____	_____	_____
Lifting	_____	_____	_____
Active exercise (running, etc)	_____	_____	_____
Minimal exercise (walking, light housework)	_____	_____	_____
Sleeping	_____	_____	_____
Nervousness/increased anxiety	_____	_____	_____
Leakage unrelated to any specific cause	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

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1. Do you experience leakage: never___ 1/week ___ 2-3/week ___ 1/month ___ >1/day ___
2. Amount of Leakage: ___ None ___ small amount ___ moderate amount ___ large amount
3. Do you use sanitary pads?___ tissue paper?___ diapers?___
4. How many pads per day?___
5. How often do you urinate during the day?____
6. How often do you urinate at night?____
7. Is the volume of urine you usually pass: large?___ average?___ small?___ very small?___
8. Do you experience any of the following Voiding Symptoms: incomplete emptying? ____ hesitancy? ____ slow stream? ____ intermittent stream? ____
9. Do you urinate frequently, before you experience the urge, just so you can stay dry? Yes____ No____
10. How many glasses of fluid do you drink per day?_____
11. How many beverages are caffeinated?_____
12. Any bowel or gas control problems? Please explain: _____
    _____
    _____
13. Are you currently sexually active? Yes No

    13a. If "no", have you been sexually active in the past? Yes No

    13b. If "yes" to 16a, are you currently refraining from sexual activity because of the problem(s) that bring you to physical therapy?
14. Does your sexual practice (past or present) include any anal entry activities? Yes No
15. Do you experience/Have you experienced painful intercourse (Dyspareunia)? Yes No
16. Have you ever experienced physical, sexual, verbal or emotional abuse or trauma? Yes No

    16a. If "yes", is the abuse occurring currently? Yes No

    16b. If "yes" to 16, is this still a factor in your life physically, emotionally and/or psychologically? Yes No