



150 Strickland Street, RR #4
Lakefield, On
KOL 2H0
www.leadtheway.ca

Pelvic Floor Therapy Questionnaire

Patient name: _____

Date: _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last Pap smear _____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominal pain Y N

Test results

Urodynamics test Y N Results: _____

Cystoscope Y N Results: _____

Urine test Y N Results: _____

Bowel test Y N Results: _____

Bladder symptoms

Do you lose urine when you:
Cough/ sneeze/ laugh Y N Lift/ exercise/ dance/ jump Y N
On the way to the bathroom Y N Have a strong urge to urinate Y N
Hear running water Y N Other _____ Y N

Do you wet the bed Y N
Have burning/ pain with urination Y N
Difficulty starting a stream of urine Y N
Strain to empty your bladder Y N
Feel unable to empty bladder fully Y N
Have a falling out feeling Y N
Have pain with a full bladder Y N
Have an urgency of urination
(A strong urge to urinate) Y N
Urinate more than 7 times/ day Y N

Bowel symptoms

Strain to have a bowel movement Y N Leak/ stain feces Y N
Include fiber in your diet Y N Have diarrhea often Y N
Take laxatives/ enema regularly Y N Leak gas by accident Y N
Have pain with bowel movement Y N
Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____ per day, week

Most common stool consistency
_____ liquid _____ soft _____ firm _____ pellets _____ other: _____

Thank you for taking the time to fill out this questionnaire.