PEDIATRIC PELVIC HEALTH SCREENING QUESTIONNAIRE

Your answers to the following questions will help us to manage your child's care better. Please fill in the following questionnaire to the best of your ability.

Name of parent or guardian completing this form_____

Describe the reason for your child's appointment_____

_____

When did your child's symptoms first begin?_____

Was your child's first episode related to a specific incident? NO / YES – specify

_____

Are your symptoms – Same _____ Getting Worse _____ Getting Better _____

Goal for physical therapy _____

Name and dates of any recent doctor/specialist visits that your child has had regarding these issues

_____

_____

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

_____

_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play

dates. _____

_____

Does your child have frequent urinary/bladder infections? YES / NO

Most recent occurrence? _____

Does your child have a history of constipation? YES / NO How long has it been a problem?_____

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

Y/N Pelvic pain

Y/N Low back pain

Y/N Diabetes

Y/N Latex sensitivity/allergy

Y/N Allergies

Y/N Asthma

Y/N Surgeries

Y/N Blood in urine

Y/N Kidney infections

Y/N Bladder infections

Y/N Vesicoureteral reflux Grade ____

Y/N Neurologic (brain, nerve) problems

Y/N Physical or sexual abuse

Y/N Other (please list)_____

Explain yes responses and include dates_____

SYMPTOM QUESTIONNAIRE

How does this impact your child's daily living?

Affects his/her choice of clothing: _____ Withholds/restricts fluid intake: _____

Cannot travel more than an hour without visiting bathroom: _____ Affects sleep _____

Worries that he/she smells: _____ Interferes with recreational or physical activity: _____

Interferes with social activities (movies, dancing, church, visitors): _____

Makes him/her anxious, depressed, embarrassed, frustrated or angry:_____

Other- please specify: _____

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

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

Bladder Symptoms:

Average fluid intake (one glass = 8 oz cup) per day _____

Of these, how many are caffeinated or with high sugar content? _____

Typical types of drinks _____

How often does your child urinate per day? <5 times 5-8 times >8 times

How much urine is typically voided? Trace _____, small _____, medium_____, large _____

How long can your child delay the urge to urinate? _____

Does your child have the sensation (urge feeling) that they need to go to the toilet? YES / NO

Does your child have the urge to urinate without warning (urinary urgency)? YES / NO

Does your child wet the bed? YES / NO

How often does your child get up at night to urinate? _____

Does your child awaken wet in the morning? YES / NO If yes, _____ days per week

Does your child take time to go to the toilet and empty their bladder? YES / NO

Does your child have difficulty initiating the urine stream? YES / NO

Does your child strain to pass urine? YES / NO

Does your child have a slow, stop/start or hesitant urinary stream? YES / NO

Does your child feel unable to fully empty bladder? YES / NO

Have pain with full bladder? YES / NO

Does your child have urinary leakage? YES / NO

How often? Daily _____ Weekly _____ Intermittent_____

How much urine is leaked? Trace _____ , small_____, medium_____, large_____

What causes leakage? Strong urge to go: _____ Light Activities: _____

Walking to the toilet: _____ Cough/Sneeze/Laugh: _____ Hearing running water _____

Vigorous Activity/Exercise: _____ Unknown: _____ Other – please specify: _____

What type of protection does your child wear for leakage? _____

On average, how many times does your child change protection per 24 hours? _____

Bowel Symptoms:

How often does your child have a bowel movement? _____ Day / Week

When your child has the urge to go, how long can your child delay before going to the toilet?

Unable _____ Seconds _____ Minutes _____ Hours _____

Does your child ever strain to have a bowel movement? YES / NO

Do you include fiber in your child's diet? YES / NO

Does your child have painful bowel movements? YES / NO

Does your child often have diarrhea? YES / NO

Leak gas/air by accident? YES / NO

Most common stool consistency? Liquid ____ Soft ____ Firm____ Pellets____ Other – specify _____

Does your child have bowel leakage/accidents? YES / NO

If yes, how often? _____

How much is leaked? Trace____ Small____ Medium____ Large____

Does your child have fecal staining on his/her underwear? YES / NO How often?_____