# Stepping Stone Rehab, Inc.

Incontinence/Pelvic Pain Questionnaire

Patient Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____

**The following is a list of questions to assist your therapist in giving you the most appropriate treatment. If a question is not applicable to your situation, please mark N/A.**
Briefly describe your current complaint:

_____

_____

When did this problem begin? _____ Is it getting better____ worse_____ same____
Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

## Surgical History:

Have you had surgery for your back/spine, brain, female organs, bladder, prostate, or abdominal organs? Y/N If yes to these or any other surgeries, please describe:

_____

_____

Do you now have or do you have a history of the following? Explain any checked responses and include dates when possible. _____

_____

- o Bladder infections
- o Pelvic pain
- o Low back pain/sciatica
- o Diabetes
- o Multiple Sclerosis
- o Stroke
- o Allergies
- o Asthma
- o Childhood bladder problems
- o Trouble holding back gas
- o Vaginal dryness
- o Constant dribbling of urine
- o Interstitial Cystitis
- o Constipation
- o Joint problems
- o Abdominal pain
- o Broken bones
- o Heart disease
- o Emphysema/bronchitis
- o High blood pressure
- o Sexually transmitted diseases
- o HIV/AIDS
- o Fecal incontinence
- o Smoking habit
- o Blood in urine
- o Feeling of bladder fullness
- o Bladder cancer
- o Other: _____

**Fall Risk Screen**: Have you fallen in the past month? Y N Past 12 months? Y N
If yes, how many falls? Did you hurt yourself and where was the location of your injury?

_____

_____

Why did you fall (for ex. Dizziness, trip over object, etc)? _____

_____

**Ob/Gyn History** (females only): Have you had a history of painful periods, painful penetration, prolapse or 'falling out' feeling, difficult childbirth? Y/N If yes, please describe:

_____

_____

**Childbirth history** (females only): # vaginal deliveries: _____ # C-sections _____
# Episiotomies _____ Menopause? Y / N Date of last period: _____

## Bladder/Bowel Habits:

Number of times you urinate during the day? 3-5 6-9 10-13 >13
Number of times you urinate after going to bed? 0 1-2 2-3 >3
# of bowel movements per day? 0-1 1-2 2-3 >3 per week? 1-3 3-5 5-9 9-12 >12
Consistency of stool: Loose Normal Hard

Y/N Do you take your time to empty your bladder?
Y/N Can you stop the flow of urine?
Y/N Do you strain to pass urine?
Y/N Do you strain to pass feces?
Y/N Do you empty your bladder frequently, before the urge?
Y/N Do you ignore the urge to defecate?
Y/N Does your bladder feel full after urination?
Y/N Do you have a slow, hesitant urine stream?
Y/N Do you have "triggers" that make you feel you can't wait to urinate or defecate?

Fluid Intake per day (one glass is 8 oz or one cup): 1-2 2-3 3-4 4-5 >5
Number of Caffeinated glasses per day: _____ Number of Alcoholic glasses per day: _____

## Urine/Fecal Leakage Questions:

Number of urinary leakages daily: 1 2 3 4 5 >5
Number of fecal/bowel leakages daily: 1 2 3 4 5 >5
Severity of Leakage: None Few drops Wets underwear Wets outerwear
Protection worn:

- No protection
- Mini-pad
- Maxi-pad
- Full adult undergarment
- Waterproof underpants

Position or Activity with Leakage:

- Vigorous activity
- Light activity
- Changing positions
- Walking to toilet
- Strong urge to go
- Intercourse or Sexual activity
- No activity changes leakage (constant)

## Pelvic Pain Questions:

Circle appropriate answer(s): "I have pain with…"

- Sexual intercourse
- Urination
- Defecation
- Sitting
- Standing
- Tight clothes
- Menstruation
- Ejaculation / Orgasm

Circle appropriate answer(s): "Pain is located…"

- Deep
- Surface
- Vagina
- Urethra
- Penis
- Anus
- Rectum
- Tailbone
- Pubic bone
- Right side / Left side