Lakefield
Physiotherapy
& Foot Health Clinic

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.