PHYSICAL THERAPY FOR WOMEN
Business Office
Phone: 817-247-1130
Fax: 817-292-7930

Locations:
Fort Worth
Dallas
Colleyville

INCONTINENCE QUESTIONNAIRE

Name _____ Date_____ Date of Birth _____

Please describe your main problem: _____
_____

When did it begin? _____; is the onset associated with one particular event? If so, what was the event _____; is it getting:
❑ better ❑ worse or ❑ staying the same

Please describe activities or things that you cannot do because of your problem _____
_____

PLEASE COMPLETE THE FOLLOWING AS COMPLETELY AS POSSIBLY. YOUR THERAPIST WILL DISCUSS THIS INFORMATION WITH YOU.

GYNECOLOGICAL HISTORY:
At what age did you start periods?_____ Are you periods regular? ❑ Yes ❑ No

Have you ever had a pelvic examination ? ❑ Yes ❑ No If so, when _____

Do you have pain with: ❑ Menses ❑ Tampon insertion

Pelvic Pain:
Location of pain _____
What makes your pain better? _____
What makes your pain worse? _____

Have you ever been taught how to do pelvic floor or Kegel exercises? ❑ Yes ❑ No
When? _____ By whom? _____
How often do you do pelvic floor exercises? _____

UROLOGICAL HISTORY:
Date of last urinalysis _____
Special Tests Performed? _____ Type _____ Date _____
Do you have a history or urinary tract infections? ❑ Yes ❑ No If yes, when was your last infection? _____

Do you have a history of urine loss as a child? ❑ Yes ❑ No
as an adolescent? ❑ Yes ❑ No
At what age did potty training begin? _____
At what age was urinary continence achieved? _____
At what age was fecal continence achieved? _____
Previous treatment for incontinence? ❑ Yes ❑ No ___exercises ___medication ___surgery
Have you had: urethral dilations? ❑ Yes ❑ No If yes, specify reason: _____
urodynamic tests? ❑ Yes ❑ No If yes, specify reason: _____
recent catheter use? ❑ Yes ❑ No If yes, specify reason: _____
cystoscopes? ❑ Yes ❑ No If yes, specify reason: _____

Name _____ **Date**_____ **Date of Birth**_____

DO YOU EXPERIENCE A LOSS OF URINE: (*check yes or no*)

With cough, laugh, sneeze?	❑ Yes	❑ No
When lifting objects?	❑ Yes	❑ No
With exercise?	❑ Yes	❑ No
When you have a strong urge to urinate?	❑ Yes	❑ No
On your way to the bathroom?	❑ Yes	❑ No
Just as you get to the toilet/remove clothing?	❑ Yes	❑ No
Other episodes of incontinence?	❑ Yes	❑ No

DO YOU: (*check yes or no*)

Experience an urge to urinate when you hear running water?	❑ Yes	❑ No
Have pain with urination?	❑ Yes	❑ No
Have burning with urination?	❑ Yes	❑ No
Have blood in your urine?	❑ Yes	❑ No
Have to strain to empty your bladder?	❑ Yes	❑ No
Dribble after you empty your bladder?	❑ Yes	❑ No
Do you feel you still have urine in your bladder after urinating?	❑ Yes	❑ No

ABSORBENT PRODUCTS USED: (*indicate # used per day*)

Pantyliner/pantyshield _____
Menstrual pads (mini, maxi) _____
Incontinence pad (poise, depends) _____
Incontinence brief or pull-ups _____
# of underwear changes _____
Do you soak the pad fully? ❑ Yes ❑ No
Do you change the pad each time it is wet? ❑ Yes ❑ No

OCCURRENCE OF INCONTINENCE OF LEAKAGE

❑ Never
❑ Less than 1/month
❑ More than 1/month
❑ Less than 1/week
❑ More than 1/week
❑ Almost every day
❑ More than 1/day # ___
❑ Just at night
❑ Just during the day

SEVERITY

❑ No leakage
❑ Few drops
❑ Wet underwear
❑ Wet outerwear

POSITION OR ACTIVITY WITH LEAKAGE

❑ Lying down
❑ Sitting
❑ Standing
❑ Changing positions (from sit to stand)
❑ Intercourse
❑ Strong Urge

HOW LONG CAN YOU DELAY THE NEED TO URINATE?

❑ Indefinitely
❑ 1+ hours
❑ ½ hour
❑ 15 minutes
❑ Less than 10 minutes
❑ 1-2 minutes
❑ Not at all

ACTIVITY THAT CAUSES URINE LOSS

❑ Vigorous activity
❑ Moderate activity
❑ Light activity
❑ No activity

Name _____ **Date**_____ **Date of Birth**_____

FREQUENCY OF URINATION (DAYTIME)

- ❑ 0 Times Per Day
- ❑ 1-4
- ❑ 5-8
- ❑ 9-12
- ❑ 13+

FREQUENCY OF URINATION (NIGHTTIME)

- ❑ 0 Times Per Night
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4+

AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?

- ❑ Can stop completely
- ❑ Can maintain a deflection of the stream
- ❑ Can partially deflect the urine stream
- ❑ Unable to deflect or slow the stream

DO YOU HAVE TROUBLE INITIATING A URINE STREAM?

- ❑ Never
- ❑ More than 1/month
- ❑ Less than 1/week
- ❑ Almost every day

ATTITUDE TOWARDS PROBLEM

- ❑ No problem
- ❑ Minor inconvenience
- ❑ Slight problem
- ❑ Moderate problem
- ❑ Major problem

CONFIDENCE IN CONTROLLING YOUR PROBLEM

- ❑ Complete confidence
- ❑ Moderate confidence
- ❑ Little confidence
- ❑ No confidence

FUNCTIONAL LIMITATIONS: (*check yes or no*)

Do you have difficulty:

Getting on/off the toilet?	❑ Yes	❑ No
Getting clothes on/off?	❑ Yes	❑ No
With toilet hygiene?	❑ Yes	❑ No
Getting out of bed?	❑ Yes	❑ No

DAILY FLUID INTAKE:

Do you restrict fluids because of your incontinence? ❑ Yes ❑ No

BOWEL HABITS:

How often do you have a bowel movement? _____

Do you strain having a bowel movement?	❑ Yes	❑ No	
Do you experience abdominal cramping?	❑ Yes	❑ No	
Do you leak/stain feces?	❑ Yes	❑ No	If yes, how often? _____
Do you experience diarrhea?	❑ Yes	❑ No	If yes, How often? _____
Do you use laxatives?	❑ Yes	❑ No	If yes, how often/week? _____
Do you use enemas?	❑ Yes	❑ No	If yes, how often/week? _____
Do you include fiber in your diet daily?	❑ Yes	❑ No	If yes, how much? _____

Have you restricted your physical activities because of incontinence?(exercise, walking, dancing, etc.) ❑Yes ❑ No

If yes, please give specific examples _____

_____

_____

Name _____ **Date**_____ **Date of Birth**_____

Have you restricted your social activities because of incontinence/pain? (Have to stay close to a bathroom, interrupted activities due to needing to go to the bathroom often, sleep overs, etc.) ❑ Yes ❑ No

If yes, please give specific examples _____

_____

_____

Please circle the number on the scale below which best indicates the extent to which **incontinence** limits your daily life:

1 2 3 4 5 6 7 8 9 10

No limits Severely Limiting

Any comments or concerns not asked? _____

_____

_____

_____

_____

_____

_____

_____

_____