

INTEGRATED PHYSICAL THERAPY OF LITTLETON, P.C.

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Lori Buxton, Physical Therapist

PHYSICAL THERAPY SCREENING QUESTIONNAIRE FOR MEN

Name: _____ Date: _____

Answering the following questions will help us to manage your care better. Please complete **both sides** prior to your appointment.

Do you now have or have you had a history of the following? Explain any yes responses and include dates.

- | | |
|-----------------------------------------|----------------------|
| Y / N Bladder infections | Y / N Constipation |
| Y / N Pelvic pain | Y / N Low back pain |
| Y / N Joint problems/ Artificial joints | Y / N Abdominal pain |
| Y / N Diabetes | Y / N Stroke |
| Y / N Multiple sclerosis | Y / N Heart disease |
| Y / N Emphysema/ Bronchitis | Y / N Asthma |
| Y / N Allergies | Y / N Smoking habit |
| Y / N Sexually transmitted disease | Y / N Broken bones |
| Y / N Painful intercourse | Y / N Other _____ |
| Y / N Cancer _____ | |

Explain the above responses: _____

	Always	Sometimes	Never
1. Do you have trouble making it to the toilet in time?	_____	_____	_____
2. Do you lose water/ stool when you have a strong urge to go?	_____	_____	_____
3. Do you lose urine with any of the following:			
Coughing or sneezing-standing/sitting/supine	_____	_____	_____
Laughing	_____	_____	_____
Lifting-check how they are lifting	_____	_____	_____
Active Exercise (running, etc.)	_____	_____	_____
Minimal exercise (walking, light housework)	_____	_____	_____
Sleeping	_____	_____	_____
Nervousness or increased anxiety	_____	_____	_____
Leakage unrelated to any specific cause	_____	_____	_____
Other, please explain: _____			

4. Is your clothing wet a few drops _____, wet underwear _____, wet outer clothes _____, wet floor _____

5. Do you use sanitary pads _____ tissue paper or diapers _____ for protection? # used per day? _____
Name brand _____ Are they damp _____, wet _____,
or saturated _____ at each change?

6. How often do you urinate each day _____, at night _____?
(Before to record this before your first appointment)

TURN OVER

7. Is the volume of urine you usually pass large _____, average _____, small _____ or very small _____?

8. Do you empty your bladder frequently, before you experience the desire to pass urine just so you can stay dry? Yes _____ No _____

9. How many glasses of fluids do you drink per day? ____ How many are caffeinated? _____

10. Any bowel or gas control problems? Please explain _____

11. How often do you have a bowel movement? _____

12. How long can you delay going to the bathroom once you feel the urge to go? _____

13. Do you have trouble initiating the urine stream? _____

14. Can you completely stop the flow of urine? _____

15. Do you find it hard to begin to urinate? _____

16. Do you have a slow urinary stream? _____

17. Do you strain to pass urine? _____

18. After you urinate, do you have the feeling that your bladder is still full? _____

Rate the severity of your problem on a scale of 1-10 with 10 being the worst _____

Date of last urine analysis _____

Previous treatment of this problem? _____

How effective was it? _____

List all medications _____

Please list all surgeries & dates _____

Any current exercise programs or hobbies? _____

Thank you for taking the time to fill out this questionnaire. This helps me to understand you better and begin appropriate treatment measures.

Lori Buxton, P.T.