

# INTEGRATED PHYSICAL THERAPY OF LITTLETON, P.C.

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## PHYSICAL THERAPY SCREENING QUESTIONNAIRE FOR WOMEN

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 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 Menopause
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 pelvic exam \_\_\_\_\_

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.