Orion
PHYSICAL THERAPY

Name:_____ DOB: _____

How long have you had leaking problems? _____ months_____years

How many times do you leak: Daytime leaks_____ Night time leaks_____

When does it occur? _____

What makes it worse? _____

What makes it better? _____

How many caffeinated beverages do you consume each day? _____

How many tomato products (nightshade plants) do you consume each day?_____

Characteristics of leaking

Do you have trouble getting to the bathroom on time? YES NO

Do you leak if you: (check all that apply)

- ☐ Cough
- ☐ Sneeze
- ☐ Lift heavy objects
- ☐ Laugh
- ☐ Run
- ☐ Jump
- ☐ Cry
- ☐ Have intercourse
- ☐ Shower
- ☐ Hear water running
- ☐ Opening front door

Do you use any protection against the leaks? YES NO

If yes, how many pads do you use during the day? _____ night? _____

Toileting

How many times do you void during the day? _____ night? _____

What prompts you to go to the toilet (circle one):

gentle urge strong urge no urge

Do you go "just in case"? YES NO

Do you have difficulty stopping when you void? YES NO

How often do you have a bowel movement? _____

Do you have problems with constipation or diarrhea? YES NO

Do you have IBS? YES NO

Daily Fluid Intake

How much fluid do you consume in a day? _____

Have you changed the amount of fluid consumption since you started leaking? YES NO

How many cups of caffeine do you consume in a day?_____

Medical History

Do you get frequent (check all that apply):

- ☐ Kidney infections
- ☐ UTI's
- ☐ Yeast infections

Do you have diabetes mellitus? YES NO

Do you have blood in your urine? YES NO

Surgery/Hospialization and the reason Date

_____
_____
_____
_____
_____

History

Number of pregnancies_____ Number of vaginal deliveries_____

Birth weight of largest baby_____Number of caesarean deliveries_____

Number of episiotomies_____ Date of last pap smear_____

Did you have any trouble healing after delivery? YES NO

Do you have a history of sexual abuse or trauma? YES NO

Are you having regular periods/menstrual cycles? YES NO

Did you have any complications with your delivery? YES NO

- ☐ Forceps
- ☐ Breech birth

Did you have any complications during your pregnancy? (check all that apply)

- ☐ Low Back Pain
- ☐ Pelvic Pain
- ☐ Sciatica
- ☐ Urinary Incontinence
- ☐ Stress Incontinence
- ☐ Urgency

Did you have any complications after your pregnancy? (check all that apply)

- ☐ Diastasis Recti
- ☐ Pelvic Pain
- ☐ Sciatica
- ☐ Urinary Incontinence
- ☐ Stress Incontinence
- ☐ Urgency
- ☐ Painful intercourse
- ☐ Allergies

Have you had any miscarriages? YES NO

Have you had a hysterectomy? YES NO

- ☐ Total
- ☐ Complete
- ☐ Partial
- ☐ One or both ovaries removed

Pain

Do you have pain with:

Sexual intercourse	YES	NO
Pelvic exam	YES	NO
Tampon use	YES	NO

Do you have back, leg or abdominal pain? If yes, where?_____

Test results

Urodynamic 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 a 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

Have you been through or are you going through menopause?_____

If yes, did menopause change your voiding pattern or leakage?_____

What medications are you currently on?
_____
_____
_____
_____

Thank you for taking the time to fill out this questionnaire. We truly appreciate the time that you took out of your busy day to complete it. This helps us to better understand what your main concerns are.

-Wendy Chorny, PT, DPT, ATC, MTC