HEALTHY CORE
WELLNESS & REHAB, LTD.

Pelvic Floor Screening Form

Directions: Please print this form and fill out the information as completely as possible. Please have the completed form available for your therapist to review with you at your appointment. The information you provide is strictly confidential and will be used to help us provide the most appropriate treatment for you. Thank you for your cooperation.

Personal Information

Name:	**Age:**	**Date of Birth:**
Signature:	**Today's Date:**	

Bladder Habits

1. How many times do you empty your bladder/urinate per day?	
2. How many times do you wake up to empty your bladder/urinate at night?	
3. Do you experience a sudden urgency to urinate? If yes, what causes it?_____	☐ Yes ☐ No
4. Do you have difficulty starting your urine stream?	☐ Yes ☐ No
5. Do you have a weak or slow urine stream?	☐ Yes ☐ No
6. Do you feel that you completely empty your bladder?	☐ Yes ☐ No
7. Have you ever had to self-catheterize to empty your bladder?	☐ Yes ☐ No
8. Do you have blood in your urine?	☐ Yes ☐ No
9. Do you have pain or burning with urination?	☐ Yes ☐ No
10. Do you ever have unintentional loss of urine (incontinence)?	☐ Yes ☐ No
If yes, what causes it? (check all that apply) ☐ Laughing ☐ Sneezing ☐ Coughing ☐ Exercise ☐ Urgency ☐ Cold temperature ☐ Running water ☐ Lifting ☐ Changing positions ☐ Other:_____	
11. Do you wear protective pads? If yes, what type and how many per day?_____	☐ Yes ☐ No

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Bowel Habits

12. Have you ever had any unintentional loss of stool?	☐ Yes ☐ No
13. Do you have uncontrollable gas?	☐ Yes ☐ No
14. Do you have constipation or a history of straining to have a bowel movement?	☐ Yes ☐ No
15. Do you take stool softeners or fiber supplements? If yes, what kind and how often?_____	☐ Yes ☐ No

Fluids

16. Approximately how much fluids (in ounces) do you drink each day?	_____ ounces
17. What types of fluids do you usually drink? ☐ Water ☐ Coffee ☐ Tea ☐ Soda (diet) ☐ Soda (regular) ☐ Other:_____	
18. Do you drink caffeine every day? If yes, what kind and approximately how much?_____	☐ Yes ☐ No

Pelvic Floor Exercises

19. Have you ever been instructed in performing pelvic floor exercises (Kegels)?	☐ Yes ☐ No
20. Do you perform pelvic floor exercises? If yes, how often?_____	☐ Yes ☐ No

Sexuality

21. Do you experience pain with sexual penetration?	☐ Yes ☐ No
22. Have you had anyone touch you without your consent, or had any traumatic sexual experience?	☐ Yes ☐ No

Thank you for your time in completing this information.

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