ELEMENT
wellness & sports rehabilitation

Pelvic Floor Questionnaire – Female *(page 1 of 2)*

Name_____ Date of Birth_____

Thank you for taking the time to fill out this questionnaire. These questions will help your physical therapist understand the full scope of your health to better treat you. Please answer to the best of your ability. If you have any questions or concerns, leave the section blank and ask your therapist. If any section does not apply to you, simply leave it blank.

Please describe your symptoms: _____

_____

When did your symptoms begin? _____

Marital status: Married / Single / Widowed / Divorced / Significant Other

How many pregnancies have you had? _____ Vaginal Deliveries _____ Cesarean Sections _____

Complications: (Circle all that apply) Baby larger than 8# Forceps Severe Tearing Episiotomy None

Did you have urinary leakage during or immediately after your pregnancy? Yes / No

Additional comments_____

Menstrual history (circle all that apply): Peri-menopause / post-menopause / pain with menses / irregular cycles

Are you pregnant? Yes / No / Possibly

What type of birth control do you use? _____

Bladder Habits:

How much do you drink each day of:

Clear liquids _____

Caffeine (# of cups) _____

Alcohol (# of drinks) _____

Do you smoke? Yes / No

How many times do you urinate during the day? _____

How many times do you urinate during the night? _____

When do you leak urine? (Circle all that apply)

Cough/sneeze	On the way to the restroom
Hear running water	Exercise
Jump	Laugh
During sleep	During intercourse
Immediately after voiding	Other: _____

Do you have burning/pain with urination? Yes / No

Do you have *bladder* pain? Yes / No If yes, is it relieved after voiding? Yes / No

Do you have difficulty starting a stream of urine? Yes / No

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Do you strain to empty your bladder? Yes / No

Do you feel unable to fully empty the bladder? Yes / No

Do you have a "falling out" feeling? Yes / No

Do you have a strong urge to urinate? Yes / No

Do you restrict your fluid intake due to fear of urinary leakage? Yes / No

Do you use a form of leakage protection? Pantiliner / Maxi Pad / Incontinence pad / Incontinence brief

How many pads per day? _____

Bowel Habits:

How many bowel movements do you have each day? _____

Most common stool consistency: Soft / Liquid / Formed / Constipated

Do you strain to have a bowel movement? Yes / No

Do you take laxatives/enema regularly? Yes / No

Do you have pain with bowel movements? Yes / No

Do you have a strong urge to move bowels? Yes / No

Do you leak/stain bowel? Yes / No

Do you have diarrhea often? Yes / No

Do you include fiber in your diet? Yes / No

Sexual Activity:

Gender of partner: Male / Female

Are you sexually active? Yes / No

Do you have pain with penetration? Yes / No

Do you have pain with manual intercourse? Yes / No

Do you have pain with oral intercourse? Yes / No

Do you have pain with tampon use? Yes / No

Do you need lubrication? Yes / No

Are you able to achieve an orgasm? Yes / No

Do you have pain after sex? Yes / No

Do you feel safe in your current relationship? Yes / No

Have you ever been forced to engage in sexual activity against your will? Yes / No

History of STD? Yes / No

What else would be helpful for us to know related to your care? _____

_____ _____

Patient Signature Date

Pelvic Floor Impact Questionnaire – Short Form 7

For each question, place an X in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the areas to the right affect the below activities:	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (i.e. cooking, cleaning, laundry)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
3. Entertainment activities such as going to a movie or concert?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
5. Participating in social activities outside your home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
6. Emotional health (i.e. nervousness, depression, etc)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
7. Feeling frustrated?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
TOTALS:			

Scoring the PFIQ-7:

All of the items use the following response scale: Not at all = 0; Somewhat = 1; Moderately = 2; Quite a bit = 3

Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 to 3) and then multiply by (100/3) to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).