



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

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? _____

Do you leak urine? Yes / No

If yes, when do you experience leakage? (Circle all that apply)

Cough/sneeze On the way to the restroom

Hear running water Exercise

Jump Laugh

During sleep During intercourse

Other: _____

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

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

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

Do you strain to empty your bladder? Yes / No

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

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

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

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



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 include fiber in your diet? 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

Sexual Activity & Pain:

Gender of partner: Male / Female

Are you sexually active? Yes / No

Are you able to achieve an orgasm? Yes / No

Do you have pain with erection? Yes / No

Do you have pain with ejaculation? Yes / No

Do you have pain after sexual activity? Yes / No

Do you have pain with prolonged sitting? 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

<i>1. Ability to do household chores (i.e. cooking, cleaning, laundry)?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>2. Ability to do physical activities such as walking, swimming, or other exercise?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>3. Entertainment activities such as going to a movie or concert?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>5. Participating in social activities outside your home?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>6. Emotional health (i.e. nervousness, depression, etc)?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
<i>7. Feeling frustrated?</i>	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> 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).