Incontinence History Questionnaire

Therapy Junction
14130 23rd Ave N
Plymouth, MN 55447
PH: 763-383-7666
Fax: 763-383-6013
www.therapyjunction.net

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages **prior to** your child's appointment.

Name of parents or guardian completing this form: ____

Child's name: ____ Date: _______________ Age: _________

Grade: ___________________________ Height: ________________________ Weight: _______________________

Describe the reason for your child's appointment: ____

____

When did this problem begin? ____

Since that time is it: **staying the same** **getting worse** **getting better**

Name and date of child's last doctor visit: ____

Date of last urinalysis: ____

Previous tests for this condition: (Please list tests and results): ____

____

____

Medications	Start date	Reason for taking
__________________	_____________	____
__________________	_____________	____
__________________	_____________	____

Has your child stopped or been unable to do certain activities because of their condition? (For example, embarrassed to play with friends, can't go to sleepovers, feels ashamed about leakage and avoids play dates.)
Y / N Explain: ____

Does your child currently have or have a history of the following? Explain all "yes" responses below.

Y / N Pelvic pain
Y / N Low back pain
Y / N Abdominal pain
Y / N Latex sensitivity
Y / N Allergies
Y / N Asthma
Y / N Surgeries
Y / N Blood in urine
Y / N Kidney infections
Y / N Bladder infections
Y / N Diabetes
Y / N Neurological (brain, nerve) problems
Y / N Vesicoureteral reflux Grade______
Y / N Physical or sexual abuse

Therapy Junction
14130 23rd Ave N
Plymouth, MN 55447
PH: 763-383-7666
Fax: 763-383-6013
www.therapyjunction.net

Y / N Other (please list) ____

Explain yes responses and include dates

____

____

Does your child need to be catheterized? **Y / N** If yes, how often? ______________________________

Ask your child to rate his/her feelings as to the severity of this problem from 0 – 10

0 ______________________________________ 10

Not a problem **Major problem**

Rate the following statement as it applies to your child's life today:

"My child's bladder is controlling his/her life."

0 ______________________________________ 10
Not true at all **Completely true**

Bladder habits:

1. How often does your child urinate during the day? _______ # times per day, every _______ hours
2. How often does your child wake up to urinate after going to bed? _______ # times
3. Does your child awaken wet in the morning Y / N If yes, _______ days per week
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y / N
5. How long does your child delay going to the toilet once he/she needs to urinate?

   ______ not at all **______ 11-30 minutes**
   ______1-2 minutes **______ 31-60 minutes**
   ______ 3-10 minutes **______ hours**
6. Does your child take time to go to the toilet and empty their bladder? Y / N
7. Does your child have difficulty initiating the urine stream? Y / N
8. Does your child strain to pass urine? Y / N
9. Does your child have a slow, stop/start or hesitant urine stream? Y / N
10. Is the volume of urine passed usually: Large Average Small Very small
11. Does your child have the feeling their bladder is still full after urinating? Y / N
12. Does your child have any dribbling after urination? (ex: once they stand up from the toilet.) Y / N
13. Fluid intake (one glass is 8 oz or one cup)
    ______ # of glasses per day (all types of fluid)
    ______ # of caffeinated glasses per day
    Typical types of drinks ____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet?(i.e. running water, etc.) Y / N please list: ____

Therapy Junction
14130 23rd Ave N
Plymouth, MN 55447
PH: 763-383-7666
Fax: 763-383-6013
www.therapyjunction.net

Bowel habits:

15. Frequency of bowel movements ______ per day ______ per week
16. Consistency: loose normal hard
17. Does your child currently strain to go? Y / N Ignore the urge to defecate? Y / N
18. Does your child have fecal staining on his/her underwear? Y / N How often? _________________
19. Does your child have a history of constipation? Y / N How long has it been a problem? ________
20. Has your child had a recent abdominal x-ray or ultrasound due to constipation? Y / N If yes, what were the results? ____

Symptom Questionnaire

Bladder leakage (check all that apply)
____ Never
____ When playing
____ While watching TV or video games
____ With a strong cough/sneeze/exercise
____ With a strong urge to go
____ Nighttime sleep wetting

Bowel leakage (check all that apply)
____ Never
____ When playing
____ While watching TV or video games
____ With a strong cough/sneeze/exercise
____ With a strong urge to go
____ Nighttime sleep leakage

Frequency of urinary leakage – # of episodes
____ # per day
____ # per week
____ # per month
____ constant leakage

Frequency of bowel leakage - # of episodes
____ # per day
____ # per week
____ # per month
____ constant leakage

Severity of leakage (check all that apply)
____ no leakage
____ few drops
____ wets underwear
____ wets outer clothing

Severity of leakage (check all that apply)
____ no leakage
____ stool staining/streaks
____ small amount in underwear
____ complete emptying

Protection worn (check all that apply)
____ none
____ tissue paper / paper towel
____ diaper
____ pull-ups