Mankato Clinic

(Patient Label)

Patient Name:

DOB:

Age:

Date:

# PHYSICAL THERAPY
# INCONTINENCE QUESTIONNAIRE

**What are you being seen for today?**

**Date of onset**:_____

**Since onset are your symptoms**: Increasing_____decreasing_____staying the same_____

**Activities/events that cause or aggravate your symptoms. Check all that apply.**

___Sitting greater than ____ minutes
___Walking greater than____minutes
___Standing greater than___minutes
___Changing positions (i.e. sit to stand)
___Light housework/activity
___Vigorous activity/exercise
___Sexual activity
___Other, please list_____

___Cough/sneeze/straining
___Laughing/yelling
___Lifting/bending
___Cold weather
___Triggers (i.e. running water/key in door)
___Nervousness/anxiety
___No activity affects this problem

**Bladder/ Bowel Habits/ Problems**

___Trouble initiating urine stream
___Slow steam
___Trouble emptying bladder
___Dribbling after urination
___Constant urine leakage

___Blood in urine
___Painful urination
___Trouble feeling bladder or bowel urge/fullness
___Constipation/straining
___Recurrent bladder infections

**Number of episodes of leakage**

___No leakage
**If yes, how many:**
___Times per week
___Times per month
___Only with physical exertion/cough

**On average, how much leakage occurs?**

___Just a few drops
___Wets underwear
___Wets outerwear
___Wets the floor

**What form of protection do you wear?**

___None
___Minimal protection (tissue paper/paper towel/pantyshields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (specialty product/diaper)

**Since your symptoms began have you had any of the following? Check all that apply.**

___Dizziness/fainting
___Numbness in genital/anal area
___Unexplained weakness
___Chest pain
___Easy bruising/bleeding
___Problems with vision/hearing/speech
___Unexplained weight change

___Chills/fever/nausea/vomiting
___Heart palpitations
___Cough/phlegm/sputum
___Night sweats/night pain
___Shortness of breath
___Wheezing