# Core Dynamics Physical Therapy

200 ENGLE STREET, SUITE 20 ENGLEWOOD, NJ 07631 ● PHONE: 201-568-5060 FAX: 201-568-5061

**PELVIC FLOOR PHYSICAL THERAPY QUESTIONNAIRE**

**NAME:**_____________________________________ **DATE:**_____________

Answering the following questions will help us to manage your care better.

Do you now have or have you had a history of the following?

____ Prostate Disorders
____ Painful Ejaculation
____ Low back pain
____ Diabetes
____ Multiple sclerosis
____ Asthma
____ Allergies
____ Smoking habit
_____ Epilepsy
____ TMJ
____ Headaches
____ Other____________________
____ Pelvic Pain
____ Constipation
____ Joint Replacement
____ Abdominal pain
____ Stroke
____ Heart Disease
____ Emphysema/bronchitis
____ Heart Problems
____ Cancer
____ Sexually transmitted disease
____ High Blood Pressure

Please list any past surgical procedures: ________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Please list any current medications (prescription and over the counter) and for what reason:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

What is your work status? Is physical activity required in this position? ______________________
____________________________________________________________________________

Do you exercise? Please give description: ______________________________________________
____________________________________________________________________________

What aggravates your pain: ________________________________________________________
____________________________________________________________________________
Eases?:_______________________________________________________________________

What are your functional limitations/What do your symptoms limit you from?_______________________________________________________________________
____________________________________________________________________________

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Do you experience urinary leakage: Never___, 1/week___, 2-3/week___, 1/month___,>1/day___

1. Amount of Leakage: None___, Small Amount___, Moderate Amount___, Large Amount___
2. How often do you urinate during the day?____
3. How often do you urinate at night?____
4. Is the volume of urine you usually pass? Large___, Average___, Small___, Very Small___
5. Do you experience any of the following Voiding Symptoms? Incomplete Emptying___, Hesitancy___, Slow Stream___, Intermittent Stream___
6. How many glasses of fluid do you drink per day?_________
7. How many beverages are caffeinated?________
8. Do you experience any bowel or gas control problems? Please explain: ______________________________________________________________ ______________________________________________________________
9. Do you experience any Fecal Incontinence? __________ How Often? __________________

Pelvic floor dysfunctions can be very distressing to people. Whether you experience urinary incontinence, fecal incontinence, pelvic floor pain, painful intercourse, or urinary frequency, these issues are frequently not discussed openly with family, friends or one's healthcare providers.

In order to fully understand the scope of your individual diagnosis, there are some very important questions that must be answered. You may be brief in your response. If your therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? Yes No
   If "no", have you been sexually active in the past? Yes No
2. Does your sexual practice (past or present) include any anal entry activities? Yes No
3. Do you experience erectile dysfunction? Yes No
4. Do you have any communicable diseases? Yes No
5. Has there been any sexual abuse in your past? Yes No