

Physical Therapy For Women, Inc. & kids!

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

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 parent or guardian completing this form _____

Child's name: _____ Prefers to be called _____ Date: _____

Age _____ Grade _____ Height _____ Weight _____

Describe the reason for your child's appointment _____

When did this problem begin? _____ Is it getting better _____ worse _____ staying the same _____

Name and date of child's last doctor visit _____ Date of last urinalysis _____

Previous tests for the condition for which your child is coming to therapy. 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 on sleepovers, feels ashamed about leakage and avoids play dates. _____

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

Y/N Pelvic pain

Y/N Blood in urine

Y/N Low back pain

Y/N Kidney infections

Y/N Diabetes

Y/N Bladder infections

Y/N Latex sensitivity/allergy

Y/N Vesicoureteral reflux Grade _____

Y/N Allergies

Y/N Neurologic (brain, nerve) problems

Y/N Asthma

Y/N Physical or sexual abuse

Y/N Surgeries

Y/N Other (please list) _____

Explain yes responses and include dates _____

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

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? (Circle one)

___ 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 urinary stream? Y/N

10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
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; i.e. 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 _____

Bowel Habits

15. Frequency of movements: ___ per day ___ per week. Consistency: loose__ normal__ hard__
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____ How long has it been a problem?_____

SYMPTOM QUESTIONNAIRE

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Bladder leakage (check all that apply) <ul style="list-style-type: none"> ___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go ___ Nighttime sleep wetting 2. Frequency of urinary leakage-number (#) of episodes <ul style="list-style-type: none"> ___ # per month ___ # per week ___ # per day ___ Constant leakage 3. Severity of leakage (circle one) <ul style="list-style-type: none"> ___ No leakage ___ Few drops ___ Wets underwear ___ Wets outer clothing 7. Protection worn (circle all that apply) <ul style="list-style-type: none"> ___ None ___ Tissue paper / paper towel ___ Diaper ___ Pull-ups | <ol style="list-style-type: none"> 4. Bowel leakage (check all that apply) <ul style="list-style-type: none"> ___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go 5. Frequency of bowel leakage-number (#) of episodes <ul style="list-style-type: none"> ___ # per month ___ # per week ___ # per day 6. Severity of leakage (circle one) <ul style="list-style-type: none"> ___ No leakage ___ Stool staining ___ Small amount in underwear ___ Complete emptying |
|--|---|
8. 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
 9. 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