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

Incontinence History 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 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.)
Please Select Explain: _____

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

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

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Please Select Other (please list) _____

Explain yes responses and include dates

_____

_____

Does your child need to be catheterized? Please Select 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 Please Select If yes, _____ **days per week**
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Please Select
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? Please Select
7. Does your child have difficulty initiating the urine stream? Please Select
8. Does your child strain to pass urine? Please Select
9. Does your child have a slow, stop/start or hesitant urine stream? Please Select
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? Please Select
12. Does your child have any dribbling after urination? (ex: once they stand up from the toilet. Please Select
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.) Please Select please list: _____

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Bowel habits:

15. Frequency of bowel movements _____ per day _____ per week
16. Consistency: loose ◉ normal ○ hard ○
17. Does your child currently strain to go? Please Select Ignore the urge to defecate? Please Select
18. Does your child have fecal staining on his/her underwear? Please Select often? _____
19. Does your child have a history of constipation? Please Select ong has it been a problem? _____
20. Has your child had a recent abdominal x-ray or ultrasound due to constipation? Please Select, 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