**PEDIATRIC BOWEL/BLADDER SCREENING QUESTIONNAIRE**

Name:____________________ Prefers to be called:______________ Age:________

Grade:________ Date of last MD visit: ______________________________________

Date this problem began? __________________________

Reason for this appointment: __________________________________________________________________

List any tests for the condition that brings your child to this appointment: _______________________________

_______________________________________________________________________________________

Siblings/Home situation: ______________________________________________________________________

List of child's medications and reason for taking: _________________________________________________

_______________________________________________________________________________________

Has your child's activities been affected by this condition, and if so what? (example: embarrassed to play with friends, unable to attend sleepovers, feeling of shame, avoiding play dates/sports)

_______________________________________________________________________________________

Does this problem seem to bother your child? _____________________________________________________

_______________________________________________________________________________________

Does your child now have or have a history of the following?

| | | | |
|---|---|---|---|
| ☐ Pelvic Pain | ☐ Blood in urine | ☐ Surgically implanted device | ☐ Low Back Pain |
| ☐ Kidney Infections | ☐ High/Low Blood pressure | ☐ Diabetes | ☐ Bladder Infections |
| ☐ Latex allergy | ☐ Vesicoureteral Reflux | ☐ Allergies | ☐ Anxiety/Depression |
| ☐ Asthma/Respiratory | ☐ Physical or Sexual Abuse | ☐ Cancer | ☐ Diabetes |
| ☐ Surgeries | ☐ Neurologic Problems | ☐ Other __________________ | |

Please explain yes responses:______________________________________________________________

_______________________________________________________________________________________

Other Present/Past Medical History: _______________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

**BLADDER HABITS**:

1. How often does your child urinate during the day? ______times per day, every ________hours.
2. How often does your child wake at night to urinate? ____________times/night.
3. Does your child awaken wet in the morning? Y/N If yes, _______ days per week.
4. Does your child have the sensation (awareness) when 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 1-2 minutes 3-10 minutes 11-30 minutes 31-60 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?
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

Therapist Signature/Date: ____________________________________________

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**Name:** ________________________________________________

12. Does your child have the feeling their bladder is still full after urinating? Y/N
13. Does your child have any dribbling after urination: i.e. once they stand up from the toilet? Y/N
14. Please indicate your child's daily fluid intake: (one glass = 8 ounces)

    _____ glasses of water _____ glasses of caffeinated drinks ______glasses of other

    Typical beverage choices: ____________________________________________

    Do you use artificial sweeteners? If yes, which ones ___________________________
15. 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 List:________________________________________

**BOWEL HABITS**:

16. Frequency of bowel movements: _____ per day/week. Consistency: loose normal hard
17. Does your child strain to go? Y/N Ignore the urge to go? 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 For how long? ________________

**SYMPTOM QUESTIONNAIRE - (check/fill in all that apply)**

1. Bladder leakage : __ never __when playing __while watching TV/ video games

   __ with strong cough/sneeze/physical exercise __ nighttime sleep wetting
2. Frequency of urinary leakage-number(#) of episodes:

   ___# per month ___# per week ___# per day ___ constant leakage
3. Severity of leakage: ___ none ___few drops ___wets underwear ___wets outer clothing
4. Bowel leakage: __ never __when playing __while watching TV/video games

   __ with strong cough/sneeze/physical exercise __with strong urge to go
5. Frequency of bowel leakage-number(#) of episodes:

   ___# per month ___# per week ___# per day
6. Severity of leakage: __none __stool staining __small amount in underwear ___large amount
7. Protection worn: ___none ___tissue/panty liner ___diaper ___pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem:

   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

What are your goals for physical therapy? ________________________________________

______________________________________ ______________________________

Signature & Relationship of person completing this form Therapist Signature/Date/Time