



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 _____

<u>Medications</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

___ 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? 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

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PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include _____

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy:

I understand that if I cancel more than 24 hours in advance; I will not be charged. I understand that if I cancel less than 24 hours in advance; I will pay a cancellation fee of \$25.00. If I cancel within 6 hours of the appointment time, I understand that I will be charged \$35.00 and there is a \$45.00 cancellation fee for not showing up for an appointment.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of

Date _____

Patient Name: _____
(Please Print)

Patient Signature

Signature of Parent or Guardian (If applicable)

Witness Signature

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