Physical Therapy & Wellness Center

Pediatric Health History and Screening Questionnaire

Patient Name: _____ **Date:** _____

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/Guardian completing this form: _____

Patient History and Symptoms

Describe the reason for your child's appointment. _____

When did this problem begin? _____ Is it getting? ☐ Better ☐ Worse ☐ Staying the same

Doctor's Name: _____ Date of Last Visit: _____

Previous tests for the condition for which your child is coming to therapy. (urinalysis, VCUG, ultrasound, renal scan, etc.)
Please list tests and results:

_____

_____

Please list all medications and supplements, including over the counter and prescription, the date started and reason for taking.

_____

_____

_____

Has your child stopped or been unable to do certain activities because of their conditions? 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?

☐ Yes	☐ No	Allergies	☐ Yes	☐ No	Neurologic (brain, nerve) problems		
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Pelvic Pain		
☐ Yes	☐ No	Bladder Infections	☐ Yes	☐ No	Physical or Sexual Abuse		
☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No	Surgeries		
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Vesicoureteral Reflux	Grade _____	
☐ Yes	☐ No	Kidney Infections	☐ Yes	☐ No	Other (please list): _____		
☐ Yes	☐ No	Latex Sensitivity/Allergy			_____		

Explain "yes responses with dates: _____

_____

Does your child need to be catheterized? ☐ Yes ☐ No

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 ater going to bed? _____ times per night every ____ hours
3. Does your child awaken wet in the morning? ☐ Yes ☐ No
   If yes, how many days per week? _____ days
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? ☐ Yes ☐ No
5. How long does your child delay going to the toiley once he/she needs to urinate? Check One
   ☐ Not at All ☐ 1-2 mins ☐ 3-10 mins ☐ 11-30 mins ☐ 30-60 mins ☐ Hours

Flip Over

6. Does your child take time to go to the toilet and empty their bladder? ☐ Yes ☐ No
7. Does your child have difficulty initiating the uring stream? ☐ Yes ☐ No
8. Does your child strain to pass urine? ☐ Yes ☐ No
9. Does your child have a slow stop/start or hesitant urinary stream? ☐ Yes ☐ No
10. Is the volume of urine passed usually (check one)
☐ Large ☐ Average ☐ Small ☐ Very Small
11. Does your child have the feeling that their bladder is still full after urinating? ☐ Yes ☐ No
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? ☐ Yes ☐ No
13. Fluid intake. Number of 8oz glasses per day?

_____ all types of fluid _____ caffinated drinks

Typical types of drinks _____

14. Does your child have "triggers" that make them feel like they can't wait to go to the toilet? (i.e. running water, etc.) ☐ Yes ☐ No

Bowel Habits

15. Frequency of movement: ____ per day ____ per week
Consistency: ☐ Loose ☐ Normal ☐ Hard
16. Does your child currently strain to go? ☐ Yes ☐ No
17. Does your child ignore the urge to defecate? ☐ Yes ☐ No
18. Does your child have fecal staining on their underwear? ☐ Yes ☐ No
If yes, how often? _____
19. Does your child have a history of constipation? ☐ Yes ☐ No

How long has it been a problem? _____

Symptom Questionnaire

1. Bladder Leakage (check all that apply)
☐ 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 or urinary leakage – number of episodes
____ # per month
____ # per week
____ # per day
____ Constant leakage

3. Severity of urinary leakage (select one)
☐ No Leakage ☐ Few Drops
☐ Wets Underwear ☐ Wets Outer Clothing

4. Bowel Leakage (check all that apply)
☐ Never
☐ When playing
☐ While watching TV or video games
☐ With a strong cough/sneeze/physical exercise
☐ With a strong urge to go

5. Frequency of bowel leakage – number of episodes
____ # per month
____ # per week
____ # per day

6. Severity of bowel leakage (select one)
☐ No Leakage ☐ Stool Staining
☐ Small amount in underwear ☐ Complete emptying

7. Protection worn (check all that apply)
☐ None ☐ Diaper
☐ Tissue Paper / Paper Towel ☐ Pull Ups

8. Ask your child to rate their feelings as to the severity of this problem from 0-10 (select one number)

Not a problem 0 1 2 3 4 5 6 7 8 9 10 Major Problem

9. Rate the following statement as it applies to your child's life today (select one number)

My child's bladder is controlling his/her life.

Not true at all 0 1 2 3 4 5 6 7 8 9 10 Completely true