Healthy Expectations Physical Therapy
Orthopedic, Pelvic Floor, and Women's Health Physical Therapy

Healthy Expectations, Inc.
1910 St Joe Center Rd Suite 33
Fort Wayne, IN 46825
Phone: (260) 483-9933
Fax: (260) 483-9931

PEDIATRIC HEALTH HISTORY & SCREENING QUESTIONNAIRE

Child's name:_____ Date: _____

Name of parent or guardian completing this form: _____

*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.*

Patient history & symptoms:

Child's age: _____ Grade:_____ Height:_____ Weight:_____

Describe the reason for your child's appointment:_____

When did this problem begin?_____ Is it getting better?____ Worse?____ 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 meds:

_____

_____

Has your child stopped or been unable to do certain activities because of this 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 or N - pelvic pain	Y or N - blood in urine	Y or N – neurologic problems
Y or N – kidney infections	Y or N – diabetes	Y or N – physical or sexual abuse
Y or N – allergies	Y or N – asthma	Y or N – latex sensitivity/allergy
Y or N – surgeries	Y or N - low back pain	Y or N – vesicoureteral reflux
Y or N – bladder infections	Y or N – other _____	

Explain "yes" responses and include dates:_____

_____

Does your child need to be catheterized?_____ 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? _____ If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y or N
5. How long does your child delay going to the toilet once he/she needs to urinate:

_____ 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 or N
7. Does your child have difficulty initiating the urine stream? Y or N

(continue to other side of this page)

8. Does your child strain to pass urine? Y or N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y or N
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? Y or N
12. Fluid intake (one glass is 8 ounce or one cup):
_____ glasses per day (all types of fluid) _____ of caffeinated glasses per day
Typical types of drinks:_____
13. 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 or N – please list:_____

Bowel habits:

Frequency of bowel movements: _____ per day _____ per week
Consistency of bowel movements: _____loose _____normal _____hard
Does your child currently strain to go? Y or N Does your child ignore the urge to defecate? Y or N
Does your child have fecal staining on his/her underwear? Y or N How often?_____
Does your child have a history of constipation? Y or N How long has it been a problem?_____

SYMPTOM QUESTIONNAIRE (Check all that apply)

Bladder leakage:
_____ never
_____ when playing
_____ while watching TV or video games
_____ with strong cough/sneeze/exercise
_____ with a strong urge to go
_____ nighttime sleep wetting

Frequency of urinary leakage-# of episodes:
_____ # per month
_____ # per week
_____ # per day
_____ constant leakage

Severity of urinary leakage:
_____ no leakage
_____ few drops
_____ wets underwear
_____ wets outer clothing

Bowel leakage:
_____ never
_____ when playing
_____ while watching TV or video games
_____ with strong cough/sneeze/exercise
_____ with a strong urge to go

Frequency of bowel leakage-# of episodes:
_____ # per month
_____ # per week
_____ # per day

Severity of bowel leakage:
_____ no leakage
_____ stool staining
_____ small amount in underwear
_____ complete emptying

Protection worn? _____ none _____tissue paper/paper towel _____ diaper or pull-ups

Ask your child to rate his/her feelings as to the severity of this problem from 0-10:
0 (*not a problem)* _____**10** *(major problem)*

Rate the following statement as it applies to your child today - *My child's bladder is controlling his/her life…*

0 *(not true at all)* _____**10** *(completely true*)