CARE CONNECTIONS

# PELVIC FLOOR WORKSHEET

NAME ______________________ DATE __________

TIME __________ AM/PM ☐ Initial Visit ☐ Discharge Visit

## CONDITION (CHECK ALL THAT APPLY)

☐ (A) Bladder incontinence
☐ (B) Urinary urgency/frequency
☐ (C) Bowel incontinence
☐ (D) Fecal urgency
☐ (E) Pelvic/perineal pain
☐ (F) Other

## ACUITY *(Answer on initial visit.)*

How long ago did onset of symptoms occur? ________________

## FUNCTION

To what degree does your condition interfere with your participation in the following activities: (if you have bowel or bladder problems, rate interference when you are NOT using a pad or leakage protection).

| | Never Interferes | 10-20% of the time | 30-40% of the time | 50-60% of the time | 70-80% of the time | Always Interferes |
|---|---|---|---|---|---|---|
| 1. Household Activities | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Physical Activity/Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Intimate Relationships | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Sitting through long events (more than 3 hours) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Work Activities | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Activities without bathroom access | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Travel | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Sleep (# times/night your sleep is interrupted) | ☐0× | ☐1× | ☐2× | ☐3× | ☐4× | ☐5+× |
| 9. Number absorbent products used per day to manage your condition | ☐0× | ☐1× | ☐2× | ☐3× | ☐4× | ☐5+× |

### 10. PLEASE INDICATE TYPE OF PROTECTION USED

☐ (A) none
☐ (B) tissue/paper towels
☐ (C) panty liner
☐ (D) medium flow pad
☐ (E) heavy flow pad
☐ (F) specialty pad/protective garment

11. Number of bowel/urine leakage accidents per 24 hours? ________________

12. Frequency of daytime urination? ________

13. Frequency of nighttime urination? ________

## PAIN INDEX

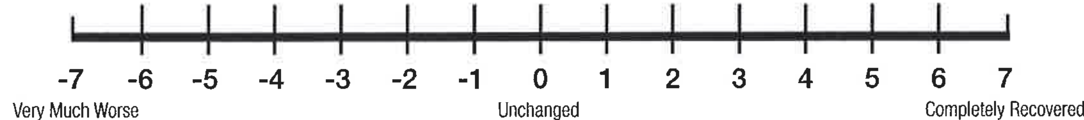
*Please indicate the worst your pain has been in the last 24 hours on the scale below*

No Pain |________________________________| Worst Pain Imaginable

**PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT**

## GLOBAL RATING OF CHANGE

*With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)*





© 2010 Therapeutic Associates, Inc. (Revised: 11/16/10) FORM C003 Pelvic