Physical Therapy & Wellness Center

# 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: _____

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

_____

_____

| Medications | Start date | Reason for taking |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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 Low back pain
◯ Y ◯ N Diabetes
◯ Y ◯ N Latex sensitivity/allergy
◯ Y ◯ N Allergies
◯ Y ◯ N Asthma
◯ Y ◯ N Surgeries
◯ Y ◯ N Blood in urine
◯ Y ◯ N Kidney infections
◯ Y ◯ N Bladder infections
◯ Y ◯ N Vesicoureteral reflux Grade _____
◯ Y ◯ N Neurologic (brain, nerve) problems
◯ Y ◯ N Physical or sexual abuse
◯ 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? _____ Hours.
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? (Check one)
   - ◯ Not at all
   - ◯ 1-2 minutes
   - ◯ 3-10 minutes
   - ◯ 11-30 minutes
   - ◯ 11-30 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

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10. Is the volume of urine passed usually (check one): ◯ Large ◯ Average ◯ Small ◯ Very small
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. Number of 8 oz glasses per day? _____ (all types of fluid) _____ of caffeinated drinks
    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

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 of urinary leakage-number (#) of episodes
   - # per month
   - # per week
   - # per day
   - Constant leakage

3. Severity of 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 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 leakage (select one)
   - ◯ No leakage
   - ◯ Stool staining
   - ◯ Small amount in underwear
   - ◯ Complete emptying

7. Protection worn (check all that apply)
   - ☐ None
   - ☐ Tissue paper / paper towel
   - ☐ Diaper
   - ☐ Pull-ups

8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10 (select a 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 a 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