First Step
Pediatric Therapy

Patient name: ________________________ Date of Birth: ________________________

Today's date: ________________________

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.

Describe the reason for your child's appointment:

____

____

When did this problem begin? ________ Is it getting better, worse or staying the same? _________

Previous tests for the condition for which your child is coming to therapy. Please list tests and results:

____

____

Medications start date and 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 to sleepovers, feels ashamed about leakage.

____

____

Does your child have a history of the following? Explain all "yes" responses below.

Y / N Kidney infections or UTI- last one: _____

Y / N Blood in urine

Y / N Vesicoureteral reflux - Grade_______

Y / N Surgeries

Y / N Latex sensitivity or allergies

Y / N Pelvic pain

Y / N Low back pain

Y / N Neurologic (brain, nerve) problems

Y / N Physical or sexual abuse

Other ________________________

Explain:____

____

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

0 (no problem) 1 2 3 4 5 6 7 8 9 10 (major problem)

2. Rate the following statement as it applies to your child's life today

"My child's bladder/bowel is controlling his/her life"

0 (not true) 1 2 3 4 5 6 7 8 9 10 (completely true)

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? (Mark 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
11. Does your child have the feeling their bladder is full after urinating? Y / N
12. Does your child have any dribbling after urination once they stand up from the toilet? Y / N
13. Fluid intake (one glass is 8oz 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 If yes, please list: ___________________________________

Bladder Symptoms

1. Bladder Leakage
   __ Never
   __ When playing
   __ While watching TV or video games
   __ With 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 (check one)
   __ no leakage
   __ few drops
   __ wets underwear
   __ wets outer clothing
4. Protection worn (check all that apply)
   __ None
   __ Toilet paper/ paper towel
   __ Dribble Pad
   __ Absorptive Underwear
   __ Diaper

__ Pull-ups

Bowel Habits:

1. Frequency of bowel movements: ___ per day ___ per week.
   Consistency: loose __ normal__ hard__
2. Does your child currently strain to go? Y / N
3. Does your child ignore the urge to go? Y / N
4. Does your child have fecal staining on his/her underwear? Y / N
   If so, how often? ____
5. Does your child have a history of constipation? Y / N
   How long has it been a problem? ______________________________

Bowel Symptoms:

1. Bowel leakage
   __ Never
   __ When playing
   __ While watching TV or video games
   __ With cough/sneeze/physical exercise
   __ With a strong urge to go
2. Frequency of bowel leakage - number of episodes
   __ per month
   __ per week
   __ per day
3. Severity of leakage (check one)
   __ No leakage
   __ Stool staining
   __ Small amount in underwear
   __ Complete emptying
4. Protection worn (check all that apply)
   __ None
   __ Toilet paper/ paper towel
   __ Skid pad
   __ Diaper
   __ Pull-up