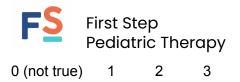


Patient name:	Date of Birth:								
Today's date:									
Patient History and Symptoms:									
our answers to the following questions will help us to manage your child's care better. Please omplete all pages prior to your child's appointment.									
Describe the reason for your child's appoin	:ment:								
When did this problem begin? I	s it getting better, worse or staying the same?								
Previous tests for the condition for which yo	our child is coming to therapy. Please list tests and results:								
Medications start date and reason for taking	g:								
	o certain activities because of their condition? For can't go to sleepovers, feels ashamed about leakage.								
Does your child have a history of the follow	ing? Explain all "yes" responses below.								
Y / N Kidney infections or UTI- last one: _	Y / N Pelvic pain								
Y / N Blood in urine	Y / N Low back pain								
Y / N Vesicoureteral reflux - Grade	Y / N Neurologic (brain, nerve) problems								
Y / N Surgeries	Y / N Physical or sexual abuse								
Y / N Latex sensitivity or allergies	Other								
Explain:									
Ask your child to rate his/her feeling	s 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 a	· • · · ·								
•	owel is controlling his/her life"								



Bladd	er 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 I	f yes, days per wee	k				
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 toile	t onc	e he/she needs to urinate	e? (Mark one):				
	Not at all 1-2 minutes 3-10 minutes	11-30) minutes 31-60 minut	es Hours				
6.	Does your child take time to go to the toilet and empty their bladder?							
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?							
10	. Is the volume of urine passed usually: Large	Α	verage Small	Very Small				
11	. Does your child have the feeling their bladder is	full a	fter urinating?	Y/N				
12	. Does your child have any dribbling after urination	onc	e 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/he							
	I.e. running water, etc. Y / N If yes, please list: _							
Bladd	er Symptoms							
	Bladder Leakage		constant leakage					
	Never	3.	Severity of leakage (chec	ck one)				
	When playing		no leakage					
	While watching TV or video games		few drops					
	With cough/sneeze/physical exercise		wets underwear					
	With a strong urge to go		wets outer clothing					
	Nighttime sleep wetting	4.	Protection worn (check a	ll that apply)				
2.	Frequency of urinary leakage - number of		None					
	episodes		Toilet paper/ p	paper towel				
	per month		Dribble Pad					
	per week		Absorptive Ur	ıderwear				
	per dav		Diaper					

3 4 5 6 7 8 9 10 (completely true)



__ per day

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

__ Pull-up