

NAME _____ DATE _____
 TIME _____ AM/PM Initial Visit Discharge Visit

CONDITION (CHECK ALL THAT APPLY)

- (A) Bladder incontinence (C) Bowel incontinence (E) Pelvic/perineal pain
 (B) Urinary urgency/frequency (D) Fecal urgency (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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Activity/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sitting through long events (more than 3 hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Activities without bathroom access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sleep (# times/night your sleep is interrupted)	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x
9. Number absorbent products used per day to manage your condition	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x

10. PLEASE INDICATE TYPE OF PROTECTION USED

- (A) none (D) medium flow pad
 (B) tissue/paper towels (E) heavy flow pad
 (C) panty liner (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)

