NORTH POLE
Physical Therapy

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:_____Prefers to be called _____ Date: _____

Age _____Grade_____Height _____Weight_____ DOB:_____

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? _____

Patient Name_____DOB_____Date _____

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 (circle one)
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 (one glass is 8 oz 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 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

Patient Name_____DOB_____Date _____

2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle 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 (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle 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
   0_____10
   Not a problem Major problem
9. Rate the following statement as it applies to your child's life today
   My child's bladder is controlling his/her life.
   0_____10
   Not true at all Completely true
10. Was your child born premature? Yes/No
    If yes, how many weeks?_____
11. Does your child have any developmental delays? Yes/No
    If Yes, please provide detail. _____
12. Does your child currently have a 504 plan or IEP? _____
13. Is there any other medical history the therapist should be aware of or that would impact care?

    _____
14. What are your goals for physical therapy?

    _____
15. What are your child's goals for physical therapy?

    _____