CITY PARK LLC
PHYSICAL THERAPY

Voiding Diary

Information gained by use of a voiding diary can be very valuable to increase the therapist's understanding of the extent of your incontinence problem. Please fill out the form for three days in a row. You should bring the completed forms to your evaluation. At that time the therapist will carefully assess the contents of the forms. It will also provide the therapist with information that will allow her to introduce relevant behavioral techniques to enhance your recovery process.

Pelvic Muscle Dysfunction History

Please fill out the questionnaire provided prior to your evaluation, and bring it with you. This will provide valuable information for the therapist to discuss with you during your first visit.

*Please call Lisa Millican, LOTR (504) 309-5811(office) or (504) 913-1622 (cell) if you have any questions about therapy or how to complete the forms.

CITY PARK LLC
PHYSICAL THERAPY

Pelvic Muscle Dysfunction History

Name: _____ Date:_____

Please skip any questions that do not pertain to you. There are many questions specifically geared for a woman.

1. Tell me about the problems you are having: _____
_____
_____

2. Do you ever leak urine when you do not want to? ____No ____Yes

3. Do you have trouble getting to the toilet in time? ____No ____Yes

4. Do you have accidents getting your clothes or bed wet? ____No ____Yes

5. How long have you had a problem with urine leaking? ____less than 1 week ____1 to 4 weeks ____1 to 3 months ____4 to 12 months ____1 to 5 years ____over 5 years (____years)

6. How often do you leak urine? ___less than once per wk ___more than once a wk. (_ per wk.) ___more than once daily (__per day) ___continual leakage ___varies
(Comments_____)

7. When does this leakage occur? ___mainly during the day (when_____) ___mainly at night (when_____) ___both day and night

8. When you leak urine, how much do you leak? ___just a few drops ___less than a cupful ___more than a cupful ___ variable ___don't know

9. Do any of the following cause you to leak urine? ___coughing ___laughing ___exercise ___lifting/straining ___sneezing ___can't get to the toilet on time

10. How often do you urinate? ___about 6 to 8 hours ___about 3 to 5 hours ___about 1 to 3 hours ___ at least every hour or more ___frequency varies

11. Do you wake up at night to urinate? ___never or rarely ___usually 1 to 3 times ___4 or more times ___frequency varies

12. Once your bladder feels full, how long can you hold your urine?
___as long as I want (several minutes at least) ___just a few minutes
___less than a minute or two ___can not tell when bladder is full

13. When you urinate, do you have: ___difficulty in getting the urine started ___burning ___very slow stream or dribbling ___discomfort or pain ___blood in the urine ___none of these

14. Do you have? ___excessive frequency ___burning ___ infections ___ spasms ___ prostate infections ___straining or pushing out urine to empty bladder

15. Do you have diarrhea? ___No ___Yes
(frequency_____)

16. Do you ever have uncontrolled loss of stool? ___No, never ___Yes
(When_____)

17. Can you tell if there is solid, liquid, or gas in the rectum? ___No ___Yes

18. Do you have trouble with constipation? ___No, never ___Yes

19. How many bowel movements do you have per week? ___without laxatives or enemas ___with laxatives or enemas
Are your stools usually _____Watery _____ Loose _____Soft and well formed _____ Hard and well formed _____ Like small pebbles

20. Do you have to work hard or strain to have a bowel movement? _____ No _____ Yes

21. How many pregnancies? _____ Birth weights? _____
Any problems with labor and delivery? _____
Did you ever have an episiotomy (cutting of the perineum)? ____No ____ Yes
Did you ever have a C-section? ___No ___Yes How many? _____
Any muscle tearing during delivery? ____No ____Yes

22. Do you use sanitary napkins for protection against leaks? ____ No ____Yes
What kind/how many per day? _____

23. Do you experience any pain with intercourse? _____No _____Yes

24. List of current medications:

_____ _____
_____ _____
_____ _____
_____ _____

25. List of previous surgeries: Date/Operations/Effect on current symptoms:
_____
_____
_____

26. Previous diagnostic work-up for bladder and/or bowel? Date/Test/Results:
_____
_____
_____

27. Medical History: _____
_____
_____
_____

28. Last check-up with your OB/GYN: _____
Last urinalysis: _____ Completed by:_____
Any Problems? _____

29. What are your goals for therapy?
_____
_____
_____

CITY PARK LLC
PHYSICAL THERAPY

VOIDING DIARY

Patient Name: _____ **Date**: ____/____/____

Time of Day	Used Toilet (+)	Did you leak urine? (Circle one)*	Activity when leak happened (lifting, sneezing, on the way to the bathroom)	Type & amt of liquid intake? (in cups)
7:00 a.m.		S M L		
8:00 a.m.		S M L		
9:00 a.m.		S M L		
10:00 a.m.		S M L		
11:00 a.m.		S M L		
12:00 noon		S M L		
1:00 p.m.		S M L		
2:00 p.m.		S M L		
3:00 p.m.		S M L		
4:00 p.m.		S M L		
5:00 p.m.		S M L		
6:00 p.m.		S M L		
7:00 p.m.		S M L		
8:00 p.m.		S M L		
9:00 p.m.		S M L		
10:00 p.m.		S M L		
11:00 p.m.		S M L		
12:00 midnight		S M L		
1:00 a.m.		S M L		
2:00 a.m.		S M L		
3:00 a.m.		S M L		
4:00 a.m.		S M L		
5:00 a.m.		S M L		
6:00 a.m.		S M L		

Urine output in ounces (measure 1x during day) – Voided ___ounces at __a.m./p.m.

***S= slightly wet M = wets pad, L = outside of clothing is wet**

CITY PARK LLC
PHYSICAL THERAPY

VOIDING DIARY

Patient Name: _____ **Date**: ____/____/____

Time of Day	Used Toilet (+)	Did you leak urine? (Circle one)*	Activity when leak happened (lifting, sneezing, on the way to the bathroom)	Type & amt of liquid intake? (in cups)
7:00 a.m.		S M L		
8:00 a.m.		S M L		
9:00 a.m.		S M L		
10:00 a.m.		S M L		
11:00 a.m.		S M L		
12:00 noon		S M L		
1:00 p.m.		S M L		
2:00 p.m.		S M L		
3:00 p.m.		S M L		
4:00 p.m.		S M L		
5:00 p.m.		S M L		
6:00 p.m.		S M L		
7:00 p.m.		S M L		
8:00 p.m.		S M L		
9:00 p.m.		S M L		
10:00 p.m.		S M L		
11:00 p.m.		S M L		
12:00 midnight		S M L		
1:00 a.m.		S M L		
2:00 a.m.		S M L		
3:00 a.m.		S M L		
4:00 a.m.		S M L		
5:00 a.m.		S M L		
6:00 a.m.		S M L		

Urine output in ounces (measure 1x during day) – Voided ___ounces at __a.m./p.m.

*** S = slightly wet, M = wets pad, L = outside of clothing is wet**

CITY PARK LLC
PHYSICAL THERAPY

VOIDING DIARY

Patient Name: _____ **Date**: ____/____/____

Time of Day	Used Toilet (+)	Did you leak urine? (Circle one)*	Activity when leak happened (lifting, sneezing, on the way to the bathroom)	Type & amt of liquid intake? (in cups)
7:00 a.m.		S M L		
8:00 a.m.		S M L		
9:00 a.m.		S M L		
10:00 a.m.		S M L		
11:00 a.m.		S M L		
12:00 noon		S M L		
1:00 p.m.		S M L		
2:00 p.m.		S M L		
3:00 p.m.		S M L		
4:00 p.m.		S M L		
5:00 p.m.		S M L		
6:00 p.m.		S M L		
7:00 p.m.		S M L		
8:00 p.m.		S M L		
9:00 p.m.		S M L		
10:00 p.m.		S M L		
11:00 p.m.		S M L		
12:00 midnight		S M L		
1:00 a.m.		S M L		
2:00 a.m.		S M L		
3:00 a.m.		S M L		
4:00 a.m.		S M L		
5:00 a.m.		S M L		
6:00 a.m.		S M L		

Urine output in ounces (measure 1x during day) – Voided ___ounces at __a.m./p.m.

*** S = slightly wet, M = wets pad, L = outside of clothing is wet**