



# **MRPT PHYSICAL THERAPY INCONTINENCE PROGRAM**

Patient name: \_\_\_\_\_

## **CONTINENCE SCREENING QUESTIONS**

	4-6x's	6-10x's	More than 10x's	YES	NO
How often do you urinate per day? (circle)					
Is your urge to urinate unusually strong?				<input type="checkbox"/>	<input type="checkbox"/>
Do you always make it to the bathroom on time?				<input type="checkbox"/>	<input type="checkbox"/>
Can you overcome the urge to void?				<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of when you leak urine?				<input type="checkbox"/>	<input type="checkbox"/>
Can you stop the flow of urine on your own?				<input type="checkbox"/>	<input type="checkbox"/>
Do you leak urine when you sneeze or cough, or during physical activities?				<input type="checkbox"/>	<input type="checkbox"/>
If so, what activities					
Do you leak urine in small amounts? Large amounts?				<input type="checkbox"/>	<input type="checkbox"/>
Do you leak urine at night?				<input type="checkbox"/>	<input type="checkbox"/>
Do you leak urine when you change positions?				<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you empty your bladder?				<input type="checkbox"/>	<input type="checkbox"/>
Do you have to strain to empty your bladder?				<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble starting your stream?				<input type="checkbox"/>	<input type="checkbox"/>
Do you start and stop your stream when voiding?				<input type="checkbox"/>	<input type="checkbox"/>
Is your stream weak or slow?				<input type="checkbox"/>	<input type="checkbox"/>
Do you dribble or leak urine after voiding?				<input type="checkbox"/>	<input type="checkbox"/>
Do you use any protective pads for urine leakage? (including panty shields, mini pads, maxi pads)				<input type="checkbox"/>	<input type="checkbox"/>
If so how many in the course of a day?					
Do you have any pain while voiding?				<input type="checkbox"/>	<input type="checkbox"/>
How many caffeinated beverages do you drink per day? How many per day? (0-2) (2-4) (4-or more)				<input type="checkbox"/>	<input type="checkbox"/>
How many non-caffeinated beverages do you drink per day? What type and amount? (0-4) (4-8) (8 or more)				<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of constipation?				<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a bowel movement?				<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of straining during a bowel movement?				<input type="checkbox"/>	<input type="checkbox"/>

How would you rate the effect of bladder/bowel dysfunction on your quality of life?  
 0|-----| 10  
 No Effect Severely Effect