Patient Name: _____

Incontinence Symptom Questionnaire

Please Choose the answer that most pertains to your situation:

1. Bladder Leakage frequency- number of episodes per day _____
    a. Never
    b. Only with strong cough/ sneeze
    c. Only premenstrual

2. Protection worn
    a. None
    b. Pantishield
    c. Minipads
    d. Maxipads
    e. Diaper
    f. Other

3. Leakage caused or increased by: (choose all that apply)
    a. Vigorous activity or exercise (i.e., Running, weight lifting)
    b. Light activity (i.e., Walking, light housework)
    c. Changing positions (i.e., Sit to stand)
    d. Walking to the toilet
    e. Strong urge to go
    f. Intercourse or sexual activity
    g. No activity changes (leakage constant despite activity)

4. Position of activity with leakage
    a. Lying Supine (on your back)
    b. Sitting
    c. Standing

5. How long can you delay the need to urinate?
    a. Not at all
    b. 1-2 minutes
    c. 3-10 minutes
    d. 11-30 minutes
    e. 31-60 minutes
    f. _____ hours

6. Fluid intake (one glass equals 8 ounces or 1 cup)
    a. _____ glasses of water per day
    b. _____ glasses of caffeinated beverages
    c. _____ glasses of alcoholic beverages per day

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____