



**Outpatient Rehabilitation Services  
Women's Health - Pelvic Floor Distress  
Inventory Questionnaire Short Form 20**

PATIENT ID LABEL

Please answer all of the questions in the following survey. These questions will ask if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box(es). If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**.

		If YES, how much does it bother you?				
		Not at all	Somewhat	Moderately	Quite a bit	
1.	Do you usually experience pressure in the lower abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you usually experience heaviness or dullness in the lower abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you usually have a bulge or something falling out that you can see or feel in the vagina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you usually lose stool beyond your control if your stool is loose or liquid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you usually have pain when you pass stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you usually experience frequent urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Do you usually experience urine leakage related to laughing, coughing or sneezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Do you usually experience small amounts of urine leakage; (that is, drops)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Therapist Signature / License #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

