



Mars Clinic
Children's Continence
Clinic

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Mars Clinic Questionnaire Bowel

Thank you for completing this questionnaire, which has been designed to provide information on your child's bowel and bladder condition. If your child is older, you may wish to complete this questionnaire with them. Teenagers may choose to complete the questionnaire independently.

Please complete the questionnaire and return (via email, fax or post) *at least 2 days before your physiotherapy appointment*, to the appropriate location as listed above.

Date: ____/____/____

Child's Name: _____

D.O.B ____/____/____

Parent's Name: _____

School: _____

School Tel: _____

School Teacher's Name: _____

School Principal's Name: _____

1. Bowel Habits		
Does your child move his/her bowels daily?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If not, how many times per week? _____(times per week)		
Is your child regularly constipated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child require any medications/medicines/enemas etc. to help manage his/her bowel problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify: _____ _____ _____		
Has your child had any surgery/procedures to help manage his/her bowel problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify: _____ _____ _____		

Mars Clinic is located within:



Mars Clinic : Your Partner in Children's Continence



2. Soiling		
Does your child soil his/her underwear?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q3
Has your child previously had complete bowel control?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, at what age? _____ For how long? _____(wks/mnths/yrs)		
Does your child soil his/her underwear during the <i>day</i> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, is the amount: small (smear) <input type="checkbox"/> large (stool) <input type="checkbox"/> how often?: _____(times per day/week/month)		
Does the soiling occur in particular situations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify: _____		
Does your child soil his/her underwear during the <i>night</i> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, is the amount: small (smear) <input type="checkbox"/> large (stool) <input type="checkbox"/> how often?: _____(times per day/week/month)		
How does your child manage his/her soiling at home? _____ _____		
How does your child manage his/her soiling at school? _____ _____		

3. Family History		
Has any other family member had problems with constipation or soiling?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q4
If yes, who and when and at what age did it stop? (see below)		
Family member: _____ When _____ Stopped _____	Day <input type="checkbox"/>	Night <input type="checkbox"/>
Family member: _____ When _____ Stopped _____	Day <input type="checkbox"/>	Night <input type="checkbox"/>
Family member: _____ When _____ Stopped _____	Day <input type="checkbox"/>	Night <input type="checkbox"/>

4. Toileting Habits		
Does your child go to the toilet himself/herself if he/she needs to?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have to send your child to the toilet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child wants to void, does he/she have to strain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child hurry and not take enough time for voiding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have a regular toileting routine? If yes, please specify: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

5. Observations		
Does your child feel a sudden urge to go to the toilet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
When your child needs to void, does he/she have to rush to the toilet immediately?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child try to postpone going to the toilet as long as possible? If yes, in what situation/s? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

6. Day-time Wetting		
Does your child wet himself/herself during the day?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q7
Has your child ever been dry during the day? If yes, at what age was your child dry during the day? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For how long? _____ (weeks/months/years)		
How many days per week does your child wet his/her clothing during the day? _____ (days per week)		
How many times per day does your child wet his/her clothing, during the daytime? _____ (times per day)		

7. Night-time Wetting		
Does your child wet himself/herself during the night?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q8
Has your child ever been dry during the night? If yes, at what age was your child dry during the night? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For how long? _____ (weeks/months/years)		
How many nights per week does your child wet his/her clothing during the night? _____ (days per week)		

8. Urinary Tract Infections		
Has your child ever had a urinary tract infection? If yes, how many times? _____ At what age/s? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your child been treated for an illness of the urinary tract? If yes, please specify: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
When was your child's most recent urinary tract infection? _____		

9. Voiding Behaviour		
Is your child distressed by the constipation/soiling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you distressed by the constipation/soiling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your child been teased because of the constipation/soiling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child avoid activities because of the constipation/soiling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child soil more often during stressful times?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child cooperative and motivated for treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child was previously continent, can you think of an event that might be associated with the relapse? If yes, please specify: _____ _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

10. General Behaviour		
Does your child have difficulty accepting rules?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child restless, always on-the-go, easily distracted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have difficulty concentrating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child sometimes anxious?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child sometimes sad, unhappy or withdrawn?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have problems at school? If yes, please specify: _____ _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have problems in other areas? If yes, please specify: _____ _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

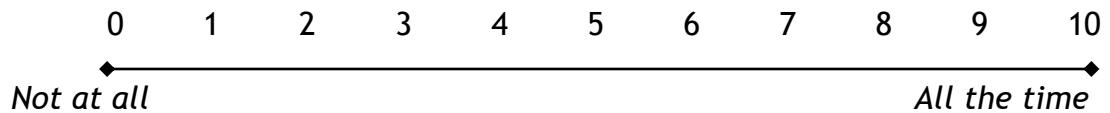
Visual Analogue Scales

Bowel

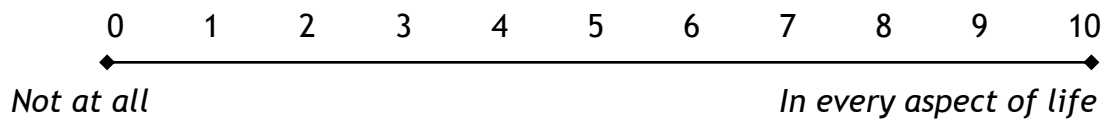
Initial Assessment

Date: _____

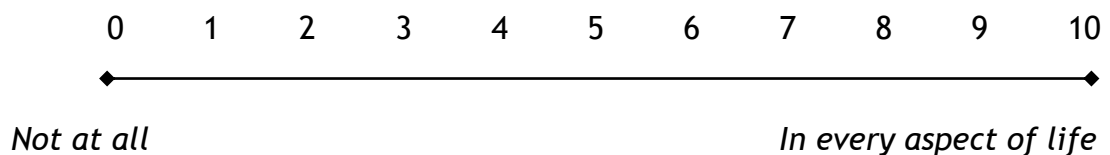
1) In your opinion, how constipated is your child:



2) How much do you think your child's condition impacts on his/her quality of life?



3) How much impact do you think your child's condition has on your own quality of life?



Outlet Obstruction Questionnaire

Initial Assessment

Date: _____

Please circle the option that best describes your poos over the last week:

I felt the urge to do a poo and tried to poo, but nothing came out	Never	Occasionally <i>(less than 25% of time)</i>	Sometimes <i>(more than 25% of the time)</i>	Every time I tried to poo
Sometimes I felt the urge to do a poo and tried to poo, but only a little bit came out	Never	Occasionally <i>(less than 25% of time)</i>	Sometimes <i>(more than 25% of the time)</i>	Every time I tried to poo
I had to strain (push very hard) to do a poo	Never	Occasionally <i>(less than 25% of time)</i>	Sometimes <i>(more than 25% of the time)</i>	Every time I tried to poo

Sometimes I had an accident and poo came out in the bath	No	Yes
Sometimes I had an accident and poo came out when I was distracted	No	Yes
Sometimes I had an accident and poo came out while I was asleep	No	Yes
I did an explosive poo that splashed up the toilet bowl	No	Yes
I had an accident within 30 minutes of trying to do a poo on the toilet	No	Yes
I did a large poo that blocked the toilet	No	Yes

This week my thinnest poo was as thin as a:	Noodle	Lolly Snake	10cent piece	20cent piece	50cent piece	Wider than a 50cent piece
This week my thickest poo was as thick as a:	Noodle	Lolly Snake	10cent piece	20cent piece	50cent piece	Wider than a 50cent piece