Mars Clinic
Children's Continence Clinic
www.marsclinic.com.au

SOUTH BRISBANE (HEAD OFFICE)
Mater Medical Centre
Level 3, 293 Vulture Street
South Brisbane Q 4101
Ph (07) 3163 1188
Fax (07) 3163 1192
mail@marsclinic.com.au

ANNERLEY
UQ Health Care
Level 4, PACE Building
20 Cornwall Street
Woolloongabba Q 4102
Ph (07) 3346 1768
Fax (07) 3392 2611
annerley@marsclinic.com.au

HOPE ISLAND
Mater Health Centre
8 Halcyon Way
Hope Island Q 4212
Ph (07) 5635 4045
Fax (07) 5635 4049
hopeisland@marsclinic.com.au

BROOKWATER
Woolworths Brookwater Village
Mater Health Centre
16/2 Tournament Drive
Brookwater Q 4300
Ph (07) 3199 3211
Fax (07) 3199 3220
brookwater@marsclinic.com.au

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? If not, how many times per week? _____(times per week)	Yes ☐	No ☐
Is your child regularly constipated?	Yes ☐	No ☐
Does your child require any medications/medicines/enemas etc. to help manage his/her bowel problems? If yes, please specify: _____ _____ _____ _____	Yes ☐	No ☐
Has your child had any surgery/procedures to help manage his/her bowel problems? If yes, please specify: _____ _____ _____ _____	Yes ☐	No ☐

2. Soiling		
Does your child soil his/her underwear?	Yes ☐	No ☐> **Q3**
Has your child previously had complete bowel control? If yes, at what age? _____ For how long? _____(wks/mnths/yrs)	Yes ☐	No ☐
Does your child soil his/her underwear during the *day*? If yes, is the amount: small (smear) ☐ large (stool) ☐ how often?: _____(times per day/week/month)	Yes ☐	No ☐
Does the soiling occur in particular situations? If yes, please specify:_____	Yes ☐	No ☐
Does your child soil his/her underwear during the *night*? If yes, is the amount: small (smear) ☐ large (stool) ☐ how often?: _____(times per day/week/month)	Yes ☐	No ☐
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 ☐	No ☐> **Q4**
If yes, who and when and at what age did it stop? (see below)		
Family member: _____When_____ Stopped_____	Day ☐	Night ☐
Family member: _____When_____ Stopped_____	Day ☐	Night ☐
Family member: _____When_____Stopped_____	Day ☐	Night ☐

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

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

6. Day-time Wetting		
Does your child wet himself/herself during the day?	Yes ☐	No ☐> **Q7**
Has your child ever been dry during the day? If yes, at what age was your child dry during the day? _____ For how long? _____ (weeks/months/years)	Yes ☐	No ☐
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 ☐	No ☐> **Q8**
Has your child ever been dry during the night? If yes, at what age was your child dry during the night? _____ For how long? _____ (weeks/months/years)	Yes ☐	No ☐
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 ☐	No ☐
Has your child been treated for an illness of the urinary tract? If yes, please specify: _____ _____ When was your child's most recent urinary tract infection? _____	Yes ☐	No ☐

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

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

Visual Analogue Scales
Bowel

Initial Assessment

Date: _____

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

0 1 2 3 4 5 6 7 8 9 10

Not at all *All the time*

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

0 1 2 3 4 5 6 7 8 9 10

Not at all *In every aspect of life*

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

0 1 2 3 4 5 6 7 8 9 10

Not at all *In every aspect 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 *(less than 25% of time)*	Sometimes *(more than 25% of the time)*	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 *(less than 25% of time)*	Sometimes *(more than 25% of the time)*	Every time I tried to poo
I had to **strain** (push very hard) to do a poo	Never	Occasionally *(less than 25% of time)*	Sometimes *(more than 25% of the time)*	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