



Mars Clinic
Children's Continence
Clinic

www.marsclinic.com.au

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Mars Clinic Questionnaire Urinary

Thank you for completing this questionnaire, which has been designed to provide information on your child's bladder and bowel 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. Day-time Wetting		
Does your child wet himself/herself during the day?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q2
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)		
If your child wets his/her clothing, is the clothing usually:	Damp <input type="checkbox"/>	Soaked <input type="checkbox"/>
Does urine dribble constantly?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child wet his/her clothing immediately after having gone to the toilet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child notice when he/she is wet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Mars Clinic is located within:



Mars Clinic : Your Partner in Children's Continence



2. Night-time Wetting		
Does your child wet himself/herself during the night?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q3
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? _____ (nights per week)		
How many times per night does your child wet his/her clothing, during the night? _____ (times per night)		
If your child wets his/her clothing/bed, is the clothing/bed usually:	Damp <input type="checkbox"/>	Soaked <input type="checkbox"/>
Does your child wake up to go to the toilet?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child wake after wetting the bed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child a deep sleeper?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

3. Family History		
Has any other family member had problems with wetting?	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		
How many times per day does your child urinate (on average)? _____ (times per day)		
How long can your child manage without going to the toilet? _____ (hours)		
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 urinate, does he/she have to strain at the beginning or the end of voiding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
When your child voids, is the stream interrupted?	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"/>

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 prevent wetting, for example, by crossing his/her legs, squatting or sitting on his/her heels	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. 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"/> > Q7
Has your child had a urinary tract infection with fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>

7. Bowel Habits		
Does your child move his/her bowels daily? If not, how many times per week? _____(times per week)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child regularly constipated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child soil his/her underwear?	Yes <input type="checkbox"/>	No <input type="checkbox"/> > Q8
Has your child previously had complete bowel control? If yes, at what age? _____ For how long? _____ (weeks/months/years)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child soil his/her underwear during the <i>day</i> ? 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? If yes, please specify: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child soil his/her underwear during the <i>night</i> ? If yes, is the amount: small (smear) <input type="checkbox"/> large (stool) <input type="checkbox"/> how often?: _____(times per day/week/month)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

8. Wetting Behaviour		
Is your child distressed by the wetting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you distressed by the wetting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your child been teased because of the wetting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child avoid activities because of the wetting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child wet 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 dry, 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"/>
What, in your opinion, is the reason for the wetting? _____ _____		

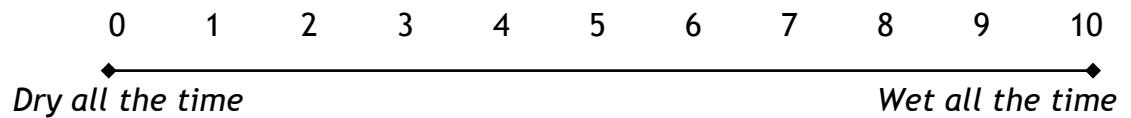
9. General Behaviour		
Does your child have difficulty accepting rules?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child restless, always on-the-go, easily distracted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have difficulty concentrating?	Yes <input 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

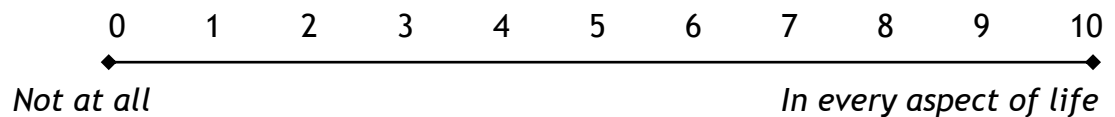
Initial Assessment

Date: _____

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



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



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

