BOWEL SYMPTOM QUESTIONNAIRE

WE REQUEST THAT YOU COMPLETE THIS QUESTIONNAIRE SO WE MAY BETTER ASSIST YOU IN YOUR CARE.
OUR PRACTICE OFFERS SEVERAL SPECIALTIES THAT MAY BE A BENEFIT TO YOU. PLEASE ANSWER THE FOLLOWING QUESTIONS.

NAME: _____ **DOB:** _____

DOCTOR: _____ **DATE:** _____

Which symptoms best describe you? Select all that apply.

- ☐ Accidental loss or leakage of stool - sometimes unable to make it to the bathroom in time
- ☐ Bowel accidents while unaware - no warning and/or while asleep
- ☐ Bowel accidents when passing gas
- ☐ No bowel problems (If checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Approximately how many bowel incidents do you have per week? _____

Have you tried medication to help your symptoms? **YES NO**

On a scale of 1 to 10, with 1 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

1	2	3	4	5	6	7	8	9	10

No Relief — Complete Symptom Relief

Behavior modification tried? (e.g., diet changes, fiber, lifestyle changes, physical therapy) _____

_____

On a scale of 1 to 10, with 1 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Circle a number.

1	2	3	4	5	6	7	8	9	10

Not Frustrated — Very Frustrated

Are you interested in learning about additional treatment alternatives to bowel medications? **YES NO**