Bowel Symptom Questionnaire

Name: _____ Date: _____

Which symptoms best describe you? Check all that apply:

[ ] Accidental loss of leakage of stool – sometimes unable to make it to the bathroom in time

[ ] Bowel accidents while unaware – no warning and/or while asleep

[ ] Frequent loose or watery stools

[ ] No bowel problems (If checked, please discontinue questionnaire.)

How long have you had these symptoms? _____

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

Have you tried medications to help your symptoms? Yes [ ] No [ ]

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you?

0	1	2	3	4	5	6	7	8	9	10
No Relief										Complete Symptom Relief

Behavior modifications tried? _____
(i.e.: lifestyle changes, fiber, diet changes, physical therapy?)

0	1	2	3	4	5	6	7	8	9	10
Not Frustrated										Very Frustrated

Are you interested in learning more about additional treatment alternatives to bowel modifications?

Yes [ ] No [ ]

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