

Voiding Clinic Questionnaire

Name: _____

Date of Birth: _____

Score: _____

Date: _____

1. Does your child wet during the day?

No	Sometimes	1-2 times/day	Always
0 points	1 point	3 points	5 points

2. How wet is your child during the day?

Damp underwear	Damp pants only	Pants soaking wet
1 point	3 points	5 points

3. Does your child wet during the night?

No	1-2 nights/wk	3-5 nights/wk	6-7 nights/wk
0 points	1 point	3 points	5 points

4. How wet is your child during the night?

Damp bedsheet only	Bed sheets soaking wet
1 point	4 points

5. How many times/day does your child urinate?

Less than 7/day	7 or more than 7/day
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6. My child strains while urinating: No – 0 points Yes – 4 points

7. My child feels pain while urinating: No – 0 points Yes – 1 point

8. My child needs to go back to pee soon after finishes urinating

No – 0 points	Yes – 2 points
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9. My child has a sudden feeling of having to pee immediately

No – 0 points	Yes – 1 point
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10. My child holds by crossing his/her legs (potty dance)

No – 0 points	Yes – 2 points
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11. My child wets on the way to toilet

No – 0 points	Yes – 2 points
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12. My child has a bowel movement every day

No – 1 point	Yes – 0 points
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If your child experiences symptoms mentioned above, does it affect his/her family, social or school life?

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|-----------|------------------|---------------------|--------------------------|
| No | Sometimes | Yes, affects | Seriously affects |
| 0 | 1 point | 2 points | 3 points |