State of Illinois
Department of Healthcare and Family Services

Neurogenic Bowel Dysfunction Questionnaire For the Adult Customer At Least 18 Years Old

Customer Name: _____ DOB: _____ RIN: _____

Check the box that most accurately answers the question. This should be completed by the customer, in conjunction with the customer, or by the caregiver if the customer cannot provide constructive input.

1. How often do you defecate?
   - ☐ Daily
   - ☐ 2-6 times per week
   - ☐ Less than once per week

2. How much time do you spend on each defecation?
   - ☐ Less than 30 minutes
   - ☐ 31-60 minutes
   - ☐ More than 60 minutes

3. Do you experience uneasiness, sweating, or headaches during or after defecation?
   - ☐ Yes
   - ☐ No

4. Do you take medication (tablets) to treat constipation?
   - ☐ Yes
   - ☐ No

5. Do you take medication (drops or liquid) to treat constipation?
   - ☐ Yes
   - ☐ No

6. How often do you use digital evacuation?
   - ☐ Less than once per week
   - ☐ Once or more per week

7. How often do you have involuntary defecation?
   - ☐ Daily
   - ☐ 1-6 times a week
   - ☐ 3-4 times a month
   - ☐ A few times a year or less

8. Do you take medication to treat fecal incontinence?
   - ☐ Yes
   - ☐ No

9. Do you experience uncontrollable flatus?
   - ☐ Yes
   - ☐ No

10. Do you have problems with the skin around your anus?
    - ☐ Yes
    - ☐ No

Name of person completing this form: _____
(Please Print)

Relationship to customer if customer is not completing this form: _____

Signature: _____ Date: _____