Windsor Center for Digestive Health
A Division of Allied Digestive Health

Phone 609.918.1222
Fax 609.918.1235

300B Princeton Hightstown Road
Suite 206
East Windsor, NJ 08520

Patient Assessment of Constipation Symptoms

Name: ______________________________ **Date of Birth:** ____________________

- This questionnaire asks you about your constipation in the past 2 weeks.
- Please tick the box that represents the severity of your symptoms. There are no right or wrong answers.

On a scale of 0-4, how severe has each of these symptoms been in the past 2 weeks?

Abdominal:	Absence of symptom 0	Mild 1	Moderate 2	Severe 3	Very Severe 4
1. Discomfort in your stomach	☐	☐	☐	☐	☐
2. Pain in your stomach	☐	☐	☐	☐	☐
3. Bloating in your stomach	☐	☐	☐	☐	☐
4. Stomach cramps	☐	☐	☐	☐	☐

Rectal:	Absence of symptom 0	Mild 1	Moderate 2	Severe 3	Very Severe 4
5. Painful bowel movements	☐	☐	☐	☐	☐
6. Rectal burning during or after a bowel movement	☐	☐	☐	☐	☐
7. Rectal bleeding or tearing during or after a bowel movement	☐	☐	☐	☐	☐

Stool:	Absence of symptom 0	Mild 1	Moderate 2	Severe 3	Very Severe 4
8. Incomplete bowel movement, felt like you didn't finish	☐	☐	☐	☐	☐
9. Bowel movements were too hard	☐	☐	☐	☐	☐
10. Bowel movements were too small	☐	☐	☐	☐	☐
11. Straining or squeezing to try and pass bowel movements	☐	☐	☐	☐	☐
12. Feeling like you had to pass a bowel movement but you could not ("false alarm")	☐	☐	☐	☐	☐