Cleveland Clinic Incontinence Score

Please tick one box in each row to indicate on average how often you experience the following:

	Never	**Rarely** Less than once a month	**Sometimes** Less than once a week	**Usually** Less than once a day	**Always** Everyday
a. Solid stool leakage	☐	☐	☐	☐	☐
b. Liquid stool leakage	☐	☐	☐	☐	☐
c. Gas leakage	☐	☐	☐	☐	☐
d. Pad use (for stool)	☐	☐	☐	☐	☐
e. Lifestyle restriction	☐	☐	☐	☐	☐

Please fill in the dates of birth of your children and if the delivery was a Normal Vaginal Delivery or a Caesarean Section.

1st Child _ _/_ _/_ _ _ _ Delivery:_____

2nd Child _ _/_ _/_ _ _ _ Delivery:_____

3rd Child _ _/_ _/_ _ _ _ Delivery:_____

4th Child _ _/_ _/_ _ _ _ Delivery:_____

Other Children _ _/_ _/_ _ _ _ Delivery:_____

Thank you very much for completing this questionnaire

KPN&SAP2008