

IMPACT: Bowel Function Assessment Tool, Short Form

Name: _____ DOB: _____

Directions: These questions will ask you if you have certain bowel symptoms and, if you do, how much they bother you. While answering, please consider your symptoms over the last 3 months.

Please think about your typical bowel movements.

1 Please choose which stool type is most like the shape of your stools.

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separate, hard lumps like nuts (hard to pass)	Sausage-shaped but lumpy	Like a sausage, but with cracks on the surface	Like a sausage or snake, smooth and soft	Soft blobs with clear-cut edges	Fluffy pieces with ragged edges, a mushy stool	Watery, no solid pieces, entirely liquid

2 During a typical month, how many times do you usually have an uncomfortable or difficult bowel movement?

Never	Daily	A few times per week	Once per week	Once every 2 weeks	Once a month
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3 Are you having difficulty with having infrequent bowel movements (less than 1 bowel movement every 3 days)?

NO
SKIP TO Q4

YES
PROCEED

Frequency	Severity	Impact
How often do you experience infrequent bowel movements? <ul style="list-style-type: none"> <input type="checkbox"/> Occasionally experience this <input type="checkbox"/> Sometimes experience this <input type="checkbox"/> Usually experience this <input type="checkbox"/> Always experience this 	How severe is this symptom for you? <ul style="list-style-type: none"> <input type="checkbox"/> Not at all severe (I go almost every day) <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe (I go 1-2 times per week) <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe (I can go up to 4 weeks without going) 	How much does this symptom bother you? <ul style="list-style-type: none"> <input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

4 Do you ever lack the urge to have a bowel movement?

NO
SKIP TO Q5

YES
PROCEED

Severity	Impact
How severe is this for you?	How much does this bother you?
<input type="checkbox"/> Not at all severe (I have a pretty good sense when I have to go) <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe (I only have a vague sense that I might have to go) <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe (I don't have any sensation in the pelvic area)	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

5 Do you feel you need to strain too hard to have a bowel movement?

NO
SKIP TO Q6

YES
PROCEED

Frequency	Severity	Impact
How often do you experience this?	How severe is this for you?	How much does this bother you?
<input type="checkbox"/> Occasionally experience this <input type="checkbox"/> Sometimes experience this <input type="checkbox"/> Usually experience this <input type="checkbox"/> Always experience this	<input type="checkbox"/> Not at all severe (I push a little) <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe (I bear down hard) <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe (I push on my belly, grunt and bear down very hard)	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

6 Do you feel you have not completely emptied your bowels at the end of a bowel movement??

NO
SKIP TO Q7

YES
PROCEED

Frequency	Severity	Impact
How often do you experience this?	How severe is this for you?	How much does this bother you?
<input type="checkbox"/> Occasionally experience this <input type="checkbox"/> Sometimes experience this <input type="checkbox"/> Usually experience this <input type="checkbox"/> Always experience this	<input type="checkbox"/> Not at all severe (Most of my bowel movement comes out) <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe (There is still a lot of stool in me after a bowel movement) <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe (I feel constant pressure in my rectum from stool or keep going back to the bathroom)	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

7 Do you sometimes have symptoms of constipation?

NO
SKIP TO Q8

YES
PROCEED

The following questions ask about symptoms of constipation. Please SKIP if you do not have constipation. If you have constipation, please indicate how severe your constipation symptoms have been for you during the past 2 weeks.

7a: Discomfort in your abdomen	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7b: Pain in your abdomen	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7c: Bloating in your abdomen	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7d: Stomach cramps	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7e: Rectal burning during or after a bowel movement	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7f: Bowel movements that were too hard	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7g: Bowel movements that were too small:	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7h: Feeling like you had to pass a bowel movement but you couldn't (false alarm)	Absent	Mild	Moderate	Severe	Very Severe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8 Do you sometimes have accidental gas or bowel leakage?

NO
SKIP TO Q9

YES
PROCEED

8A.) Do you usually lose stool beyond your control if your stool is well-formed?

NO
SKIP TO 8B

YES
PROCEED

8B.) Do you usually lose stool beyond your control if your stool is loose (liquid)?

NO
SKIP TO 8C

YES
PROCEED

8C.) Do you usually lose gas from the rectum beyond your control?

NO
SKIP TO 8D

YES
PROCEED

8D.) Do you wear pads because of fear of losing stool?

8E.) Do you take medication to make you more constipated to help with bowel leakage?

8F.) Do you adjust your lifestyle because of concerns for possible accidental bowel leakage (for example: avoid going out; avoid certain foods; avoid sex)?

Frequency	Severity	Impact
How often do you experience this?	Did you leak stool, and if so how much?	How much does this bother you?
<input type="checkbox"/> Rarely (<1/month) <input type="checkbox"/> Sometimes (<1/week) <input type="checkbox"/> Weekly (but <1/day) <input type="checkbox"/> Daily (1/day or more)	<input type="checkbox"/> None <input type="checkbox"/> Stain only <input type="checkbox"/> More than a stain <input type="checkbox"/> Entire bowel moment	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

Frequency	Severity	Impact
How often do you experience this?	Did you leak stool, and if so how much?	How much does this bother you?
<input type="checkbox"/> Rarely (<1/month) <input type="checkbox"/> Sometimes (<1/week) <input type="checkbox"/> Weekly (but <1/day) <input type="checkbox"/> Daily (1/day or more)	<input type="checkbox"/> None <input type="checkbox"/> Stain only <input type="checkbox"/> More than a stain <input type="checkbox"/> Entire bowel moment	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

Frequency	Impact
How often do you experience this?	How much does this bother you?
<input type="checkbox"/> Rarely (<1/month) <input type="checkbox"/> Sometimes (<1/week) <input type="checkbox"/> Weekly (but <1/day) <input type="checkbox"/> Daily (1/day or more)	<input type="checkbox"/> Not at all bothersome <input type="checkbox"/> A little bothersome <input type="checkbox"/> Somewhat bothersome <input type="checkbox"/> Very bothersome <input type="checkbox"/> Extremely bothersome

Never	Rarely (less than 1x/month)	Sometimes (less than 1x/week)	Weekly	Daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Never	Rarely (less than 1x/month)	Sometimes (less than 1x/week)	Weekly	Daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

NO
SKIP TO Q10

YES
PROCEED

Not at all bothersome	A little bothersome	Somewhat bothersome	Very bothersome	Extremely bothersome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10 Do you usually have pain when you pass your stool?

NO
SKIP TO Q11

YES
PROCEED

Last month	At present	Impact
During the last month, on average, how severe was the pain in your rectum/anus?	Rate the level of your rectal/anal pain at the present moment.	How much suffering or bother do you experience because of rectal/anal pain?
<input type="checkbox"/> I haven't experienced this <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe	<input type="checkbox"/> No pain <input type="checkbox"/> Mild <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe	<input type="checkbox"/> None <input type="checkbox"/> Mild suffering <input type="checkbox"/> Somewhat severe suffering <input type="checkbox"/> Severe suffering <input type="checkbox"/> Extremely severe

11 Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

NO
SKIP TO Q12

YES
PROCEED

Not at all bothersome	A little bothersome	Somewhat bothersome	Very bothersome	Extremely bothersome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12 During the past month, due to your bowel habits, how often have you had bleeding during/after a bowel movement?

Never	Rarely	Occasionally	Usually	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>