Patient name: _____ DOB: _____ Date: _____

Persistent Pelvic Pain In Women

Please describe your pain problem(s) _____

_____

_____

_____

_____

Is there an event that you associate with the onset of your pain? ☐☐ Yes ☐☐ No

If so, what? _____

How long have you had pain? _____ years _____ months

What have you been told is causing your pain? _____

What do you think is causing your pain? _____

Has the pain spread from its original problem? ☐☐ Yes ☐☐ No

Social History

The Adverse Childhood Experience (ACE) study (1997) demonstrated with > 17,000 participants that traumatic experiences during childhood have a direct impact on the health of adults, especially if they have not been given the opportunity to talk about these events in a safe and empathetic environment. In that regard, your social history is very important and confidential.

Where were you born? _____

How any siblings do you have? _____

How would you describe your childhood? Average / Happy / Sad / Other:

Where you physically/emotionally abused as a child? ☐☐ Yes ☐☐ No

Have you been touched sexually when you did not want it? ☐☐ Yes ☐☐ No

Have you ever had sex against your will? ☐☐ Yes ☐☐ No

Has anyone in your family been killed? ☐☐ Yes ☐☐ No

Has anyone in your family had a nervous breakdown? ☐☐ Yes ☐☐ No

Has anyone in your family committed suicide? ☐☐ Yes ☐☐ No

Has anyone in your family been a drug abuse user or alcoholic? ☐☐ Yes ☐☐ No

Do you abuse drugs or alcohol? ☐☐ Yes ☐☐ No

Have you ever fought in a war? ☐☐ Yes ☐☐ No

Have you ever lived in a war zone? ☐☐ Yes ☐☐ No

Are you: ☐☐ Married ☐☐ Widowed ☐☐ Separated ☐☐ Single ☐☐ Remarried

☐☐ Divorced ☐☐ Committed relationship

Who lives in your home? _____

Patient name: _____ DOB: _____ Date: _____

Who are the people you talk to when you are in pain? _____

What do you do to cope with stress? _____

How does your partner cope with your pain/stress? _____

How does your pain affect your family? _____

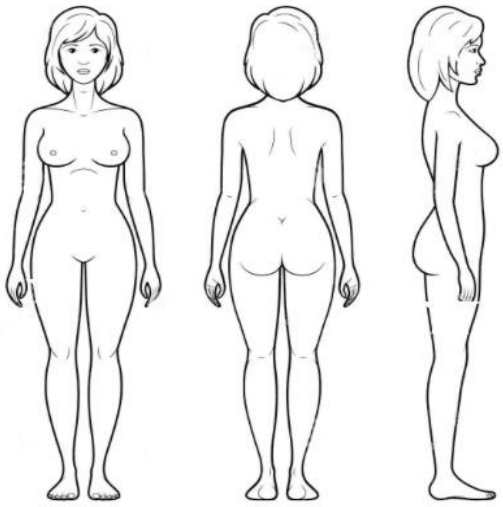
What type of work are you trained for? _____

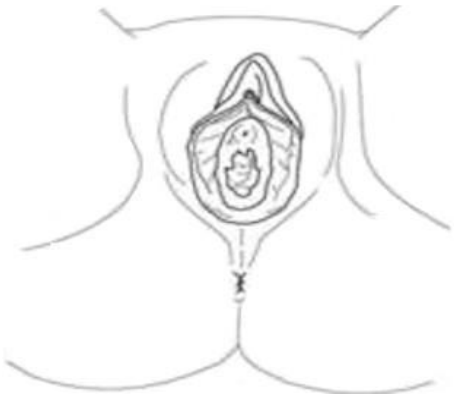
What type of work are you doing? _____

Do you like your job? _____

Have you ever been for counseling? _____

Please mark on the diagrams below where your pain is located





Some of these questions may not be applicable or uncomfortable; please answer all appropriate questions

Are you physically intimate with your partner without penetration?	☐ No	☐ Sometimes	☐ Yes
Do you have pain with penetration?	☐ Yes	☐ No	☐ Sometimes
Do you have pain at the vaginal opening?	☐ Yes	☐ No	☐ Sometimes
Do you have pain with thrusting?	☐ Yes	☐ No	☐ Sometimes
Are you able to orgasm?	☐ No	☐ Sometimes	☐ Yes
Do you have pain <u>with</u> orgasm?	☐ Yes	☐ No	☐ Sometimes
Do you have pain <u>after</u> orgasm?	☐ Yes	☐ No	☐ Sometimes
Do you have clitoral pain?	☐ Yes	☐ No	☐ Sometimes
If you are unable to have intercourse with penetration, can you orgasm with clitoral stimulation?	☐ No	☐ Sometimes	☐ Yes
Do you participate in anal sex?	☐ Yes	☐ No	☐ Sometimes
If yes, is anal sex painful?	☐ Yes	☐ No	☐ Sometimes
Does your partner have sexual dysfunction?	☐ Yes	☐ No	☐ Sometimes

If yes, what type? _____

How is your libido? ☐ Normal ☐ Increased ☐ Decreased ☐ Non-existent

Do you regularly self-pleasure? ☐ Yes ☐ No ☐ Sometimes

Patient name: _____ DOB: _____ Date: _____

Have you ever talked to a professional about sexual function? ☐☐ Yes ☐☐ No

Any further comments? _____

What makes your pain worse?

☐☐ Intercourse	☐☐ Orgasm	☐☐ Stress	☐☐ Full meal	☐☐ Bowel movement
☐☐ Full bladder	☐☐ Urination	☐☐ Standing	☐☐ Walking	☐☐ Exercise
☐☐ Time of day	☐☐ Sitting	☐☐ Contact with clothing	☐☐ Coughing/sneezing	☐☐ Weather
☐☐ Not related to anything	☐☐ Other: _____			

What helps soothe your pain?

☐☐ Meditation	☐☐ Relaxation	☐☐ Lying down	☐☐ Music	☐☐ Massage
☐☐ Ice	☐☐ Hot bath	☐☐ Heating pad	☐☐ Pain medication	☐☐ Laxatives/enema
☐☐ Injection	☐☐ TENS unit	☐☐ Bowel movement	☐☐ Emptying bladder	☐☐ Nothing
☐☐ Other: _____				

Have you been diagnosed by a doctor with any of the following conditions?

Please check the box to the right for each diagnosis and write the year of diagnosis

			Date of Diagnosis
Restless leg syndrome	☐☐ Yes	☐☐ No	_____
Chronic fatigue syndrome	☐☐ Yes	☐☐ No	_____
Fibromyalgia	☐☐ Yes	☐☐ No	_____
Temporomandibular joint disorder (TMJ)	☐☐ Yes	☐☐ No	_____
Migraine or tension headaches	☐☐ Yes	☐☐ No	_____
Irritable bowel syndrome	☐☐ Yes	☐☐ No	_____
Multiple chemical sensitivities	☐☐ Yes	☐☐ No	_____
Neck injury (including whiplash)	☐☐ Yes	☐☐ No	_____
Anxiety or panic attacks	☐☐ Yes	☐☐ No	_____
Depression	☐☐ Yes	☐☐ No	_____

What physician's or health care providers have you seen for these problems	
Physician/provider	Treatment provided

Patient name: _____ DOB: _____ Date: _____

Please list the medications you are currently taking (including vitamins and supplements)				
Medication/dose	Provider			
		☐☐ Yes	☐☐ No	☐☐ Currently taking
		☐☐ Yes	☐☐ No	☐☐ Currently taking
		☐☐ Yes	☐☐ No	☐☐ Currently taking
		☐☐ Yes	☐☐ No	☐☐ Currently taking
		☐☐ Yes	☐☐ No	☐☐ Currently taking
		☐☐ Yes	☐☐ No	☐☐ Currently taking

In the past, have you taken any of the following supplements for this problem?

			Dosage
Vitamin D	☐☐ No	☐☐ Yes	_____
Magnesium	☐☐ No	☐☐ Yes	_____
Omega 3	☐☐ No	☐☐ Yes	_____
Cranberry juice/extract	☐☐ No	☐☐ Yes	_____

In the past, what lotions/creams have you used for this problem?

_____

_____

_____

Sleep Hygiene

Does it usually take you longer than 30 minutes to fall asleep?	☐☐ Yes	☐☐ No
Do you wake up more than twice a night?	☐☐ Yes	☐☐ No
Do you regularly drink coffee, tea, caffeinated pop or alcoholic drinks?	☐☐ Yes	☐☐ No
Do you feel that you are currently under significant stress?	☐☐ Yes	☐☐ No
Do you feel stress/anxiety contributes to your sleeping difficulties?	☐☐ Yes	☐☐ No
Do you feel that you are sensitive to noises and/or that noises wake you up?	☐☐ Yes	☐☐ No
Do you have sources of light in your bedroom at night?	☐☐ Yes	☐☐ No
Does your sleeping partner keep you awake?	☐☐ Yes	☐☐ No
Do you feel that the air in your bedroom is too hot, cold or not fresh enough?	☐☐ Yes	☐☐ No
Do you feel that your mattress or your pillow is uncomfortable or > 10 years old?	☐☐ Yes	☐☐ No
Do you sleep on your stomach?	☐☐ Yes	☐☐ No
Do you have "creeping, crawling or tingling" feelings in your legs?	☐☐ Yes	☐☐ No
Do you think you snore loudly, gasp or stop breathing during sleep?	☐☐ Yes	☐☐ No
Do you take narcotics for pain?	☐☐ Yes	☐☐ No

Patient name: _____ DOB: _____ Date: _____

Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
I have headaches.	Never	Rarely	Sometimes	Often	Always
I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
I do not sleep well.	Never	Rarely	Sometimes	Often	Always
I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
I have low energy.	Never	Rarely	Sometimes	Often	Always
I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always
				TOTAL	_____

Patient name: _____ DOB: _____ Date: _____

PCS Questionnaire

(Reference: on Quartana et al. Pain Catastrophizing: A Critical review. Expert Rev Neurother. 2009 May; 9(5):745-758)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.
0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time

When I'm in pain……

(H) _____I worry all the time about whether the pain will end

(H) _____I feel I can't go on

(H) _____It's terrible and I think it's never going to get any better

(H) _____It's awful and I feel that it overwhelms me

(H) _____I feel I can't stand it anymore

(M) _____I become afraid that the pain will get worse

(M) _____I keep thinking of other painful events

(R) _____I anxiously want the pain to go away

(R) _____I can't seem to keep it out of my mind

(R) _____I keep thinking about how much it hurts

(R) _____I keep thinking about how badly I want the pain to stop

(H) _____There's nothing I can do to reduce the intensity of my pain

(M) _____I wonder whether something serious will happen

TOTAL: _____

Patient name: _____ DOB: _____ Date: _____

PANAS

(Reference: Watson, D., Clark, L. A., & Tellegan, A. (1988). Development and validation of brief measures of the PANAS scales. Journal of Personality and Social Psychology, 54(6), 1063–1070.)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment *OR* indicate the extent you have felt this way over the past week. Please circle if you used this measure for the present moment or over the past week.

1	2	3	4	5
Very slightly or not at all	**A little**	**Moderately**	**Quite a bit**	**Extremely**

____ Interested	____Irritable
____ Distressed	____Alert
____ Excited	____Ashamed
____ Upset	____Inspired
____ Strong	____Nervous
____ Guilty	____Determined
____ Scared	____Attentive
____ Hostile	____Jittery
____ Enthusiastic	____Active
____ Proud	____Afraid

Patient name: _____ DOB: _____ Date: _____

Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?

Please check the box to the right for each diagnosis and write the year of diagnosis

	No	Yes	Diagnosed
1. Restless leg syndrome			
2. Chronic fatigue syndrome			
3. Fibromyalgia			
4. Temporomandibular joint disorder (TMJ)			
5. Migraine or tension headaches			
6. Irritable bowel syndrome			
7. Multiple chemical sensitivities			
8. Neck injury (including whiplash)			
9. Anxiety or panic attacks			
10. Depression			

Patient name: _____ DOB: _____ Date: _____

DASS Questionnaire

Please read each statement and circle a number, o, 1, 2, or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time 3 =
Applied to me very much, or most of the time

I find it hard to wind down……	S	0	1	2	3
I was aware of dryness of my mouth……	A	0	1	2	3
I could not seem to experience any feeling at all……	D	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness					
In the absence of physical exertion……	A	0	1	2	3
I found it difficult to work up the initiative to do things……	D	0	1	2	3
I tended to overreact to situations……	S	0	1	2	3
I experienced trembling (e.g. hands)……	A	0	1	2	3
I felt that I was using a lot of nervous energy……	S	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself…..	A	0	1	2	3
I felt that I had nothing to look forward to……	D	0	1	2	3
I found myself getting agitated……	S	0	1	2	3
I found it difficult to relax……	S	0	1	2	3
I felt downhearted and blue……	D	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing….	S	0	1	2	3
I felt I was close to panic……	A	0	1	2	3
I was unable to become enthusiastic about anything……	D	0	1	2	3
I felt I was not much of a person……	D	0	1	2	3
I felt that I was rather touchy……	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g.					
Sense of heart rate increase, heart missing a beat)……	A	0	1	2	3
I felt scared without any good reason……	A	0	1	2	3
I felt that life was meaningless……	D	0	1	2	3

Patient name: _____ DOB: _____ Date: _____

PSEQ-2

(Michael. K Nicholas, PhD, Brian E. McGuire, PhD, and Ali Asghari, PhD)

Please rate how **confident** you are that you can do the following things at present, **despite the pain.** To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

1.	I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work)	0 Not at all confident	1	2	3	4	5	6 Completely confident
2.	I can live a normal lifestyle, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident

Patient name: _____ DOB: _____ Date: _____

Tampa Questionnaire

(Reference: the original TSK9 is copied without restriction from the Work Cover Victoria website)

For Office use only: Rvs 4, 8, 12, 16 Score: _____

Please read each of the following statements and circle the number that best represents your feelings.

1 = Strongly disagree 2 = Somewhat Disagree3 = Somewhat Agree 4 = Strongly Agree

(S)	I'm afraid I might injure myself if I exercise	1	2	3	4
(A)	If I were to try to overcome it, my pain would increase	1	2	3	4
(S)	My body is telling me that I have something dangerously wrong	1	2	3	4
(A)	My pain would probably be relieved if I were to exercise	1	2	3	4
(S)	People aren't taking my medical condition seriously enough	1	2	3	4
(S)	My accident has put my body at risk for the rest of my life	1	2	3	4
(S)	Pain always means that I have injured my body	1	2	3	4
(A)	Just because something aggravates my body does not mean it is dangerous	1	2	3	4
(A)	I am afraid that I might injure myself accidentally	1	2	3	4
(A)	Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening	1	2	3	4
(S)	I wouldn't have this much pain if there weren't something potentially dangerous going on in my body	1	2	3	4
(A)	Although my condition is painful, I would be better off if I were physically active	1	2	3	4
(A)	Pain lets me know when to stop exercising so that I don't injury myself	1	2	3	4
(A)	It's really not safe for a person with a condition like mine to be physically active	1	2	3	4
(A)	I can't do all the things normal people do because it's too easy for me to get injured	1	2	3	4
(A)	Even though something is causing me a lot of pain, I don't think it's actually dangerous	1	2	3	4
(A)	No one should have to exercise when he/she is in pain	1	2	3	4

TOTALS

Patient name: _____ DOB: _____ Date: _____

The Fremantle_____Awareness Questionnaire

This questionnaire has been tested on those people who have back pain. It measures how people with low back pain are aware of how their low back moves and functions. The researchers have agreed that therapists can use this questionnaire to also measure how people with pain are aware of their painful parts and how they move them.

Therefore, please fill in the blanks on this questionnaire with your painful part (the most painful one if you have multiple painful areas), and then answer the questions to the best of your ability.

Here are some things that other patients have told us about how their _____feels to them. Using the following scale, please indicate the degree to which your____feels this way when you are experiencing _____pain

	Never	Rarely	Occasionally	Often	Always
1. My_____feels as though it is not part of the rest of my body	0	1	2	3	4
2. I need to focus all my attention on my _____ to make it move the way I want it to	0	1	2	3	4
3. I feel as if my _____ sometimes moves involuntarily, without my control	0	1	2	3	4
4. When performing everyday tasks, I don't know how my_____is moving	0	1	2	3	4
5. When performing everyday tasks, I am not sure exactly what position my _____ is in	0	1	2	3	4
6. I can't perceive the exact outline of my _____	0	1	2	3	4
7. My_____feels like it is enlarged (swollen)	0	1	2	3	4
8. My_____feels like it has shrunk	0	1	2	3	4
9. My_____feels lopsided (asymmetrical)	0	1	2	3	4

Score: _____

Patient name: _____ DOB: _____ Date: _____

Patient name: _____ DOB: _____ Date: _____