women's & men's health PHYSIOTHERAPY

Female Pelvic Pain Questionnaire

We would appreciate you completing as much of this form as you are able to, or choose to. Please bring it with you to your first appointment.
All information is strictly confidential. Your physiotherapist will discuss these answers with you in your consultation.

A. PERSONAL INFORMATION

Name:…… DOB: / / Age:……
Height: …… Weight: …….
Referring doctor:…… Next review date with doctor:……..

B. INFORMATION ABOUT YOUR PAIN

1. Please describe your pain/problem(s): why you are attending physiotherapy?

……
……
……

2. Please rate your level of pain over the last month using the scale below:

0	1	2	3	4	5	6	7	8	9	10
No pain / bother										Worst pain / bother you have experienced

(complete 1 or all 3 as relevant):
i) Where is your worst pain? …… Rate this pain using the number scale above: ……
ii) Where is your 2nd worst pain? …… Rate this pain using the number scale above: ……
iii) Where is your 3rd worst pain? …… Rate this pain using the number scale above: ……

3. Below is a list of words that describe some of the qualities of pain. Please put an 'X' in the box that best describes the intensity of each quality. Use None if the word does not describe your pain:

PAIN QUALITY	NONE 0	MILD 1	MODERATE 2	SEVERE 3
Eg: 1. Throbbing	☐ 0	X 1	☐ 2	☐ 3
1. Throbbing	☐ 0	☐ 1	☐ 2	☐ 3
2. Shooting	☐ 0	☐ 1	☐ 2	☐ 3
3. Stabbing	☐ 0	☐ 1	☐ 2	☐ 3
4. Sharp	☐ 0	☐ 1	☐ 2	☐ 3
5. Cramping	☐ 0	☐ 1	☐ 2	☐ 3
6. Gnawing	☐ 0	☐ 1	☐ 2	☐ 3
7. Hot-burning	☐ 0	☐ 1	☐ 2	☐ 3
8. Aching	☐ 0	☐ 1	☐ 2	☐ 3
9. Heavy	☐ 0	☐ 1	☐ 2	☐ 3
10. Tender	☐ 0	☐ 1	☐ 2	☐ 3
11. Splitting	☐ 0	☐ 1	☐ 2	☐ 3

12. Tiring-exhausting	☐ 0	☐ 1	☐ 2	☐ 3
13. Sickening	☐ 0	☐ 1	☐ 2	☐ 3
14. Fearful	☐ 0	☐ 1	☐ 2	☐ 3
15. Punishing-cruel	☐ 0	☐ 1	☐ 2	☐ 3

4. How long have you had this pain? ☐ <6 months ☐ 6months - 1 year ☐ 1-2 years ☐ >2 years

5. What do you think may be causing your pain/problem(s)?

……

……

6. Is there an event which you associate with the onset of pain? ☐ No ☐ Yes
If 'yes', please describe: ……

……

C. 1. What physicians or health care providers have you seen for this pain – current and past?

Please include all healthcare providers, whether they were doctors or not:

Health professional	When?	What investigation or treatment?	How long tried for?	How helpful?

Who is the medical practitioner / health care provider managing your condition at present?.....

2. What types of treatments have you tried in the past for this pain? ☐ Nil

☐ Creams ointments ☐ Homeopathic or naturopathic medicine ☐ Herbal medicine
☐ Non-prescription medication ☐ Nutrition /diet
☐ Psychotherapy ☐ Counselling ☐ Anti depressants
☐ Surgery
☐ Acupuncture ☐ Massage ☐ Relaxation ☐ Trigger point therapy
☐ Meditation ☐ Biofeedback ☐ Dilators ☐ Ultrasound ☐ Skin magnets
☐ Myo-fascial techniques ☐ Mobilization (joint, soft tissue)
☐ TENS / electrical stimulation ☐ Trigger point injections ☐ Pelvic Floor Physiotherapy
☐ General Exercise ☐ Pelvic Floor Exercises ☐ Pilates ☐ Physiotherapy
☐ Previous medication:……
☐ Other:……

D. Current Medications for your pain:

1. Are you <u>currently</u> taking medication for this pain? ☐ No ☐ Yes: If yes, please list:

Medication name	Condition required for	Dosage	Commenced when?

2. Are you currently taking medication for any condition <u>other</u> than this pain? ☐ No ☐ Yes

If yes, please list:

Medication name	Condition required for	Dosage	Commenced when?

E. Have you ever been hospitalised for anything (surgery or other treatment) besides childbirth? ☐ No ☐ Yes

If yes, please explain:……..

……

……

……

Have you had any major accidents such as falls, car accidents or a back injury? ☐ No ☐ Yes

If yes, please explain

……

……

F. Gynecological/Obstetric History:

1. If relevant, please complete details for <u>all</u> pregnancies:

Number of pregnancies: ……..

Date	Vaginal or Caesarean	Weight	Forceps (Yes/No)	Episiotomy/ tear	Length of pushing stage	Other

2. Hormonal Status: Are you currently……?

Pregnant	☐ No	☐ Yes	Weeks:
Breastfeeding	☐ No	☐ Yes	
Menstruating	☐ No	☐ Yes	
Menopausal	☐ No	☐ Yes	
Post menopausal	☐ No	☐ Yes	Age at end of menopause: ……

G. LIFESTYLE

1. What is your daily fluid intake?

Water …… Coffee……. Tea……. Milk…….Alcohol…….. Coke ……. Soft drink…… Other ……

2. Do you currently engage in regular exercise? ☐ No ☐ Yes (circle)

Type:…… How often? … x/week How hard: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard

Type:…… How often? … x/week How hard: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard

Type:…… How often? … x/week How hard: Easy 0 1 2 3 4 5 6 7 8 9 10 Hard

Have you previously (in the last 5 yrs) engaged in regular exercise of which you are no longer continuing? ☐ No ☐ Yes

3. What do you do for relaxation?.....
   Do you take time out to: relax each day? ☐ No ☐ Yes relax each week? ☐ No ☐ Yes

4. Generally, do you sleep well at night? ☐ No ☐ Yes
   Do you feel you get enough sleep? ☐ No ☐ Yes

H. PAIN THOUGHTS

Please answer these 5 questions regarding your pain, circling the number that reflects your feelings:

	Strongly Disagree				**Strongly Agree**
"I find it hard to cope with my pain"	1	2	3	4	5
"I can't manage my pain without medication"	1	2	3	4	5
"I seem to spend a lot of time thinking about my pain"	1	2	3	4	5
"I feel that there is nothing I can do about my pain"	1	2	3	4	5
"I often wonder if anything more serious is wrong"	1	2	3	4	5

I. Other Health Issues: *(Past and / or current, please tick one or more)*

☐ Neurological disease: ☐ Parkinson's ☐ M/S ☐ Other: ……
☐ Diabetes ☐ Thyroid
☐ Stroke ☐ High blood pressure ☐ Heart Disease/condition
☐ Lung disease/condition ☐ Asthma (cough) ☐ Chronic cough
☐ Arthritis: where?..... ☐ Back problems ……
☐ Hernia …… ☐ Osteoporosis
☐ Bladder infections ☐ Incontinence (bladder or bowel) ☐ Constipation/straining
☐ Pelvic Prolapse ☐ Vaginal infections (eg. thrush)
☐ Heavy lifting ☐ Prolonged standing (standing >2hrs)
☐ Psychiatric illness ☐ Anxiety ☐ Depression:
Have you ever been treated for depression? ☐ No ☐ Yes
If yes, what treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

☐ Fibromyalgia ☐ Endometriosis ☐ Chronic pelvic pain ☐ Scleroderma
☐ Lupus ☐ Cancer ☐ Vulvar/perineal skin condition
☐ Other (please specify): ……

Smoking status:
☐ Non smoker ☐ Past : when did you quit ……? ☐ Current : No. of cigarettes per day __

J. How do you best describe your condition you are attending for now? **1**. Normal **2**. Mild **3**. Moderate **4**. Severe

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Thank you for taking the time to complete this form. It is much appreciated, and we look forward to discussing this with you further at your first appointment.

Women's and Men's Health Physiotherapy