women's & men's health PHYSIOTHERAPY

IN INFO
SURNAME……
CLIENT #……..

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 appointment. All information is strictly confidential. Your physiotherapist will discuss these answers with you in your consultation.

A. PERSONAL INFORMATION

Name:…… 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?

……
……
……
……

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

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

……
……
……
……

5. What was going on in your life at the time of pain onset? Please describe:

……
……
……
……

6. 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 experienced										Worst pain / bother you have

(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: ……

7. 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	☐	☒	☐	☐
1. Throbbing	☐	☐	☐	☐
2. Shooting	☐	☐	☐	☐
3. Stabbing	☐	☐	☐	☐
4. Sharp	☐	☐	☐	☐
5. Cramping	☐	☐	☐	☐
6. Gnawing	☐	☐	☐	☐
7. Hot-burning	☐	☐	☐	☐
8. Aching	☐	☐	☐	☐
9. Heavy	☐	☐	☐	☐
10. Tender	☐	☐	☐	☐
11. Splitting	☐	☐	☐	☐
12. Tiring-exhausting	☐	☐	☐	☐
13. Sickening	☐	☐	☐	☐
14. Fearful	☐	☐	☐	☐
15. Punishing-cruel	☐	☐	☐	☐

8. Does your pain change with:

- Your level of stress? YES NO UNSURE
- Whether you are doing something you love or hate? YES NO UNSURE
- What you are thinking about at the time? YES NO UNSURE
- Where you are? YES NO UNSURE
- Who you are with? YES NO UNSURE
- Things you hear people saying? YES NO UNSURE

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 / wands ☐ 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:……

☐ Google search/u-tube:……

☐ Other:……..

D. Current Medications for your pain:

1. Are you currently 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 other than this pain? ☐ No ☐ Yes

If yes, please list:

Medication name	Condition required for	Dosage	Commenced when?

E. Have you ever been hospitalised (not including 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. Gynaecological /Obstetric History: If relevant, please complete details for all pregnancies:

Number of pregnancies: …….

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

2. **Hormonal Status (if appropriate):** Are you? Menstruating ☐ No ☐ Yes

Pregnant ☐ No ☐ Yes Weeks:

Breastfeeding ☐ No ☐ Yes

Peri Menopausal ☐ No ☐ Yes

Post-menopausal ☐ No ☐ Yes : Age at end of menopause: …….

G. LIFESTYLE

1. What is your average 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: What?…….

3. What do you do for relaxation?.....

……

Do you take time out to: relax each day? ☐ No ☐ Yes; or 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 7 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 feel that my problem is terrible and that it's never going to get any better"	1	2	3	4	5
"I often wonder if anything more serious is wrong"	1	2	3	4	5
"I can't enjoy all the things I used to enjoy"	1	2	3	4	5

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

Neurological disease: ☐ Parkinson's ☐ Multiple Sclerosis ☐ 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) ☐ Erectile Dysfunction

☐ 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 ☐ Psychiatry

☐ Endometriosis ☐ Chronic pelvic pain ☐ Scleroderma

☐ Lupus ☐ Cancer ☐ Vulval/perineal skin condition

☐ Other (please specify): ……

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

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

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CSI: PART A

Please circle the best response to the right of each statement.

1. I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always
2. My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
3. I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
4. I grind or clench my teeth	Never	Rarely	Sometimes	Often	Always
5. I have problems with diarrhea &/ constipation	Never	Rarely	Sometimes	Often	Always
6. I need help in performing my daily activities	Never	Rarely	Sometimes	Often	Always
7. I am sensitive to bright lights	Never	Rarely	Sometimes	Often	Always
8. I get tired very easily when I am physically active	Never	Rarely	Sometimes	Often	Always
9. I feel pain all over my body	Never	Rarely	Sometimes	Often	Always
10. I have headaches	Never	Rarely	Sometimes	Often	Always
11. I feel discomfort in my bladder &/or burning when I urinate	Never	Rarely	Sometimes	Often	Always
12. I do not sleep well	Never	Rarely	Sometimes	Often	Always
13. I have difficulty concentrating	Never	Rarely	Sometimes	Often	Always
14. I have skin problems such as dryness, itchiness or rashes	Never	Rarely	Sometimes	Often	Always
15. Stress makes my physical conditions get worse	Never	Rarely	Sometimes	Often	Always
16. I feel sad or depressed	Never	Rarely	Sometimes	Often	Always
17. I have low energy	Never	Rarely	Sometimes	Often	Always
18. I have muscle tension in my neck and shoulders	Never	Rarely	Sometimes	Often	Always
19. I have pain in my jaw	Never	Rarely	Sometimes	Often	Always
20. Certain smells, such as perfumes, make me feel dizzy and nauseated	Never	Rarely	Sometimes	Often	Always
21. I have to urinate frequently	Never	Rarely	Sometimes	Often	Always
22. My legs feel uncomfortable and restless when I am to go to sleep at night	Never	Rarely	Sometimes	Often	Always
23. I have difficulty remembering things	Never	Rarely	Sometimes	Often	Always
24. I suffered trauma as a child	Never	Rarely	Sometimes	Often	Always
25. I have pain in my pelvic area	Never	Rarely	Sometimes	Often	Always
				TOTAL:	

CSI: PART B

Have you been diagnosed by a doctor with any of the following disorders?
Please tick the box to the right for each diagnosis and write the year of the diagnosis.

	NO	YES	Year 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			

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 appointment.

Women's and Men's Health Physiotherapy