# EmpowHer's Pelvic pain intake

Name: ______________________________________

Dob : ____________________

Date : ____________________

Allergies : ____________________________________

**Demographic information:**

Are you: Single ___ Widowed _____ Married ____ Committed Relationship _____

Divorced ____ Separated _____ Remarried ____ how long? ______

Education: Did not finished HS _____ Finished HS ____ Associates Degree ____

College _____ Graduate School ______ Degree ________________

Occupation: ______________________________

Due to pain, do you have a reduction in job performance? _____

Please explain : ____________________________________

__________________________________________________

Describe your pain/complaint:

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

**Current Meds/Supplements**

| Prescription and OTC | Dose |
| --- | --- |
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**Additional**

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| Past meds, Imaging for this Problem | Date | Findings /Effect |
| --- | --- | --- |
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Additional:

_______________________________________________

_______________________________________________

At what age did the pain/problem start? _________

Did the pain stop then return? ______ Explain: _______________________________________

_______________________________________________

Was there an event that provoked the problem: ______ Please Explain: ____________________

_______________________________________________

What do you think is causing the issue? _______________________________________________

_______________________________________________

Describe circumstances related to the start of the issue: __________________________________

_______________________________________________

Is the pain/problem: Worsening ___ Stable _____ Decreasing ____ Changing ____

Circle the best answer/answers: Is your pain/problem pattern:

| | | |
|---|---|---|
| Continuous | Rhythmic | Brief |
| Steady | Constant | Intermittent |

Throbbing    Momentary

How many times have you gone to the ER for pain? ________

Have you ever been hospitalized other than childbirth? ___Y ___N please explain:

_______________________________________________

_______________________________________________

What treatments/providers have you tried for your complaint?

- ☐ Acupuncture
- ☐ Anesthesiologist
- ☐ Biofeedback
- ☐ Gastroenterologist
- ☐ Gynecologist
- ☐ Family Doctor
- ☐ Massage therapist
- ☐ Neurosurgeon
- ☐ Physical Therapist
- ☐ Counselor
- ☐ Psychiatrist
- ☐ Rheumatologist
- ☐ Urologist
- ☐ Pain mgmt Specialist

- ☐ Antidepressants
- ☐ Anti-seizure meds
- ☐ Botox injections
- ☐ Depo-provera
- ☐ Danazol
- ☐ Leupron/Zoladex
- ☐ Orilissa
- ☐ Narcotics
- ☐ Birth Control Pills
- ☐ Herbal medicine
- ☐ IUD/Nexplanon
- ☐ Prescription anti inflammatory

- ☐ Nutrition
- ☐ Dietician
- ☐ Biofeedback
- ☐ Bladder instillations
- ☐ Nerve blocks
- ☐ Skin Magnets
- ☐ TENS unit
- ☐ Surgery
- ☐ Trigger point injection
- ☐ Other: ____________________

Check the box that corresponds to your pain?
0 = no pain    10 = the most pain

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Right now | | | | | | | | | | | |
| At it’s worst in the past month | | | | | | | | | | | |
| At it’s least in the past month | | | | | | | | | | | |

| At it’s average in the past month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At mid-cycle (ovulation) | | | | | | | | | | | |
| Before period or menses | | | | | | | | | | | |
| During period or menses | | | | | | | | | | | |
| With intercourse | | | | | | | | | | | |
| On entry | | | | | | | | | | | |
| Deep pain | | | | | | | | | | | |
| Pain or burning after intercourse | | | | | | | | | | | |
| Pain with sitting | | | | | | | | | | | |
| Labor | | | | | | | | | | | |
| Worst headache/toothache ever? | | | | | | | | | | | |
| Ideal acceptable level of pain. | | | | | | | | | | | |

What does your AVERAGE pain feel like in your pelvis? Please check correct box below on each.

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Throbbing | | | | |
| Shooting | | | | |
| Stabbing | | | | |
| Sharp | | | | |
| Cramping | | | | |
| Gnawing | | | | |
| Hot/Burning | | | | |
| Aching | | | | |

| Heavy | | | | |
|---|---|---|---|---|
| Tender | | | | |
| Exhausing | | | | |
| Nauseating | | | | |
| Scary | | | | |
| Cruel | | | | |

Please mark the box below that best describes how, in the last month, pain has interfered with:

0 = did not interfere     10 = completely interfered

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | | | | | | | | | | | |
| Housework | | | | | | | | | | | |
| Walking | | | | | | | | | | | |
| Sleeping | | | | | | | | | | | |
| Happiness | | | | | | | | | | | |
| Friendships | | | | | | | | | | | |
| Sex | | | | | | | | | | | |

Circle the number that best describes your overall sense of well-being for the past month

*(physical, mental, emotional, spiritual, social)*

0 - worst you have every been     10 - best you have ever been

0 1 2 3 4 5 6 7 8 9 10

What makes your pain better?

| | | | |
|---|---|---|---|
| ☐ Meditation | ☐ Relaxation | ☐ Ice | ☐ Lying down |
| ☐ Heat | ☐ Hot bath | ☐ Hot bath | ☐ Injections |
| ☐ Pain meds | ☐ TENS | ☐ Laxatives | ☐ Voiding |
| ☐ Massage | ☐ Nothing | ☐ ________ | ☐ __________ |

What makes your pain worse?

| | | | |
|---|---|---|---|
| ☐ Sex | ☐ Stress | ☐ Full bladder | ☐ Full Meal |
| ☐ Walking | ☐ Voiding | ☐ Orgasm | ☐ Standing |
| ☐ Exercise | ☐ Time of day | ☐ Sitting | ☐ Clothing |
| ☐ Coughing | ☐ Weather | ☐ Bowel mvmt | ☐ Nothing |

Who do you talk to regarding your pain?

| | | | |
|---|---|---|---|
| ☐ Spouse/ Partner | ☐ Doctor/RN | ☐ Support Group | ☐ Chaplain |
| ☐ Friend | ☐ Relative | ☐ Counselor | ☐ No one |

How does your partner deal with your pain?

| | | | |
|---|---|---|---|
| ☐ Withdraws | ☐ Ignores | ☐ Helps | ☐ Lost |
| ☐ Gets Angry | ☐ Distracts Me | ☐ ________ | ☐ _________ |

What doctors have seen you for this pain?

| Name | Specialty | City/State | Phone Number |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |

Obstetric History

How many pregnancies have you had? Result?

____ Full Term. _____ Premature ______Miscarriage ______ Abortion ______ Living

Complications?

| ☐ 4th° tear | ☐ C/S | ☐ Vacuum | ☐ Forceps |
| --- | --- | --- | --- |
| ☐ 3rd ° tear | ☐ Hemorrhage | ☐ Stillbirth | ☐ Vaginal tear |

Birth control method

| Nothing | Pills | Vas | Ring | Depo | Rod |
| --- | --- | --- | --- | --- | --- |
| Condom | IUD | Tubal | Hyst | ________ | |

Menstrual History

How old were you when your menses started? _____ stopped? ________

Periods are _____ light _____ moderate _____ heavy ______ soaking through

How many days between periods? ____

How many days of flow? ______ How many days of heavy flow? ______

Do you have pain with cycles? ___ Y ____ N
Does pain start before cycles? ___ Y ____ N
Are they regular? ___ Y ____ N
Do you pass clots? ___ Y ____ N

Bowel Issues

Have you had a colonoscopy? ______ Date ____________Findings

| | Y | N |
|---|---|---|
| Less than 3 bowel movements/week | | |
| More than 3 bowel movements/day | | |
| Hard or lumpy stools | | |
| Loose or watery stools | | |
| Straining during a bowel movement | | |
| Urgent need for bowel movement | | |
| Feeling of incomplete emptying of bowels | | |
| Passing mucous or blood with bowel movements | | |
| Abdominal bloating | | |
| Pain with bowel movement | | |
| Pain relieved with bowel movement | | |

Eating

Describe your diet:

Well-balanced ___ Vegan/Vegetarian ____ Fast Food ______ Eating out ______

Do you have nausea? _____ No _____ With meds _____ With eating

Do you have vomiting? _____ No _____ With meds _____ With eating

Have you ever had an eating disorder? _____ No _____ Yes

**Health Habits**

Circle the correct answer

| How often do you exercise? | rarely | 1-2/wk | 3-5/wk | daily |
|---|---|---|---|---|
| What is your caffeine intake? (cups of any) | 0 | 1-2 | 3-4 | >5 |
| Do you smoke?  If yes? | ___/d | ___/yrs | | |
| Have you ever been addicted to drugs? | ___Y | ___N | | |
| Are you currently using drugs? | ___Y | ___N | | |

If yes please note drug/drugs and circumstances including marijuana

______________________________________________________________________

**Vulvar Hygiene**

Do you douche? ___N ___ Y describe ______________________________________________

Underwear material and style : ______________________________________________

Soap: ______________________________________________________________

Topical creams/lotions: ______________________________________________

**Urinary Symptoms:**

Have you had a cystoscopy? ___Y _____ N When? _______ Findings? _______________

______________________________________________________________________

Do you experience on a regular basis?

| | Y | N |
|---|---|---|
| Loss of urine with laugh/sneeze or exercise? | | |
| Incomplete emptying of urine? | | |
| Frequent bladder infections? | | |

| | | |
|---|---|---|
| Blood in the urine? | | |
| Difficulty voiding/ Hesitancy? | | |
| Having to void again quickly just after finishing? | | |
| Can you hold your urine for a 2-4 hour car ride? | | |

## IC Questionnaire

On a bad day with your bladder, please note below

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| How many times do you urinate in the day? | 3-6 | 7-10 | 11-14 | 15-19 | 20 + |
| How many times do you urinate at night? | 0 | 1 | 2 | 3 | 4+ |
| If you get up to void at night, does it bother you? | No | Mild | Mod | Severe | |
| Do you have the urge to go again just after voiding? | No | Occ | Usually | Always | |
| If you have urgency, it it usually<br>(compelling desire to urinate due to pain/pressure) | No | Mild | Mod | Severe | |
| Does your urgency bother you? | No | Occ | Usually | Always | |
| Do you have pain with your bladder or pelvis?<br>(lower abdomen, labia, vagina, rectum) | No | Occ | Usually | Always | |
| If you have pelvic pain, is it usually: | | Mild | Mod | Severe | |
| Are you sexually active:<br>*if no, is it because of pain? | Yes<br>No | No*<br>Yes | | | |
| Have you had pain during intercourse? | No | Occ | Usually | Always | |
| Does it bother you? | No | Occ | Usually | Always | |

Office score: _____

**Sexual Pain History**

Have you ever been sexually active ____Y _____N

If yes have you been in the past 6 months? _____Y _____N

Number lifetime sexual partners? (approx) _____

Age at first intercourse? _____

If pain with intercourse -

| | Yes | No |
|---|---|---|
| Pain with first sexual encounter? | | |
| Only with current partner? | | |
| Also with previous partner? | | |
| Were/are tampons difficult to insert? | | |
| Is discomfort at opening? | | |
| Is discomfort deep? | | |
| Is it affecting your relationship? | | |
| Does your partner have sexual difficulty? If Y - describe ________________________________________________ | | |

**Sexual and Physical Abuse History**

Have you ever been the victim of emotional abuse or insulted? ____ Y _____ N
Have you ever been kicked/hit or beat as a child? ____Y _____ N
Have you ever been kicked/hit or beat as an adult? ____Y _____N

Check an answer for BOTH child and adult:

| | Child <13 | | Adult | |
|---|---|---|---|---|
| | Y | N | Y | N |
| Has anyone ever exposed genitals to you when you did not want it? | | | | |
| Has anyone threatened to have sex with you when you did not want? | | | | |
| Has anyone ever touch your breast/genitals when you did not want? | | | | |

| | | | | |
|---|---|---|---|---|
| Has anyone forced you to have sex? | | | | |
| Have you had any other unwanted sexual encounters? | | | | |

**Headache History**

Do you have a history of headaches? ____ Y _____ N

When did they begin? _______

What is the frequency? ________

Are the around your menses? _________

Do you suffer from migraines? ____Y _____ N

Do you take medicines? What? _____________________________________

**Sleep problems**

| | Y | N |
|---|---|---|
| Do you have trouble falling asleep? | | |
| Do you have trouble staying asleep? | | |
| Do you take anything to help you sleep? | | |

**Surgical History**

| Procedure | Surgeon | Year | Findings |
|---|---|---|---|
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**Medical problems**

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**Personal Trauma History** :

Throughout your life have you ever been in a car accident? ____Y ______N

Have you ever had broken bones/straddle injuries/concussions? ____Y ______N

Please describe above: ____________________________________________________________

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Please list all major physical activities /sports/work-out competitively or recreationally:

| Activity | Years of participation |
|---|---|
| | |
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**Significant Emotional Stressors:** Please circle

| | | | |
|---|---|---|---|
| How would you describe your current relationship? | No tension | Some tension | A lot of tension |
| Do you and your partner work out arguments with? | No difficulty | Some difficulty | A lot of difficulty |
| Do arguments result in you feeling down about yourself? | Never | Sometimes | Often |
| Do you ever feel afraid by what your partner says/does? | Never | Sometimes | Often |
| Has your current partner ever abused you emotionally? | Never | Sometimes | Often |
| Has your current partner ever abused you sexually? | Never | Sometimes | Often |

**Any other important life stressors:**

______________________________

______________________________

______________________________

What is Your pain keeping you from doing?

______________________________

______________________________

______________________________

What is your biggest fear regarding your pain?

______________________________

______________________________

______________________________

**Vulvar Pain Functional Questionnaire (V-Q)**

*These are statements about how your pelvic pain affects your everyday life. Please check the one that is more appropriate for you.*

1. Because of my pain
   - ☐ I can't wear tight-fitting clothing like pantihose that puts pressure over my painful area
   - ☐ I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
   - ☐ I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
   - ☐ I can where whatever I like without pelvic pain.

2. My pelvic pain
   - ☐ Gets worse when I walk, so I can only walk far enough to move around in my house, no further.
   - ☐ Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in the store.
   - ☐ Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
   - ☐ My pain does not get worse with walking; I can walk as far as I want to.
   - ☐ I have a hard time walking because of another medical problem, but pelvic pain does not make it hard to walk.

3. My pelvic pain
   - ☐ Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
   - ☐ Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
   - ☐ Occasionally gets worse when I sit, but most of the time sitting is uncomfortable.
   - ☐ My pain does not get worse with sitting.
   - ☐ I have trouble sitting for a long time because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of the pain pills I take for my pelvic pain
   - ☐ I am sleepy and I have trouble concentrating at work or while I do homework.
   - ☐ I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
   - ☐ I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
   - ☐ I don't have any problems with the pills that I take for pelvic pain.

- ☐ I don’t take pills for pelvic pain.

5. Because of my pelvic pain
   - ☐ I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
   - ☐ It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
   - ☐ Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
   - ☐ It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
   - ☐ I don’t get together with my friends or go out to parties or events.
   - ☐ I only get together with my friends or go out to parties or events every now and then.
   - ☐ I usually will go out with friends or to events if I want to, but every now and then I don’t because of the pain.
   - ☐ I get together with friends or go to events whenever I want, pelvic pain does not get in the way.

7. Because of my pelvic pain
   - ☐ I can’t stand for the doctor to insert the speculum when I go to the gynecologist.
   - ☐ I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
   - ☐ It usually doesn’t hurt when the doctor inserts the speculum, but every now and then it does hurt.
   - ☐ It never hurts for the doctor to insert the speculum when I go to the gynecologist.

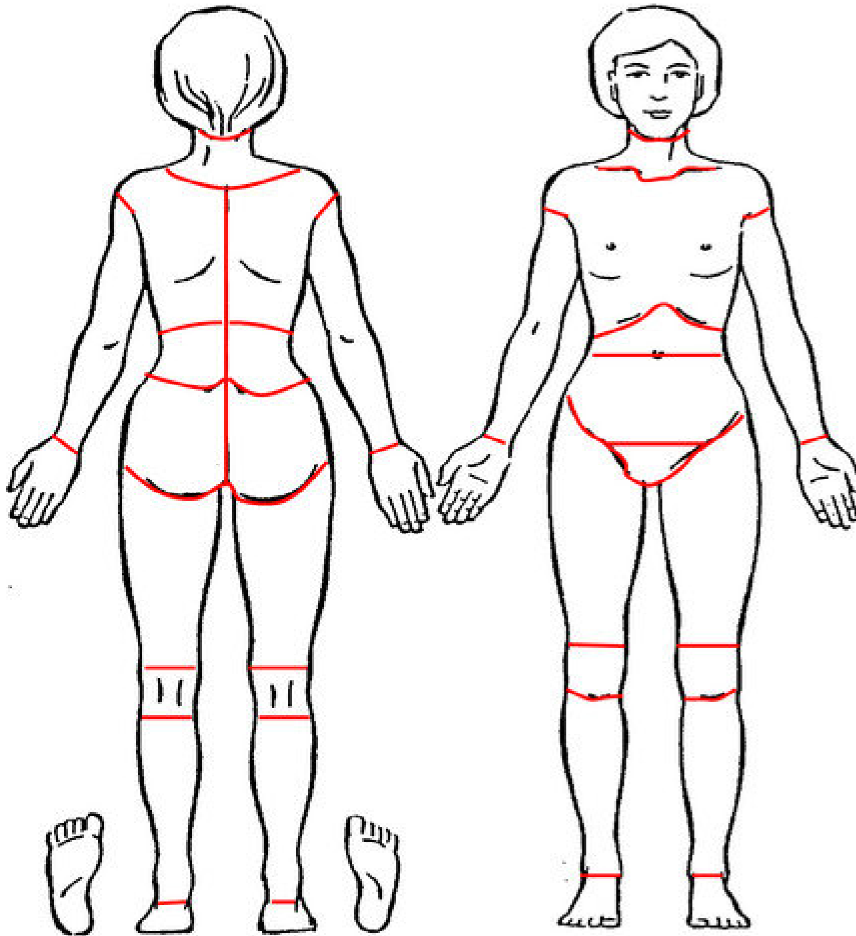
8. Because of my pelvic pain
   - ☐ I cannot use tampons at all, because they make my pain much worse
   - ☐ I can only use tampons if I put them in very carefully
   - ☐ It usually doesn’t hurt to use tampons, but occasionally it does.
   - ☐ It never hurts to use tampons
   - ☐ This question doesn’t apply to me, because I don’t need to use tampons or I would not choose to use them whether they hurt or not.

9. Because of my pelvic pain
   - ☐ I can’t let my partner put a finger or penis in my vagina during sex at all.
   - ☐ My partner can put a finger or penis in my vagina very carefully, but it still hurts
   - ☐ It usually doesn’t hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt
   - ☐ It doesn’t hurt to have a finger or penis in my vagina at all

- ☐ This question does not apply to me because I don’t have a sexual partner.
- ☐ Specifically, I won’t get involved with a sexual partner because i am worried about pain during sex.

10. Because of my pelvic pain
    - ☐ It hurts too much for my partner to touch me sexually even if the touching doesn’t go in my vagina.
    - ☐ My partner can touch me sexually outside my vagina if we are careful
    - ☐ It doesn’t usually hurt for my partner to touch me sexually outside the vagina, but every now and again it does.
    - ☐ It never hurts for my partner to touch me sexually outside the vagina.
    - ☐ This question does not apply to me because I don’t have a sexual partner.
    - ☐ Specifically, i won’t get infolved with a partner because I worry about pelvic pain during sex.

On the diagram below, shade in ALL OF THE AREAS of your body where you feel pain. If there is an area that is worse, put an X on that area.



back

right

left

front

Shade the inside view of the deep pelvis

| Notes for provider only: |
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