

Male 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

Today's date: / /

Name:..... Age:..... Height: Weight:
 Referring doctor/practitioner:..... Next review date:.....

B. INFORMATION ABOUT YOUR PAIN

1. Please describe your pain/problem(s):

.....

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

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

.....

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

.....

5. 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:

6. 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
<i>Eg: 1. Throbbing</i>	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
1. Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Gnawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Hot-burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Splitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Tiring-exhausting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Sickening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Punishing-cruel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. 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?

- Creams / ointments Homeopathic or naturopathic medicine Nil
- Non-prescription medication Nutrition /diet Herbal medicine
- Psychotherapy Counselling Anti-depressants
- Surgery
- Acupuncture Massage Relaxation Trigger point therapy
- Meditation Biofeedback Ultrasound Skin magnets
- Myofascial 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 for anything (surgery or other treatment)? 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. 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 or do you relax each week? No Yes

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

G. 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 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	

H. 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
- Rectal Prolapse 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 Hospitalisation Psychotherapy
- Fibromyalgia Chronic pelvic pain Scleroderma
- Lupus Cancer Perineal skin condition
- Other (please specify):

Smoking status: Nonsmoker Past: when did you quit? Current: No. of cigarettes per day __

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