MANHATTAN
PAIN MEDICINE

Pelvic Pain Intake Questionnaire

Please **Name** and **Describe** each different pain in chronological order of appearance

1. _____
2. _____
3. _____
4. _____

For each of these pains, do they feel superficial (skin level) or deep internal? (circle)
Superficial: 1 2 3 4 **Deep:** 1 2 3 4 **Both:** 1 2 3 4

Trauma - Has there been any physical trauma to the area? (Describe):

_____
Were any of the above pains associated with the trauma? (circle) 1 2 3 4

Viscera - Is there any abnormality in Bowel/Bladder function or other internal organ(s)?

_____

Hormones - Is there any cyclical variation in any of the pain(s) (i.e. w/ menstruation)? 1 2 3 4

_____

Nerve Involvement - Do you feel altered sensation, burning, itching, pins/needles? 1 2 3 4

_____

Sensitization - Hypersensitivity: intolerance of light touch, heat/cold, pressure? 1 2 3 4

_____
Does this extend into either leg? Yes / No

Autoimmune - Do you have any autoimmune conditions? Anyone in your family?

_____

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Mechanics - Which activities trigger which pain?

Sitting	1	2	3	4	Sleeping	1	2	3	4
Standing	1	2	3	4	Sidelying	1	2	3	4
Walking	1	2	3	4	Toileting	1	2	3	4
Stairs	1	2	3	4	Intercourse	1	2	3	4
Travel	1	2	3	4	Orgasm	1	2	3	4

Medications - How has each medication affected each pain?

Medication/Dose	1	2	3	4

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Procedures - How has each procedure affected each pain?

Procedure	1	2	3	4

Pain Diary:
Template for Tracking Responses

List Each Symptom	Medication 1	Diagnostic Block 1	PT	Medication 2	Diagnostic Block 2...
1					
2					
3					
4					