Pelvic Pain Patient Questionnaire

Patient information

Name: _____ DOB: _____ Age: _____

Address: _____

Suburb: _____ Postcode: _____

Phone (daytime): _____

Private Health Insurance provider: _____

Doctor that diagnosed you with pelvic pain: _____

Have you had a hysterectomy or any other surgeries? _____

_____

What other health care practitioners or therapists have you seen for your condition?

_____

_____

_____

When did you start to have pelvic pain? _____

Do you associate an event or trigger with the onset of your pain? _____

_____

Describe your pain, what does it feel like? _____

_____

_____

_____

When and how often do you experience it?

Also write the pain level on a scale of 1 to 10 (10 is the worst) in those times

All the time: _____

During or before menstruation: _____

Mid-cycle: _____

During bowel movements: _____

During urination: _____

During/after sex: _____

Sitting/Standing: _____

Other: _____

_____

_____

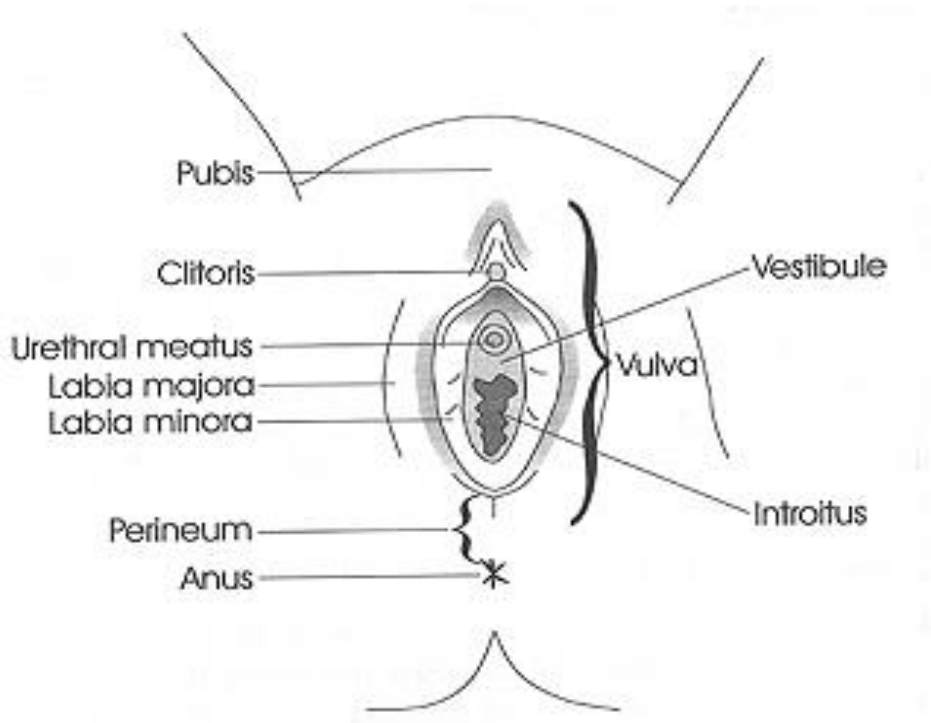
_____

What makes the pain worse? _____
_____

What makes the pain better? _____
_____

_____
What areas do you feel pain? _____
_____
_____

Please highlight or shade the areas where you experience pain. Also write the pain level on a scale of 1 to 10 (10 is the worst) in those areas.



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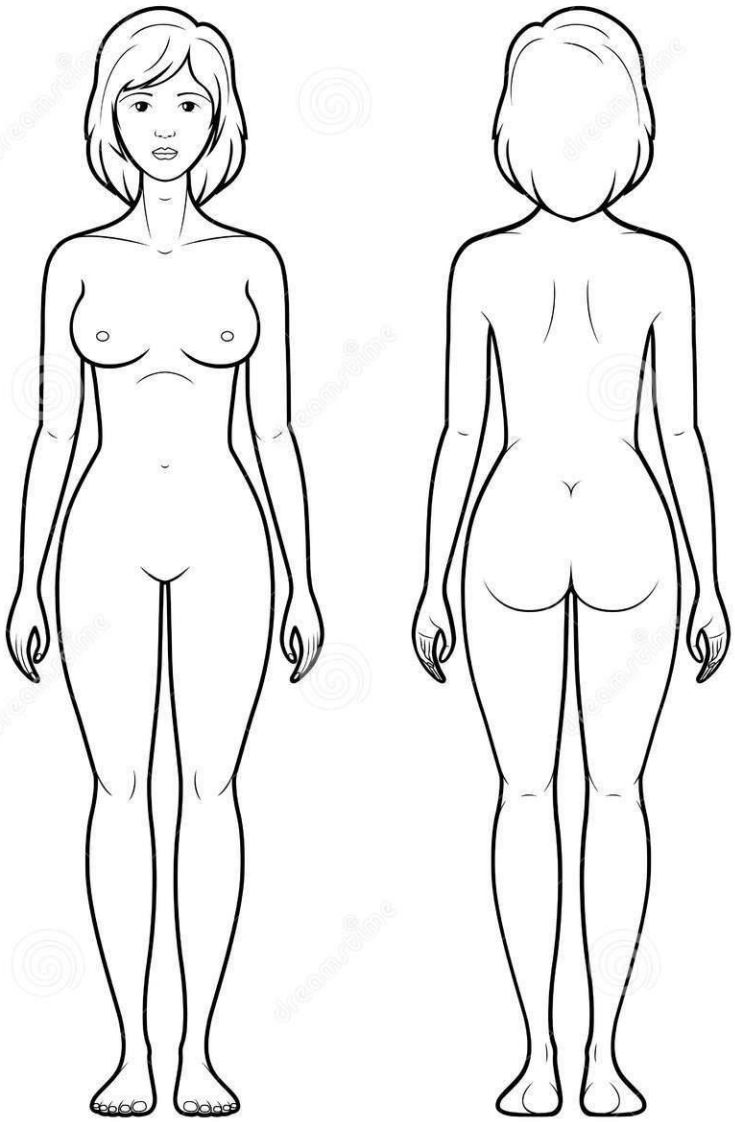

Are you able to work or do normal activities? _____
What type of work do you do? _____

Please list what medications, supplements/herbs and any therapies you are currently using:

Medications: _____
_____

Supplements, herbs, natural therapies: _____

What therapies or medicine have you tried in the past that have not given any results?
_____
_____
_____

Menstrual History-
What age did you start menstruating? _____ Is your cycle regular? _____
Are there blood clots in your menstrual flow? _____ Do you use tampons? _____
Is the flow light, moderate or heavy? _____
How many days does the flow last? _____ Date of first day your last menstrual cycle: _____

How many pregnancies have you had? _____
Resulting in: Full term _____ Premature _____ Miscarriage/Abortion _____
C-Section or Vaginal birth? _____ Were there any complications during pregnancy, labour, delivery or post partum? _____
_____
_____

How did you find us? _____

If internet, what did you search for? _____

Consent to Treatment & Privacy statement:

I request and consent to any bodywork or naturopathic therapies as found appropriate.
I understand that not all risks can be anticipated or explained by my practitioner.
I have had the opportunity to ask questions about the proposed therapy to my satisfaction.
I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

This information will only be used for record keeping purposes and will not be shared with a third party unless legally required or your consent has been received.

Signature _____ Date _____

(Or guardian's signature if under 16 years old)