Women's Medicine Collaborative*

Lifespan. Delivering health with care.™

*The Miriam Hospital d.b.a. Women's Medicine Collaborative

PELVIC PAIN PROGRAM
146 West River St.
Providence, RI 02904
(401) 793-7917
WomensMedicine.org

Dear _____,

Welcome to the **Women's Medicine Collaborative.**

Your appointment with _____ is on _____

at _____ am/pm on the THIRD floor.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

The information requested is important for your care. We appreciate you taking the time to complete all the paperwork and bringing it with you to your appointment.

Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time for registration.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.
Please call us at (401) 793-5700 if you have any questions.

Expect your first visit to be focused on your pain history. Your second visit will include a physical exam and discussion of a plan of care.
You can discuss the role of prescription pain medication at your visit. However, the doctor will not prescribe pain medication at the first visit.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

We look forward to seeing you.

Sincerely,
Women's Medicine Collaborative

"Helping women reach their greatest health potential in body, mind, and spirit."

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146 West River Street
Providence, RI 02904

Tel 401 793-5700
Fax 401 793-7801

About Your Billing

To our patients:

This letter is to give you notice that the Women's Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor's office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women's Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible:
The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.

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2nd Floor - Bone Density Testing, Pulmonary Function Testing, Lifestyle Medicine Center, Acupuncture, Chiropractic Care, Massage Therapy, Nutrition, Stress Reduction, Yoga, Lifespan Laboratory

3rd Floor - Behavioral Medicine, Bone Health, High-Risk Breast Program, Cancer Survivorship, Cardiology, Colposcopy Clinic, Diabetes in Pregnancy, Gastrointestinal Medicine, Genetics, GYN Oncology, Menopause Consultation, Maternal-Fetal Medicine, Obstetric Medicine, Program for Pelvic Floor Disorders , Pelvic Pain Program, Primary Care, Pulmonary Medicine, Rheumatology, Urology, Urogynecology

Directions

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 146 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

BUS ROUTES

Best service to take is **Route# 51, 52 or 72** to Charles Street and West River Street. Route 51 runs every half hour. Route 52 and 72 both run every 45 minutes or so. Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter into the South parking lot entrance. Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

02/2017

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146 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone
	( )

City	State	Zip Code	Mobile Phone
			( )

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated
❑ Widowed ❑ Significant Other ❑ Other:_____

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male

Religion: _____

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone
		( )

Which provider you are here to see today?

How did you hear about us?

Primary Care Provider (PCP) / Practice Name

PCP Address	PCP Phone
	( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date	Address (if different)	Home Phone
	/ /		( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date	Patient's relationship to subscriber
	/ /	❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber	Subscriber's Employment Status	Subscriber's Employer
❑ Self ❑ Spouse ❑ Child ❑ Other _____	❑ Full Time ❑ Part Time ❑ Unemployed	

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone	Mobile Phone
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the Women's Medicine Collaborative Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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Patient Label

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: _____

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (_____) _____

MOBILE telephone # (_____) _____

WORK telephone # (_____) _____

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a general message about appointments? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a detailed message? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

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Pelvic Pain Program
146 West River St, Providence, RI 02904
3rd Floor, Suite 11D (401) 793-7917

Patient Label

Physician: _____ Date: _____
Patient's Name: _____ Date of Birth: _____
Phone: Home _____ Cell _____ Work _____
Referring Provider's Name: _____ Address: _____

Information About Your Pain

Please describe your pain problem (use a separate sheet of paper if needed): _____

What do you think is causing your pain? _____
Is there an event that you associate with the onset of your pain? ☐ No ☐ Yes If so, what? _____
How long have you had this pain? _____ years _____ months

*For each of the symptoms listed below, please circle your level of pain **over the last month** using a 10-point scale.*

0 = no pain 3-4 = able to do activity and distract yourself from the pain 4-5 = pain interrupts activities
6-7 = unable to focus 8 = you are thinking about going to the hospital 9-10 = to the hospital

Pain at ovulation (mid-cycle)	0	1	2	3	4	5	6	7	8	9	10
Pain just before period	0	1	2	3	4	5	6	7	8	9	10
Pain (not cramps) before period	0	1	2	3	4	5	6	7	8	9	10
Level of cramps with period	0	1	2	3	4	5	6	7	8	9	10
Pain after period is over	0	1	2	3	4	5	6	7	8	9	10
Deep pain with intercourse	0	1	2	3	4	5	6	7	8	9	10
Burning vaginal pain after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pelvic pain lasting hours or days after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pain when bladder is full	0	1	2	3	4	5	6	7	8	9	10
Pain with urination	0	1	2	3	4	5	6	7	8	9	10
Pain in groin when lifting	0	1	2	3	4	5	6	7	8	9	10
Muscle/Joint pain	0	1	2	3	4	5	6	7	8	9	10
Backache	0	1	2	3	4	5	6	7	8	9	10
Pain with sitting	0	1	2	3	4	5	6	7	8	9	10
Migraine headache	0	1	2	3	4	5	6	7	8	9	10

Pain scores over **the last week** (0-10): Average _____ Maximum _____ Minimum _____

Information About Your Pain Management

What types of treatments/providers have you tried in the past for your pain? Please check all that apply.

☐ Acupuncture
☐ Anesthesiologist
☐ Anti-seizure medications
☐ Antidepressants
☐ Biofeedback
☐ Botox injection
☐ Contraceptive pills/patch/ring
☐ Danazol (Danocrine)
☐ Depo-Provera
☐ Gastroenterologist
☐ Gynecologist
☐ Family Practitioner
☐ Herbal Medicine
☐ Homeopathic medicine
☐ Lupron, Synarel, Zoladex
☐ Massage
☐ Meditation
☐ Narcotics
☐ Naturopathic medication
☐ Nerve blocks
☐ Neurosurgeon
☐ Nonprescription medication
☐ Nutrition/Diet
☐ Physical Therapy
☐ Psychotherapy
☐ Psychiatrist
☐ Rheumatologist
☐ Skin magnets
☐ Surgery
☐ TENS unit
☐ Trigger point injections
☐ Urologist
☐ Other: _____

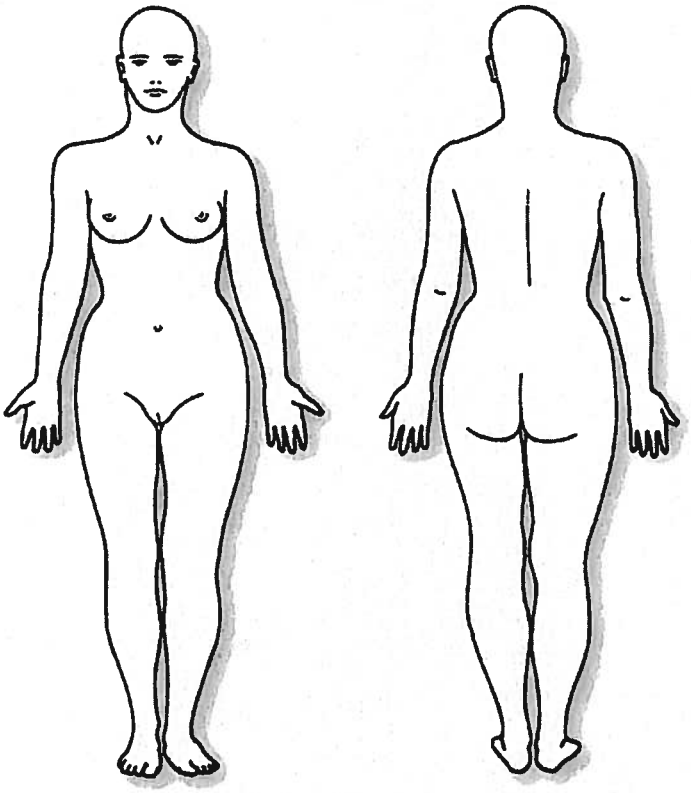
Patient Label

Of all the problems or stresses in your life, how does your pain compare in importance?

☐ The most important problem ☐ Just one of many problems

Pain Maps

Please shade area(s) of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)



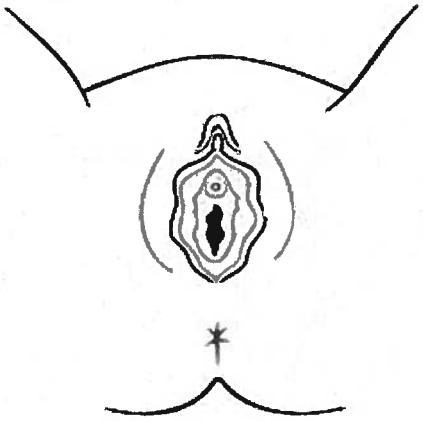
RIGHT LEFT LEFT RIGHT

Vulvar/Perineal Pain

(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful area(s) and write a number from 1 to 10 at the painful site(s).

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No



RIGHT LEFT

*What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?*

Physician / Provider	***Specialty***	***City, State, Phone #***

Social History

Are you (check all that apply): ☐ Married ☐ Single ☐ Widowed ☐ Remarried ☐ Separated ☐ Divorced ☐ Committed Relationship

Who do you live with? _____

Education: ☐ Less than 12 years ☐ High School graduate ☐ College degree ☐ Postgraduate degree

What type of work are you trained for? _____

What type of work are you doing? _____

Family History

Has anyone in your family had:

☐ Fibromyalgia ☐ Chronic pelvic pain ☐ Irritable bowel syndrome

☐ Depression ☐ Interstitial Cystitis ☐ Pain syndromes

☐ Endometriosis ☐ GYN cancers ☐ Substance abuse

☐ Other cancer type _____ ☐ Other chronic condition _____

Patient Label

Surgical History (use a separate sheet of paper if needed)
Please list all surgical procedures you have had **related to this pain**.

Year	*Procedure*	*Surgeon*	*Findings*

Please list all **other** surgical procedures:

Year	*Procedure*	*Surgeon*	*Findings*

Medications (use a separate sheet of paper if needed)
Please list **pain medication** you have taken for your pain condition **in the past 6 months**, and the providers who prescribed them.

Medication & Dose	*Provider*	*Did it help?*
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them.

Medication & Dose	*Medical Condition*	*Provider*

Medical History
Please list any medical problems/diagnoses _____
_____
_____
Allergies (including latex allergy) _____
Who is your Primary Care Provider? Name: _____

Have you ever been hospitalized for anything besides childbirth or the surgeries listed above? ☐ No ☐ Yes If yes, explain
_____
_____

Have you had major accidents such as falls or a back injury? ☐ No ☐ Yes
Have you ever been treated for depression? ☐ No ☐ Yes Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy
Birth control method: ☐ Nothing ☐ Pill ☐ Vaginal Ring ☐ Depo-Provera ☐ Condom ☐ IUD
☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization ☐ Vasectomy ☐ Other: _____

Patient Label

Menstrual History

How old were you when your menses started? _____ Are you still having menstrual periods? ☐ No ☐ Yes

Answer the following only if you are still having menstrual periods.

Periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Bleeding through protection

How many days between your periods? _____

How many days of menstrual flow? _____

Date of first day of last menstrual period: _____

Are your periods regular? ☐ No ☐ Yes

Do you have any pain with your periods? ☐ No ☐ Yes

Does pain start the day flow starts? ☐ No ☐ Yes Pain starts _____ days before flow.

Do you pass clots in menstrual flow? ☐ No ☐ Yes

Obstetric History

How many pregnancies have you had? _____

Resulting in (#): _____Full 9 months _____Premature _____Miscarriage/Abortion _____Living Children

Where there any complications during pregnancy, labor, delivery, or post-partum?

☐ 4^0 Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhaging

☐ Vaginal laceration ☐ Forceps ☐ Medications for bleeding ☐ Other _____

Gastrointestinal / Eating

Do you have nausea? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other _____

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other _____

Have you ever had an eating disorder such as anorexia or bulimia? ☐ No ☐ Yes

Are you experiencing rectal bleeding or blood in your stool? ☐ No ☐ Yes

Do you have increased pain with bowel movements? ☐ No ☐ Yes

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition which may be the cause of pelvic pain. **Do you have pain or discomfort that is associated with the following?**

Change in frequency of bowel movements? ☐ No ☐ Yes

Change in appearance of stool or bowel movements? ☐ No ☐ Yes

Does your pain improve after completing a bowel movement? ☐ No ☐ Yes

The following questions help to diagnose Pelvic Varicosity Pain Syndrome, which may cause pelvic pain.

Is your pelvic pain aggravated by prolonged physical activity? ☐ No ☐ Yes

Does your pelvic pain improve when you lie down? ☐ No ☐ Yes

Do you have pain that is deep in the vagina or pelvis *during* sex? ☐ No ☐ Yes

Do you have pelvic throbbing or aching *after* sex? ☐ No ☐ Yes

Do you have pelvic pain that moves from side to side? ☐ No ☐ Yes

Do you have sudden episodes of severe pelvic pain that come and go? ☐ No ☐ Yes

Urinary Symptoms

Do you experience any of the following?

Loss of urine when coughing, sneezing, or laughing? ☐ No ☐ Yes

Difficulty passing urine? ☐ No ☐ Yes

Frequent bladder infections? ☐ No ☐ Yes

Blood in the urine? ☐ No ☐ Yes

Bladder still feeling full after urination? ☐ No ☐ Yes

Having to void again within minutes of voiding? ☐ No ☐ Yes

Patient Label

The following questions help to diagnose Painful Bladder Syndrome, which may cause pelvic pain.
Please CIRCLE the answer that best describes your bladder function and symptoms.

How many times do you go to the bathroom **DURING THE DAY** (to void or empty your bladder)?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom **AT NIGHT** (to void or empty your bladder)?	0	1	2	3	4 or more
If you get up at night to void or empty your bladder, does it bother you?	Never	Mildly	Moderately	Severely	
Are you sexually active?	No	Yes			
If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
If you have pain with intercourse, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?	Never	Occasionally	Usually	Always	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
If you have pain, is it usually	Never	Mild	Moderate	Severe	
Does your pain bother you?	Never	Occasionally	Usually	Always	
If you have urgency, is it usually	Never	Mild	Moderate	Severe	
Does your urgency bother you?	Never	Occasionally	Usually	Always	

Health Habits

How often do you exercise? ☐ Rarely ☐ 1-2 times weekly ☐ 3-5 times weekly ☐ Daily

What is your caffeine intake? (number of cups per day, include coffee, tea, soft drinks, etc.) ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

How many cigarettes do you smoke per day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, number of drinks per week _____

Have you ever received treatment for substance abuse? ☐ No ☐ Yes

What is your use of recreational drugs? ☐ Never used ☐ Used in the past, but not now ☐ Presently using ☐ No answer
☐ Heroin ☐ Amphetamines ☐ Marijuana ☐ Barbiturates ☐ Cocaine ☐ Other: _____

How would you describe your diet? (check all the apply)
☐ Well balanced ☐ Vegan ☐ Vegetarian ☐ Fried Food ☐ Special Diet: _____

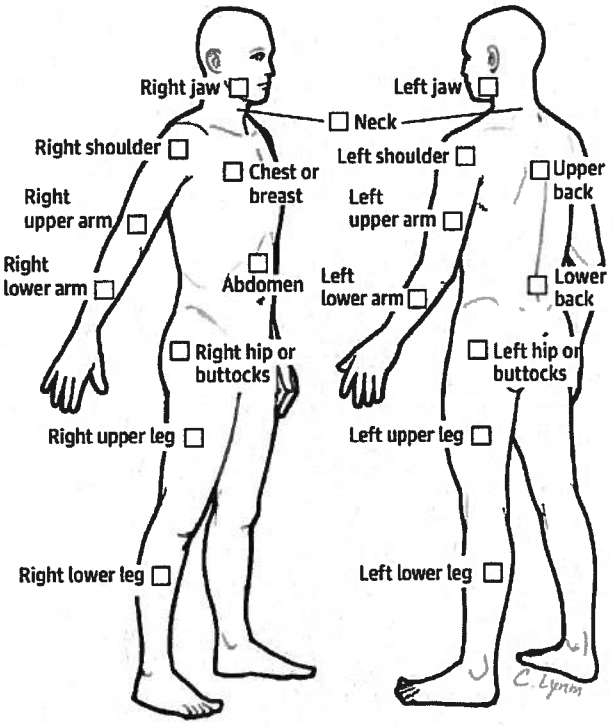
How many hours of sleep do you typically get each night? _____ hours

Patient Label

Musculoskeletal

Patient Self-report Survey for the Assessment of Fibromyalgia

(1) Please indicate if you have had pain or tenderness during the past 7 days in the areas shown below.
Check the boxes in the diagram for each area in which you have had pain or tenderness.



(2) For each symptom listed below, use the following scale to indicate the severity of the symptom during the past 7 days.
- No problem
- Slight or mild problem: generally mild or intermittent
- Moderate problem: considerable problems; often present and/or at a moderate level
- Severe problem: continuous, life-disturbing problems

	No problem	Slight or mild problem	Moderate problem	Severe problem
A. Fatigue	☐	☐	☐	☐
B. Trouble thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed)	☐	☐	☐	☐

(3) During the past 6 months have you had any of the following symptoms?

A. Pain or cramps in lower abdomen	☐ No	☐ Yes
B. Depression	☐ No	☐ Yes
C. Headache	☐ No	☐ Yes

(4) Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months?

☐ No ☐ Yes

(5) Do you have a disorder that would otherwise explain the pain?

☐ No ☐ Yes

Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

☐ Spouse/Partner ☐ Relative ☐ Support Group ☐ Clergy
☐ Doctor/Nurse ☐ Friend ☐ Mental Health provider ☐ I take care of myself

How does your partner deal with your pain?

☐ Not applicable ☐ Doesn't notice when I'm in pain ☐ Takes care of me ☐ Withdraws
☐ Feels helpless ☐ Distracts me with activities ☐ Gets angry

What helps your pain?

☐ Meditation ☐ Relaxation ☐ Lying down ☐ Music ☐ Massage
☐ Ice ☐ Heating Pad ☐ Hot bath ☐ Pain medication ☐ Laxatives/Enema
☐ Injection ☐ TENS unit ☐ Bowel movement ☐ Emptying bladder ☐ Nothing
☐ Other: _____

What makes your pain worse?

☐ Intercourse ☐ Orgasm ☐ Stress ☐ Full meal ☐ Bowel movement
☐ Full bladder ☐ Urination ☐ Standing ☐ Walking ☐ Exercise
☐ Time of day ☐ Weather ☐ Contact with clothing ☐ Coughing/Sneezing ☐ Not related to anything
☐ Other: _____

Patient Label

Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted. ☐ No ☐ Yes ☐ No Answer

Check the answer for **both** as a child and as an adult.	As a Child (13 and younger)		As an Adult (14 and over)	
Has anyone ever exposed the sex organs of their body to you when you did not want it?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever threatened to have sex with you when you did not want it?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever touched the sex organs of your body when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever made you touch the sex organs of their body when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone forced you to have sex when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Have you had any other unwanted sexual experiences not mentioned above?	☐ No	☐ Yes	☐ No	☐ Yes

If yes, please explain _____

When you were a child (13 or younger), did an older person do the following?

Hit, kick, or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threaten your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

When you were an adult (14 or older), has any other adult done the following?

Hit, kick, or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threatened your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

Currently:

Is anyone close to you threatening to hurt you? ☐ Yes ☐ No

Is anyone hitting, kicking, choking, or hurting you physically? ☐ Yes ☐ No

Is anyone forcing you to do something sexually that you do not want to do? ☐ Yes ☐ No

The words below describe average pain. Please put a **check mark** in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of **the pain in your pelvic area only**.

What does your pain feel like?

Type	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot/Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Punishing/Cruel				

Thank you for completing this questionnaire.

(205) 877-2950 www.pelvic pain.org (800)624-9676 (if in the U.S.)