

PERSISTENT PELVIC PAIN in MEN

Name: _____

Date: _____

Please describe your pain problems: (use a separate sheet if needed): _____

What do you think is causing your pain? _____

Is there an event that you associate with the onset of the pain? Yes No If so, what? _____

How long have you had pain? ____ years ____ months

Demographic Information: Please check all that apply:

- Married Widowed Separated Single Remarried Divorced
 Committed Relationship Who do you live with? _____

Education:

- < 12 years High school grad University Degree Postgraduate Degree

What type of work are you trained for? _____

What type of work are you doing? _____

What physician's or health care providers have evaluated you for persistent pelvic pain?

Physician/Provider	Specialty



Please list pain medications 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
		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	Provider	Medical Conditions

What types of treatment/providers have you tried in the past for your pain? Check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Family Practitioner | <input type="checkbox"/> Nutrition/diet |
| <input type="checkbox"/> Anesthesiologist (Pain blocks) | <input type="checkbox"/> Herbal medicine | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Anti-seizure medication (Gabapentin, Lyrica) | <input type="checkbox"/> Homeopathic medicine | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Antidepressants (Amitriptyline, Cymbalta) | <input type="checkbox"/> Lidocaine/Xylocaine | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Massage | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Botox injection | <input type="checkbox"/> Meditation | <input type="checkbox"/> Skin magnets |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Hormone medication | <input type="checkbox"/> Naturopathic medication | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Cognitive Behavioral Therapy | <input type="checkbox"/> Nerve blocks | <input type="checkbox"/> Topical Diazepam |
| <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Trigger point injections |
| — | — | — |

Colonoscopy

Cystoscopy

Urologist

Has anyone in your family been diagnosed with:

Fibromyalgia

Chronic pelvic pain

Irritable Bowel syndrome

Depression

Interstitial Cystitis

Endometriosis

Other chronic condition

Cancer

Gastro-Intestinal Function:

Do you have nausea?

No

With pain

With eating

Other

Do you have vomiting?

No

With pain

With eating

Other

Have you ever had an eating disorder such as anorexia/bulimia?

Yes

No

Are you experiencing rectal bleeding or blood in your stool?

Yes

No

Do you have increased pain with bowel movements?

Yes

No

Do you have changes in the frequency of your bowel movements?

Yes

No

Is there a change in the appearance of stool or bowel movements?

Yes

No

Does your pain improve after completing a bowel movement?

Yes

No

Lifestyle Questions:

How often do you exercise?

Rarely

1-2/week

3-5/week

Daily

What is your caffeine intake (#cups/day)?

0

1-3

4-6

>6

How many cigarettes do you smoke/day?

Yes

No

___ # packs/week

Do you drink alcohol?

Yes

No

___ #/week

Have you ever received treatment for Substance abuse?

Yes

No

Have you used recreational drugs?

Never

In the past

Presently using

No answer

Which drugs have you used?

Heroin

Amphetamines

Marijuana

Barbituates

Cocaine

Other

How would you describe your diet?

Vegetarian

Well balanced

Fast food

Special diet

How well do you sleep?

Well-

Difficulty falling

Wake up often

How many

— rested — Asleep — hours total

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?

- Doesn't notice Takes care of me Not applicable Withdraws
 Feels helpless Distracts me with activity 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 movements 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 Sitting
 Contact with clothing Coughing/sneezing Not related to anything Weather
 Other: _____

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

- The most important problem Just one of many problems

How you ever been the victim of emotional abuse? This can include being humiliated or insulted?

- Yes No No Answer

Threat Assessment:

These questions are private and personal; however, the pelvic floor muscles have been shown in studies to have a very protective function when we feel threatened. The answers to the following questions will help your therapist understand previous threats that may have caused your pelvic floor to tighten.

Check an answer for both as a child and as an adult:

	As a Child (<13)		As an adult (14+)	
Has anyone ever exposed the sex organs of their body to you when you did not want it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever threatened to have sex with you when you did not want it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever touched the sex organs of your body when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever made you touch the sex organs of their body when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone forced you to have sex when you did not want this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any other unwanted sexual experiences not mentioned above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Hit, kick or beat you?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
Seriously threaten your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
Now that you are an adult (14+), has any other adult done the following?				
Hit, kick or beat you?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often
Seriously threaten your life?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often

Tampa Questionnaire

(Reference: the original TSK9 is copied without restriction from the Work Cover Victoria website)

Please read each of the following statements and circle the number that best represents your feelings.

1 = Strongly disagree 2 = Somewhat Disagree 3 = Somewhat Agree 4 = Strongly Agree

I'm afraid I might injury myself if I exercise.....	1	2	3	4
If I were to try to overcome it, my pain would increase.....	1	2	3	4
My body is telling me that I have something dangerously wrong.....	1	2	3	4
My pain would probably be relieved if I were to exercise.....	1	2	3	4
People aren't taking my medical condition seriously enough.....	1	2	3	4
My accident has put my body at risk for the rest of my life.....	1	2	3	4
Pain always means that I have injured my body.....	1	2	3	4
Just because something aggravates my body does not mean it is dangerous.....	1	2	3	4
I am afraid that I might injure myself accidentally.....	1	2	3	4
Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.....	1	2	3	4
I wouldn't have this much pain if there weren't something potentially dangerous going on in my body	1	2	3	4
Although my condition is painful, I would be better off if I were physically active.....	1	2	3	4
Pain lets me know when to stop exercising so that I don't injury myself.....	1	2	3	4
It's really not safe for a person with a condition like mine to be physically active.....	1	2	3	4
I can't do all the things normal people do because it's too easy for me to get injured.....	1	2	3	4
Even though something is causing me a lot of pain, I don't think it's actually dangerous.....	1	2	3	4
No one should have to exercise when he/she is in pain.....	1	2	3	4

TOTALS:

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For Office use only: Rvs 4, 8, 12, 16
Score: _____/68 = _____

PCS QUESTIONNAIRE

(Reference: on Quartana et al. Pain Catastrophizing: A Critical review. Expert Rev Neurother. 2009 May; 9(5):745-758)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.

0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time

When I'm in pain.....

- _____ I worry all the time about whether the pain will end.
- _____ I feel I can't go on
- _____ It's terrible and I think it's never going to get any better
- _____ It's awful and I feel that it overwhelms me
- _____ I feel I can't stand it anymore
- _____ I become afraid that the pain will get worse
- _____ I keep thinking of other painful events
- _____ I anxiously want the pain to go away
- _____ I can't seem to keep it out of my mind
- _____ I keep thinking about how much it hurts
- _____ I keep thinking about how badly I want the pain to stop
- _____ There's nothing I can do to reduce the intensity of my pain
- _____ I wonder whether something serious will happen

TOTAL: ____/52 = ____%

PAIN DETECT

If 1 = no pain and 10 = the worst imaginable pain, please mark the following statements from 1-10

Section 1:

How would you assess your pain now, right at this moment?

1 2 3 4 5 6 7 8 9 10

How strong was the strongest pain during the past 4 weeks?

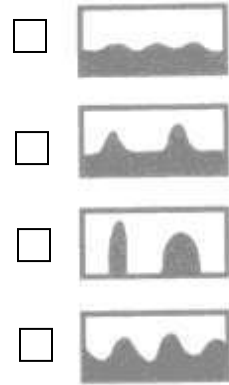
1 2 3 4 5 6 7 8 9 10

How strong was the pain during the past 4 weeks on average?

1 2 3 4 5 6 7 8 9 10

Section 2:

Mark the picture that best describes the course of your pain:

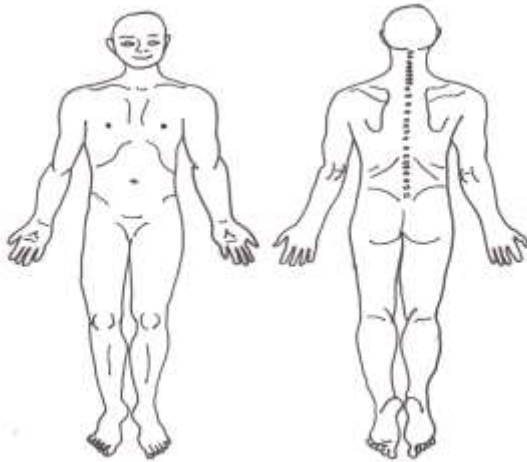


Section 3: Please mark your main area of pain:

Does your pain radiate to other regions of the body?

Yes No

If yes, please draw the direction in which the pain radiates



Please shade in the areas of your body that you are experiencing pain, numbness or tingling.

Please use: **N** for Numbness; **T** for Tingling; **P** for Pain; **X** for Itching; **B** for Burning

Section 4:

Do you suffer from a burning sensation (e.g. stinging nettles) in the marked areas?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Do you have tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Is light touching (clothing, a blanket) in this area painful?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Do you have sudden pain attacks in the area of your pain like electric shocks?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Is cold or heat (bath water) in this area occasionally painful?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Do you suffer from a sensation of numbness in the areas that you marked?

Never Hardly noticed Lightly Moderately Strongly Very strongly

Does slight pressure in this area, e.g. with a finger, trigger pain?

Never Hardly noticed Lightly Moderately Strongly Very strongly