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 <u>pain medications</u> 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

Please list <u>all other medications</u> 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

- ☐ Acupuncture
- ☐ Anesthesiologist (Pain blocks)
- ☐ Anti-seizure medication (Gabapentin, Lyrica)
- ☐ Antidepressants (Amitriptylline, Cymbalta)
- ☐ Biofeedback
- ☐ Botox injection
- ☐ Chiropractor
- ☐ Hormone medication
- ☐ Cognitive Behavioral Therapy
- ☐ Gastroenterologist
- ☐ Family Practitioner
- ☐ Herbal medicine
- ☐ Homeopathic medicine
- ☐ Lidocaine/Xylocaine
- ☐ Massage
- ☐ Meditation
- ☐ Narcotics
- ☐ Naturopathic medication
- ☐ Nerve blocks
- ☐ Neurosurgeon
- ☐ Nutrition/diet
- ☐ Physiotherapy
- ☐ Psychotherapy
- ☐ Psychiatrist
- ☐ Rheumatologist
- ☐ Skin magnets
- ☐ Surgery
- ☐ TENS unit
- ☐ Topical Diazepam
- ☐ 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 ☐ Cocaine	☐ Amphetamines ☐ Other	☐ Marijuana	☐ Barbituates
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?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever threatened to have sex with you when you did not want it?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever touched the sex organs of your body when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone ever made you touch the sex organs of their body when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Has anyone forced you to have sex when you did not want this?	☐ Yes	☐ No	☐ Yes	☐ No
Have you had any other unwanted sexual experiences not mentioned above?	☐ Yes	☐ No	☐ Yes	☐ No

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

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

Now that you are an adult (14+), has any other adult done the following?

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

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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: | | | | |

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?

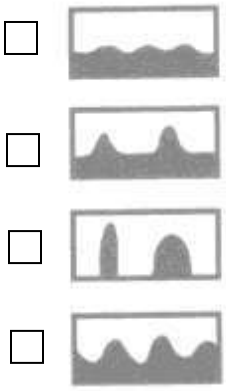
1 2 3 4 5 6 7 8 9 10

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:

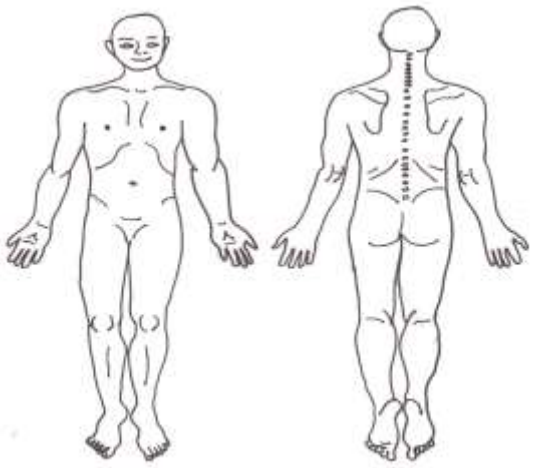


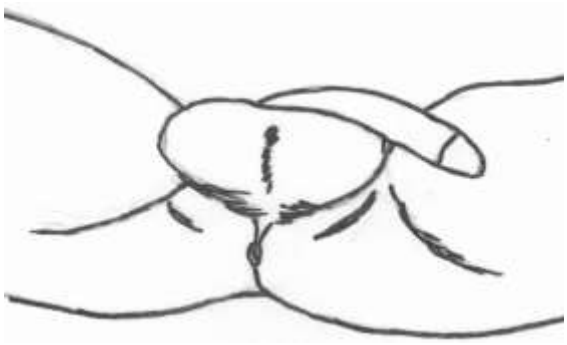
Section 3: Please mark your main area of pain:

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