***THE INFORMATION YOU PROVIDE IN THIS SURVEY CAN HELP YOUR CLINICIAN MAKE THERAPY RECOMMENDATIONS.***

**THIS FORM WILL TAKE LESS THAN *1O MINUTES* TO COMPLETE. PLEASE TAKE YOUR TIME, ANSWER THE QUESTIONS AS COMPLETEY AS YOU CAN.**

**YOU CAN COMPLETE THIS FORM ELECTRONICALLY OR WITH PEN AND PAPER.**

**WHEN YOU ARE DONE, GIVE THE FORM TO YOUR CLINICIAN OR A MEMBER OF YOUR HEALTHCARE TEAM.**

***PLEASE TELL US HOW YOU ARE DOING SINCE YOUR LAST CLINICAL VISIT.***

1. **Since your last visit, have you been diagnosed with any NEW MEDICAL PROBLEMS?**

[ ] No [ ] Yes, please describe here:Click or tap here to enter text.

Or select from the list below:

[ ] Endometriosis [ ] Fibromyalgia [ ] Chronic pelvic pain

[ ] Irritable bowel syndrome [ ]  Interstitial Cystitis [ ] Colon Cancer [ ] Breast Cancer

[ ] Uterine Cancer [ ] Ovarian Cancer [ ] Depression [ ] Chronic Fatigue Syndrome

[ ]  Anxiety/Panic Attacks [ ] Temporomandibular Joint Disorder [ ] Migraine Headache [ ] Post-Traumatic Stress Disorder (PTSD)

1. **Since your last visit have you had any NEW SURGERIES?**

[ ] No [ ] Yes, please describe here:Click or tap here to enter text.

1. ***If* you had BOWEL symptoms, how would you describe your BOWEL symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any bowel symptoms.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your bowel symptoms? Click or tap here to enter text. %**
2. ***If* you had URINARY symptoms, how would you describe your URINARY symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any bowel symptoms.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your URINARY symptoms?** Click or tap here to enter text. **%**
2. ***If* you had PAIN symptoms, how would you describe your PAIN symptoms now?**

[ ] Much better

[ ] Better

[ ] About the same

[ ] Worse

[ ] Much worse

[ ] I did not have any bowel symptoms.

1. **On a scale from 0% (not improved at all) to 100% (completely better), how would you rate the change in your PAIN symptoms?** Click or tap here to enter text. **%**
2. **In the last 30-60 days, or since your last visit with us, how many times have you been to the Emergency Room to get treated for this pain?**

[ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 [ ] 11 or more times

1. **Compared with before receiving treatment from us, how would you describe yourself now *overall*?**

Patient global impression of severity

[ ] Much better [ ]  Better [ ] About the same [ ] Worse [ ] Much worse

1. **If you are being treated for pain, which statement best describes your pain? *(Check only one)***

[ ] Always present (always the same intensity)

[ ] Always present (level of pain varies)

[ ] Often present (pain free periods less than 6 hours)

[ ] Occasionally present (once to several times per day lasting up to an hour)

[ ] Rarely present (pain occurs every few days or weeks)

1. **Rate the SEVERITY OF YOUR PAIN (*YOUR WORSE OR MAIN PAINFUL AREA*) on the scales below:**

|  |
| --- |
| [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |

 **No Pain Worse imaginable pain**

|  |
| --- |
| In the past *7 days….* |
|  | **Had no pain** | **Mild** | **Moderate** | **Severe** | **Very severe** |
| 1. How intense was your pain at its worse? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |
| 2. How intense was your average pain? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |
| 3. What is your level of pain right now? | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 |

Pain Intensity Scale Short Form 3a

1. **Mark the one box that describes how much, during the past week, pain has interfered with:**

|  |  |
| --- | --- |
|  | 0= does NOT interfere 10= completely interferes |
| General activity | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Mood | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Walking activity | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Normal activity (outside the home or with housework) | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Relations with other people | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Sleep | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| Enjoyment of life | [ ] 0 [ ]  1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |

1. **Listed below are statements describing different thoughts and feelings that may be associated with pain. Please read each statement and circle a number 0,1,2,3, or 4 which indicates how much the statement applies to you when you are experiencing pain.**

PCS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| When I am in pain… | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |
| I worry all the time about whether the pain will end. | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I feel I can’t go on | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| It’s terrible and I think it’s never going to get any better | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| It’s awful and I feel it overwhelms me | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I feel I can’t stand it anymore | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I become afraid that the pain will get worse | [ ] 0 | [ ] 1 | [x] 2 | [ ] 3 | [ ] 4 |
| I keep thinking of other painful events | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I anxiously want the pain to go away | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I can’t seem to keep it out of my mind | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I keep thinking about how much it hurts | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I keep thinking about how badly I want the pain to stop | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| There’s nothing I can do to reduce the intensity of the pain | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |
| I wonder whether something serious may happen | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 |

1. **Have you been sexually active since your last visit?**

[ ] No, ***SKIP TO QUESTION 17.***

[ ] Yes, please proceed to answering question 16

1. **Please complete the sexual questionnaire designed to capture the impact of your chronic pain on your experience of sex and sexuality.**

PROMIS Sexual Function Profile v1.0-Female

|  |
| --- |
| Interest in Sexual activity in the PAST 30 DAYS |
| 1. How interested have you been in sexual activity? | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit [ ] 4 | Very [ ] 5 |  |
| 2. How often have you felt like you wanted to have sex? | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |  |
| Lubrication over the PAST 4 WEEKS…  |
| 3. How often did you become lubricated ‘wet’ during sexual activity or intercourse? | No sexual activity[ ] 0 | Almost always or always[ ] 5 | Most times (more than half the time)[ ] 4 | Sometimes (about half the time)[ ] 3 | A few times (less than half of the time)[ ] 2 | Almost never or ever[ ] 1 |
| In the past 30 days… |
| 4. How difficult has it been for your vagina to be lubricated or ‘wet’ when you wanted it to? | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit[ ] 4 | Very [ ] 5 |  |
| Vaginal Discomfort in the PAST 30 DAYS…  |
| 5. How would you describe the comfort of your vagina during sexual activity? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |
| 6. How often have you had difficulty with sexual activity because of discomfort or pain in your vagina? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[x] 5 |
| 7. How often have you stopped sexual activity because of discomfort or pain in your vagina? | Have not had any sexual activity in the past 30 days[ ] 0 | Never[ ] 1 | Rarely[ ] 2 | Sometimes[ ] 3 | Often[ ] 4 | Always[ ] 5 |
| Orgasm in the PAST 30 DAYS... |
| 8. How would you rate your ability to have a satisfying orgasm/climax? | Have not tried to have an orgasm/climax in the past 30 days[ ] 0 | Excellent[ ] 5 | Very good[ ] 4 | Good[ ] 3 | Fair[ ] 2 | Poor[ ] 1 |
| Satisfaction in the PAST 30 DAYS… |
| 9. When you have had sexual activity how much have you enjoyed it? | Have not had any sexual activity in the past 30 days[ ] 0 | Not at all [ ] 1 | A little bit [ ] 2 | Somewhat [ ] 3 | Quite a bit[ ] 4 | Very [ ] 5 |
| 10. When you have had sexual activity, how satisfying has it been? | Have not had any sexual activity in the past 30 days□0 | Not at all □1 | A little bit □2 | Somewhat □3 | Quite a bit □4 | Very □5 |

1. **Since you were last seen by this pain management service, have you seen any other healthcare professionals for pain management?**

[ ] No [ ] Yes, describe:Click or tap here to enter text.

1. **Since you were last seen, have you done any other treatments that were NOT originally prescribed by this pain management service? *(Check all that apply)***

[ ] Acupuncture [ ] Massage [ ] Nutrition/Diet [ ] Physical Therapy

[ ] Biofeedback [ ] Cognitive Behavioral Therapy

[ ] Trigger Point Injections [ ] TENS Unit [ ] Botox Injections [ ] Nerve Blocks

[ ] Epidural [ ] Sex Therapy [ ] Joint Injections [ ] Neurostimulation

[ ] Mental Health [ ] Bladder instillations

[ ] Aqua Therapy [ ] Radio Frequency Ablation

[ ] Percutaneous Tibial Nerve Stimulation

[ ] Hormonal treatment-- if yes, what type of hormonal treatment?

 (***Check all that apply)***

[ ] Pills [ ] Patch [ ] Ring [ ]  Injections [ ] Estrogen [ ] Progesterone

[ ] Other treatments:Click or tap here to enter text.

1. **Please respond to each question or statement about your GENERAL HEALTH by marking 1 box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In general, would you say your health is? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, would you say your quality of life is? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your physical health? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your mental health, including mood and your ability to think? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, how would you rate your satisfaction with your social activities and relationships? | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1 |
| In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.) | Excellent□5 | Very good□4 | Good□3 | Fair□2 | Poor□1PROMIS Global Health v.1.1 |
| To what extend are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair | Completely□5 | Mostly□4 | Moderately□3 | A little□2 | Not at all□1 |
|  |  |  |  |  |  |
| *In the past 7 days…* |  |  |  |  |  |
| How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? | Never□1 | Rarely□2 | Sometimes□3 | Often□4 | Always□5 |
| How would you rate your fatigue on average? | None□1 | Mild□2 | Moderate□3 | Severe4□ | Very severe□5 |
| How would you rate your pain on average? | □ □□ □ □ □ □ □ □ □ □0-no pain 1 2 3 4 5 6 7 8 9 10- worst pain |

1. **Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no wrong or right answers, do not spend too much time on any statement.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DASS-21 | Not at all | Some of the time | A good part of the time | Most of the time |
| I found it hard to wind down | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was aware of dryness of my mouth | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I couldn’t seem to experience any positive feeling at all | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found it difficult to work up the initiative to do things | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I tended to overreact to situations | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I experienced trembling (e.g. in the hands) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I was using a lot of nervous energy | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was worried about situations in which I might panic and make a fool of myself | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I had nothing to look forward to | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found myself getting agitated | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I found it difficult to relax | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt downhearted and blue | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was intolerant of anything that kept me from getting on with what I was doing | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt I was close to panic | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was unable to become enthusiastic about anything | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt I wasn’t worth much as a person | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt that I was rather touchy | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I was aware of the action of my heart in the absence of physical exertion (e.g. a sense of heart rate increase, heart missing a beat) | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |
| I felt scared without good reason | [ ] 0 | [ ] 1 | [ ] 2 | [ ] 3 |

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. THIS INFORMATION WILL HELP YOUR CLINICIAN TAKE BETTER CARE OF YOU.**