Patient name: _____ DOB: _____ Date: _____

Symptom Monitor and Pain Questionnaire

We take a whole-person approach to your symptoms. We recognize that pain, bladder/bowel symptoms, muscle spasm and other symptoms have both a physical and emotional component to them. To get to the root of your problem(s), we will be asking you many questions that will help us to fully assess your problem and the impact that it is having on your life. If any of these questions don't apply to you or your symptoms, just leave them blank. Thank you for taking the time to share your story with us!

Presenting symptoms _____

_____

When/How did this start? _____

_____

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

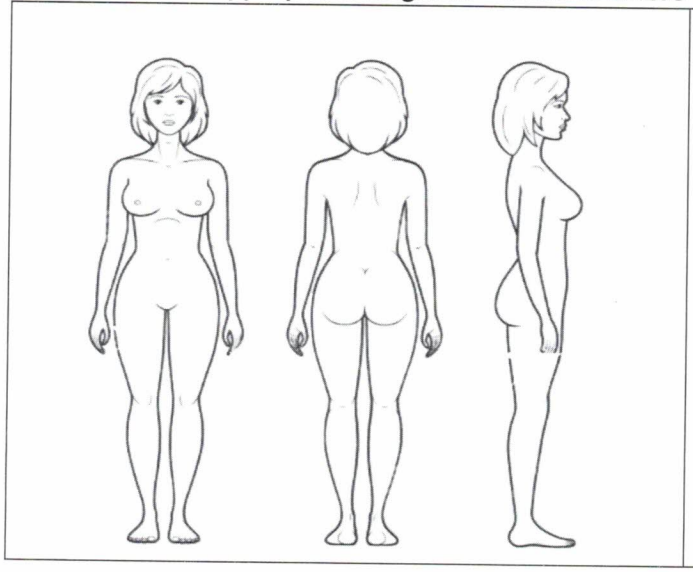
Have your pain/symptoms spread from its original problem? _____

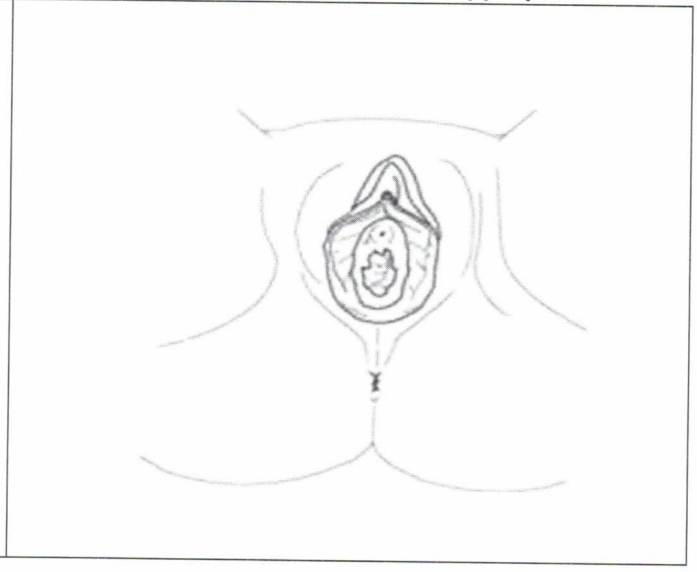
Are you sensitive to light touch or pressure? _____

What do you think is causing your problem? _____

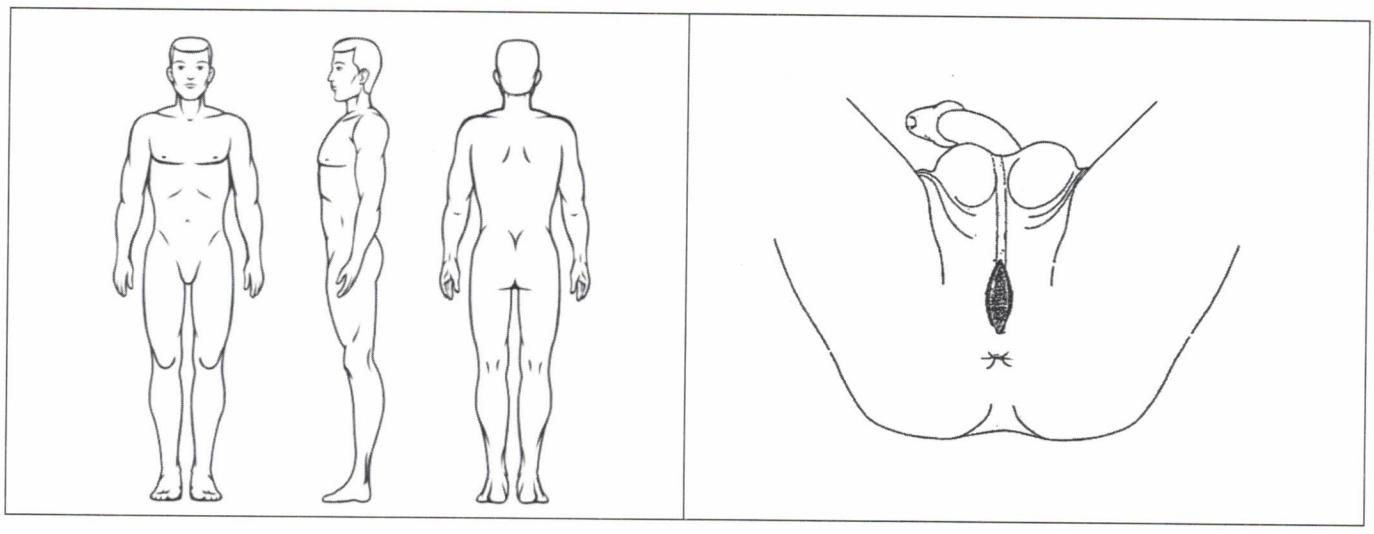
What do you think needs to be done for your problem that has not been done already? _____

Please mark the appropriate diagrams – indicate where your symptoms are and describe as appropriate





Patient name: _____ DOB: _____ Date: _____



Medical History/Screen- *to be filled out by everyone*

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks _____

Urinary tract infections? ☐ Yes ☐ No How often? _____

Repeat antibiotic use? ☐ Yes ☐ No Last UTI? _____

Probiotics? ☐ No ☐ Yes Cranberry supplementation? ☐ No ☐ Yes

Smoking ☐ Yes ☐ No # _____ packs/day Chronic cough ☐ Yes ☐ No

Yeast infections ☐ Yes ☐ No How often? _____

Last infection _____ Treatment _____

Is there blood in your urine/stool? ☐ Yes ☐ No Do you have unusual, odorous discharge? Yes No

Allergies (including latex): _____

Do you exercise? ☐ No ☐ Yes Type: _____ Frequency: _____

Low back problems? ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Mid back problems? ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Neck problems? ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Immediately after a good workout, do you feel (check one): ☐ Nourished ☐ Depleted

Two hours later, do you feel (check one): ☐ Nourished ☐ Depleted

The morning after a good workout, do you feel (check one): ☐ Nourished ☐ Depleted

Have you ever been treated for depression? ☐ Yes ☐ No What treatment? _____

Is/was treatment effective? ☐ No ☐ Yes

Have you ever been treated for anxiety? ☐ Yes ☐ No What treatment? _____

Is/was treatment effective? ☐ No ☐ Yes

Patient name: _____ DOB: _____ Date: _____

Have you ever been diagnosed with a mental health condition? ☐ No ☐ Yes If yes, what? _____

Please check off any of the following medical conditions that you currently have or have had in the past:

☐ Skin conditions	☐ Overactive bladder	☐ Breathing difficulties	☐ High blood pressure
☐ Heart disease	☐ Pacemaker	☐ Paralysis	☐ Arthritis
☐ Osteoporosis	☐ Chronic fatigue	☐ Night pain	☐ Numbness
☐ Diabetes	☐ Stroke	☐ Cancer or malignancy	☐ Sjogren's disease
☐ Joint replacements	☐ Speech difficulties	☐ Vision changes	☐ Dizziness
☐ Thyroid problems	☐ Endometriosis	☐ PCOS	☐ Lupus
☐ Multiple sclerosis	☐ Interstitial cystitis	☐ Chronic prostatitis	☐ Bladder pain syndroı

Please list any additional medical issues, illness or diagnosis you are currently undergoing treatment or investigation for:

_____

_____

_____

Please list the medications you are currently taking (including vitamins and supplements)		
Medication	Dose	Provider

Have you had any of the following medical procedures? If so, please provide the approximate date:

Appendectomy	_____	Bartholin Cyst	_____	Bowel resection	_____
Laparoscopy	_____	Cystoscopy	_____	Colonoscopy	_____
Hernia Repair	_____	Gallbladder removal	_____	Hemorrhoid surgery	_____

Patient name: _____ DOB: _____ Date: _____

Mesh procedure _____ Prolapse/Vaginal repair _____ Hysterectomy _____

Colostomy _____ Vasectomy _____ Prostatectomy _____

Gynecological History – please complete the following section *only if this applies to you*

What age did your period start? _____ Is your cycle regular? No Yes

Pain inserting a tampon? Yes No Do you suffer from PMS? Yes No Is your bleeding heavy? Yes No

Do you have pain with your period? No Yes Tell us more _____

Are you sexually active? No Yes How was your first sexual experience? Positive Negative

Pain with intercourse? Yes No Pain after intercourse? Yes No

Do you use lubricant? Yes No If yes, what type? _____

Birth control? Yes No Type: _____

# of pregnancies _____ # of live births _____ Wt. heaviest baby _____lbs _____oz

Age of child(ren) _____ Longest pushing stage _____ hours

# of vaginal deliveries _____ # of C-sections _____ Forceps? Yes No

Did you have a vacuum-assisted delivery? Yes No

Episiotomies/Tears? Yes No Grade of Tear: _____ Residual Pain at scar site? Yes No

During my labour(s) and delivery, I felt supported and cared for:
All or most of the time Some of the time A little bit Not at all

Were there times during labour and delivery that you were (or thought you were) in danger of death or injury? Yes No

Were there times when the baby was or seemed to be in danger during labour & delivery? Yes No

Do you suffer/have you suffered from post-partum depression? Yes No

Have you gone through menopause? Yes No If so, when? _____ Do you suffer from vaginal dryness? Yes No

Hormone replacement therapy? Yes No If yes, what? _____

Do you use vaginal moisturizer Yes No

If yes, what type? _____

Have you ever been told you have a prolapse? Yes No

Do you have persistent vaginal or rectal itchiness? Yes No

Do you have feelings of heaviness/pressure in your vagina? Yes No

Patient name: _____ DOB: _____ Date: _____

Prostate/Penile Health – please complete the following section *only if this applies to you*

Last PSA score: _____ When? _____ Last digital rectal exam? _____

Does your prostate get painful/irritated?	☐ Yes	☐ No	Has your prostate fluid been expressed and tested?	☐ Yes	☐ No
Do you have painful erections?	☐ Yes	☐ No	Can you achieve a satisfactory erection?	☐ No	☐ Yes
How was your first sexual experience	☐ Positive	☐ Negative	Do you have premature ejaculation?	☐ Yes	☐ No
Do you have pain during intercourse?	☐ Yes	☐ No	When? _____		

Do you have scrotal/rectal itching? ☐ Yes ☐ No

Bladder Symptoms – please complete this *only if your bladder is involved in your presentation*

Do you have leakage associated with sneezing, coughing, running and/or laughing? Other_____	☐ Yes	☐ No	☐ Sometimes
Do you have leakage during intercourse?	☐ Yes	☐ No	☐ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	☐ Yes	☐ No	☐ Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	☐ Yes	☐ No	☐ Sometimes
Do you have pain when your bladder fills?	☐ Yes	☐ No	☐ Sometimes
Does your pain improve when you void/urinate?	☐ Yes	☐ No	☐ Sometimes
Do you have pain when you void/urinate?	☐ Yes	☐ No	☐ Sometimes
Do you have to strain in order to empty your bladder?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty starting your urine steam?	☐ Yes	☐ No	☐ Sometimes
Do you have dribbling after you get up from the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you sit relaxed on the toilet?	☐ No	☐ Yes	☐ Sometimes
Do you not feel empty after you void and feel like you have to go again soon?	☐ Yes	☐ No	☐ Sometimes
Do your bladder problems cause you to leak in bed at night?	☐ Yes	☐ No	☐ Sometimes
Does your incontinence fluctuate with your menstrual cycle?	☐ Yes	☐ No	☐ Sometimes
Does your incontinence require you to wear pads?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how often? _____ Type of pads _____			
Do you void more than 8x/day?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how often? _____			
Do you need to get up at night to void?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how many times? _____			

Patient name: _____ DOB: _____ Date: _____

Fluid intake in 24 hours

_____ cups of water/day # _____ cups of coffee/day # _____ cups of tea/day

_____ cups of other fluids/day # _____ alcoholic drinks/day/week/month

Digestion & Bowel Function- *everyone should fill this section out*

Do you empty your bowels every day?	☐ Always	☐ Sometimes	☐ Never
Do you have an urge to empty your bowels daily?	☐ Never	☐ Sometimes	☐ Always
• Do you have hard, lumpy stools?	☐ Always	☐ Sometimes	☐ Rarely
• Do you strain to have a bowel movement?	☐ Always	☐ Sometimes	☐ Rarely
• Do you splint or assist to pass stool?	☐ Always	☐ Sometimes	☐ Rarely
• Do you have a sensation of incomplete emptying?	☐ Always	☐ Sometimes	☐ Rarely
• Do you have a sensation of blockage or obstruction?	☐ Always	☐ Sometimes	☐ Rarely
Do you have bowel urgency that is difficult to control?	☐ Always	☐ Sometimes	☐ Rarely
Do you have accidental bowel leakage?	☐ Always	☐ Sometimes	☐ Rarely
Do you have loose stools/diarrhea?	☐ Always	☐ Sometimes	☐ Rarely
Do you have pain <u>with</u> a bowel movement?	☐ Always	☐ Sometimes	☐ Rarely
Do you have pain <u>after</u> a bowel movement?	☐ Always	☐ Sometimes	☐ Rarely
Does it take longer than 5 minutes to have a bowel movement?	☐ Always	☐ Sometimes	☐ Rarely
Do you have bloating? (Increased pressure in abdomen)	☐ Always	☐ Sometimes	☐ Rarely
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	☐ Always	☐ Sometimes	☐ Rarely

Do you regularly use ☐ Laxatives ☐ Stool softeners ☐ Enemas ☐ _____

Have you ever been diagnosed with (and by whom?):

Irritable bowel syndrome When? _____ Who? _____

Ulcerative colitis When? _____ Who? _____

Crohn's Disease When? _____ Who? _____

Celiac Disease When? _____ Who? _____

Do you have any food allergies or sensitivities? _____

_____

Have your bowel habits changed recently including unexplained weight loss, abdominal pain, rectal bleeding or excessive straining? (circle any symptoms in the last sentence that have **<u>changed</u>** recently)

Patient name: _____ DOB: _____ Date: _____

On a scale of 1-10, please rate how <u>bothersome</u> this problem is for you

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how <u>hopeful</u> you are that you will be able to correct this problem

1 2 3 4 5 6 7 8 9 10

Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?

	No	Yes	Diagnosed
1. Restless leg syndrome			
2. Chronic fatigue syndrome			
3. Fibromyalgia			
4. Temporomandibular joint disorder (TMJ)			
5. Irritable bowel syndrome			
6. Multiple chemical sensitivities			
7. Neck injury (including whiplash)			
9. Anxiety or panic attacks			
10. Depression			

Patient name: _____ DOB: _____ Date: _____

Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
I have headaches.	Never	Rarely	Sometimes	Often	Always
I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
I do not sleep well.	Never	Rarely	Sometimes	Often	Always
I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
I have low energy.	Never	Rarely	Sometimes	Often	Always
I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

Patient name: _____ DOB: _____ Date: _____

DASS Questionnaire

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

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time
3 = Applied to me very much, or most of the time

I find it hard to wind down	S	0	1	2	3
I was aware of dryness of my mouth	A	0	1	2	3
I could not seem to experience any feeling at all	D	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion	A	0	1	2	3
I found it difficult to work up the initiative to do things	D	0	1	2	3
I tended to over-react to situations	S	0	1	2	3
I experienced trembling (e.g. hands)	A	0	1	2	3
I felt that I was using a lot of nervous energy	S	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself	A	0	1	2	3
I felt that I had nothing to look forward to	D	0	1	2	3
I found myself getting agitated	S	0	1	2	3
I found it difficult to relax	S	0	1	2	3
I felt down-hearted and blue	D	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing	S	0	1	2	3
I felt I was close to panic	A	0	1	2	3
I was unable to become enthusiastic about anything	D	0	1	2	3
I felt I was not much of a person	D	0	1	2	3
I felt that I was rather touchy	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	A	0	1	2	3
I felt scared without any good reason	A	0	1	2	3
I felt that life was meaningless	D	0	1	2	3

Patient name: _____ DOB: _____ Date: _____

Insomnia Severity Index

Please fill out if you struggle with sleep. For each question, please CIRCLE the number that best describes your answer. Please rate the CURRENT (in the last two weeks) SEVERITY of your sleep problems.

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

If you struggle with any TYPE of PAIN as part of your symptoms, please fill out the following questionnaires

If you DO NOT have pain, you can top filling out this questionnaire at this point. Thank you!

Patient name: _____ DOB: _____ Date: _____

The Fremantle _____ Awareness Questionnaire

This questionnaire has been tested on those people who have back pain. It measures how people with low back pain are aware of how their low back moves and functions. We have adapted this questionnaire to measure your MOST painful part. Choose one body part and put it in the _____ area for each question. Use the same body part for ALL questions. Using the following scale, please indicate the degree to which your painful body part feels this way when you are experiencing "your typical" pain.

	Never	Rarely	Occasionally	Often	Always
1. My_____ feels as though it is not part of the rest of my body	0	1	2	3	4
2. I need to focus all my attention on my _____ to make it move the way I want it to	0	1	2	3	4
3. I feel as if my _____ sometimes moves involuntarily, without my control	0	1	2	3	4
4. When performing everyday tasks, I don't know how my _____ is moving	0	1	2	3	4
5. When performing everyday tasks, I am not sure exactly what position my _____ is in	0	1	2	3	4
6. I can't perceive the exact outline of my _____	0	1	2	3	4
7. My _____ feels like it is enlarged (swollen)	0	1	2	3	4
8. My _____ feels like it has shrunk	0	1	2	3	4
9. My _____ feels lopsided (asymmetrical)	0	1	2	3	4

Patient name: _____ DOB: _____ Date: _____

PCS Questionnaire

(Reference: Quartana et al. 2009)

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.....

(H) _____ I worry all the time about whether the pain will end

(H) _____ I feel I can't go on

(H) _____ It's terrible and I think it's never going to get any better

(H) _____ It's awful and I feel that it overwhelms me

(H) _____ I feel I can't stand it anymore

(M) _____ I become afraid that the pain will get worse

(M) _____ I keep thinking of other painful events

(R) _____ I anxiously want the pain to go away

(R) _____ I can't seem to keep it out of my mind

(R) _____ I keep thinking about how much it hurts

(R) _____ I keep thinking about how badly I want the pain to stop

(H) _____ There's nothing I can do to reduce the intensity of my pain

(M) _____ I wonder whether something serious will happen

TOTAL: _____

Patient name: _____ DOB: _____ Date: _____

PANAS

(Reference: Watson, D., Clark, L. A., & Tellegan, A. 1988)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment *OR* indicate the extent you have felt this way over the past week. Please circle if you used this measure for the present moment or over the past week.

1	2	3	4	5
Very slightly or not at all	**A little**	**Moderately**	**Quite a bit**	**Extremely**

1. ____ Interested
2. ____ Distressed
3. ____ Excited
4. ____ Upset
5. ____ Strong
6. ____ Guilty
7. ____ Scared
8. ____ Hostile
9. ____ Enthusiastic
10. ____ Proud
11. ____ Irritable
12. ____ Alert
13. ____ Ashamed
14. ____ Inspired
15. ____ Nervous
16. ____ Determined
17. ____ Attentive
18. ____ Jittery
19. ____ Active
20. ____ Afraid

Pain Self-Efficacy Questionnaire PSEQ-2

(Michael. K Nicholas, PhD, Brian E. McGuire, PhD, and Ali Asghari, PhD)

Please rate how **confident** you are that you can do the following things at present, **despite the pain.** To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

1.	I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work)	0 Not at all confident	1	2	3	4	5	6 Completely confident
2.	I can live a normal lifestyle, despite the pain	0	1	2	3	4	5	6

Patient name: _____ DOB: _____ Date: _____

TSK-11 Questionnaire

This is a list of phrases which other patients have used to express how they view their condition. Please circle the number that best describes how you feel about each statement.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
1. I'm afraid I might injure myself if I exercise.	1	2	3	4
2. If I were to try to overcome it, my pain would increase.	1	2	3	4
3. My body is telling me I have something dangerously wrong.	1	2	3	4
4. People aren't taking my medical condition serious enough.	1	2	3	4
5. My accident/problem has put my body at risk for the rest of my life.	1	2	3	4
6. Pain always means I have injured my body.	1	2	3	4
7. 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
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
9. Pain lets me know when to stop exercising so that I don't inquire myself.	1	2	3	4
10. I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
11. No one should have to exercise when he/she is in pain.	1	2	3	4

Patient name: _____ DOB: _____ Date: _____

IEQ

When injuries happen, they can have profound effects on our lives. This scale was designed to assess how your injury has affected your life.

Listed below are twelve statements describing different thoughts and feelings that you may experience when you think about your injury. Using the following scale, please indicate how frequently you experience these thoughts and feelings when you think about your injury.

0 - Never **1** - Rarely **2** - Sometimes **3** - Often **4** – Always

_____ Most people don't understand how severe my condition is

_____ My life will never be the same

_____ I am suffering because of someone else's negligence

_____ No one should have to live this way

_____ I just want to have my life back

_____ I feel that this has affected me in a permanent way

_____ It all seems so unfair

_____ I worry that my condition is not being taken seriously

_____ Nothing will ever make up for all that I have gone through

_____ I feel as if I have been robbed of something very precious

_____ I am troubled by fears that I may never achieve my dreams

_____ I can't believe this has happened to me

Total _____