



*Women's
Advantage Inc.*

310-373-5800
23332 Hawthorne Boulevard Suite 202
Torrance, California 90505
www.womens-advantage.com

Patient Introductory Packet

This packet is designed to help new patients by providing most of the information that they need for their first visit. Please fill out the forms in the following pages and **bring your prescription and Health insurance info.**
Women's Advantage Physical Therapy is located within Skypark Physical Therapy.

DIRECTIONS: There is parking in front and directly behind the building. If you are in pain you may wish to use the rear parking lot as there is better ramp access. Take the elevator to the second floor and proceed to the right to the end of the hall to Suite 202.

From the 110 Harbor Freeway:

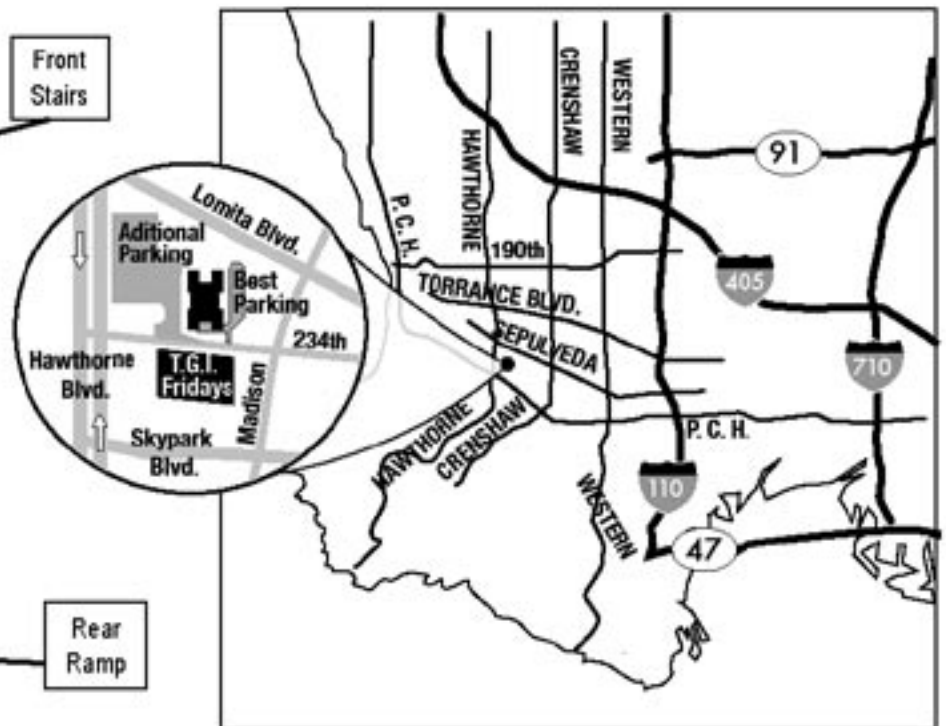
Take Sepulveda West till you reach Hawthorne Boulevard. At Hawthorne Boulevard Turn Left (south) You will pass Lomita Blvd.. The next left will have a TGIF restaurant sign.
This is 234th Street, Skypark Physical Therapy/Women's Advantage Inc. is the building to the left.

From The Palos Verdes Peninsula:

Take Hawthorne Blvd. North toward the Del Amo Mall Pass PCH and Skypark Blvd. Then turn RIGHT at the TGIFridays sign on 234th street. Skypark Physical Therapy/Women's Advantage Inc. is the building to the left.

From the Beach Cities:

Take Sepulveda East to Hawthorne Blvd. Turn right (South) on Hawthorne Blvd. You will pass Lomita Blvd. The next left will have a TGIF restaurant sign. This is 234th Street, Skypark Physical Therapy/Women's Advantage Inc. is the building to the left.



NAME: _____ DATE: _____



Women's Advantage Physical Therapy

23332 Hawthorne Boulevard, Suite 202

Torrance, CA 90505

(310) 373-5800 Fax (310) 373-6223

Patient Information

Full name: _____

Address: _____

Home phone #: _____

Birth date (mn/day/yr): _____

If under 18, guardian name: _____

Gender: male female

Emergency contact: _____

Friend/relative not living with you: _____

Referred by (physician, friend, etc.): _____

Employer & occupation: _____

Address: _____

Work phone/pager/cellular #: _____

Driver's license # (required): _____

Social Security # (required): _____

E-mail (optional): _____

Relation: _____ Phone: _____

Phone: _____

Phone: _____

Billing and Insurance

Insurance (those that apply): Medicare Private Cash Other

Insured Party: Self Spouse Other

Is condition: Work Auto Other

Name of insured: _____

Date of injury / onset: _____

Reason for referral / condition: _____

Please provide insurance information of all applicable policies that may cover services while under our care:

Insurance: _____

Group / Policy #: _____

ID: _____

Claim #: _____

Phone #: _____

Adjuster: _____

Insurance: _____

Group / Policy #: _____

ID : _____

Claim #: _____

Phone #: _____

Adjuster: _____

Please submit your insurance card(s) and Driver's License for photocopy to maintain in your medical records (this is required)

Accountability and Patient's Rights

My signature below certifies the information contained herein as correct and true. I understand that I am ultimately financially responsible for services provided regardless of insurance payment or legal representation. As designated legal guardian for this patient, my signature authorizes treatment for this minor.

Patient's Rights'. I understand that I have the right to:

- Respectful and courteous care regardless of race, religion, gender, nationality, orientation, age or disability
- Participate in my healthcare treatment plan
- Continue to self-pay for services after insurance benefits have ceased

- Be informed of risks / benefits of treatment and alternatives
- Choose my own therapist, and know their qualifications
- Grant or deny access of my confidential medical records to other persons or agencies

X _____
Signature of patient or guardian Date

Office use only	Onset date: _____
Dx code 1: _____	Dx code 2: _____
Dx code 3: _____	Dx code 4: _____
Admit condition (0-10) _____	

NAME: _____ DATE: _____



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Medical History

Please provide your detailed medical history by filling out this form. This is a requirement by Medicare for us to keep a detailed record of your health history.

Personal History

Please check <input checked="" type="checkbox"/>	Yes	No
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia or emphysema	<input type="checkbox"/>	<input type="checkbox"/>

Please check <input checked="" type="checkbox"/>	Yes	No
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid dysfunction.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Surgical implants	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Please list all surgeries, invasive medical procedures, fractures and other serious injuries. Include approximate date and any lasting complications or disabilities:

Please list present medications that you are taking:

Do you have any allergies to the following?

Please check <input checked="" type="checkbox"/>	Yes	No
Novocaine / Lidocain	<input type="checkbox"/>	<input type="checkbox"/>
Iodine compounds	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list): _____		

Your weight: _____ Height: _____

Family History

Has any immediate family relative ever had any of the following:

Please check <input checked="" type="checkbox"/>	Yes	No
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Please check <input checked="" type="checkbox"/>	Yes	No
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

I certify that this information is correct and true: X _____ / / _____
Signature date

NAME: _____ DATE: _____



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Instructions: Look at the Legend to determine the pain that you are experiencing now. Using a pen place any of the letters that apply to you on the location on the diagram below.

A = Ache

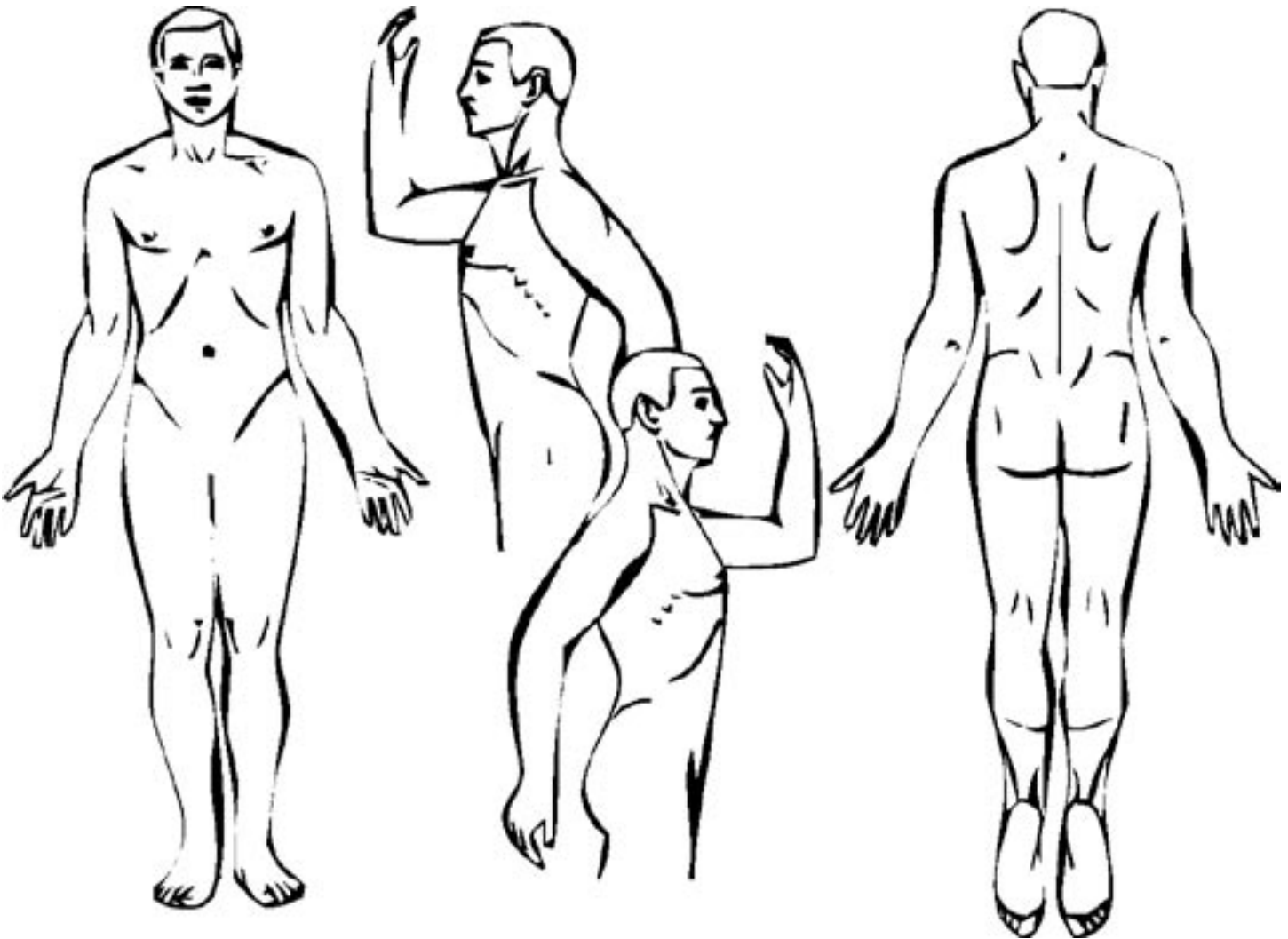
P = Pins & Needles

B = Burning

S = Stabbing

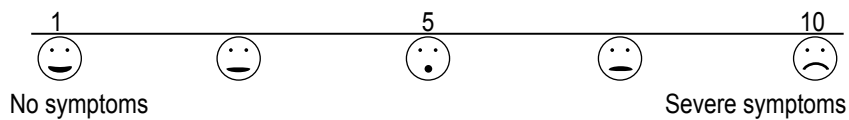
N = Numbness

O = Other



Pain Scale

Make a vertical line to indicate your present pain level



NAME: _____ DATE: _____



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Patient Self-Assessment for Assistive Services

Please complete the following to help us better understand any concerns or needs you may have. Our Social Services Consultant will contact you directly to provide you with a list of resources & their telephone numbers for the items you have checked.

Please check the following items you need assistance with:

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| Transportation | <input type="checkbox"/> | Meals | <input type="checkbox"/> |
| Personal Care | <input type="checkbox"/> | Domestic Chores | <input type="checkbox"/> |
| Shopping/Errands | <input type="checkbox"/> | Financial Concerns | <input type="checkbox"/> |
| Individual/Family
Problems | <input type="checkbox"/> | Support Groups..... | <input type="checkbox"/> |
| Domestic Violence/spousal Abuse Services | <input type="checkbox"/> | Services | <input type="checkbox"/> |
- Other (Please Explain):

Do you need referrals for these services? Yes_____ No_____

What telephone number would you like our Social Services Consultant to contact you ? (_____) _____ - _____

Do you prefer A.M.._____ P.M._____

I am declining the need for social services_____

Patient Signature

Date

NAME: _____ DATE: _____



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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At Skypark Physical Therapy/Women's Advantage Inc., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give this notice, and to follow the terms of this notice.
- The law permits us to disclose or use your health information to those involved in your treatment. For example, a review of your file may be given to a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information.
- We may also want to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.

- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above.
- We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with our health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whichever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing and if you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include you statement in your files. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the **Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201**. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at **(310) 373-5800**. This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the Skypark Physical Therapy/Women's Advantage Inc. Notice of Privacy Practice.

Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

NAME: _____ DATE: _____



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ASSIGNMENT FOR DIRECT PAYMENT

I HEREBY AUTHORIZED PAYMENT BY CHECK BE MADE OUT DIRECTLY TO:

Skypark Physical Therapy
23332 Hawthorne Blvd, Ste 202
Torrance, CA 90505
310/373-5288
TIN 33-0152163

FOR THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD CHARGES FOR PROFESSIONAL SERVICES RENDERED BY SKYPARK PHYSICAL THERAPY. THE PAYMENT WILL NOT EXCEED MY INDEPTENDNESS TO THE ABOVE MENTIONED ASSIGNED AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT YOU TO MAKE OUT THE CHECK TO ME, AND MAIL IT TO ME IN CARE OF SKYPARK PHYSICAL THERAPY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE OF PATIENT

DATE



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Financial Policy

Please read and sign our financial policy. Check only what applies to you, then sign and date the bottom statement. Your signature is required before rehabilitation services can be provided at our facility: **(Women's Advantage Inc. is billed under Skypark Physical Therapy)**

Check insurance/payment type that applies:

Medicare: Our facility accepts Medicare reimbursement for rehabilitation services. Payment from Medicare only covers approximately 80% of rehabilitation services; therefore your secondary insurance (Medi-gap) is responsible for the remaining 20%. Our facility cannot bill for additional expenses or charges not covered by Medicare and secondary policies and must accept reimbursement as payment in full.

Exceptions:

- If you have not met your annual \$100.00 deductible, you are rightfully responsible to pay this.
- Your secondary insurance has a deductible, or limited reimbursement, which requires you to pay the remaining applicable balance.
- Our office will notify when you reach the number of visits allowed per your diagnosis.
- You desire to continue treatment after benefits have ceased, therefore you may elect to self-pay (i.e. cash).
- You received physical or speech therapy elsewhere and did not disclose this.
- You were involved in litigation (i.e. car accident, slip and fall) for which liability insurance should cover medical care primarily. If this information was not disclosed and settlement was made, you may be required to reimburse Medicare for any payment made to our facility.

Private Insurance: As a courtesy to our patients, we will bill your insurance company for you and withhold action for 45 days. If your insurance has failed to pay w/in 45 days we will expect you to pay your bill, in full, & seek reimbursement from your insurance. We will also assist you in verifying your insurance benefits. Any remaining balance, co-pay, delinquent payment or deductible amounts due for services rendered are your responsibility. Co-payments are due at the time of visit. Delinquent, late or overdue balance amounts may accrue interest. If you are unable to keep your appointment, please provide a 24-hour notice of cancellation. If you do not, you will be charged for the full appointment time.

Cash: Our facility will accommodate check or credit card payment plans in the event of non-payment from insurers, out-of-network plans, or non-coverage of rehabilitation services. I agree to pay:

AUTHORIZATION TO RELEASE RECORD:

I hereby authorize Skypark Physical Therapy/Women's Advantage Inc. to release my medical records to my attorney, my insurance company or Skypark Physical Therapy representatives for collection and also to myself upon my request.

I have read and fully agree to this information presented: X _____

Signature of patient or guardian

Date: _____

PFDI – 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bladder, pelvic or bowel symptoms and, if you do, how much they bother you. Answer these by marking the appropriate number. While answering these questions, please consider your symptoms over the last **3 months**. The PFDI - 20 has 20 items and 3 scales for your symptoms. All item use the following format with a response scale from 0-4.

Symptoms Present = YES, scale of bother: 1 = Not at All
 2 = Somewhat
 3 = Moderately
 4 = Quite a Bit

Symptoms Not Present = NO 0 = Not Present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI – 6)

Do you...	No	YES			
1. Usually experience pressure in the lower abdomen?	0	1	2	3	4
2. Usually experience heaviness or dullness in the pelvic area?	0	1	2	3	4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
4. Ever have to push on the vagina or around the rectum to complete a bowel movement?	0	1	2	3	4
5. Usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4

Colorectal-Anal Distress Inventory 9 (CRAD – 8)

Do you...	No	YES			
7. Feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9. Usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10. Usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
11. Usually lose gas from the rectum beyond your control?	0	1	2	3	4
12. Usually have pain when you pass your stool?	0	1	2	3	4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4

Urinary Distress Inventory 6 (UDI – 6)

Do you...	No	YES			
15. Usually experience frequent urination?	0	1	2	3	4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1	2	3	4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
19. Usually experience difficulty emptying your bladder?	0	1	2	3	4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

Scoring the PFDI – 20

Scale Scores: Obtain the mean values of all of the answered items within the corresponding scale (Possible 0 to 4) and then multiple by 25 to obtain the scale score (range 0 to 100). Missing Items are dealt with by using the mean from answered items only.

PFSI – 20 Summary Score: Add the scores from the 3 scale scores together to obtain the summary score (range 0 to 300).

PFIQ – 7 Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your ... ↓	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household chores (cooking, housecleaning, laundry)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
2. Ability to do physical activities such as walking, swimming or other exercise?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
3. Entertainment activities such as going to a movie or concert?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
5. Participating in social activities outside your home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
6. Emotional health (nervousness, depression, etc)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
7. Feeling frustrated?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

All of the item use the following response scale:

0 = Not at all, 1 = Somewhat, 2 = Moderately, 3 = Quite a bit

Adapted by Herman & Wallace Pelvic Rehabilitation Institute 2006 from Barber, M., Walters, M., et al. (2005) "Short form of two conditions-specific quality of life questionnaires for women with pelvic floor disorders (PFDI – 20 and PFIQ – 7)." American Journal of Obstetrics and Gynecology 193: 103-113.

VULVAR PAIN FUNCTIONAL QUESTIONNAIRE (V-Q)

These are statements about how your pelvic pain affects your everyday life. Please check one box for each item below, choosing the one that best describes your situation. Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment. Your responses will be kept completely confidential at all times.

1. Because of my pelvic pain
 - 3 I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
 - 2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
 - 1 I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
 - 0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
 - 3 Gets worse when I walk, so I can only walk far enough to move around in my house, no further.
 - 2 Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
 - 1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
 - 0 My pain does not get worse with walking; I can walk as far as I want to
 - 0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain
 - 3 Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
 - 2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
 - 1 Occasionally gets worse when I sit, but most of the time sitting is comfortable.
 - 0 My pain does not get worse with sitting, I can sit as long as I want to.
 - 0 I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain
 - 3 I am sleepy and I have trouble concentrating at work or while I do housework.
 - 2 I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
 - 1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
 - 0 I don't have any problems with the pills that I take for pelvic pain.
 - 0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
 - 3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
 - 2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
 - 1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
 - 0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
- 3 I don't get together with my friends or go out to parties or events.
 - 2 I only get together with my friends or go out to parties or events every now and then.
 - 1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
 - 0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way
7. Because of my pelvic pain
- 3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.
 - 2 I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
 - 1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
 - 0 It never hurts for the doctor to insert the speculum when I go to the gynecologist.
8. Because of my pelvic pain
- 3 I cannot use tampons at all, because they make my pain much worse.
 - 2 I can only use tampons if I put them in very carefully.
 - 1 It usually doesn't hurt to use tampons, but occasionally it does hurt.
 - 0 It never hurts to use tampons.
 - 0 This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.
9. Because of my pelvic pain
- 3 I can't let my partner put a finger or penis in my vagina during sex at all.
 - 2 My partner can put a finger or penis in my vagina very carefully, but it still hurts.
 - 1 It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.
 - 0 It doesn't hurt to have my partner put a finger or penis in my vagina at all.
 - 0 This question does not apply to me because I don't have a sexual partner.
 - 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.
10. Because of my pelvic pain
- 3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
 - 2 My partner can touch me sexually outside the vagina if we are very careful
 - 1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt
 - 0 It never hurts for my partner to touch me sexually outside the vagina
 - 0 This question does not apply to me because I don't have a sexual partner.
 - 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.
11. Because of my pelvic pain
- 3 It is too painful to touch myself for sexual pleasure.
 - 2 I can touch myself for sexual pleasure if I am very careful.
 - 1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
 - 0 It never hurts to touch myself for sexual pleasure.
 - 0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.