

The Pelvic Pain Impact Questionnaire



Name: _____

Date: ____/____/____

Directions:

For each of the following 8 questions, tick the box that best indicates how much your pelvic pain has affected these aspects of your life during the past month. Your answers to these questions can then be summed to give you a final score.

In the past month, how much has your pelvic pain affected your:	Not at all (0)	A little bit (1)	Somewhat (2)	Quite a bit (3)	A great deal (4)
energy levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stomach and intestinal function?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ability to sit for longer than 20 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ability to perform and function normally at home/work/school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ability to take part in physical activity? (e.g. jogging, yoga, bicycling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ability to wear certain clothes? (e.g. underwear, tight fitting clothes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total:

If the following questions apply to you, please answer. If not, please leave these blank. These questions will not be added to your summed score.

During your last period, how much did your pelvic pain affect your ability to use tampons?

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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In the past month, how much has your pelvic pain affected your levels of intimacy or sexual relationships? (e.g. having sex, masturbating)

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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