# 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? | ☐ | ☐ | ☐ | ☐ | ☐ |
| mood? | ☐ | ☐ | ☐ | ☐ | ☐ |
| sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| stomach and intestinal function? | ☐ | ☐ | ☐ | ☐ | ☐ |
| ability to sit for longer than 20 minutes? | ☐ | ☐ | ☐ | ☐ | ☐ |
| ability to perform and function normally at home/work/school/university? | ☐ | ☐ | ☐ | ☐ | ☐ |
| ability to take part in physical activity? (e.g. jogging, yoga, bicycling) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ability to wear certain clothes? (e.g. underwear, tight fitting clothes) | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | **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? | ☐ | ☐ | ☐ | ☐ | ☐ |
| In the past month, how much has your pelvic pain affected your levels of intimacy or sexual relationships? (e.g. having sex, masturbating) | ☐ | ☐ | ☐ | ☐ | ☐ |