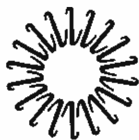

Women's Medicine Collaborative[*]
Lifespan. Delivering health with care.[℠]

PELVIC PAIN PROGRAM
146/148 West River St.
Providence, RI 02904
(401) 606-3800
WomensMedicine.org

Dear ____ ,

Welcome to the **Pelvic Pain Program.**

Your appointment with ________________________ is on ______________________
at ___________________ am/pm on the **FIRST floor, Suite 8.**

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

The information requested is important for your care. We appreciate you taking the time to complete all the paperwork and bringing it with you to your appointment.

Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time for registration.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.
Please call us at (401) 606-3800 if you have any questions.

Expect your first visit to be focused on your pain history. Your second visit will include a physical exam and discussion of a plan of care.
You can discuss the role of prescription pain medication at your visit. However, the doctor will not prescribe pain medication at the first visit.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

We look forward to seeing you.

Sincerely,
Women's Medicine Collaborative

"Helping women reach their greatest health potential in body, mind, and spirit."

Women's Medicine Collaborative*

Lifespan. Delivering health with care.℠

*The Miriam Hospital d.b.a. Women's Medicine Collaborative

146 West River Street
Providence, RI 02904

Tel 401 793-5700
Fax 401 793-7801

About Your Billing

To our patients:

This letter is to give you notice that the Women's Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor's office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women's Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible:
The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.

Women's Medicine Collaborative
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DRIVING DIRECTIONS

146/148 West River Street
Providence, RI 02904
(401) 793-5700

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right at the stop sign to stay on West River Street
- 146/148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street/RI-246
- Turn left onto West River Street
- 146/148 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right at the stop sign to stay on West River Street
- 146/148 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right at the stop sign to stay on West River Street
- 146/148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

GA 02.12.2019

Women's Medicine Collaborative
Lifespan. Delivering health with care.

Pelvic Pain Program First Floor-Suite 8
146/148 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)			
Last Name		First Name	Middle
Birth Date	Social Security #	Email	
Street Address			Home Phone ( )
City	State	Zip Code	Mobile Phone ( )

Marital Status	Preferred Language
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other ❑ Other:________	Spoken: ____________ Written: ____________ Interpreter Required? ❑ YES ❑ NO
Sex: ❑ Female ❑ Male	Religion: ______________

Preferred Pharmacy: Name: Address:	Phone #:
Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time ❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time	

Employer	Occupation	Employer Phone ( )
Which provider you are here to see today?	How did you hear about us?	
Primary Care Provider (PCP) / Practice Name		
PCP Address		PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST			
Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )
Is this patient covered by insurance? ❑ Yes ❑ No	Primary Insurance Plan Name		
Group #	Policy #		Co-Pay Amount
Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ________	
Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer		
Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #
Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ________	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer	

IN CASE OF EMERGENCY			
Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the MyLifespan Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

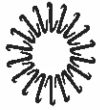
03.05.2019

Women's Medicine Collaborative
A program of The Miriam Hospital
Lifespan. Delivering health with care.™

Patient Label

ETHNICITY – PLEASE SELECT We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.
❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer
RACE - PLEASE SELECT
❑ Unknown ❑ Prefer not to answer ❑ American Indian or Alaska Native ❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian) ❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African) ❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian) ❑ White or Caucasian ❑ Other: ________________________________

PHONE PRIVACY In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.
HOME telephone # (________) ______________________ MOBILE telephone # (________) ______________________ WORK telephone # (________) ______________________ BEST number to reach you: ❑ Home ❑ Mobile ❑ Work May we leave a **general** message about appointments? HOME: ❑ Yes ❑ No MOBILE: ❑ Yes ❑ No WORK: ❑ Yes ❑ No May we leave a **detailed** message? HOME: ❑ Yes ❑ No MOBILE: ❑ Yes ❑ No WORK: ❑ Yes ❑ No



Women's Medicine Collaborative
Lifespan. Delivering health with care.

Pelvic Pain Program
146/148 West River St.
Providence, RI 02904
1st Floor – Suite 8 (401) 606-3800

Patient Label

Date: ____________________

Legal Name: ____ Date of Birth: ________________________

Preferred Name: ____

Who referred you to the Pelvic Pain program? ____

Information About Your Pain

Please describe your pain problem (use a separate sheet of paper if needed): ______________________________

____

____

____

____

____

What do you think is causing your pain? ____

Is there an event that you associate with the onset of your pain? ☐ No ☐ Yes If so, what? ____________________

How long have you had this pain? ________ years _________ months

Pain scores over **the last week** (0-10): Average ______ Maximum ________ Minimum _______

For each of the symptoms listed below, please circle your level of pain ***over the last month*** *using a 10-point scale.*

0 = no pain 3-4 = able to do activity and distract yourself from the pain 4-5 = pain interrupts activities
6-7 = unable to focus 8 = you are thinking about going to the hospital 9-10 = to the hospital

Pain at ovulation (mid-cycle)	0	1	2	3	4	5	6	7	8	9	10
Pain just before period	0	1	2	3	4	5	6	7	8	9	10
Pain (not cramps) before period	0	1	2	3	4	5	6	7	8	9	10
Level of cramps with period	0	1	2	3	4	5	6	7	8	9	10
Pain after period is over	0	1	2	3	4	5	6	7	8	9	10
Deep pain with intercourse	0	1	2	3	4	5	6	7	8	9	10
Burning vaginal pain after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pelvic pain lasting hours or days after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pain when bladder is full	0	1	2	3	4	5	6	7	8	9	10
Pain with urination	0	1	2	3	4	5	6	7	8	9	10
Pain in groin when lifting	0	1	2	3	4	5	6	7	8	9	10
Muscle/Joint pain	0	1	2	3	4	5	6	7	8	9	10
Backache	0	1	2	3	4	5	6	7	8	9	10
Pain with sitting	0	1	2	3	4	5	6	7	8	9	10
Migraine headache	0	1	2	3	4	5	6	7	8	9	10

Gastrointestinal / Eating

Do you have nausea? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other ____________________

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other ____________________

Do you have constipation (hard or infrequent bowel movements)? ☐ No ☐ Yes

Do you have diarrhea (liquid or frequent bowel movements)? ☐ No ☐ Yes

Have you ever had an eating disorder such as anorexia or bulimia? ☐ No ☐ Yes

Are you experiencing rectal bleeding or blood in your stool? ☐ No ☐ Yes

Do you have increased pain with bowel movements? ☐ No ☐ Yes

Does your pain improve after completing a bowel movement? ☐ No ☐ Yes

Do you experience bloating associated with your pain? ☐ No ☐ Yes

Patient Label

The following questions help to diagnose Pelvic Varicosity Pain Syndrome, which may cause pelvic pain.

Is your pelvic pain aggravated by prolonged physical activity?	☐ No	☐ Yes
Does your pelvic pain improve when you lie down?	☐ No	☐ Yes
Do you have pain that is deep in the vagina or pelvis *during* sex?	☐ No	☐ Yes
Do you have pelvic throbbing or aching *after* sex?	☐ No	☐ Yes

Urinary Symptoms

How often do you void during the day? ______________________________

How many times do you wake at night to void? ______________________________

Do you experience any of the following?

Loss of urine when coughing, sneezing, or laughing?	☐ No	☐ Yes
Difficulty passing urine?	☐ No	☐ Yes
Frequent bladder infections?	☐ No	☐ Yes
Blood in the urine?	☐ No	☐ Yes
Bladder still feeling full after urination?	☐ No	☐ Yes
Having to void again within minutes of voiding?	☐ No	☐ Yes

Musculoskeletal

For each system listed below, use the following scale to indicate the severity of the symptom <u>during the past 7 days</u>.

- No problem
- Slight or mild problem: generally mild or intermittent
- Moderate problem: considerable problems; often present and/or at a moderate level
- Severe problem: continuous, life-disturbing problems

	No problem	Slight or Mild problem	Moderate problem	Severe problem
A. Fatigue	☐	☐	☐	☐
B. Trouble thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed)	☐	☐	☐	☐

During the <u>past 6 months</u> have you had any of the following symptoms?

A. Pains or cramps in lower abdomen	☐ No	☐ Yes
B. Depression	☐ No	☐ Yes
C. Headache	☐ No	☐ Yes

Have the symptoms in the above questions and pain been present at a similar level for <u>at least 3 months</u>? ☐ No ☐ Yes

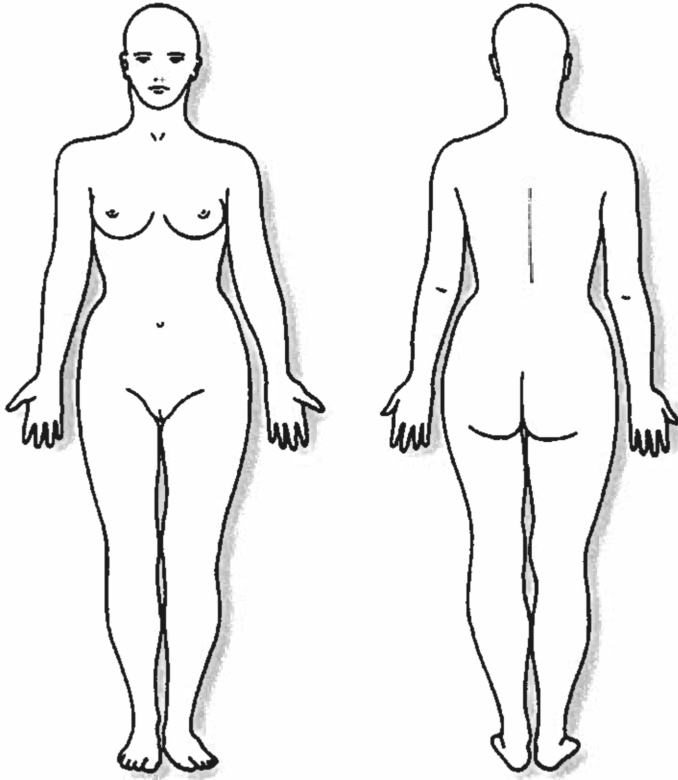
Patient Label

Of all the problems or stresses in your life, how does your pain compare in importance?

☐ The most important problem ☐ Just one of many problems

Pain Maps

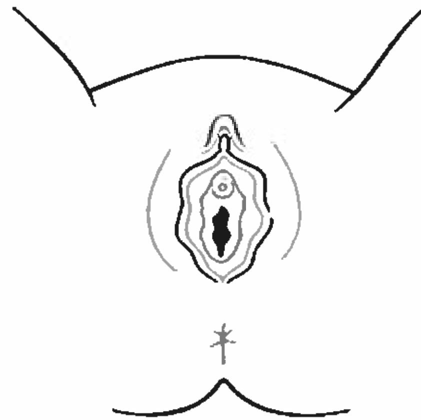
Please shade area(s) of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)



RIGHT LEFT LEFT RIGHT

Vulvar/Perineal Pain
(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful area(s) and write a number from 1 to 10 at the painful site(s).
Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No



RIGHT LEFT

*What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?*

Physician / Provider	***Specialty***	***City, State, Phone #***

Information About Your Pain Management

What types of treatments/providers have you tried in the past for your pain? Please check all that apply.

☐ Acupuncture
☐ Anesthesiologist
☐ Anti-seizure medications
☐ Antidepressants
☐ Biofeedback
☐ Botox injection
☐ Contraceptive pills/patch/ring
☐ Danazol (Danocrine)
☐ Depo-Provera
☐ Gastroenterologist
☐ Gynecologist
☐ Family Practitioner
☐ Herbal Medicine
☐ Homeopathic medicine
☐ Lupron, Synarel, Zoladex
☐ Massage
☐ Meditation
☐ Narcotics
☐ Naturopathic medication
☐ Nerve blocks
☐ Neurosurgeon
☐ Nonprescription medication
☐ Nutrition/Diet
☐ Physical Therapy
☐ Psychotherapy
☐ Psychiatrist
☐ Rheumatologist
☐ Skin magnets
☐ Surgery
☐ TENS unit
☐ Trigger point injections
☐ Urologist
☐ Other: ______________

Patient Label

If answering these questions is upsetting to you, please feel free to leave blank.

When you were growing up, did you ever experience any traumatic events, such as violence in or out of the home, family members with substance abuse, or sexual violence? ☐ No ☐ Yes

As an adult, have you experienced any physical, emotional, or sexual abuse? ☐ No ☐ Yes

Are you experiencing physical, emotional, or sexual abuse currently? ☐ No ☐ Yes

The words below describe average pain. Please put a **check mark** in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of **the pain in your pelvic area only**.

What does your pain feel like?

Type	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot/Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Punishing/Cruel				

Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

- ☐ Spouse/Partner ☐ Relative ☐ Support Group ☐ Clergy
- ☐ Doctor/Nurse ☐ Friend ☐ Mental Health provider ☐ I take care of myself

How does your partner deal with your pain?

- ☐ Not applicable ☐ Doesn't notice when I'm in pain ☐ Takes care of me ☐ Withdraws
- ☐ Feels helpless ☐ Distracts me with activities ☐ Gets angry

What helps your pain?

- ☐ Meditation ☐ Relaxation ☐ Lying down ☐ Music ☐ Massage
- ☐ Ice ☐ Heating Pad ☐ Hot bath ☐ Pain medication ☐ Laxatives/Enema
- ☐ Injection ☐ TENS unit ☐ Bowel movement ☐ Emptying bladder ☐ Nothing
- ☐ Other: ______________________________

What makes your pain worse?

- ☐ Intercourse ☐ Orgasm ☐ Stress ☐ Full meal ☐ Bowel movement
- ☐ Full bladder ☐ Urination ☐ Standing ☐ Walking ☐ Exercise
- ☐ Time of day ☐ Weather ☐ Contact with clothing ☐ Coughing/Sneezing ☐ Not related to anything
- ☐ Other: ______________________________

Patient Label

Please put a check mark in the column that represents the degree to which you feel the following:

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

Thank you for completing this questionnaire.