

# Pelvic Pain Flare Record

Document each flare as it happens. Fill in one row per flare — the sooner after the flare starts, the more useful the record.

Name: \_\_\_\_\_

<b>Pain scale:</b>	0	1	2	3	4	5	6	7	8	9	10
	none					moderate					severe

Date	Duration	Pain (0–10) <i>select one</i>	Pain location <i>circle all that apply</i>	What helped <i>circle all that apply</i>	Notes
	hrs / days	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="checkbox"/> Bladder <input type="checkbox"/> Pelvis <input type="checkbox"/> Perineum <input type="checkbox"/> Low back <input type="checkbox"/> Abdomen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Heat <input type="checkbox"/> Rest <input type="checkbox"/> Medication <input type="checkbox"/> Movement <input type="checkbox"/> Nothing <input type="checkbox"/> Other: _____	
	hrs / days	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="checkbox"/> Bladder <input type="checkbox"/> Pelvis <input type="checkbox"/> Perineum <input type="checkbox"/> Low back <input type="checkbox"/> Abdomen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Heat <input type="checkbox"/> Rest <input type="checkbox"/> Medication <input type="checkbox"/> Movement <input type="checkbox"/> Nothing <input type="checkbox"/> Other: _____	
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**Pelvic Pain Flare Record – continued**

Date	Duration	Pain (0–10) <i>select one</i>	Pain location <i>circle all that apply</i>	What helped <i>circle all that apply</i>	Notes
	hrs / days	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> Bladder <input type="radio"/> Pelvis <input type="radio"/> Perineum <input type="radio"/> Low back <input type="radio"/> Abdomen <input type="radio"/> Other: _____	<input type="radio"/> Heat <input type="radio"/> Rest <input type="radio"/> Medication <input type="radio"/> Movement <input type="radio"/> Nothing <input type="radio"/> Other: _____	
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	hrs / days	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	<input type="radio"/> Bladder <input type="radio"/> Pelvis <input type="radio"/> Perineum <input type="radio"/> Low back <input type="radio"/> Abdomen <input type="radio"/> Other: _____	<input type="radio"/> Heat <input type="radio"/> Rest <input type="radio"/> Medication <input type="radio"/> Movement <input type="radio"/> Nothing <input type="radio"/> Other: _____	
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**Patterns to discuss with your provider**



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