

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: _____

Pain scale:	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	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 0 1 2 3 4 5 6 7 8 9 10	○ Bladder ○ Pelvis ○ Perineum ○ Low back ○ Abdomen ○ Other: _____	○ Heat ○ Rest ○ Medication ○ Movement ○ Nothing ○ Other: _____	
	hrs / days	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 0 1 2 3 4 5 6 7 8 9 10	○ Bladder ○ Pelvis ○ Perineum ○ Low back ○ Abdomen ○ Other: _____	○ Heat ○ Rest ○ Medication ○ Movement ○ Nothing ○ Other: _____	
	hrs / days	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 0 1 2 3 4 5 6 7 8 9 10	○ Bladder ○ Pelvis ○ Perineum ○ Low back ○ Abdomen ○ Other: _____	○ Heat ○ Rest ○ Medication ○ Movement ○ Nothing ○ Other: _____	
	hrs / days	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 0 1 2 3 4 5 6 7 8 9 10	○ Bladder ○ Pelvis ○ Perineum ○ Low back ○ Abdomen ○ Other: _____	○ Heat ○ Rest ○ Medication ○ Movement ○ Nothing ○ Other: _____	
	hrs / days	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 0 1 2 3 4 5 6 7 8 9 10	○ Bladder ○ Pelvis ○ Perineum ○ Low back ○ Abdomen ○ Other: _____	○ Heat ○ Rest ○ Medication ○ Movement ○ Nothing ○ 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: _____	
	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: _____	
	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: _____	
	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: _____	
	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: _____	

Patterns to discuss with your provider



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