**Welcome at the tailbone therapist**

To understand your problems and the factors of influence optimally, I like to request to you to fill out the questionnaire below for me. The answers give me valuable information which enables me to help you better and treat your problems as effective as possible.

Thanks for the cooperation.

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| **Name: Date:** |

**How tall are you?** …… cm **What is your body weight?** …… kg

(This question refers to your Body Mass Index, which has an influence on tailbone problems)

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| 1. **The restrictions and discomfort during activities in daily life**
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**Painscore**

|  |  |
| --- | --- |
| What score would you rate your pain on average during the day? 0 = no pain at all, 10 = unbearable pain |  |

**Restrictions**

Name the activities that are most painful and restricted in order of importance, where the upper one bothers you most and so on. You can think of sitting, cycling, toilet stops, lying in bed, standing, bending over, touching or pressing on it, walking, doing specific work activities or sports and so on.

Rate first the severity of the problem during the activity with 0= no pain and 10 unbearable pain

If you already had your first treatment with me, please rate how it was BEFORE the first session.

Rate then the amount of restriction where 0 is no restriction at all executing the activity and with 10 it is impossible to do the activity at all.

Please name at least three activities.

|  |  |  |
| --- | --- | --- |
| Activity | Amount of pain - 0-10 | Restriction - 0-10 |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

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| 1. **The influence of other problems**
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Answer in the list below how much you experience the problems mentioned.
Put a circle around only one of the answers.

|  |  |  |
| --- | --- | --- |
| 1  | I don’t feel rested in the morning when I wake up  | Never Seldom Sometimes Often Always |
| 2  | My muscles feel stiff and painful | Never Seldom Sometimes Often Always |
| 3  | I have panic attacks  | Never Seldom Sometimes Often Always |
| 4  | I grind or clench my teeth  | Never Seldom Sometimes Often Always |
| 5  | I have diarrhea and/or constipation  | Never Seldom Sometimes Often Always |
| 6  | I need help with doing daily activities  | Never Seldom Sometimes Often Always |
| 7  | I am sensitive for bright lights | Never Seldom Sometimes Often Always |
| 8  | I am tired quickly with physical activities | Never Seldom Sometimes Often Always |
| 9  | I experience pain over my complete body | Never Seldom Sometimes Often Always |
| 10  | I suffer from headaches | Never Seldom Sometimes Often Always |
| 11  | I have an uncomfortable feeling in my bladder and/or burning sensation during urinating | Never Seldom Sometimes Often Always |
| 12  | I don’t sleep well | Never Seldom Sometimes Often Always |
| 13  | I have a hard time concentrating | Never Seldom Sometimes Often Always |
| 14  | I have skin issues like dry skin, itch or rashes | Never Seldom Sometimes Often Always |
| 15  | Stress aggravates my physical problems | Never Seldom Sometimes Often Always |
| 16  | I feel down and depressed | Never Seldom Sometimes Often Always |
| 17  | I am low in energy | Never Seldom Sometimes Often Always |
| 18  | I have muscle tension in my neck and shoulders | Never Seldom Sometimes Often Always |
| 19  | I experience pain in my jaw | Never Seldom Sometimes Often Always |
| 20  | Certain scents, like perfumes, make me dizzy and nauseous | Never Seldom Sometimes Often Always |
| 21  | I have to pee often  | Never Seldom Sometimes Often Always |
| 22  | My legs feel uncomfortable and restless when I want to go to sleep at night | Never Seldom Sometimes Often Always |
| 23  | I have a hard time remembering things | Never Seldom Sometimes Often Always |
| 24  | As a child I had traumatic experiences | Never Seldom Sometimes Often Always |
| 25 | I have pain in my pelvic area | Never Seldom Sometimes Often Always |

Is there:

|  |  |
| --- | --- |
| Recent unexplainable weight loss?A diagnosis of cancer in your medical history?A nagging or burning pain in the sitting area or buttocks?A nagging or burning pain in the reproductive organsNumbness or tingling in the skin in the area of the buttocks or gluteal region? | Yes / NoYes / NoYes / NoYes / NoYes / No |
| What was the level of stress/restlessness in your life in the period before and around the onset of the problems, and how is that now? 0 = completely zen, 10 = total restlessness, out of control | **Around onset** | **Now** |

1. **Medical Diagnosis**

Did a doctor diagnose you with one of the next things? Circle the answer and if yes when that was.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | Year of diagnosis |
| 1 | Restless legs syndrome | Yes | No |  |
| 2 | Chronic fatigue syndrome  | Yes | No |  |
| 3 | Fibromyalgia | Yes | No |  |
| 4 | Jaw problems  | Yes | No |  |
| 5 | Migraine or tension headache | Yes | No |  |
| 6 | Irritable bowl syndrome | Yes | No |  |
| 7 | Oversensitivity for chemical substances | Yes | No |  |
| 8 | Neck injury (including whiplash)  | Yes | No |  |
| 9 | Anxiety of panic attacks | Yes | No |  |
| 10 | Depression | Yes | No |  |

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| 1. **Tension Pelvic Floor Musculature**
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Are one or more of these applicable? Circle the answer.

|  |  |  |
| --- | --- | --- |
| Lacking the control to get to the toilet in time | Yes | No |
| Feeling the urge but having trouble to come to urination or defecation at the toilet | Yes | No |
| Undesired loss of urine or defecation | Yes | No |
| Pain, sensitivity or discomfort during sexual intercourse | Yes | No |
| Regular obstipation | Yes | No |
| Pain, discomfort or a heavy feeling in and around the sexual organs | Yes | No |

|  |  |
| --- | --- |
| How many times did you give birth?Please add if this were vaginal deliveries or C-sections |  |

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| 1. **Previous therapy**
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Did you consult any other therapists for these problems already? Think of physiotherapists but also pelvic(bekken)physios, chiropractors, osteopaths and so on. Please mention per therapist what the treatment was (like massage, dry needling, exercises or direct work on the tailbone) and the effect of it.

|  |  |  |
| --- | --- | --- |
| Kind of therapist | Kind of treatment | Effect |
|  |  |  |

Did you consult a doctor for these problems already? Please mention per physician what the treatment was (like medication or injection) and the effect of the treatment. If you had any injections how many and the effect of each one of them.

|  |  |  |
| --- | --- | --- |
| Kind of doctor | Kind of treatment | Effect |
|  |  |  |

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| --- |
| 1. **Other**
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If there is anything you like to add or clarify, please do that here or on the back of the form.