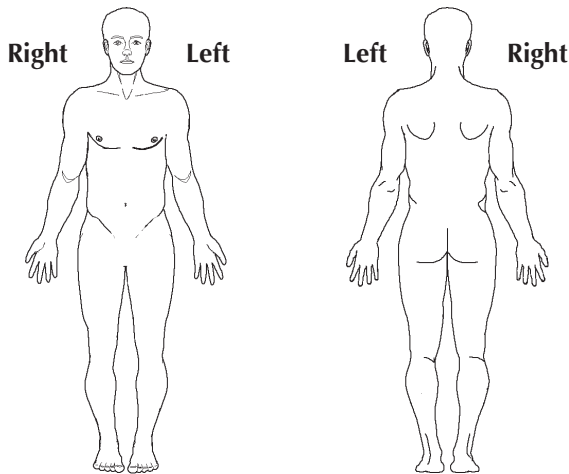


BRIEF PAIN INVENTORY

Date ____/____/____ Time: _____

Name: _____
Last First Middle Initial

- Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
 1. Yes 2. No
- On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



- Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

No Pain Pain as bad as you can imagine

- What treatments or medications are you receiving for your pain?

- In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No relief

Complete relief

- Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

| | | |
|------------|-----------|-------------|
| aching | throbbing | shooting |
| stabbing | gnawing | pricking |
| sharp | tender | burning |
| exhausting | tiring | penetrating |
| nagging | numb | miserable |
| unbearable | dull | radiating |
| squeezing | cramping | deep |

How long have you had this pain? (Circle one)

| | |
|------------------|-------------------|
| less than a week | 1 to 2 weeks |
| 2 to 4 weeks | more than a month |

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

What kinds of things make your pain worse (for example, walking, standing, lifting)?

Do you have any other symptoms? Circle any that apply:

| | |
|---------------------|----------------|
| nausea | vomiting |
| constipation | diarrhea |
| lack of appetite | indigestion |
| difficulty sleeping | feeling drowsy |
| nightmares | dizziness |
| tiredness | itching |
| urinary problems | sweating |
| weakness | headaches |

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.
