

Brief Pain Inventory

Date: _____

Name: _____
Last First Middle Initial

Phone: (_____) _____

Sex: Female Male

Date of Birth: _____

1) Marital Status (at present):

1. Single 2. Married 3. Widowed 4. Separated/Divorced

2) Education (Circle only the highest grade or degree completed)

Grade: 0 1 2 4 5 6 7 8 9 10 11 12 13 14 15 16

Professional Degree (please specify): _____

3) Current Occupation: _____

(specify titles; if you are not working, tell us your previous occupation)

4) Spouse's Occupation: _____

5) Which of the following best describes your current job status?

1. Employed outside the home, full time.
2. Employed outside the home, part time.
3. Homemaker
4. Retired
5. Unemployed
6. Other

6) How long has it been since you first learned your diagnosis? _____ months

7) Have you ever had pain due to your present disease?

1. Yes 2. No 3. Uncertain

8) When you first received your diagnosis, was pain one of your symptoms?

1. Yes 2. No 3. Uncertain

9) Have you had surgery in the past month? 1. Yes 2. No

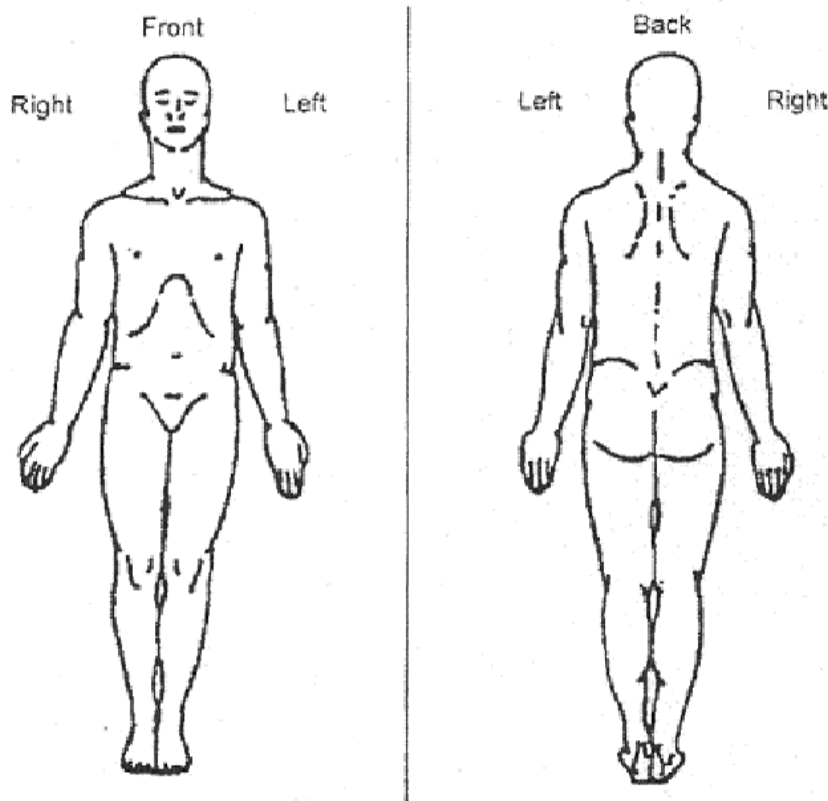
If YES, what kind? _____

- 10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain ***other*** than these everyday kind of pain during the ***last week***? 1. Yes 2. No
- 10a) Did you take pain medications in the last 7 days? 1. Yes 2. No
- 10b) Do you feel you have some form of pain now that requires medication each and every day? 1. Yes 2. No

IF YOUR ANSWERS TO 10, 10a, AND 10b WERE **ALL NO**, PLEASE STOP HERE AND GO TO THE LAST PAGE OF THE QUESTIONNAIRE AND SIGN WHERE INDICATED ON THE BOTTOM OF THE PAGE.

IF ANY OF YOUR ANSWERS TO 10, 10a, AND 10b WERE **YES**, PLEASE CONTINUE.

- 11) On the diagram, shade in the areas where you feel pain. Put an **X** on the area that hurts the most.



- 12) Please rate your pain by circling the one number that best describes your pain at its **worst** in the last week.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

- 13) Please rate your pain by circling the one number that best describes your pain at its **least** in the last week.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

14) 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

15) 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

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

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

18) What treatments or medications are you receiving for pain? _____

19) In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 1% 2% 3% 4% 5% 6% 7% 8% 9% 10%
No Relief Complete Relief

20) If you take pain medication, how many hours does it take before the pain returns?

- | | |
|---|--|
| 1. <input type="checkbox"/> Pain medication doesn't help at all | 5. <input type="checkbox"/> Four hours |
| 2. <input type="checkbox"/> One hour | 6. <input type="checkbox"/> Five to twelve hours |
| 3. <input type="checkbox"/> Two hours | 7. <input type="checkbox"/> More than twelve hours |
| 4. <input type="checkbox"/> Three hours | 8. <input type="checkbox"/> I don't take pain medication |

21) Check the appropriate answer for each item.

I believe my pain is due to:

- a) The effects of treatment (for example; medication, surgery, radiation, prosthetic device). Yes No
- b) My primary disease (meaning the disease currently being treated and evaluated). Yes No
- c) A medical condition unrelated to my primary disease (for example; arthritis). Yes No

If yes, please describe condition: _____

25) I take my pain medicine (in a 24 hour period):

- 1. Not every day
- 2. 1 to 2 times per day
- 3. 3 to 4 times per day
- 4. 5 to 6 times per day
- 5. More than 6 times per day

26) Do you feel you need a stronger type of pain medication?

- 1. Yes
- 2. No
- 3. Uncertain

27) Do you feel you need to take more of the pain medication that your doctor has prescribed?

- 1. Yes
- 2. No
- 3. Uncertain

28) Are you concerned that you use too much pain medication?

- 1. Yes
- 2. No
- 3. Uncertain

If yes, please explain why: _____

29) Are you having problems with side effects from your pain medication?

- 1. Yes
- 2. No

If yes, what side effects? _____

30) Do you feel you need to receive further information about your pain medication?

- 1. Yes
- 2. No

31) Other methods I use to relieve my pain include: (Please check all that apply)

Warm Compress Cold Compress Relaxation Techniques

Distraction Biofeedback Hypnosis

Other If other, please specify: _____

32) Medications not prescribed by my doctor that I take for pain are: _____

Please Sign this Questionnaire.

Patient Signature

Date