

Study ID: _____ Hospital #: _____

DO NOT WRITE ABOVE THIS LINE

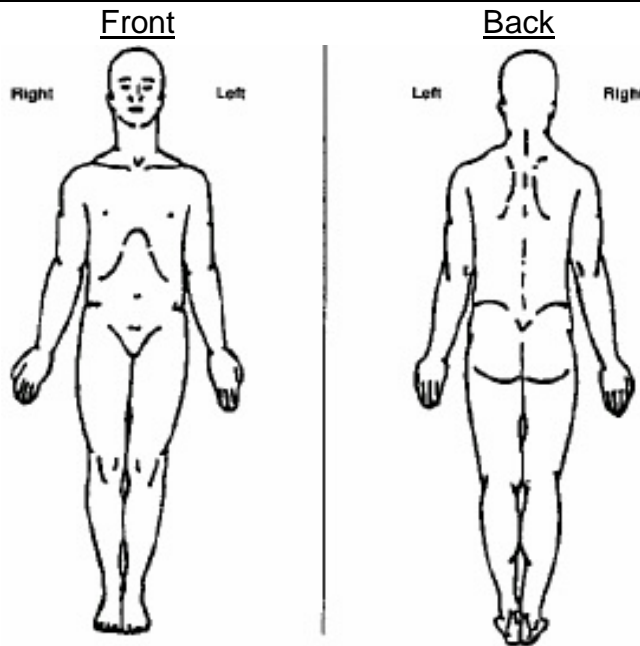
Name: _____ Date: _____ Time: _____

Brief Pain Inventory (Short Form)

1. 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?

Yes No

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



3. Please rate your pain by marking the box beside the 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

4. Please rate your pain by marking the box beside the 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

5. Please rate your pain by marking the box beside the 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

6. Please rate your pain by marking the box beside the 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

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

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

No Relief

Complete Relief

9. Mark the box beside the 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