

Form Approved  
OMB Control No.: 0920-XXXX  
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# The Brief Pain Inventory

Subject ID Number: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ & Time: \_\_\_\_am/pm  
Month Day Year HH:MM

Complete Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ & Time: \_\_\_\_am/pm  
Month Day Year HH:MM

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# Brief Pain Inventory

1) 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 kinds of pain during the last week?

1.  Yes

2.  No

1a) Did you take pain medications in the last 7 days?

1.  Yes

2.  No

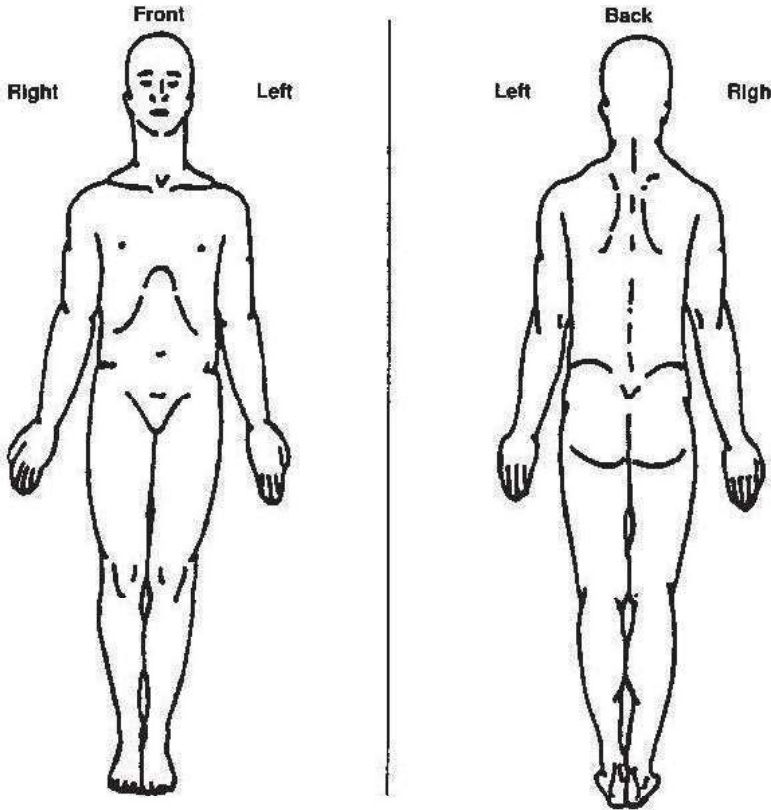
1b) I feel I have some form of pain now that requires medication each and every day.

1.  Yes

2.  No

IF YOUR ANSWERS TO 1, 1a, AND 1b WERE ALL NO, PLEASE STOP HERE AND GO TO THE NEXT QUESTIONNAIRE.  
IF ANY OF YOUR ANSWERS TO 1, 1a, AND 1b WERE YES, PLEASE CONTINUE.

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





10) 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 do not take pain medication |

11) Check the appropriate answer for each item.  
I believe my pain is due to:

- Yes  No 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).
- Yes  No 2. A medical condition (for example, arthritis).  
Please describe condition: \_\_\_\_\_

12) For each of the following words, check Yes or No if that adjective applies to your pain.

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| 1) Aching       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Throbbing    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Shooting     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Stabbing     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Gnawing      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Sharp        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Tender       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Burning      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) Exhausting   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10) Tiring      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11) Penetrating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12) Nagging     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13) Numb        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14) Miserable   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15) Unbearable  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

13) Circle the one number that describes how, during the past week, 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

14) I prefer to take my pain medicine:

1.  On a regular basis
2.  Only when necessary
3.  Do not take pain medicine (STOP-- GO TO NEXT QUESTIONNAIRE)

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

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

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

1.  Yes                      2.  No                      3.  Uncertain

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

1.  Yes                      2.  No                      3.  Uncertain              4.  N/A

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

1.  Yes                      2.  No                      3.  Uncertain

If Yes, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

1.  Yes                      2.  No

Which side effects? \_\_\_\_\_  
\_\_\_\_\_

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

1.  Yes                      2.  No

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

- Warm compresses               Cold compresses               Relaxation techniques   
Distraction                       Biofeedback                       Hypnosis   
Other                       Please specify \_\_\_\_\_