Appendix 16

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

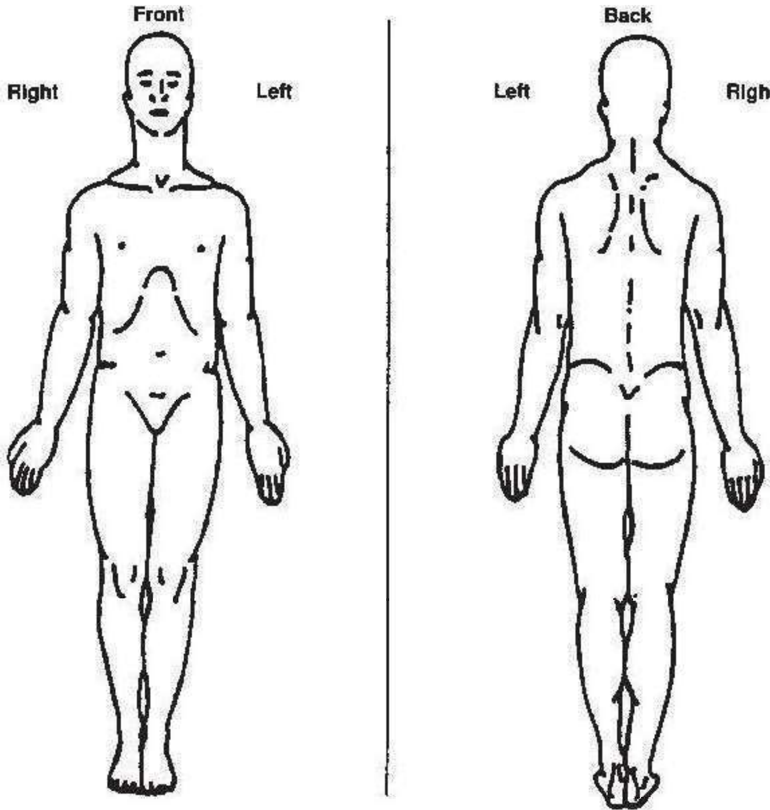
1b) I feel I have some form of pain now that requires medication each and every day.

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.



3) 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

4) Please rate your pain by circling the one number that best describes your pain at its east n the last week.

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 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

6) 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

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

____

____

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

____

____

9)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%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

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

1. ☐ Pain medication doesn't help at all
2. ☐ One hour
3. ☐ Two hours
4. ☐ Three hours
5. ☐ Four hours
6. ☐ Five to twelve hours
7. ☐ More than twelve hours
8. ☐ 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	☐ Yes	☐ No
2) Throbbing	☐ Yes	☐ No
3) Shooting	☐ Yes	☐ No
4) Stabbing	☐ Yes	☐ No
5) Gnawing	☐ Yes	☐ No
6) Sharp	☐ Yes	☐ No
7) Tender	☐ Yes	☐ No
8) Burning	☐ Yes	☐ No
9) Exhausting	☐ Yes	☐ No
10) Tiring	☐ Yes	☐ No
11) Penetrating	☐ Yes	☐ No
12) Nagging	☐ Yes	☐ No
13) Numb	☐ Yes	☐ No
14) Miserable	☐ Yes	☐ No
15) Unbearable	☐ Yes	☐ 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
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

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 ____________________