

STUDY ID #: \_\_\_\_\_

DO NOT WRITE ABOVE THIS LINE

HOSPITAL #: \_\_\_\_\_

## Brief Pain Inventory (Short Form)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time: \_\_\_\_\_

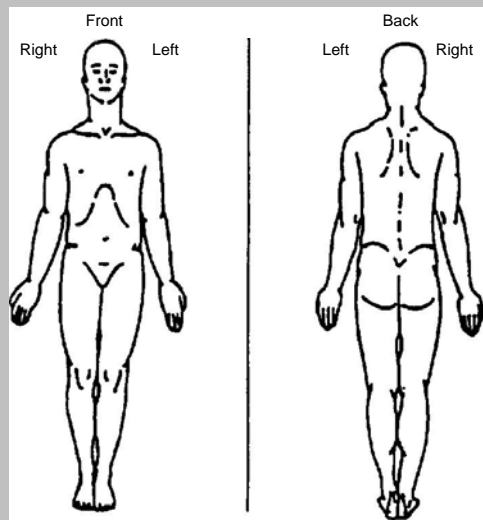
Name: \_\_\_\_\_  
Last First Middle Initial

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?

1. Yes

2. 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 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

4. 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

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

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Time: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

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 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 Complete  
Relief Relief

9. 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 Completely  
Interfere Interferes

B. Mood  
0 1 2 3 4 5 6 7 8 9 10  
Does not Completely  
Interfere Interferes

C. Walking Ability  
0 1 2 3 4 5 6 7 8 9 10  
Does not Completely  
Interfere 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 Completely  
Interfere Interferes

E. Relations with other people  
0 1 2 3 4 5 6 7 8 9 10  
Does not Completely  
Interfere Interferes

F. Sleep  
0 1 2 3 4 5 6 7 8 9 10  
Does not Completely  
Interfere Interferes

G. Enjoyment of life  
0 1 2 3 4 5 6 7 8 9 10  
Does not Completely  
Interfere Interferes

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