The Brief Pain Inventory

PROTOCOL # _____ INSTITUTION _____

PATIENT SEQUENCE # _____ HOSPITAL CHART # _____

DO NOT WRITE ABOVE THIS LINE

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	3	4	5	6	7	8	9
	10	11	12	13	14	15	16	M.A./M.S.		

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 kinds of pain during the last week?

1. ☐ Yes 2. ☐ No

10a) Did you take pain medications in the last 7 days?

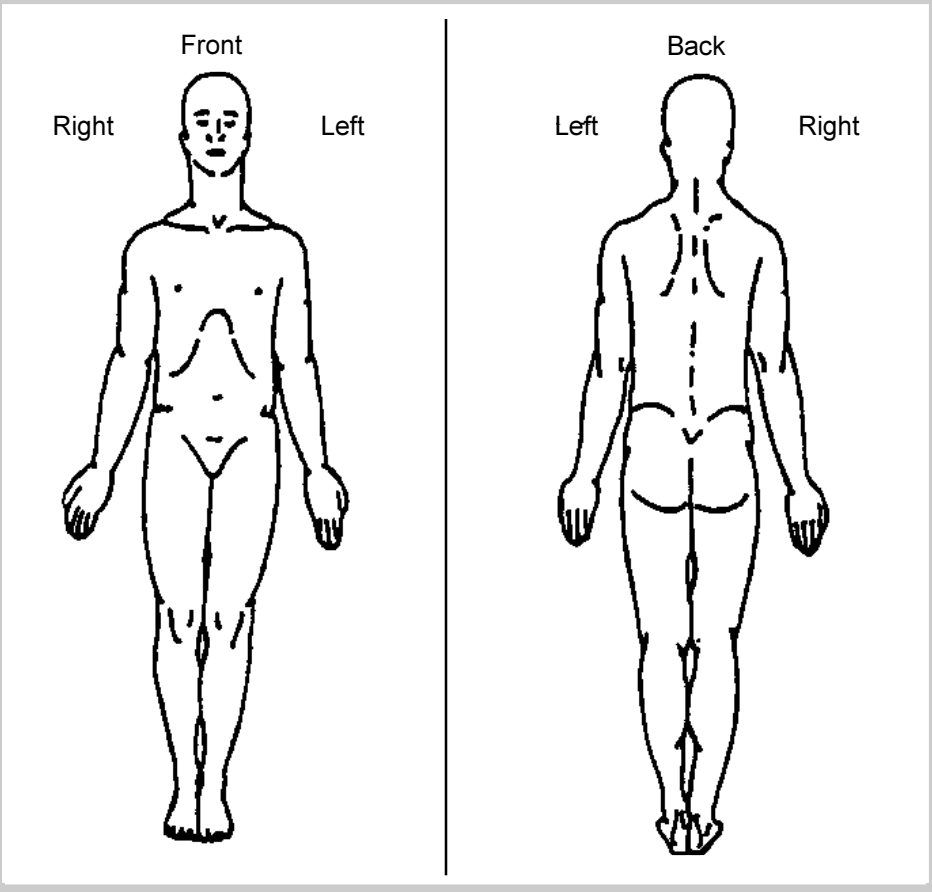
1. ☐ Yes 2. ☐ No

10b) I feel I 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%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

20) 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

21) 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. My primary disease (meaning the disease currently being treated and evaluated).
☐ Yes ☐ No 3. A medical condition unrelated to my primary disease (for example, arthritis).
Please describe condition: _____

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

Aching	☐ Yes	☐ No
Throbbing	☐ Yes	☐ No
Shooting	☐ Yes	☐ No
Stabbing	☐ Yes	☐ No
Gnawing	☐ Yes	☐ No
Sharp	☐ Yes	☐ No
Tender	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Exhausting	☐ Yes	☐ No
Tiring	☐ Yes	☐ No
Penetrating	☐ Yes	☐ No
Nagging	☐ Yes	☐ No
Numb	☐ Yes	☐ No
Miserable	☐ Yes	☐ No
Unbearable	☐ Yes	☐ No

23) 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

24) I prefer to take my pain medicine:

1. ☐ On a regular basis
2. ☐ Only when necessary
3. ☐ Do not take pain medicine

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 than 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, why? _____

_____

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

1. ☐ Yes 2. ☐ No

Which 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 compresses ☐ Cold compresses ☐ Relaxation techniques ☐

Distraction ☐ Biofeedback ☐ Hypnosis ☐

Other ☐ Please specify _____

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

_____

_____

Please sign the back of this questionnaire.

Patient's Signature

Thank you for your participation.