

# Brief Pain Inventory (Short Form)

Study ID# \_\_\_\_\_ Hospital # \_\_\_\_\_  
Do not write above this line.

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

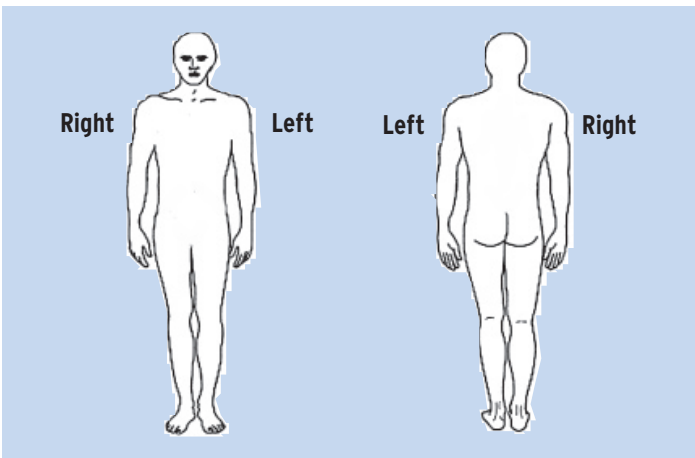
Time: \_\_\_\_\_

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 past 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 past 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 tell 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 past 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 Relief Complete 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 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. Relation 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