

# Brief Pain Inventory (Short Form)

Name \_\_\_\_\_ Date \_\_\_\_\_

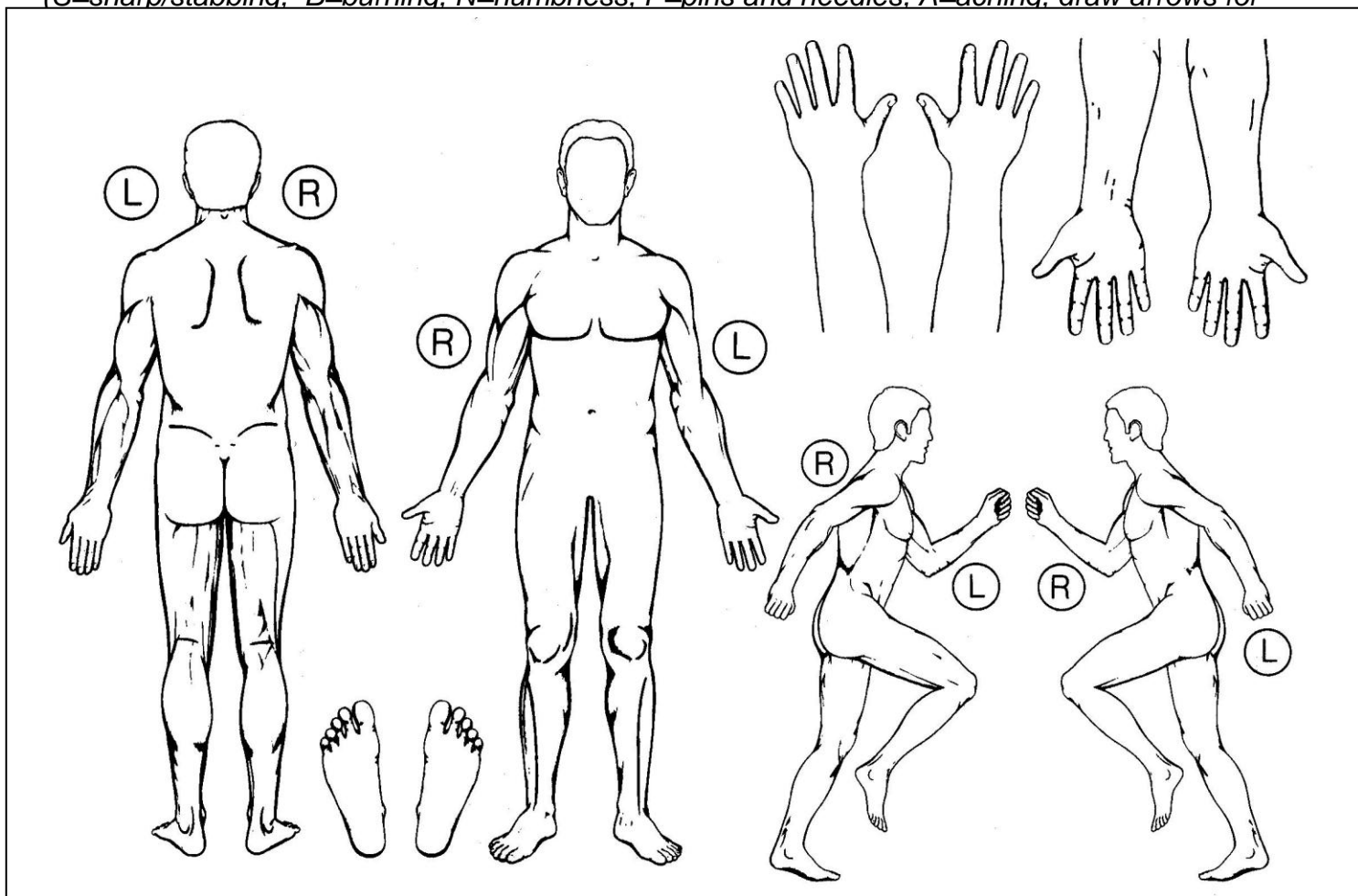
Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes

2. No

On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most.

*(S=sharp/stabbing, B=burning, N=numbness, P=pins and needles, A=aching, draw arrows for*



3. Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

No pain    0    1    2    3    4    5    6    7    8    9    10

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.

No pain    0    1    2    3    4    5    6    7    8    9    10

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**.

No pain      0    1    2    3    4    5    6    7    8    9    10      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**.

No pain      0    1    2    3    4    5    6    7    8    9    10      Pain as bad as you can imagine

7. What treatments or medications are you currently 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 shows most how much **RELIEF** you have received.

No relief   0   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%   Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**A. General Activity:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**B. Mood:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**C. Walking Ability:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**D. Normal Work (includes both work outside the home and housework)**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**E. Relations with other people:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**F. Sleep:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes

**G. Enjoyment of Life:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    Completely interferes