Patient Brief Pain Inventory

(Please Use **BLACK** or **BLUE** Ink Only)

IDENTIFICATION DATA

Name: _____ Date of Birth: _____

Referred by: _____ Today's Date: _____

What is your main focus today? *(check all that apply)*

☐ Medication Refill ☐ Discuss Injections ☐ New Pain ☐ Other: _____

☐ Medication Change: ○ Unavailable ○ Ineffective ○ Not Tolerated

SINCE LAST VISIT

List any changes in medical care since your last visit to our office. **Include dates, as applicable.**

☐ ER Visit: ☐ Hospital Stay: ☐ Falls:

☐ New Imaging ☐ New Diagnosis:

☐ New Allergy(ies): ☐ New Physician *(name)*

List any medication changes *(started or stopped)* and the prescribing doctor. ☐ *None*

Medication	Dose	Daily Frequency	Prescribing MD	Reason

CURRENT FUNCTIONAL STATUS

☐ Working ☐ Not Working, due to: ☐ Retired ☐ Disabled ☐ Other: _____

Exercise? ☐ No ☐ Yes, regimen: _____

History of depression/anxiety/or other psychological disease? ☐ Yes ☐ No

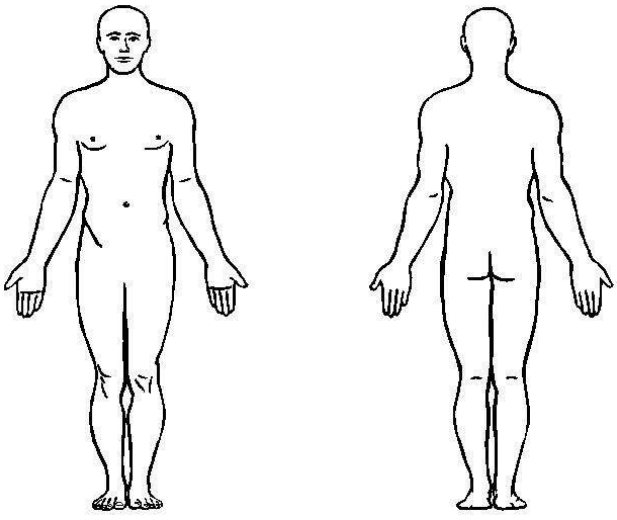
If yes, are you stable? ☐ Yes ☐ No Any thoughts of harming yourself? ☐ Yes ☐ No

Do you feel safe in your current environment? ☐ Yes ☐ No

Recent major changes to your health or hospitalizations? ☐ Yes ☐ No

BRIEF PAIN INVENTORY

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



Current Level of Pain 1 – 10 *(10 is worst)*: _____

Since last visit, your pain has:

☐ Improved ☐ Worsened ☐ No Change ☐ Resolved

Describe the frequency of your pain:

☐ Intermittent ☐ Constant ☐ Occasional ☐ Rare

Select the words that describe your pain:

☐ Ache ☐ Burning ☐ Dull ☐ Numb ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing

What makes your pain worse?

☐ Lying Down ☐ Movement ☐ Sitting ☐ Standing
☐ Stress ☐ Walking ☐ Weather ☐ Other: _____

What relieves your pain?

☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Medication ☐ Physical Therapy ☐ Rest ☐ Sitting

Other methods you use to relieve your pain?

☐ Warm Compress ☐ Cold Compress ☐ Relaxation/Distraction Techniques ☐ Biofeedback
☐ Hypnosis ☐ Other: _____

Rate your pain by choosing the ONE number that best describes your pain at its *worst* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No Pain *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain at its *least* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No Pain *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain on *average*.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No Pain *Worst Pain Imaginable*

Your pain over *the past week*, choose the number that best describes how it has interfered with your-

General Activity:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Mood:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Walking Ability:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Normal Work:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Relations with Other People:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Sleep:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*

Enjoyment of Life:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Does Not Interfere *Completely Interferes*