

# **The Brief Pain Inventory**

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Pain Research Group  
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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?

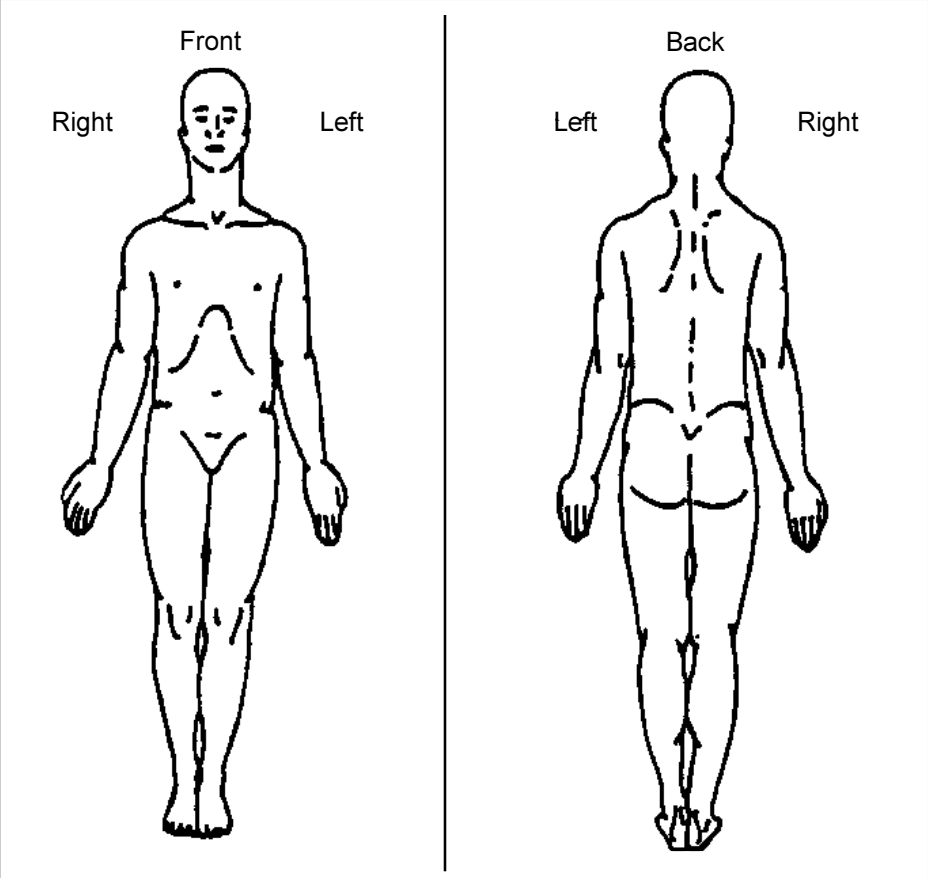
1.  Yes    2.  No

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)?

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17) What kinds of things make your pain worse (for example, walking, standing, lifting)?

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18) What treatments or medications are you receiving for pain?

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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. <input type="checkbox"/> Pain medication doesn't help at all | 5. <input type="checkbox"/> Four hours                    |
| 2. <input type="checkbox"/> One hour                            | 6. <input type="checkbox"/> Five to twelve hours          |
| 3. <input type="checkbox"/> Two hours                           | 7. <input type="checkbox"/> More than twelve hours        |
| 4. <input type="checkbox"/> Three hours                         | 8. <input type="checkbox"/> I do not take pain medication |

21) Check the appropriate answer for each item.

I believe my pain is due to:

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. My primary disease (meaning the disease currently being treated and evaluated).                                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. A medical condition unrelated to my primary disease (for example, arthritis).<br>Please describe condition: _____ |

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

- |             |                              |                             |
|-------------|------------------------------|-----------------------------|
| Aching      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Throbbing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shooting    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stabbing    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gnawing     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sharp       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tender      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Exhausting  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tiring      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penetrating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nagging     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Numb        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Miserable   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unbearable  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?

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

- 1.  Yes
- 2.  No

Which side effects?

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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:

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Please sign the back of this questionnaire.

Patient's Signature

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Thank you for your participation.