# BRIEF PAIN INVENTORY

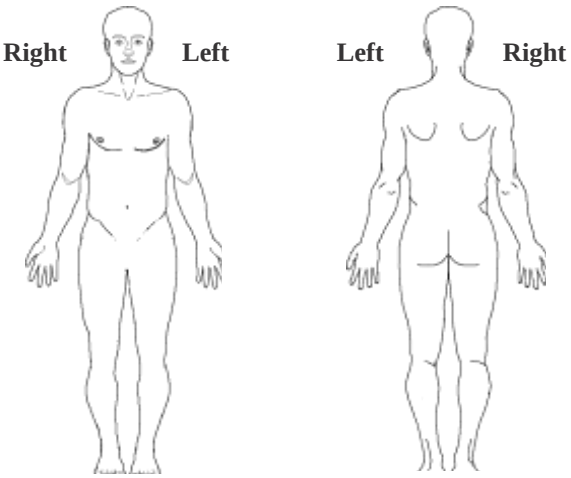
**Date** _____/_____/_____ **Time:** _____

**Name:** _____ _____ _____
Last Name: First Middle

**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 last 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 last 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 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 |

**7) What treatments or medications are you 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 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. 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 |

**In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:**

## What does the pain feel like? Circle those words that describe your pain.

| | | |
|---|---|---|
| aching | throbbing | shooting |
| stabbing | gnawing | pricking |
| sharp | tender | burning |
| exhausting | tiring | penetrating |
| nagging | numb | miserable |
| unbearable | dull | radiating |
| squeezing | cramping | deep |

## How long have you had this pain? (Circle one)

| | |
|---|---|
| less than a week | 1 to 2 weeks |
| 2 to 4 weeks | more than a month |

## What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

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

_____

_____

## Do you have any other symptoms? Circle any that apply:

| | |
|---|---|
| nausea | vomiting |
| constipation | diarrhea |
| lack of appetite | indigestion |
| difficulty sleeping | feeling drowsy |
| nightmares | dizziness |
| tiredness | itching |
| urinary problems | sweating |
| weakness | headaches |

## Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

## Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

## Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

## Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____

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# Patient Data Questionnaire

Please answer each question carefully and return the completed sheet to the receptionist. This is not a substitute for a history and examination by your attending doctors.

Please mark the appropriate box with an "**X**" to answer each question

| | YES | NO | DON'T KNOW |
|---|---|---|---|
| Do you have private health insurance or extended benefits? | | | |
| Do you take medication for the treatment of: | | | |
| • Heart Disease (ex. Angina or Heart Failure) | | | |
| • Lung Disease (ex. Bronchitis or Asthma) | | | |
| • High Blood Pressure | | | |
| • Depression or Psychiatric Disorders | | | |
| Do you suffer from | | | |
| • Chest Pain | | | |
| • Shortness of Breath | | | |
| • Any recent illness | | | |
| • A tendency to, or excessive bleeding (ex. Easy Bruising or Nosebleeds) | | | |
| • Heartburn, Regurgitation or Esophagitis | | | |
| Have you ever taken a steroid medication in the last year? (ex. Prednisone, Cortisone, ACTH) | | | |
| Have you ever had a reaction or a complication to a local anesthetic? | | | |
| Do you have loose or false teeth? | | | |
| Are you allergic to any medications? If so, list: | | | |
| Please list any medication you are taking: | | | |
| Please list any major operations and illnesses | | | |
| What is your weight? | | | |
| What is your height? | | | |
| Emergency contact name and phone number: | | | |

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# Psychology Intake Form

Many people experience emotional difficulties as a result of their chronic pain. Please indicate which of the following common occurrences you experience.

| | YES | NO |
|---|---|---|
| • disturbing nightmares | ☐ | ☐ |
| • frequent sadness or crying | ☐ | ☐ |
| • sleeping difficulties, including trouble falling asleep or staying asleep | ☐ | ☐ |
| • increased fear while being in or around cars | ☐ | ☐ |
| • changes in appetite | ☐ | ☐ |
| • increased stress in your relationships with others | ☐ | ☐ |
| • feeling tense, worried or nervous | ☐ | ☐ |
| • difficulties with concentration and getting things done | ☐ | ☐ |
| • low energy, including less interest in previously enjoyed activities | ☐ | ☐ |
| • memory problems | ☐ | ☐ |
| • irritability, frustration or outbursts of anger | ☐ | ☐ |
| • difficulty coping with the pain | ☐ | ☐ |
| • efforts to avoid situations that are associated with …… | | |
| • flashbacks or intrusive thoughts of …….. | | |

Signature of Patient, Parent or Guardian: _____

# DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions

## To be completed by the PATIENT

**QUESTION 1: Does the pain have one or more of the following characteristics?**

| | YES | NO |
|---|---|---|
| Burning | ❑ | ❑ |
| Painful cold | ❑ | ❑ |
| Electric shocks | ❑ | ❑ |

**QUESTION 2: Is the pain associated with one or more of the following symptoms in the same area?**

| | YES | NO |
|---|---|---|
| Tingling | ❑ | ❑ |
| Pins and needles | ❑ | ❑ |
| Numbness | ❑ | ❑ |
| Itching | ❑ | ❑ |

## To be completed by PHYSICIAN

**QUESTION 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?**

| | YES | NO |
|---|---|---|
| Hypoesthesia to touch | ❑ | ❑ |
| Hypoesthesia to pinprick | ❑ | ❑ |

**QUESTION 4: In the painful area, can the pain be caused or increased by:**

| | YES | NO |
|---|---|---|
| Brushing? | ❑ | ❑ |

**Yes = 1 Point**
**No = 0 Points**

**Patient's score: /10**

**Your Gender:** ❑ Male ❑ Female

**Do you have a <u>family history</u> (e.g. parents, siblings, children etc.) of substance abuse involving any of the following?**

- Alcohol ❑ Yes ❑ No
- Prescription drugs ❑ Yes ❑ No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) ❑ Yes ❑ No

**Do you have any history yourself of substance abuse, or have you been diagnosed with a substance abuse disorder involving any of the following?**

- Alcohol ❑ Yes ❑ No
- Prescription drugs ❑ Yes ❑ No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) ❑ Yes ❑ No

**Your age:** ❑ 16-45 ❑ over 45

**Do you have, or have you ever been diagnosed with any of the following:**

- attention-deficit/hyperactivity disorder
- obsessive compulsive disorder
- bipolar disorder
- schizophrenia

❑ Yes ❑ No

**Do you have, or have you ever been diagnosed with depression?**

❑ Yes ❑ No

**We understand that this may be a sensitive matter, and your answer will be treated in the strictest confidence within your family circle of care, however it is important in your assessment. Do you have a history of preadolescent abuse?**

❑ None ❑ Physical ❑ Emotional ❑ Sexual