Name: _____ Date: _____ Time: _____

Brief Pain Inventory

Site: _____

Please answer honestly!

For the following three items, rate your experience along the following scale and circle the appropriate number:

0 no pain at all - - - - - - - - 10 worst imaginable

Pain right now 0 1 2 3 4 5 6 7 8 9 10

Pain on average 0 1 2 3 4 5 6 7 8 9 10

Pain at its worst last 24 hrs 0 1 2 3 4 5 6 7 8 9 10

* * *

For the following seven items, rate your experience along the following scale and circle the appropriate number ***as it applies to the past 48 hours (2 days)***:

0 no interference - - - - - - 10 completely interferes

Interference with general activity 0 1 2 3 4 5 6 7 8 9 10

Interference with work 0 1 2 3 4 5 6 7 8 9 10

Interference with walking ability 0 1 2 3 4 5 6 7 8 9 10

Interference with mood 0 1 2 3 4 5 6 7 8 9 10

Interference with relations/other people 0 1 2 3 4 5 6 7 8 9 10

Interference with sleep 0 1 2 3 4 5 6 7 8 9 10

Interference with enjoyment of life 0 1 2 3 4 5 6 7 8 9 10

* * *

For re-evaluations only: Please describe any noteworthy positive/negative responses to treatment, or other observations/experiences since the beginning of treatment course:

_____

_____

For office use only: sumtotal _____