BRIEF PAIN INVENTORY – LONG FORM

Date: 
Name: 

1) Marital Status (at present)
   - Single
   - Widowed
   - Married
   - 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?
   - Employed outside the home, full-time
   - Employed outside the home, part-time
   - Homemaker
   - Retired
   - Unemployed
   - 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?
   - Yes
   - No
   - Uncertain
8) When you first received your diagnosis, was pain one of your symptoms?
   - Yes
   - No
   - Uncertain

9) Have you had surgery in the past month?
   - Yes
   - 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?
   - Yes
   - No

10a) Did you take pain medications in the last 7 days?
   - Yes
   - No

10b) I feel I have some form of pain now that requires medication each and every day.
   - Yes
   - 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.

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13) Please rate your pain by circling the one number that best describes your pain at its least in the last week.

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14) Please rate your pain by circling the one number that best describes your pain on the average.

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15) Please rate your pain by circling the one number that tells how much pain you have right now.

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

______________________________________________________________________________________

______________________________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________
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.

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20) If you take pain medication, how many hours does it take before the pain returns?

- Pain medication doesn't help at all
- One hour
- Two hours
- Three hours
- Four hours
- Five to twelve hours
- More than twelve hours
- I do not take pain medication

21) Check the appropriate answer for each item. I believe my pain is due to:

- Yes  No  1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).
- Yes  No  2. My primary disease (meaning the disease currently being treated and evaluated).
- Yes  No  3. A medical condition unrelated to my primary disease (for example, arthritis).

Please describe condition: __________________________________________

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

- Aching     Yes  No
- Throbbing  Yes  No
- Shooting    Yes  No
- Stabbing    Yes  No
- Gnawing     Yes  No
- Sharp       Yes  No
- Tender      Yes  No
- Burning     Yes  No
- Exhausting  Yes  No
- Tiring      Yes  No
- Penetrating Yes  No
- Nagging     Yes  No
- Numb        Yes  No
- Miserable   Yes  No
- Unbearable  Yes  No
23) Circle the one number that describes how, during the past week, pain has interfered with your:

A. General Activity

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B. Mood

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C. Walking Ability

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

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E. Relations with other people

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F. Sleep

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G. Enjoyment of life

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24) I prefer to take my pain medicine:
   - [ ] On a regular basis
   - [ ] Only when necessary
   - [ ] Do not take pain medicine

25) I take my pain medicine (in a 24 hour period):
   - [ ] Not every day
   - [ ] 1 to 2 times per day
   - [ ] 3 to 4 times per day
   - [ ] 5 to 6 times per day
   - [ ] More than 6 times per day

26) Do you feel you need a stronger type of pain medication?
   - [ ] Yes
   - [ ] No
   - [ ] Uncertain

27) Do you feel you need to take more of the pain medication than your doctor has prescribed?
   - [ ] Yes
   - [ ] No
   - [ ] Uncertain

28) Are you concerned that you use too much pain medication?
   - [ ] Yes
   - [ ] No
   - [ ] Uncertain
   If yes, why?
   __________________________________________
   __________________________________________
   __________________________________________

29) Are you having problems with side effects from your pain medication?
   - [ ] Yes
   - [ ] No
   Which side effects? __________________________________________

30) Do you feel you need to receive further information about your pain medication?
   - [ ] Yes
   - [ ] 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:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Patient's Signature ___________________________________________________________
DRIVING INSTRUCTIONS FOR PATIENTS TAKING OPIOIDS

Opioid medications can cause side effects that impair your ability to drive. The final decision on whether you should drive while using opioid medications is a legal issue and should be addressed with your automobile insurance carrier. Out of concern for your safety and the safety of others, please observe the following guidelines:

- Do not drive for 4 – 5 days after beginning opioid treatment or after a change in opioid treatment such as a dose increase.
- Do not drive if you ever feel sedated or cognitively impaired.
- Report sedation/unsteadiness/cognitive decline to our office as soon as possible.
- Under no circumstances should you use alcohol or illicit drugs such as cannabis (marijuana) and drive.
- Avoid taking over-the-counter antihistamines, as contained in numerous cold and allergy medications.
- Do not make any changes in your medication regimen without consulting our office.

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