Brief Pain Inventory

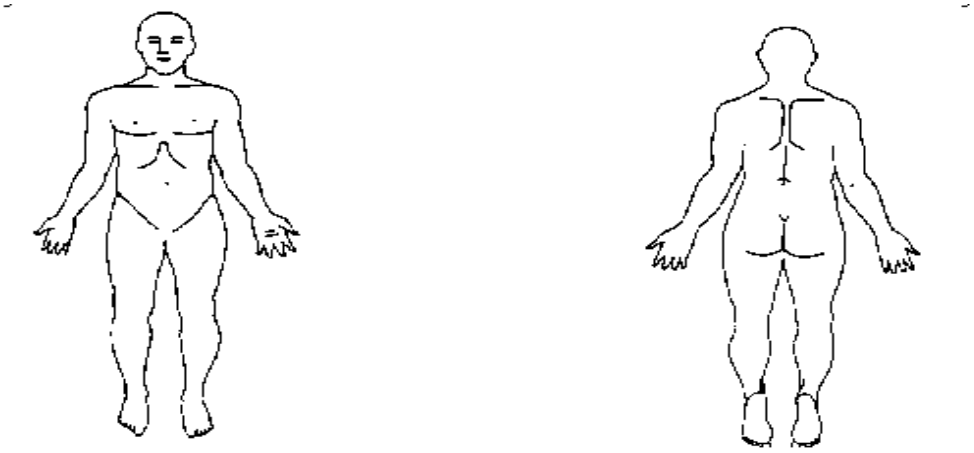
Date: _____

Name: _____ _____ _____
Last First Middle Initial

Date of Birth: ____/_____/_____

Phone: (_____)

How long has it been since you first learned of your diagnosis? _____
On the diagram, shade the areas where you feel pain. Put at "X" on the area that hurts the most.



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

Describe the frequency of your pain:

Circle one: Intermittent Constant Occasional Rare

Please circle the following words that describe your pain:

Ache Burning Deep Discomforting Dull Numbness Piercing Sharp
Shooting Stabbing Throbbing

What makes your pain worse? Circle those that apply.

Movement Sitting Standing Walking Stress Other: _____

What relieves your pain? Circle those that apply.

Exercise Heat Ice Injections Medication Physical Therapy Rest Sitting

Other methods I use to relieve my pain include: Please circle all that apply:

Warm Compress Cold Compress Relaxation Techniques Distraction Techniques Biofeedback
Hypnosis Other (Please specify) _____

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 Worst pain imaginable

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 Worst pain imaginable

Please rate your pain by circling 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

In the past 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

Circle the 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:

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

Have you ever had pain due to your present disease? Yes No

When you first received your diagnosis, was pain one of your symptoms? Yes No Uncertain

Have you had surgery in the past month? Yes No

If YES, what kind?

_____

Circle the appropriate response to each item.

I believe my pain is due to:

Yes No A. The effects of treatment (for example medication, surgery, radiation, prosthetic device).

Yes No B. My primary disease (meaning the disease currently being treated and evaluated).

Yes No C. A medical condition unrelated to my primary disease (for example, arthritis).

What treatments or medication are you receiving for your pain?

_____

I prefer to take my pain medicine:

A. On a regular basis

B. Only when necessary

C. Do not take pain medicine

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

A. Pain medication doesn't help at all

B. One hour

C. Two hours

D. Three hours

E. Four hours

F. Five to Twelve hours

G. More than twelve hours

H. I do not take pain medication

I take my pain medicine (in a 24 hour period):

A. Not every day

B. 1 to 2 times per day

C. 3 to 4 times per day

D. 5 to 6 times per day

E. More than 6 times per day

Do you feel you need a stronger type of pain medication?

Yes No Uncertain

Do you feel you need to take more of the pain medication that your doctor has prescribed?

Yes No Uncertain

Are you concerned that you use too much pain medication?

Yes No Uncertain If yes, why? _____

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

Yes No Uncertain If yes, which side effects? _____

Do you feel you need to receive further information about your pain medication?

Yes No

Medications not prescribed by my doctor that I take for pain are:

_____

_____

_____

_____

Marital status at present? Single Married Separated Divorced Widowed

Education (Circle only the highest grade or degree completed)

Grade 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 M.A./M.S.

Professional degree (please specify) _____

Current occupation: _____

(specify times; if you are not working tell us your previous occupation)

Which of the following best describes your current job status?

A. Employed outside the home, full-time

B. Employed outside the home, part-time

C. Homemaker

D. retired

E. Unemployed

F. Other

Spouse's occupation: _____

Please sign this questionnaire.

_____

Patient Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: Mike Test DATE: 12/12/2022 09:06 AM

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself; Feeling that you are a failure or have let ourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people	0	1	2	3

TOTAL **TOTAL** **TOTAL** **TOTAL**

FORM TOTAL: