



BRIEF PAIN INVENTORY SELF REPORT

The purpose of the questionnaire is to tell us about the severity of your pain and how the pain affects your day to day activities

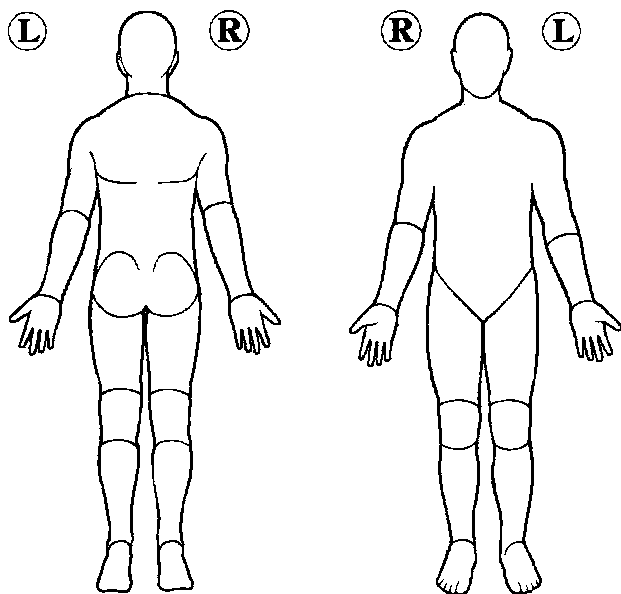
PAIN MANAGEMENT
 DAY CARE UNIT

Completed by: patient family/care giver
 SIGNATURE _____ DATE _____

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?

yes no

2 On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



ADDITIONAL TOH ASSESSMENTS

Circle the words that best describe your pain.

- | | | |
|----------|-----------|--------------|
| tingling | cramping | exhausting |
| shooting | heavy | continuous |
| stabbing | aching | nagging |
| burning | throbbing | excruciating |
| deep | sharp | unbearable |
| numb | | |

3 Please rate your pain by circling the one number that best describes your pain at its WORST in the past 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 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

