Pain Assessment Tool

Brief Pain Inventory (Short Form) - Modified

Date:_____ /_____ /_____

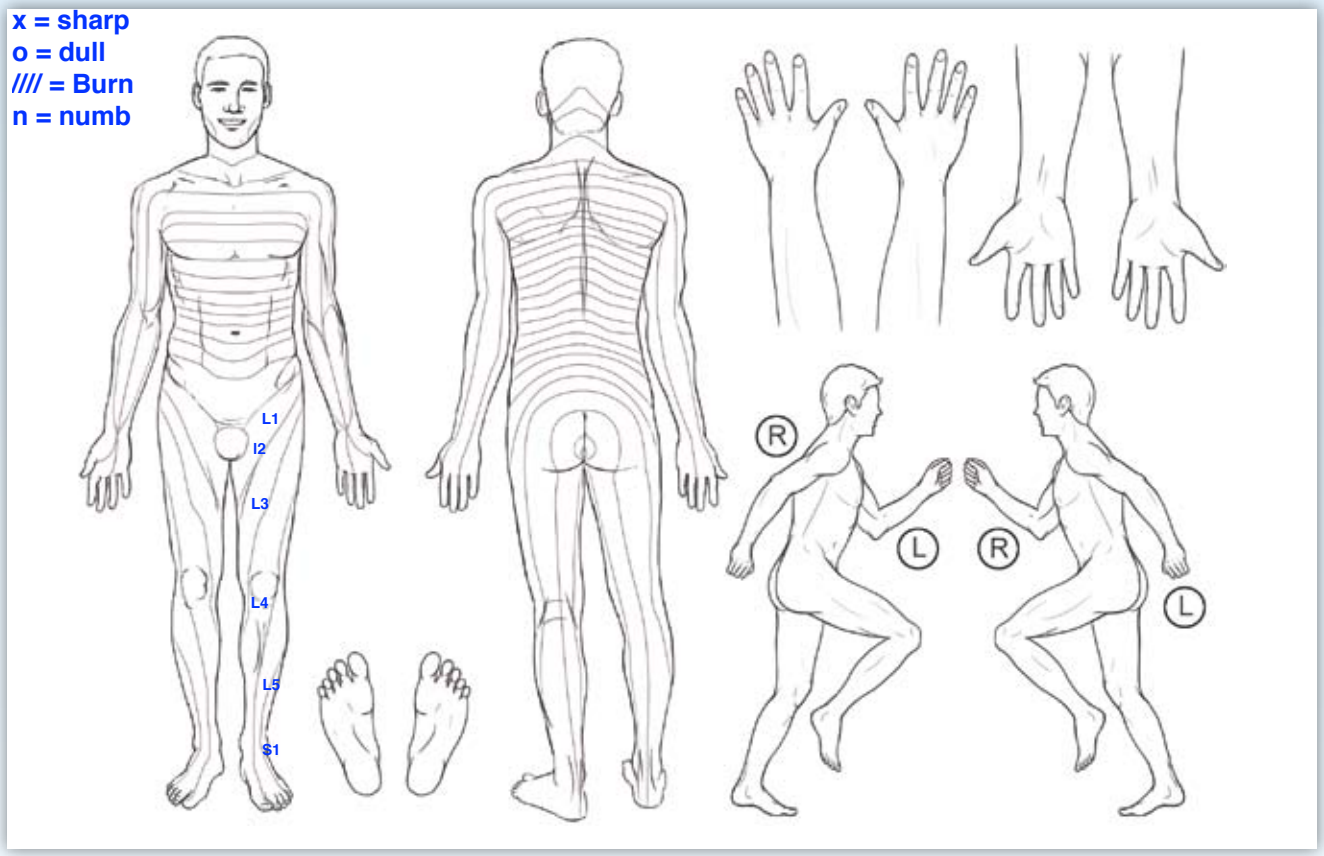
Name:_____ , _____
Last First

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

Text

On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most.



What things make your pain feel worse? **Aggravating factors**

_____

_____

What things make your pain feel better? **Relieving factors**

_____

_____

What treatments or medications are you receiving for your pain? **Current Pain MEDS:**

_____

_____

Date:_____ /_____ /_____

Name:_____ , _____
Last First

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

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

In the last week, how much relief have your pain treatments or medications provided?
Please circle the one percentage that shows how much RELIEF you have received.

No relief	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief

In the last week how much % have the intervention / injection help your pain ? ____ & how long?_____

Circle the one number that describes how, during the past week, pain has interfered with your:

Compared to before Rx: improved same worse

A. General activity

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

B. Mood

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

C. Walking ability

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

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

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

E. Relations with other people

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

F. Sleep

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

G. Enjoyment of life

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Interference Scale total score: / 70

Adapted from Cleeland and Ryan.[1]

By signing below I reaffirm prior written consent for the procedure being conducted today. I also agree to remain in the clinic 30 minutes after my procedure.

Patient Signature _____ **Physician/ Nurse** _____