AUSLON MEDICAL GROUP

BRIEF PAIN INVENTORY SELF REPORT

Name :.....

DOB :.....

Phone :.....

Email :.....

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

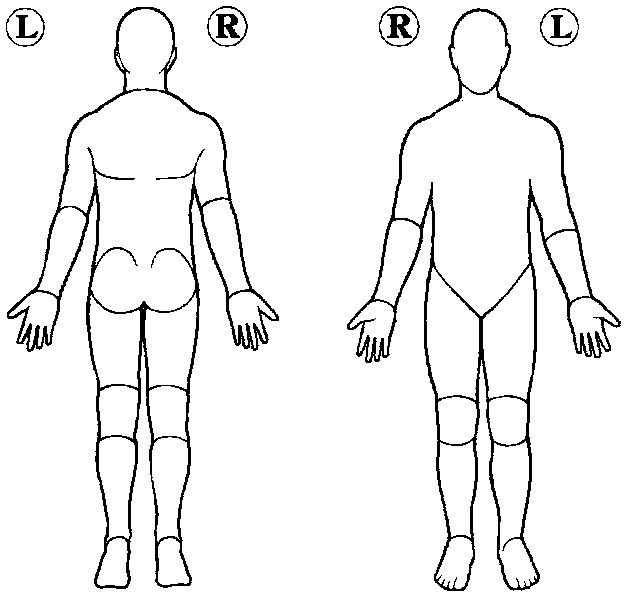
Completed by: ❑ patient ❑ family/care giver

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.



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

0 = No pain; 10 = 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

0 = No pain; 10 = 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

0 = No pain; 10 = 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

0 = No pain; 10 = Pain as bad as you can imagine

7 What treatments or medications are you receiving for your pain?

8 In the past 24 hours, 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

9 Circle the one number that best describes how, during the past 24 hours, 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 (includes both work outside the home and housework)

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

10 Please circle any other symptoms that you may have.

nausea	vomiting	constipation	diarrhea	urinary problems
indigestion	sweating	feeling drowsy	tiredness	itching