

PATIENT'S NAME: _____

DATE: ____/____/____

Brief Pain Inventory (Short Form) - Modified

1) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain
Imaginable

2) 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 Worst Pain
Imaginable

3) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**:

0 1 2 3 4 5 6 7 8 9 10

4) 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 Worst Pain
Imaginable

5) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **RELIEF** you have received

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

6) Circle the one number that 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

H. Ability to concentrate

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

I. Appetite

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes