



**\*IOPHEALTHIST\***  
**Institute of Psychiatry**  
**Brief Pain Inventory (Short Form)**

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Form Origination Date: 2/05  
Version: 1

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Patient Name \_\_\_\_\_  
MRN \_\_\_\_\_

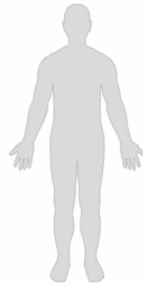
STAMP PLATE AREA

Date: \_\_\_\_\_

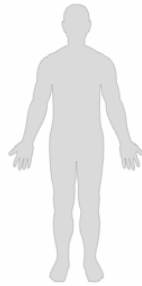
### Brief Pain Inventory (Short Form)

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 below, shade in the areas where you feel pain. Put an X on the area that hurts the most:



front



back

3) Please rate your pain by checking 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 as bad as you can imagine

4) Please rate your pain by checking 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 as bad as you can imagine

5) Please rate your pain by checking the one number that best describes your pain on average.

0  1  2  3  4  5  6  7  8  9  10  
No Pain as bad as you can imagine

6) Please rate your pain by checking 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 as bad as you can imagine

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REVIEWED BY:  
CLINICIAN SIGNATURE \_\_\_\_\_ PAGER ID \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_ AM/PM  
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