

BRIEF PAIN INVENTORY

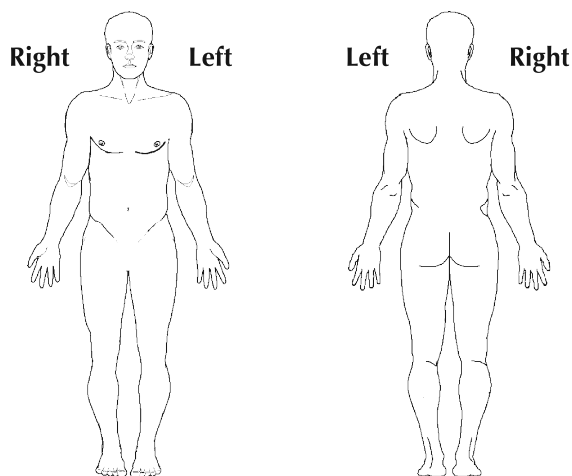
Date ____/____/____ Time:_____

Name: _____
Last First Middle Initial

- 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?

1. Yes 2. No

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



- 3) 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

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 the 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

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

- 8) 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

- 9) 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

Affix patient label within this box

Edmonton Symptom Assessment System Revised (ESAS-r)

Please circle the number that best describes how you feel **NOW**:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression <i>(Depression = feeling sad)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety <i>(Anxiety = feeling nervous)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing <i>(Wellbeing = how you feel overall)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem <i>(For example constipation)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient Name _____	Completed by <i>(Check one)</i> ☐ Patient ☐ Family Caregiver ☐ Health Care Professional Caregiver ☐ Caregiver-assisted Body Diagram on Reverse
Date <i>(yyyy-Mon-dd)</i>	
Time <i>(hh:mm)</i>	

Modified Oswestry Low Back Pain Disability Questionnaire

Name: _____ Date: ____/____/____

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity ☐ I can tolerate the pain I have without having to use pain medication. ☐ The pain is bad but I manage without having to take pain medication. ☐ Pain medication provides me complete relief from pain. ☐ Pain medication provides me moderate relief from pain. ☐ Pain medication provides me little relief from pain. ☐ Pain medication has no effect on the pain	Section 6 – Standing ☐ I can stand as long as I want without increased pain. ☐ I can stand as long as I want but increases my pain. ☐ Pain prevents me from standing for more than 1 hour. ☐ Pain prevents me from standing for more than ½ hour. ☐ Pain prevents me from standing for more than 10 mins. ☐ Pain prevents me from standing at all.
Section 2 – Personal Care (Washing, Dressing, etc.) ☐ I can take care of myself normally without causing increased pain. ☐ I can take care of myself normally but it increases my pain. ☐ It is painful to take care of myself and I am slow and careful. ☐ I need help but I am able to manage most of my personal care. ☐ I need help every day in most aspects of my care. ☐ I do not get dressed, wash with difficulty and stay in bed.	Section 7 – Sleeping ☐ Pain does not prevent me from sleeping well. ☐ I can sleep well only by using pain medication. ☐ Even when I take pain medication, I sleep less than 6 hours. ☐ Even when I take pain medication, I sleep less than 4 hours. ☐ Even when I take pain medication, I sleep less than 2 hours. ☐ Pain prevents me from sleeping at all
Section 3 – Lifting ☐ I can lift heavy weights without increased pain. ☐ I can lift heavy weights but it causes increased pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table. ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. ☐ I can lift only very light weights. ☐ I cannot lift or carry anything at all.	Section 8 – Social Life ☐ My social life is normal and does not increase my pain. ☐ My social life is normal, but it increases my level of pain. ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc). ☐ Pain prevents me from going out very often. ☐ Pain has restricted my social life to my home. ☐ I have hardly any social life because of my pain.
Section 4 - Walking ☐ Pain does not prevent me walking any distance. ☐ Pain prevents me walking more than 1 mile. ☐ Pain prevents me walking more than ½ mile ☐ Pain prevents me walking more than ¼ mile ☐ I can only walk using crutches or a cane. ☐ I am in bed most of the time and have to crawl to the toilet.	Section 9 – Traveling ☐ I can travel anywhere without increased pain. ☐ I can travel anywhere but it increases my pain. ☐ Pain restricts travel over 2 hours. ☐ Pain restricts travel over 1 hour. ☐ Pain restricts my travel to short necessary journeys under ½ hour. ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.
Section 5 - Sitting ☐ I can it in any chair as long as I like. ☐ I can only sit in my favorite chair as long as I like. ☐ Pain prevents me sitting more than 1 hour. ☐ Pain prevents me from sitting more than ½ hour. ☐ Pain prevents me from sitting more than 10 mins. ☐ Pain prevents me from sitting at all.	Section 10 – Employment/Homemaking ☐ My normal homemaking/job activities do not cause pain. ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming). ☐ Pain prevents me from doing anything but light duties. ☐ Pain prevents me from doing even light duties. ☐ Pain prevents me from performing any job/homemaking chores.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult