

BRIEF PAIN INVENTORY – LONG FORM

Date:

Name:

1) Marital Status (at present)

- Single Widowed
 Married Separated/Divorced

2) Education (Circle only the highest grade or degree completed)

Grade 0 1 2 3 4 5 6 7 8 9
 10 11 12 13 14 15 16 M.A./M.S.

Professional degree (please specify): _____

3) Current occupation (specify titles; if you are not working, tell us your previous occupation):

4) Spouse's occupation

5) Which of the following best describes your current job status?

- Employed outside the home, full-time
 Employed outside the home, part-time
 Homemaker
 Retired
 Unemployed
 Other

6) How long has it been since you first learned your diagnosis? _____ months

7) Have you ever had pain due to your present disease?

- Yes No Uncertain

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8) When you first received your diagnosis, was pain one of your symptoms?

- Yes No Uncertain

9) Have you had surgery in the past month?

- Yes No

If yes, what kind? _____

10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week?

- Yes No

10a) Did you take pain medications in the last 7 days?

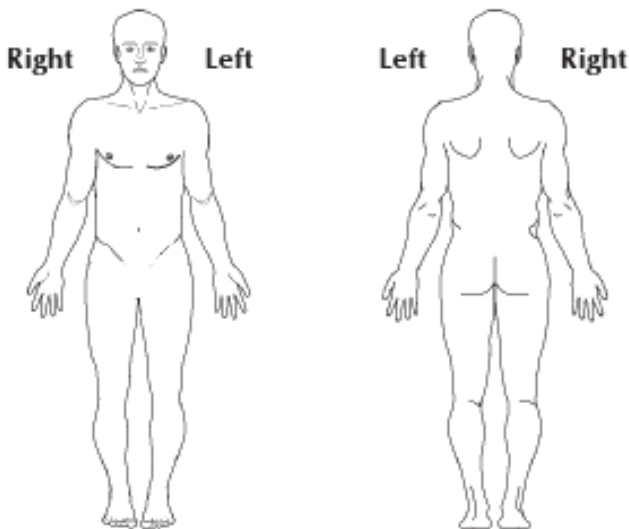
- Yes No

10b) I feel I have some form of pain now that requires medication each and every day.

- Yes No

IF YOUR ANSWERS TO 10, 10a, AND 10b WERE ALL NO, PLEASE STOP HERE AND GO TO THE LAST PAGE OF THE QUESTIONNAIRE AND SIGN WHERE INDICATED ON THE BOTTOM OF THE PAGE. IF ANY OF YOUR ANSWERS TO 10, 10a, AND 10b WERE YES, PLEASE CONTINUE.

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



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12) Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

13) Please rate your pain by circling the one number that best describes your pain at its least in the last week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

14) 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

15) 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

16) What kinds of things make your pain feel better (for example, heat, medicine, rest)?

17) What kinds of things make your pain worse (for example, walking, standing, lifting)?

18) What treatments or medications are you receiving for pain?

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23) Circle the one number that describes how, during the past week, 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
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

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

0	1	2	3	4	5	6	7	8	9	10
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
NO PAIN									PAIN AS BAD AS YOU CAN IMAGINE	

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24) I prefer to take my pain medicine:

- On a regular basis
- Only when necessary
- Do not take pain medicine

25) I take my pain medicine (in a 24 hour period):

- Not every day 4.
- 1 to 2 times per day
- 3 to 4 times per day
- 5 to 6 times per day
- More than 6 times per day

26) Do you feel you need a stronger type of pain medication?

- Yes
- No
- Uncertain

27) Do you feel you need to take more of the pain medication than your doctor has prescribed?

- Yes
- No
- Uncertain

28) Are you concerned that you use too much pain medication?

- Yes
- No
- Uncertain

If yes, why? _____

29) Are you having problems with side effects from your pain medication?

- Yes
- No

Which side effects? _____

30) Do you feel you need to receive further information about your pain medication?

- Yes
- No

31) Other methods I use to relieve my pain include: (Please check all that apply)

- Warm compresses
- Cold compresses
- Relaxation techniques
- Distraction
- Biofeedback
- Hypnosis
- Other (Please specify): _____

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32) Medications not prescribed by my doctor that I take for pain are:

Patient's Signature _____

DRIVING INSTRUCTIONS FOR PATIENTS TAKING OPIOIDS

Opioid medications can cause side effects that impair your ability to drive. The final decision on whether you should drive while using opioid medications is a legal issue and should be addressed with your automobile insurance carrier. Out of concern for your safety and the safety of others, please observe the following guidelines:

- Do not drive for 4 – 5 days after beginning opioid treatment or after a change in opioid treatment such as a dose increase.
- Do not drive if you ever feel sedated or cognitively impaired.
- Report sedation/unsteadiness/cognitive decline to our office as soon as possible.
- Under no circumstances should you use alcohol or illicit drugs such as cannabis (marijuana) and drive.
- Avoid taking over-the-counter antihistamines, as contained in numerous cold and allergy medications.
- Do not make any changes in your medication regimen without consulting our office.

Patient Name	
Patient Signature	Date
Practitioner Signature	Date