

BRIEF PAIN INVENTORY

Date:

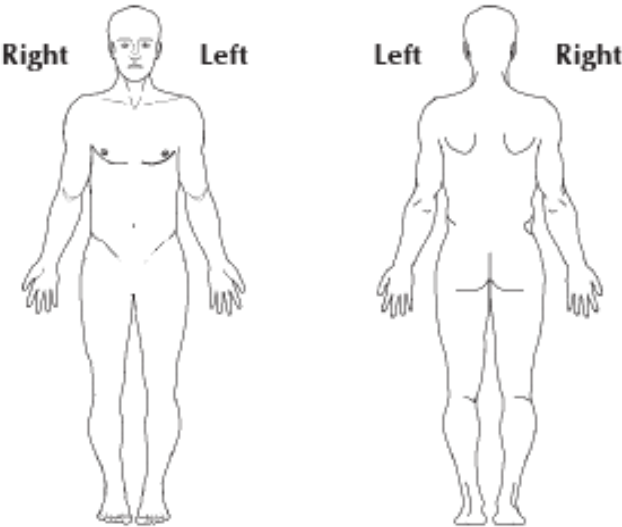
Time:

Name:

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 past 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 past 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 tell 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 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 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	

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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. Relation 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

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