# Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# _____

*Do not write above this line*

Date: _____ Time: _____

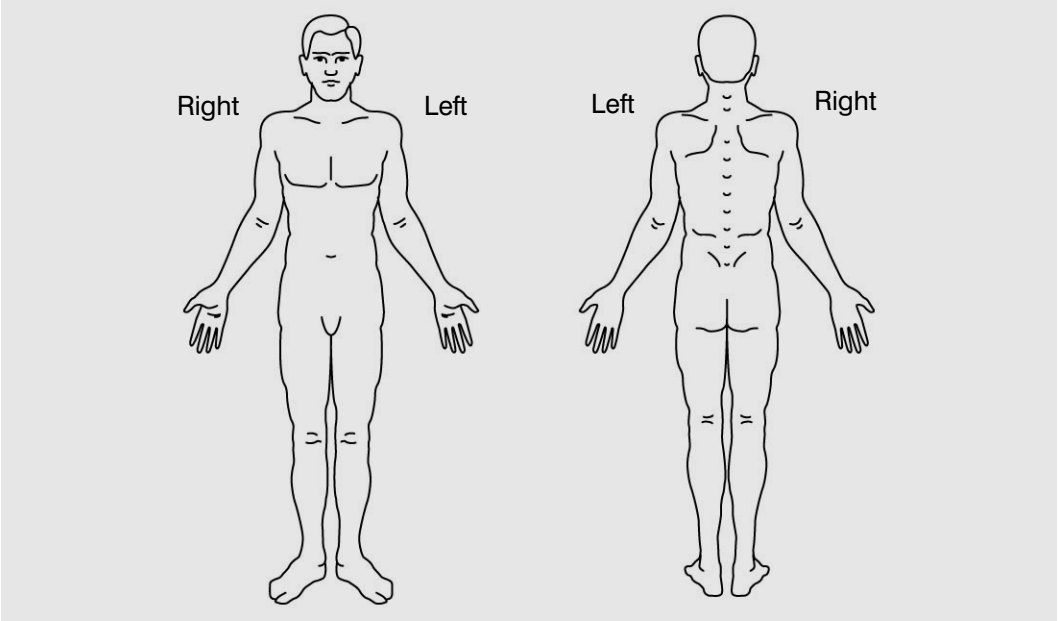
Name: _____

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 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 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 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 |

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 |

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# Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | 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?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

# PATIENT QUESTIONNAIRE – PHQ-9

**Patient Name:** _____ **MRN** _____

**Physician:** _____ **Date:** _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

| | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| | **0** | **1** | **2** | **3** |
| 1. Little interest or pleasure in doing things. | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless. | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling/staying asleep, sleep too much. | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy. | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating. | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | ☐ | ☐ | ☐ | ☐ |
| 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. | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☐ | ☐ | ☐ |
| | 0 | _____ | _____ | _____ |

A. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

B. In the past **two years** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

**Symptoms** _____ **Severity Score** _____

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Michael JL Sullivan

# PCS

Client No.: _____ Age: _____ Sex: M(__) F(__) Date: _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

**0** – not at all **1** – to a slight degree **2** – to a moderate degree **3** – to a great degree **4** – all the time

***When I'm in pain …***

1. ☐ I worry all the time about whether the pain will end.
2. ☐ I feel I can't go on.
3. ☐ It's terrible and I think it's never going to get any better.
4. ☐ It's awful and I feel that it overwhelms me.
5. ☐ I feel I can't stand it anymore.
6. ☐ I become afraid that the pain will get worse.
7. ☐ I keep thinking of other painful events.
8. ☐ I anxiously want the pain to go away.
9. ☐ I can't seem to keep it out of my mind.
10. ☐ I keep thinking about how much it hurts.
11. ☐ I keep thinking about how badly I want the pain to stop.
12. ☐ There's nothing I can do to reduce the intensity of the pain.
13. ☐ I wonder whether something serious may happen.

***…Total***

# SOAPP® Version 1.0

Name: _____ Date: _____

***The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.***

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

| | |
|---|---|
| 1. How often do you feel that your pain is "out of control?" | 0 1 2 3 4 |
| 2. How often do you have mood swings? | 0 1 2 3 4 |
| 3. How often do you do things that you later regret? | 0 1 2 3 4 |
| 4. How often has your family been supportive and encouraging? | 0 1 2 3 4 |
| 5. How often have others told you that you have a bad temper? | 0 1 2 3 4 |
| 6. Compared with other people, how often have you been in a car accident? | 0 1 2 3 4 |
| 7. How often do you smoke a cigarette within an hour after you wake up? | 0 1 2 3 4 |
| 8. How often have you felt a need for higher doses of medication to treat your pain? | 0 1 2 3 4 |
| 9. How often do you take more medication than you are supposed to? | 0 1 2 3 4 |
| 10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 11. How often have any of your close friends had a problem with alcohol or drugs? | 0 1 2 3 4 |

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**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

| | |
|---|---|
| 12. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 13. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 14. How often have you had a problem getting along with the doctors who prescribed your medicines? | 0 1 2 3 4 |
| 15. How often have you taken medication other than the way that it was prescribed? | 0 1 2 3 4 |
| 16. How often have you been seen by a psychiatrist or a mental health counselor? | 0 1 2 3 4 |
| 17. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |
| 18. How often have your medications been lost or stolen? | 0 1 2 3 4 |
| 19. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 20. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 21. How often has more than one doctor prescribed pain medication for you at the same time? | 0 1 2 3 4 |
| 22. How often have you been asked to give a urine screen for substance abuse? | 0 1 2 3 4 |
| 23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 1 2 3 4 |
| 24. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |

*Please include any additional information you wish about the above answers. Thank you.*

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