Neurology and Pain Management
Compassionate Medicine for the 21st century

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Date: _____

Please Check the circles below if there are any changes.

Name: _____

Date of Birth: _____

◯ Phone Number: _____

◯ Address: _____

_____

◯ Insurance: _____

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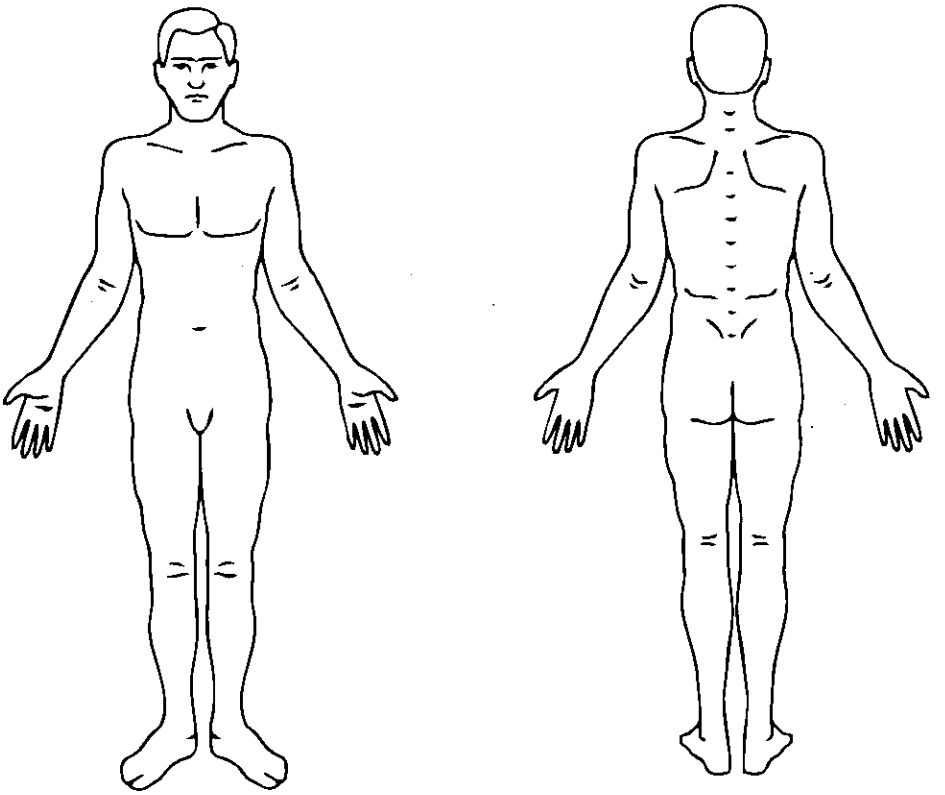
BRIEF PAIN INVENTORY SHORT FORM

Patient 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? ❑ YES ❑ 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.

No Pain 0 1 2 3 4 5 6 7 8 9 10 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.

No Pain 0 1 2 3 4 5 6 7 8 9 10 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.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain As Bad As You Can Imagine

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BRIEF PAIN INVENTORY SHORT FORM

6. Please rate your pain by circling the one number that tells how much pain you have right **NOW.**

No Pain 0 1 2 3 4 5 6 7 8 9 10 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 has pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Completely Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

B. Mood

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

C. Walking Activity

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

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

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

E. Relations With Other People

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

F. Sleep

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

G. Enjoyment of Life

Does not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interfere

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SOAPP Version 1.0-14Q

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 have mood swings?	1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	1 2 3 4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	1 2 3 4
4.	How often have any of your close friends had a problem with alcohol or drugs?	1 2 3 4
5.	How often have others suggested that you have a drug or alcohol problem?	1 2 3 4
6.	How often have you attended an AA or NA meeting?	1 2 3 4
7.	How often have you taken medication other than the way that it was prescribed?	1 2 3 4
8.	How often have you been treated for an alcohol or drug problem?	1 2 3 4
9.	How often have your medications been lost or stolen?	1 2 3 4
10.	How often have others expressed concern over your use of medication?	1 2 3 4
11.	How often have you felt a craving for medication?	1 2 3 4
12.	How often have you been asked to give a urine screen for substance abuse?	1 2 3 4
13.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	1 2 3 4
14.	How often, in your lifetime, have you had legal problems or been arrested?	1 2 3 4

Below please include any additional information you wish about the above answers. Thank you.

_____

_____

_____

_____

_____

_____

_____