IMMEDIATE MED

NEW PATIENT QUESTIONNAIRE

The information you provide is strictly confidential and will not be released without your written consent

Name: (Last)______________________________First:______________________________

Today's date_____/_____/_____Who referred you here? ______________________________

Your Address:______________________________City/Town:__________State:__________ZIP:__________

Phone: Work ( )______________________________ Home ( ) ______________________________

Cell ( )____________________Pager ( )____________________E-mail: ______________________________

Date of birth:_____/_____/_____Current Age:______Place of birth:______________________________

Social security number:____________________Nationality: [ ] U.S. [ ] Other (specify):____________________

Gender: [ ] Male [ ] Female *Race*: [ ] Caucasian [ ] African American [ ] Hispanic [ ] Asian [ ] Other:

Marital status: [ ] Single, Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Current living situation: [ ] alone [ ] with spouse/mate [ ] with parents [ ] with siblings [ ] Other:

In what religion were you raised: [ ] None [ ] Protestant [ ] Catholic [ ] Jewish [ ] Muslim [ ] Greek Orthodox [ ] Hindu [ ] Buddhist [ ] Other (specify)

Ethnic background of your mother's family: ______________________________

Ethnic background of your father's family: ______________________________

EMERGENCY CONTACT Name:______________________________Relationship to you:____________________

Daytime phone: ( )______________________________Evening phone: ( ) ____________________

Your Primary Care Physician:______________________________Phone number: ( )____________________

YOUR CURRENT OCCUPATION:______________________________ POSITION:____________________

Employer:______________________________How long at this job?____________________

Level of satisfaction with your job: [ ] excellent [ ] good [ ] fair [ ] poor

YOUR EDUCATION & TRAINING

School or Facility	Dates Attended	Degree	Major Area of Study

Patient Initials__________

ALCOHOL USE

When you drink alcohol, what types of beverages do you most often drink? (check all that apply)
[ ] beer [ ] wine [ ] vodka [ ] gin [ ] scotch/whiskey [ ] other (specify)____________________

How many drinks do you usually have ? per day _ per week ________________

Do you experience any physical problems when you try to stop drinking? [ ] No [ ] Yes, check all that apply
[ ] shakes or trembling [ ] sweating [ ] vomiting [ ] sleep problems [ ] seizures [ ] hallucinations

Have you ever experienced physical withdrawal or other medical complications from prior attempts to stop drinking alcohol?
[ ] No [ ] Yes, please describe

SUBSTANCE USE PROFILE

- Have you ever found yourself thinking a great deal about alcohol/drugs or being preoccupied with using? [ ] Yes [ ] No
- Have you ever experienced cravings or a strong compulsion to use alcohol/drugs? [ ] Yes [ ] No
- Have you ever had difficulty in reducing or totally stopping your alcohol/drug use? [ ] Yes [ ] No
- Have you ever used more frequently and/or in larger amounts than you intended to? [ ] Yes [ ] No
- Have you ever been under this influence of alcohol/drugs while driving a car or operating dangerous machinery? [ ] Yes [ ] No
- Has your use ever caused you to miss workdays or impaired your productivity or judgment at work? [ ] Yes [ ] No
- Have you ever become less sociable, socially withdrawn, or isolated as a result of using alcohol/drugs? [ ] Yes [ ] No
- Have you ever given up recreational activities/exercise, or other healthy pursuits due to alcohol/drug use? [ ] Yes [ ] No
- Has your self-esteem or self-image ever been negatively affected by your alcohol/drug use? [ ] Yes [ ] No
- Have relationships with a mate, family members or significant others been damaged by your alcohol/drug use? [ ] Yes [ ] No
- Have you ever used alcohol/drugs to "medicate" yourself for depression, anxiety, or other negative moods? [ ] Yes [ ] No
- Has your substance use been associated "STD risky" sexual behavior such as having sexual encounters with unknown partners or having STD-risky unprotected sex with someone other than your primary mate while under the influence of alcohol/drugs? [ ] Yes [ ] No
- Do you feel a need for professional help to deal with your alcohol/drug problem? [ ] Yes [ ] No [ ] Not Sure

YOUR TOTAL NUMBER OF "YES" RESPONSES ______________

CONSEQUENCES OF YOUR ALCOHOL AND DRUG USE

Check all that apply during the past 3-6 months or similar period prior to any recent discharge from inpatient rehab

PSYCHOLOGICAL [ ] Irritability, short temper [ ] Self-hate [ ] Depression [ ] Suicidal thoughts or actions [ ] Homicidal thoughts or actions
[ ] Paranoia, suspiciousness [ ] Memory [ ] Anxiety or panic attacks [ ] Other (describe):

SEXUAL [ ] Loss of sexual desire [ ] Sexual obsession [ ] Sex with strangers [ ] AIDS-risky sex [ ] Inability to achieve orgasm
[ ] Inability to achieve or sustain erection [ ] Other (describe):

RELATIONSHIPS [ ] Arguments with mate [ ] Violence with mate [ ] Breakup of marriage or relationship [ ] Loss of friends
[ ] Arguments with parents or siblings [ ] Other (describe):

JOB OR FINANCIAL [ ] Job loss or threatened job loss [ ] Lateness or absenteeism [ ] Less productive at work [ ] In debt
[ ] Falling behind in paying bills [ ] Other (describe):

LEGAL [ ] Arrested for possession of illegal drugs [ ] Arrested for sale of illicit drugs [ ] Arrested for DWI [ ] Other:

OTHER CONSEQUENCES: please describe

Please Answer ALL Questions Below

- Have you ever been hospitalized or treated in an ER for alcohol/drug overdose? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever had seizures, convulsions, or epilepsy? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever had blackouts (memory gaps) due to alcohol/drug use? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever felt suicidal or had repeated thoughts about harming yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever planned out or chosen a specific method for killing yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever attempted to kill or seriously harm yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever been hospitalized due to a suicide attempt or suicidal thoughts? [ ] No [ ] Yes [ ] Past 30 days?
- Are you afraid that you might try to harm yourself in the near future? [ ] No [ ] Yes [ ] Past 30 days?
- Do you have a history of being violent toward other people? [ ] No [ ] Yes [ ] Past 30 days?
- Do you ever have persistent thoughts or fantasies about harming other people? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever (when not under the influence of drugs/alcohol seen or heard things that others did not? [ ] No [ ] Yes [ ] Past 30 days?

Please explain any "YES" answers:

____

Mood and Mental State: OVER THE PAST 30-60 DAYS:

- Have you been feeling depressed, down, blue, or hopeless on a regular basis? [ ] No [ ] Yes
- Has your appetite significantly increased or decreased? [ ] No [ ] Yes
- Have you lost or gained a significant amount of weight? [ ] No [ ] Yes
- Have you experienced problems falling asleep or staying asleep on most nights? [ ] No [ ] Yes
- Have you been sleeping too much or having trouble getting out of bed?[[ ] No [ ] Yes
- Have you been feeling worthless and/or overwhelmed with guilt? [ ] No [ ] Yes
- Have you been feeling irritable, agitated, restless, or unable to concentrate? [ ] No [ ] Yes
- Have you lost interest or reduced participation in pleasurable activities? [ ] No [ ] Yes
- Have you been less interested in sex? [ ] No [ ] Yes
- Have you been avoiding social contact or become withdrawn and isolated? [ ] No [ ] Yes
- Have you been feeling overwhelmed with sadness or had crying spells? [ ] No [ ] Yes
- Has your overall energy level decreased or been much lower than usual? [ ] No [ ] Yes
- Have you been feeling that life may not be worth living? [ ] No [ ] Yes
- Do you feel that you worry excessively about many things? [ ] No [ ] Yes
- Do you avoid social situations because of feelings of fear? [ ] No [ ] Yes
- Do you have recurrent thoughts or images in your head that refuse to go away? [ ] No [ ] Yes

- In the last month, has there been a period of time when you were feeling so good, high, excited or hyper that other people thought you were not your normal self or you got into trouble? (Did anyone say you were manic? .... [ ] No [ ] Yes
- Have you ever had a time when you were feelings so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble: (Did anyone say you were manic, then?) .... [ ] No [ ]Yes
- Have you had any unusual experiences, for example did it ever seem like people were talking about you or taking special notice of you? .... [ ] No [ ] Yes
- What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV? .... [ ] No [ ] Yes
- Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell? .... [ ] No [ ] Yes
- Or did you do something to call attention to yourself like dressing in some odd way or doing something strange? .... [ ] No [ ] Yes
- Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)? .... [ ] No [ ] Yes
- If yes, has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks? .... [ ] No [ ] Yes
- Have you ever been bothered by thoughts, impulses or images that caused anxiety and kept coming back even when you tried not to have them? .... [ ] No [ ] Yes

If Yes to any of the above, please describe below and answer the following questions:

- Do you re-experience the negative or traumatic event in at least one of the following ways?
  - [ ] No [ ] Yes Repeated, distressing memories and/or dreams?
  - [ ] No [ ] Yes Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?
  - [ ] No [ ] Yes Intense physical and/or emotional distress when you are exposed to things that remind you of the event

- Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways?
  - [ ] No [ ] Yes Avoiding thoughts, feelings, or conversations about it?
  - [ ] No [ ] Yes Avoiding activities, places, or people who remind you of it?
  - [ ] No [ ] Yes Blanking on important parts of it?
  - [ ] No [ ] Yes Losing interest in significant activities of your life?
  - [ ] No [ ] Yes Feeling detached from other people?
  - [ ] No [ ] Yes Feeling your range of emotions is restricted?

- Are you troubled by any of the following:
  - [ ] No [ ] Yes Problems sleeping?
  - [ ] No [ ] Yes Irritability or outbursts of anger?
  - [ ] No [ ] Yes Problems concentrating?
  - [ ] No [ ] Yes Feeling "on guard"?
  - [ ] No [ ] Yes An exaggerated startle response?

GAMBLING

- Do you lose time from work due to gambling? [ ] No [ ] Yes
- Has gambling ever made your home life unhappy? [ ] No [ ] Yes
- Have you ever felt remorse after gambling? [ ] No [ ] Yes
- Do you ever gamble to get money to pay debts or to otherwise solve other financial difficulties? [ ] No [ ] Yes
- After losing, do you feel you must return as soon as possible and win back your losses? [ ] No [ ] Yes
- After a win, do you have a strong urge to return and win more? [ ] No [ ] Yes
- Do you often gamble until your last dollar is gone? [ ] No [ ] Yes
- Do you ever have to borrow to finance your gambling? [ ] No [ ] Yes
- Does gambling make you careless of the welfare of your family? [ ] No [ ] Yes
- Do you ever gamble longer than you had planned? [ ] No [ ] Yes
- Have you ever gambled to escape worry or trouble? [ ] No [ ] Yes
- Have you ever committed, or considered committing, an illegal act to finance gambling? [ ] No [ ] Yes
- Does gambling cause you to have difficulty sleeping? [ ] No [ ] Yes
- Do arguments, disappointments or frustrations give you an urge to gamble? [ ] No [ ] Yes
- Do you have an urge to celebrate any good fortune by gambling? [ ] No [ ] Yes
- Can you conceive of life without gambling? [ ] No [ ] Yes
- Do you see payment of all your outstanding debts as the solution to your problem? [ ] No [ ] Yes
- Do you expect to be bored, depressed, irritable, or anxious when you stop gambling? [ ] No [ ] Yes
- Do you drink or use drugs before, during or after you gamble? [ ] No [ ] Yes
- Do you promise your spouse or mate to stop gambling? [ ] No [ ] Yes
- Are you away from home or unavailable to the family for long periods of time when you gamble? [ ] No [ ] Yes
- Do you promise faithfully that you will stop gambling and beg for another change, yet continue to gamble? [ ] No [ ] Yes
- Has your personality changed as a result of your continued gambling? [ ] No [ ] Yes
- Are you addicted to the "action" and stimulation in gambling? [ ] No [ ] Yes

Total Number of "YES" responses ____________________

- Has sex been a way for you to escape your problems? [ ] No [ ] Yes
- When you have sex, do you feel depressed or humiliated afterwards? [ ] No [ ] Yes
- Have you felt the need to discontinue certain types of sexual activity? [ ] No [ ] Yes
- Has your sexual activity interfered with your family life? [ ] No [ ] Yes
- Do you feel controlled by your sexual desire? [ ] No [ ] Yes
- Do you ever think your sexual desire is stronger than you are? [ ] No [ ] Yes

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LINKAGE between DRUG USE and SEX

- Has your substance use ever been associated with sex? [ ] Yes (answer all questions below) [ ] No (skip this section)
- Which of the substances that you have used are most strongly linked with sex? [ ] cocaine [ ] methamphetamine [ ] alcohol [ ] other-
- When using substances do you get involved in (check all that apply): [ ] compulsive masturbation [ ] sex with prostitutes/escorts [ ] strip clubs [ ] porno movies [ ] telephone sex [ ] internet pornography [ ] sadomasochistic sex [ ] asphyxiation [ ] sex with transvestites [ ] Other: *specify* –
- Approximately how often does your substance use involve sexual thoughts, feelings, fantasies, or behaviors? [ ] always [ ] almost always [ ] most of the time [ ] sometimes [ ] almost never [ ] never

- Does your substance use stimulate your sex drive and fantasies? [ ] No [ ] Yes
- Does your substance use impair your sexual performance (e.g., prevent orgasm and/or erection) ? [ ] No [ ] Yes
- Are you more likely to have sex (intercourse, oral sex, masturbation, etc..) when using substances? [ ] No [ ] Yes
- Are you more likely to have sex with a prostitute, pickup, other unknown partner, or someone besides your spouse or primary mate when using substances? [ ] No [ ] Yes
- Has your use of substances increased your preoccupation and obsession with sex or made your sex drive abnormally high? [ ] No [ ] Yes
- Do you think your substance use is so strongly associated with sex that the two are difficult for you to separate from one another? [ ] No [ ] Yes
- In prior attempts to stop using substances, have sexual thoughts, feelings, and/or fantasies perpetuated your drug use and contributed to relapse? [ ] No [ ] Yes
- Are you concerned that if you stop using this substance sex will not be as interesting or pleasurable for you? [ ] No [ ] Yes
- Have sexual fantasies or desires ever increased your chances of using substances? [ ] No [ ] Yes
- If you try to stop using substances are you concerned that your sexual fantasies or desires will make it harder for you to stop ? [ ] No [ ] Yes
- If you are heterosexual, have you experienced homosexual fantasies or engaged in sex with men while under the influence of substances? [ ] No [ ] Yes
- Are you less likely to practice safe sex under the influence of substances (e.g., not use condoms, be less careful about who you choose as a sex partner, etc.) ? [ ] No [ ] Yes
- Has your sexual behavior under the influence of substances caused you to feel that you are sexually perverted or have a sex problem? [ ] No [ ] Yes
- Prior to getting involved with substances were you ever have concerned that your sex drive was abnormally high or that you were preoccupied or obsessed with sex? [ ] No [ ] Yes
- Prior to getting involved with substances were you ever concerned that your sex drive was abnormally low or that your sexual performance was inadequate? [ ] No [ ] Yes
- Do you feel that your treatment should address substance-related sexual issues? [ ] No [ ] Yes

MEDICAL

- Any current medical problems? [ ] No [[Yes, describe-
- Currently under a doctor's care for these problems? [ ] No [ ] Yes, name of doctor:
- Any serious illness within the past year? [ ] No [ ] Yes, describe-
- EVER had? (check all that apply): [ ] high blood pressure [ ] heart disease [ ] epilepsy, seizures, convulsions [ ] kidney disease [ ] diabetes [ ] colitis [ ] thyroid disease [ ] pancreatitis [ ] cancer [ ] TB [ ] HIV [ ] Hep A [ ] Hep B [ ] Hep C [ ] serious head/brain injury [ ] other serious illnesses or major surgeries (describe):

B

Patient's Name:	Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.
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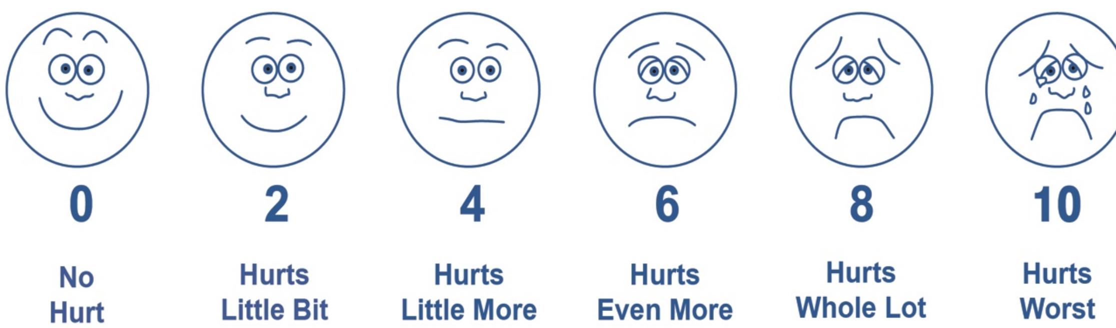
Circle the face that represents how you feel today. Print and complete before coming in.



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Instructions for Usage

Explain to the person that each face represents a person who has no pain (hurt), or some, or a lot of pain.

Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little bit more. Face 6 hurts even more. Face 8 hurt a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain.

Ask the person to choose the face that best depicts the pain they are experiencing.

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed 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 very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e. g, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

.

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

Patient Comfort Assessment Guide

Name:____________________________________ Date:______________

1. Where is your pain?____
2. Circle the words that describe your pain.

aching	shooting	gnawing
sharp	numb	unbearable
penetrating	stabbing	tiring
throbbing	exhausting	nagging
tender	miserable	burning

3. Circle one. occasional continuous
4. What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

5. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. Rate your pain by circling the number that best describes your pain on average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

8. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

9. What makes your pain better?______________________________________
10. What makes your pain worse?– _____________________________________

11. What treatments or medicines are you receiving for your pain?
Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a. ______________________________
Treatment or Medicine (include dose)
No relief 0 1 2 3 4 5 6 7 8 9 10 Complete relief

b. ______________________________
Treatment or Medicine (include dose)
No relief 0 1 2 3 4 5 6 7 8 9 10 Complete relief

c. ______________________________
Treatment or Medicine (include dose)
No relief 0 1 2 3 4 5 6 7 8 9 10 Complete relief

d. ______________________________
Treatment or Medicine (include dose)
No relief 0 1 2 3 4 5 6 7 8 9 10 Complete relief

12. What side effects or symptoms are you having?
Circle the number that best describes your experience during the past week.

a. Nausea Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
b. Vomiting Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
c. Constipation Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
d. Lack of Appetite Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
e. Tired Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
f. Itching Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
g. Nightmares Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
h. Sweating Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
i. Difficulty Thinking Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine
j. Insomnia Barely Noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medicine

13. Circle the one number that describes how during the past week pain has interfered with your:

a. General Activity Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
b. Mood Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
c. Normal Work Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
d. Sleep Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
e. Enjoyment of life Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
f. Ability to concentrate Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
g. Relations with others Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Prepared by Elizabeth J. Narcessian, MD, Clinical Chief of Pain Management, Kessler Institute for Rehabilitation, Inc. H5375 PAP023 05/13
®Sources: Brief Pain Inventory. Charles Cleeland, PhD. Pain Research Group, Copyright 1991.
McCorkle R, Young K. Development of a symptom distress scale. Cancer Nursing. 1978;1(5):373-378.
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Brief Pain Inventory (Short Form)

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.

Right Left Left Right

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 **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 best describes 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. **General Activity 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 (including work inside & outside the home)**

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

E. **Relationship with other people**

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

F. Mood **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