



## BRIEF PAIN INVENTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

Middle Initial

1. On the diagram, shade in the areas where you feel pain. Put an "X" on the area(s) that hurt the most. Also please identify area(s) of numbness and weakness by placing a "Z" on specific area(s).

2. Please rate your pain by circling the one number that best describes your typical pain.

No Pain

0      1      2      3      4      5      6      7      8      9      10

Very High Pain

