

BRIEF PAIN INVENTORY (SHORT FORM) for Female Participants

Female Participant completes via Online Survey at **ALL Clinic** and **Online** Contacts.

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 during the last week? ₁ Yes ₀ No

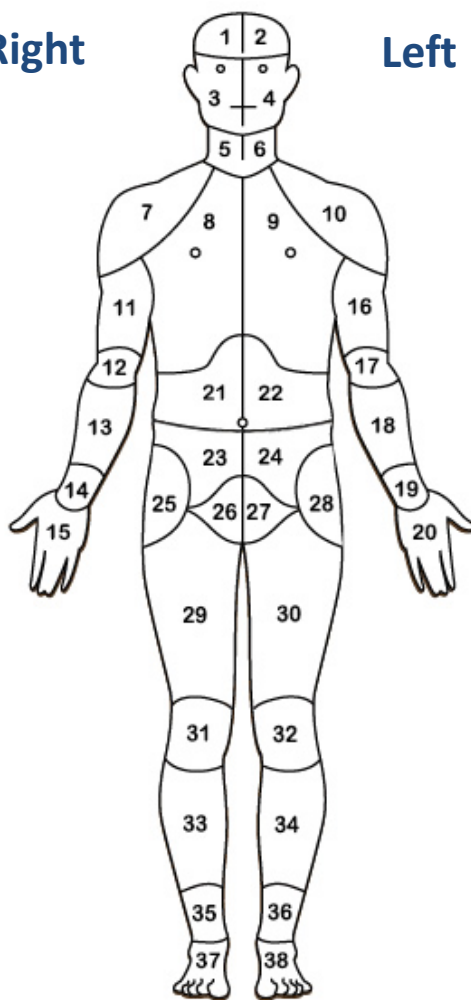
2. Select each area on the body map where you have had pain or tenderness over the **past 7 days** and indicate the intensity of pain in that area:

₀ No Pain

₀ No Pain

Right

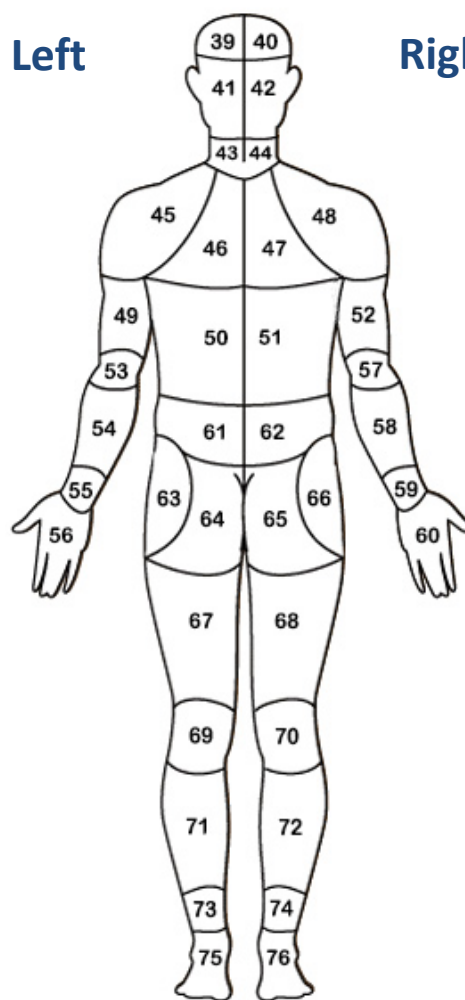
Left



Front

Left

Right



Rear

a. Select the area on the body map that hurts the most and indicate the intensity of pain in that area.

(Archived)

Participant ID: _____

Pin # _____

Discovery Site: _____

Clinical Center _____

CRF Date: ____/____/____

Visit #: _____

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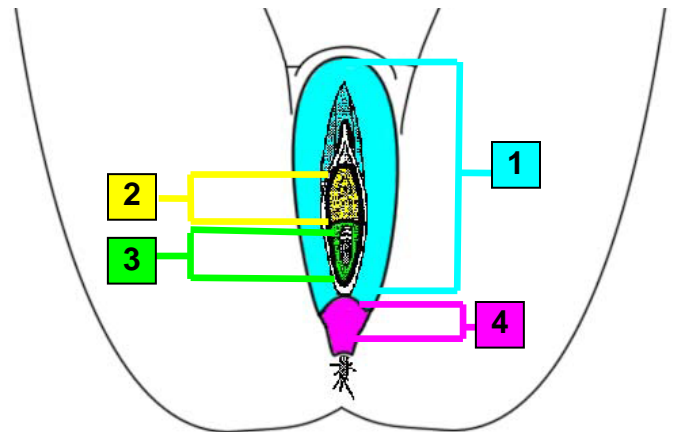
3. Check the boxes listed below for each area on the genital diagram where you feel pain:

1 - ₁

2 - ₂

3 - ₃

4 - ₄



a. Enter the number here for the area on the genital diagram that hurts the most: ____

4. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last week.

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 at its **least** in the last week.

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 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



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7. 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

8. What treatments or medications are you receiving for your pain?

9. In the last week, 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

10. Circle the one number that describes how much, during the past week, 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



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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