Pain Assessment Tool

Assessment date: _____ Name: _____

Does the person have a diagnosis or condition likely to cause pain? ❑ Yes ❑ No PPS: _____

Condition (*check any of the following that apply*):

Arthritis	❑	Dementia	❑	Headaches	❑	Osteoporosis	❑	Wounds/ulcer	❑
Back problem	❑	Depression	❑	Immobility	❑	Recent falls	❑	Vascular disease	❑
Cancer	❑	Diabetes	❑	MS	❑	Shingles (Zoster)	❑	Neck problem	❑
Constipation	❑	Falls/trauma	❑	Migraines	❑	Stroke	❑	HIV	❑
Contractures	❑	UTI	❑	Other (describe): _____					

Is the person currently receiving pain medications? ❑ Yes ❑ No

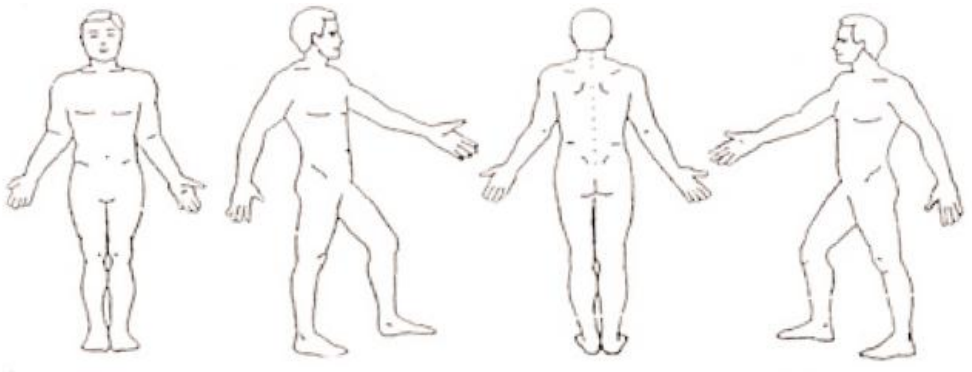
Current Medication Dosages and Usage:_____

_____

_____

Is person satisfied with current pain control? ❑ Yes ❑ No

Location of Pain: Use letters to identify different pains.



Intensity: Use appropriate pain tool to rate pain subjectively/objectively on a scale of 0-10.

Location	Pain A	Pain B	Pain C
What is your/their present level of pain			
What makes the pain better?			
What is the rate when the pain is at it's least?			
What makes the pain worse?			
What is the rate when the pain is at it's worst?			
Is the pain continuous or intermittent (come & go)?			
When did this pain start?			
What do you think is the cause of this pain?			
What level of pain are you satisfied with?			

Quality: Circle the words that describe the pain and indicate the letter of the pain (A,B,C) being described.

aching	❑	throbbing	❑	shooting	❑	stabbing	❑	gnawing	❑	sharp	❑
burning	❑	tender	❑	exhausting	❑	tiring	❑	penetrating	❑	numb	❑
nagging	❑	hammering	❑	miserable	❑	unbearable	❑	tingling	❑	stretching	❑
pulling	❑	Other: _____									

Pain Quality Description Guide**:** Is pain described as:

1. Sharp, aching, gnawing, soreness, worse on movement, deep, better with certain positions, able to pinpoint location, worse in morning? ***Source of pain may be in muscle, joints, soft tissues (somatic).***
2. Squeezing, cramping, pressure-like, spreads from one location to another (stomach to back, liver to shoulder), wave-like, in chest or abdomen, difficult to pinpoint location?
   Source of pain may be in internal organs: heart, lungs, liver, gall bladder, intestines (visceral).
3. Burning, itching, tearing, numbness, pins and needles, persistent or lightning-like, shock-like sensations, occurs with light touch or pressure, worse at night, moves down leg or arm? ***May be in nervous system (neuropathic).***

Effects of pain on activities of daily living	**Yes**	**No**	**Comments**
Sleep and rest			
Social activities			
Appetite			
Physical activity and mobility			
Emotions			
Sexuality/intimacy			

Effects of Pain on your Quality of Life: ***(happiness, contentment, fulfillment, independence)***
What can't you do that you would like to do or what activity would improve the person's quality of life?

Symptoms: What other symptoms are they experiencing?

☐ constipation	☐ nausea	☐ vomiting	☐ fatigue	☐ insomnia
☐ depression	☐ short of breath	☐ sore mouth	☐ weakness	☐ drowsiness
☐ other	_____			

Non-verbal Pain Expression: Complete for all persons, but especially important in cognitively impaired or people with a language barrier. (***Circle best descriptor,*** *indicate if changed from baseline behaviour or status)*

Activity	**Descriptors**	**Baseline**	**Change**
Vocalization	Moaning, groaning, crying, yelling, sighing, blowing	❑	❑
Facial Expression	Grimacing, fearful, sad, withdrawn, tense, frowning	❑	❑
Body position	Bracing, guarding, walking, sitting position, stiff	❑	❑
Activity patterns	Rocking, pulling, rubbing, sleeping, hyper alert, responsive, fidgeting, distracted, withdrawn	❑	❑
Body movements	Immobilization, purposeless movement, protective movements, rhythmic movement	❑	❑
Mood changes	Angry, sad, withdrawn, aggressive, passive, irritable	❑	❑
Resistance to care	Less able to assist in care, actively resists care	❑	❑
Appetite	Diminished, loss of interest in food	❑	❑

Elaborate if needed :_____
_____

Nursing Pain Diagnosis:

☐ somatic	☐ visceral	☐ neuropathic	☐ suffering	☐ incident pain
☐ other	☐ muscle spasm	☐ raised intracranial pressure		

Patient Goals for Pain Management:

1 _____ 2 _____ 3 _____

Signature _____ Date _____