

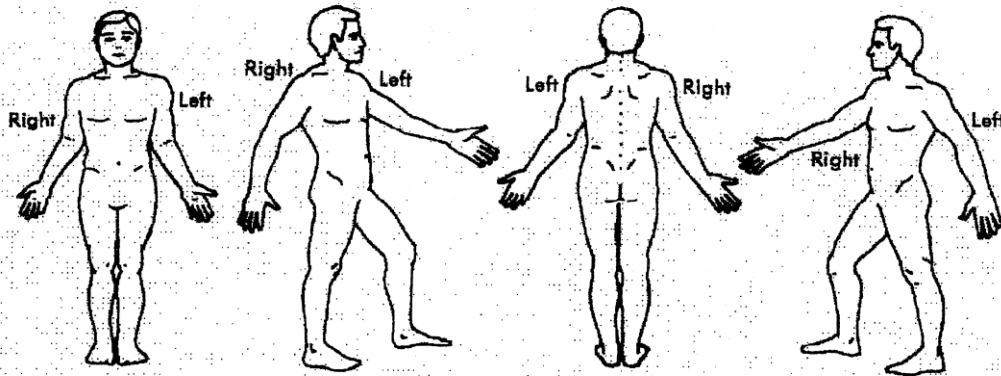
PAIN ASSESSMENT TOOL

Assessment Date (M/D/Y): _____

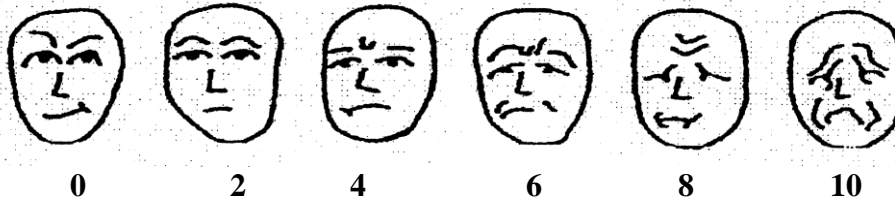
Reason for Assessment:

- New Admission Re-Admission
 Further Assessment Needed

Location Of Pain:



Intensity: Use appropriate pain tool to rate pain subjectively on a scale of 0-10. (Rate pain on a scale of 0-10)



QUESTIONS	COMMENTS
What is the present level of pain?	
What is the rate when the pain is at it's least?	
What makes the pain better?	
What is the rate when the pain is at it's worst?	
What makes the pain worse?	
Is the pain continuous or intermittent (come & go)?	
When did the pain start?	
What do you think is the cause of this pain?	
What level of pain are you satisfied with? (if 0 is unattainable)	

Quality: Indicate the words that describe the pain:

- | | | | | | |
|----------------------------------|---------------------------------------|---|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> throbbing | <input type="checkbox"/> shooting | <input type="checkbox"/> stabbing | <input type="checkbox"/> gnawing | <input type="checkbox"/> sharp |
| <input type="checkbox"/> burning | <input type="checkbox"/> tender | <input type="checkbox"/> exhausting | <input type="checkbox"/> tiring | <input type="checkbox"/> penetrating | <input type="checkbox"/> numb |
| <input type="checkbox"/> nagging | <input type="checkbox"/> hammering | <input type="checkbox"/> pins & needles | <input type="checkbox"/> unbearable | <input type="checkbox"/> tingling | <input type="checkbox"/> stretching |
| <input type="checkbox"/> pulling | <input type="checkbox"/> Other: _____ | | | | |

Effects of Pain On Activities of Daily Living:

- | | | | |
|--------------------------------|------------------------------|-----------------------------|----------------|
| sleep and rest | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| social activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| physical activity and mobility | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| emotions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| sexuality/intimacy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |

Effects of Pain On Your Quality of Life: (happiness, contentment, fulfillment). What would you like to do now that you can't because of the pain or what activity would improve the person's quality of life?

Symptoms: What other symptoms are being experienced?

- | | | | | | | |
|---------------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|-----------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> constipation | <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> fatigue | <input type="checkbox"/> insomnia | <input type="checkbox"/> depression | <input type="checkbox"/> S.O.B. |
| <input type="checkbox"/> sore mouth | <input type="checkbox"/> weakness | <input type="checkbox"/> drowsy | <input type="checkbox"/> Other:_____ | | | |

Behaviours: What behaviours are present as a result of pain or treatment?

- | | | | | |
|---|---------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> calling out | <input type="checkbox"/> restlessness | <input type="checkbox"/> resistant to movement | <input type="checkbox"/> not eating | <input type="checkbox"/> pacing |
| <input type="checkbox"/> not sleeping | <input type="checkbox"/> withdrawn | <input type="checkbox"/> groaning / moaning | <input type="checkbox"/> rocking | <input type="checkbox"/> new immobility |
| <input type="checkbox"/> disorientation <input type="checkbox"/> Other_____ | | | | |

Has a significant degree of pain been experienced in the past? How was that managed?

Past Medication Used For Pain Management:

Support System:

Are There Any Other Concerns Related to Pain?

Pain Diagnosis:

- Visceral** – poorly localized, referred, often gradual onset (i.e. liver, pancreas, bowel, bladder)
- Somatic** – well localized, worse with movement (i.e. muscle, bone, joint)
- Incident pain** - breakthrough pain, worse with movement (i.e. severe Osteoarthritis, bone metastases)
- Neuropathic** – burning, deep aching, possibly with numbness and tingling, caused by pressure, invasion or destruction of peripheral or central nervous tissues
- Mixed** – combination of visceral, somatic, and/or neuropathic (i.e. tumor invasion of pancreas, with spread to and destruction of vertebra)
- Unknown** – persistent pain, cause cannot be determined by history and investigations

Care Plan Updated: Yes

Signature:_____

Date: (M/D/Y)_____