

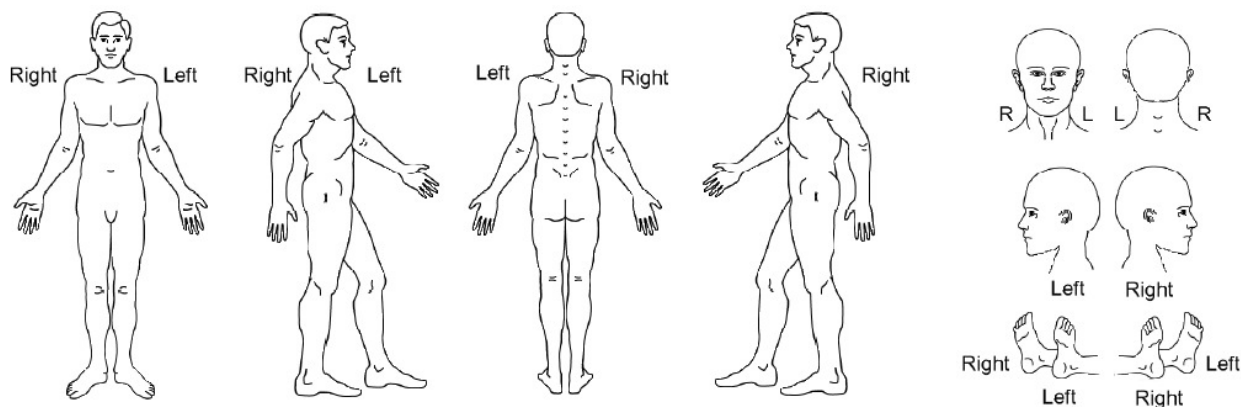
Pain Assessment Tool

Patient's Name _____ Date _____

Age _____ Diagnosis _____

Physician _____

1. LOCATION: Patient or nurse mark drawing.



2. INTENSITY: Patient rates the pain: None-1 2 3 4 5 6 7 8 9 10-Severe

Present pain: _____ Worst pain gets: _____

Best pain gets: _____ Acceptable level of pain: _____

3. Is this pain constant? (circle) YES NO If no, how often does it occur?

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. Onset, duration, variations, rhythms: _____

6. Manner of expressing pain: _____

7. What relieves the pain? _____

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8. What causes or increases the pain? _____

9. Effects of Pain: (Note decreased function, decreased quality of life.) _____

Accompanying symptoms (e.g., nausea)_____

Sleep_____

Appetite_____

Physical activity_____

Relationship with others (e.g., irritability)_____

Emotions (e.g., anger, suicidal, crying)_____

Concentration_____

10. Other Comments:_____

11. Plan:_____

Form Completed By _____

_____ Date