

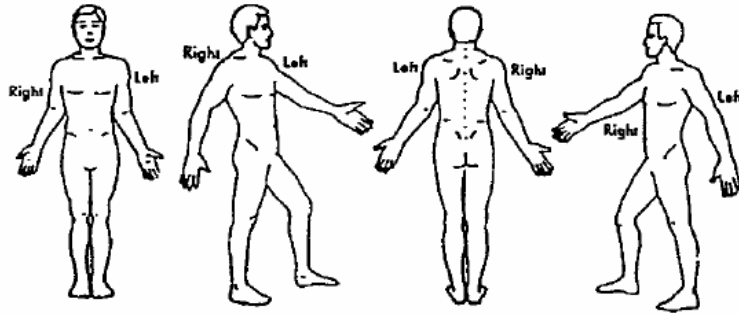
## Pain Assessment Tool

Addressograph

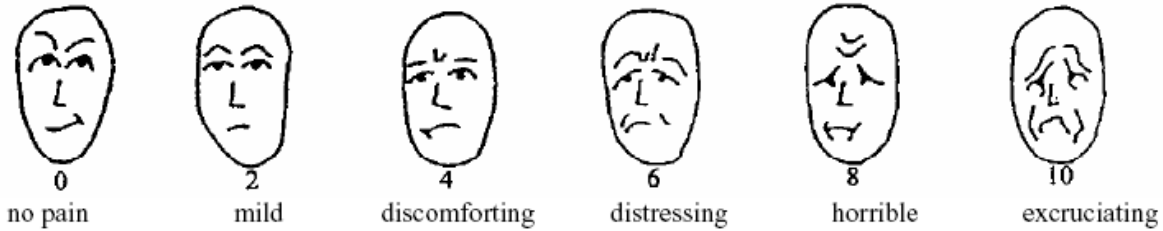
**Reason for assessment:**

- New admission   
  Readmission   
  Further Assessment  
 Change in condition   
  Quarterly

**1. Location of pain:**



**2. Severity of Pain:**



QUESTIONS	COMMENTS
What is the present level of pain? <b>(if no pain is present complete sections 6 and 7)</b>	
What is the rate when the pain is at its least?	
What makes the pain better?	
What is the rate when the pain is at its worst?	
What makes the pain worse?	
Is the pain continuous or intermittent?	
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)	

**3. 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	other: _____				

**4. Effects of pain on activities of daily living**

Activities of daily living	Yes	No	Comments
sleep and rest			
social activities			
appetite			
physical activity and mobility			
emotions			
sexuality/intimacy			

**5. Effects of pain on quality of life**

What would you like to do now that you can't do because of the pain or What activity would improve your quality of life?

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**6. 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"/> drowsy
<input type="checkbox"/> sore mouth	<input type="checkbox"/> weakness	<input type="checkbox"/> short of breath	other:			

**7. Behaviours:** What behaviours are present that may be a result of pain or treatment?

<input type="checkbox"/> calling out	<input type="checkbox"/> restlessness	<input type="checkbox"/> disorientation	<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"/> tense	<input type="checkbox"/> distressed	<input type="checkbox"/> distracted	<input type="checkbox"/> crying	<input type="checkbox"/> inexpressive
<input type="checkbox"/> fists clenched	<input type="checkbox"/> striking out	<input type="checkbox"/> knees pulled up	<input type="checkbox"/> frowning	<input type="checkbox"/> facial grimacing
<input type="checkbox"/> resistant to movement	<input type="checkbox"/> pulling or pushing away	<input type="checkbox"/> sad	<input type="checkbox"/> frighten	other

**8. Past pain management**

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

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Past use of pharmacological and non-pharmacological pain management?

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**9. Support system:** \_\_\_\_\_

**10. Other concerns related to pain** \_\_\_\_\_

**11. Nursing pain diagnosis:**

<input type="checkbox"/> visceral	<input type="checkbox"/> somatic (muscle or bone)	<input type="checkbox"/> raised intracranial pressure
<input type="checkbox"/> neuropathic	<input type="checkbox"/> mixed	<input type="checkbox"/> unknown

Date Care Plan updated: \_\_\_\_\_

Signature: \_\_\_\_\_

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