Form 1.1 Initial Pain Assessment Tool

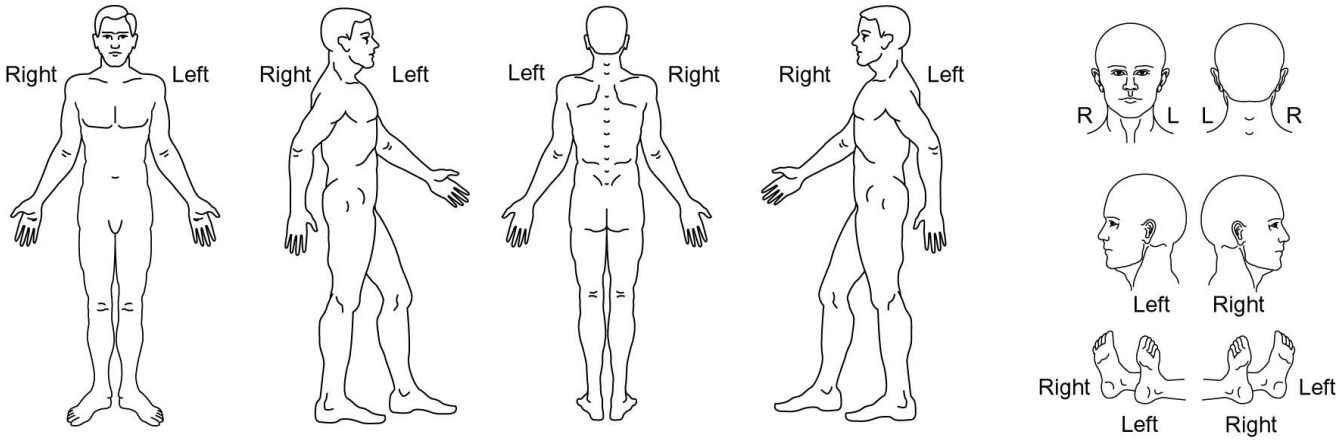
Date _____

Patient's Name _____ Age _____ Room _____

Diagnosis _____ Physician _____

Nurse _____

1. LOCATION: Patient or nurse mark drawing.



2. INTENSITY: Patient rates the pain. Scale used _____

Present pain: _____ Worst pain gets: _____ Best pain gets: _____ Acceptable level of pain: _____

3. IS THIS PAIN CONSTANT? _____ YES; ____ NO IF NOT, 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 PAIN? _____

_____

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 _____

Other _____

10. OTHER COMMENTS: _____

_____

11. PLAN: _____

_____