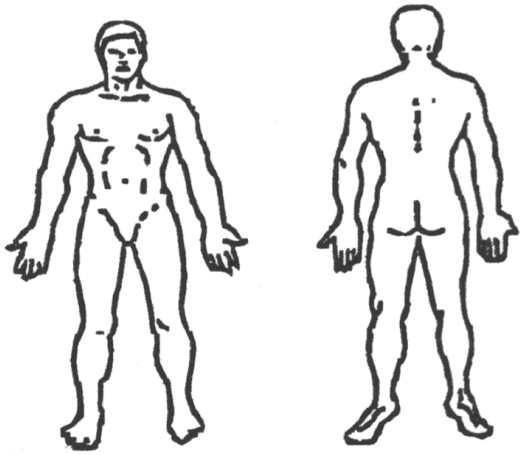
PAIN ASSESSMENT TOOL

PATIENT NAME **ADMISSION #** **DATE**

PAIN LOCATION

Indicate on figures all pain sites and label (A, B, C, etc.)



DESCRIPTION OF PAIN

Pain is worse
- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night

Onset of Pain
- ☐ Acute – 48 hours – 6 months
- ☐ Chronic – longer than 6 months

Pain feels better when _____

_____

Pain feels worse when _____

_____

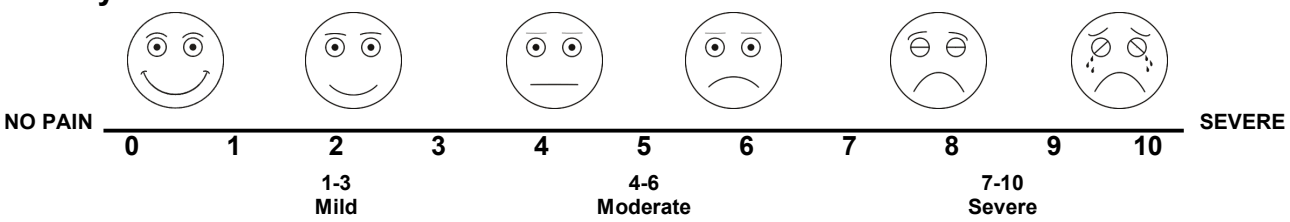
Patient Description of Pain – check all that apply

- ☐ Sharp
- ☐ Dull
- ☐ Ache
- ☐ Tingles
- ☐ Stings
- ☐ Tender
- ☐ Throbbing
- ☐ Burning
- ☐ Other _____

_____

☐ **Patient unable to describe/respond**

Intensity: **PAIN SCALE**



Pain Rating _____

NURSE performing pain assessment _____