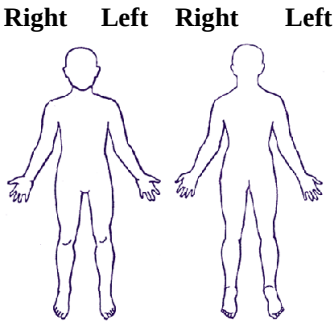
Pain Assessment Tool

Name:_____Date:_____Time:_____

1. **Where is your pain? (Indicate on the diagram below the location of your pain)**
   Does it start in one place and go to another? If so, please indicate it with an arrow



2. **Check the word that best describes your pain:**

Aching	**Sharp**	**Penetrating**
Throbbing	**Tender**	**Nagging**
Shooting	**Burning**	**Numb**
Stabbing	**Exhausting**	**Miserable**
Gnawing	**Tiring**	**Unbearable**

3. **When Did your pain start?_____**
4. **Is your pain: (Circle one) Occasional Continuous**

5. **What time of the day is your pain worse?**
   Morning Afternoon Evening Nighttime

6. **Choose the Face that best describes how you feel:**

7. **Rate your pain by circling the number that best describes your pain with 0 being no pain and 10 being the worst pain you can imagine.**

No Pain **Distressing Pain** **Unbearable Pain**

0 1 2 3 4 5 6 7 8 9 10

8. What makes your pain better_____

_____

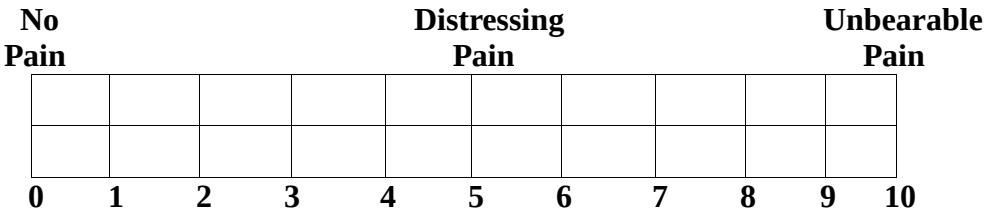
9. What makes your pain worse?_____

_____

10. What treatments or medications are you receiving for your pain?_____

_____

11. Circle the number to describe the amount of pain being felt after treatment or medication. (To establish the effects of the therapy given.)



PAIN LOG

Date	Time	Pain Site	Type of Pain	Intensity	Interven-tion Code	Intensity (30 min. & 1 Hr. after PO or IM Medications. Intensity	Time	Initials

Intervention Code:

A. Medication
B. Relaxation
C. Environmental Change
D. Humor
E. Position Change
F. Music/TV
G. Back Massage
H. Imagery
I. Rhythmic Breathing
J. Cold Therapy
K. Heat Therapy
L. Other:_____

Nurse's Signature:

_____

_____

_____

_____