# Pain Management Communication

Provider Name: _____
Patient Name: _____ DOB: _____/_____/_____

| | |
|---|---|
| ☐ Cognitively Impaired? (check if yes) | Observed Behaviors: ☐ Crying ☐"Ouch" ☐Winces ☐Bracing ☐Gasping ☐"That hurts" ☐Wrinkled forehead ☐Guarding ☐Furrowed brow ☐Rubbing body part/area ☐Clenched jaw ☐Clutching/holding body part/area during movement ☐ Guarding ☐ Other: _____ |

**Pain Intensity:**
_____ (Before meds)
_____ (After meds)

**Standard pain scale used:**
☐ Numeric Rating Scale (0-10)
☐ Verbal Descriptor Scale (no pain, mild pain, moderate pain, severe pain, extreme pain, pain as bad as could be)
☐ Faces Pain Scale
☐ PAINAD; score: _____
☐ Other: _____

**Pain Interferes with:** ☐ Sleep ☐ Ambulation ☐ Appetite ☐ Activities ☐ Transfers

**Types of Pain:**
☐ Neuropathic
☐ Nociceptive (Joint/bone/soft tissue)
☐ Other: _____

**Location(s) of Pain:** _____
_____

**Pain Pattern:** ☐ Constant ☐ Intermittent
☐ Constant with Breakthrough

**Quality of pain (use descriptive adjectives of patient):** ☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Dull ☐ Numbness ☐ Pins & Needles ☐ Sharp ☐Stabbing ☐Throbbing
☐ Other: _____

Non-pharmacological interventions: _____

Current analgesic regimen: _____

Analgesics tried in the past:_____

Relevant side effects: _____

**Treatment Suggestions**
_____
_____
☐ Patient/Family requests
☐ Nurse requests
_____
_____
Date: _____/_____/_____