Comprehensive Pain Assessment - Cognitively Intact

Name_____ **ID #**_____ **Room #** _____

Assessment Date _____ **Time**_____**Physician** _____

Individual's Pain Control Goal	Individual's Pain Intensity Goal
Check all that apply. ☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Other:_____	Circle the number that represents the pain intensity goal. 0 1 2 3 4 5 6 7 8 9 10 No Pain — Worst Pain Possible

Current Pain-related Diagnosis(es):

_____

Type of Pain: ☐ Nociceptive (Joint/bone/soft tissue) ☐ Neuropathic ☐ Mixed

Depression (yes/no): _____ Depression Scale: _____ Score: _____ Date: _____

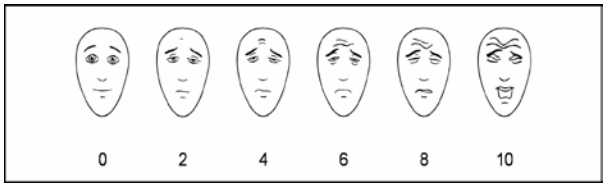
Intensity of Pain: Check Scale Used

☐ **Numerical 0-10** (circle the correct rating)

0 1 2 3 4 5 6 7 8 9 10

↑ No Pain ↑ Moderate Pain ↑ Worst Possible Pain

☐ **Faces Pain Scale-Revised (FPS-R)**



Used with permission from IASP; this figure may not be used or modified without express written consent from IASP

For FPS-R score the chosen face as 0, 2, 4, 6, 8 or 10 counting left to right with 0="no pain" and 10= "very much pain"

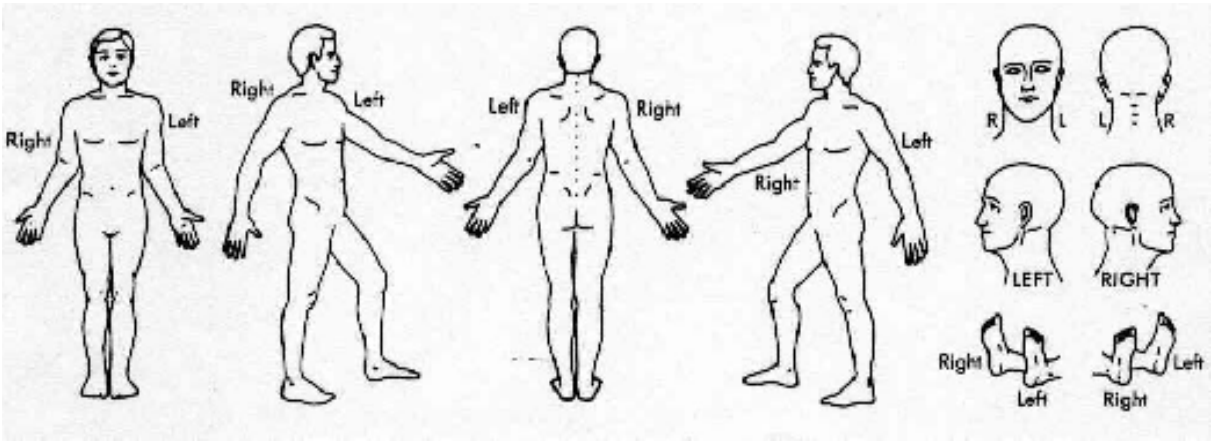
☐ **Verbal Descriptor Scale**

Circle the word(s) that best represent pain in the past week

No pain Mild pain Moderate pain Severe pain Extreme pain Worst pain possible

Location: (Individual or nurse mark drawing) Mark the areas where you feel pain. If you feel more than one sensation in same area, mark all the symbols that apply. Make sure you show all affected areas.

O Aching
/ Burning
 # Cramping
= Crushing
◆ Dull
*** Numbness**
+ Pins/needles
● Sharp
↓ Stabbing
↑ Throbbing



History of Pain

Onset of Pain: ☐New (last 7 days) ☐Recent (last 3 mos) ☐More distant (> 3 mos) ☐Unknown

Frequency of Pain: ☐Constant ☐Frequent ☐Infrequent ☐Unknown

Description of Pain: ☐Aching ☐Burning ☐Cramping ☐Crushing ☐Dull ☐Numbness

☐Pins & Needles ☐Sharp ☐Shooting ☐Throbbing ☐Other: _____

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days?

☐ Yes ☐No ☐Unknown If yes, describe change: _____

Causes/Increases in Pain: ☐Movement ☐Coughing ☐Cold ☐Heat ☐Fatigue ☐Anxiety

☐Other, describe: _____

What Relieves the Pain: ☐Cold ☐Heat ☐Exercise ☐Eating ☐Opioids ☐Non-Opioid Meds

☐Adjuvants ☐Herbals ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction

☐Other: _____

Pain Medication History: _____

_____

Effects of Pain: Using the following scale, rate how the pain has had an effect in each area in the past 24 hours: **0** (no effect) **2** (mild effect) **5** (moderate effect) **10** (severe effect)

Accompanying Symptoms (e.g., nausea) ___ Sleep Disturbance ___ Appetite Change ___
Physical Activity Change ___ Mood/Behavior ___ Concentration ___Relationship with Others ___
Other (describe): _____

Worst Pain in 24 Hours (circle correct number): 0 1 2 3 4 5 6 7 8 9 10

↑ No Pain ↑ Moderate Pain ↑ Worst Possible Pain

In the past 24 hours, how much have the medications or treatments eased your pain?

0 No relief **2** Mild relief **5** Moderate relief **8** Most Relief **10** Complete relief

Plan for Addressing Pain (check all that apply):

☐Initiate pain management flow sheet ☐Call Prescriber ☐Refer to pain team
☐Medications prescribed ☐Rehab referral (PT, OT, ST) ☐Non-med intervention
☐Spiritual counseling ☐Staff education/communication ☐ Other, describe:_____

Comments: _____

_____

Signature of person completing assessment: _____

Title: _____ **Date**: _____

Form updated 12.12.2023