

Comprehensive Pain Assessment - Cognitively Intact

Name _____ ID # _____ Room # _____

Assessment Date _____ Time _____ Physician _____

Individuals Pain Control Goal	Individuals Pain Intensity Goal
Check all that apply <input type="checkbox"/> Sleep comfortably <input type="checkbox"/> Comfort at rest <input type="checkbox"/> Comfort with movement <input type="checkbox"/> Total pain control <input type="checkbox"/> Stay alert <input type="checkbox"/> Perform desired activities <input type="checkbox"/> Other: _____	0 1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Check the correct rating)

Current Pain-related Diagnosis(es):

Reason for Assessment: MDS Admission MDS Significant Change MDS Readmission

MDS Quarterly MDS Annual New Condition Routine Monitoring

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

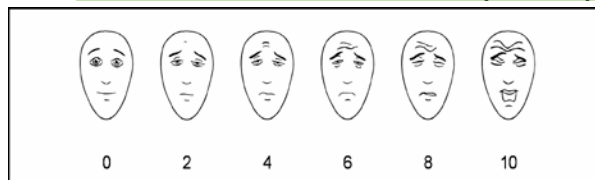
Depression (yes/no): _____ Depression Scale: _____ Score: _____ Date: _____

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)



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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 "worst possible pain"

No pain Mild pain Moderate pain Severe pain Extreme pain Pain as bad as could be

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

