

Comprehensive Pain Assessment Form

Cognitively Intact

Resident Name _____ ID # _____ Room # _____
 Assessment Date _____ Time _____ Physician _____

Residents Pain Control Goal	Residents Pain Intensity Goal
<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

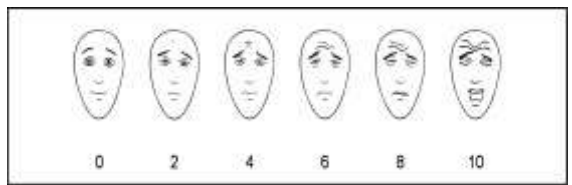
Depression (yes/no): _____ Depression Scale and Score: _____ Date: _____

Intensity of Pain: 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



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Score the chosen face as 0, 2, 4, 6, 8 or 10, counting left to right with 0= "no pain" and 10 "worst pain possible".

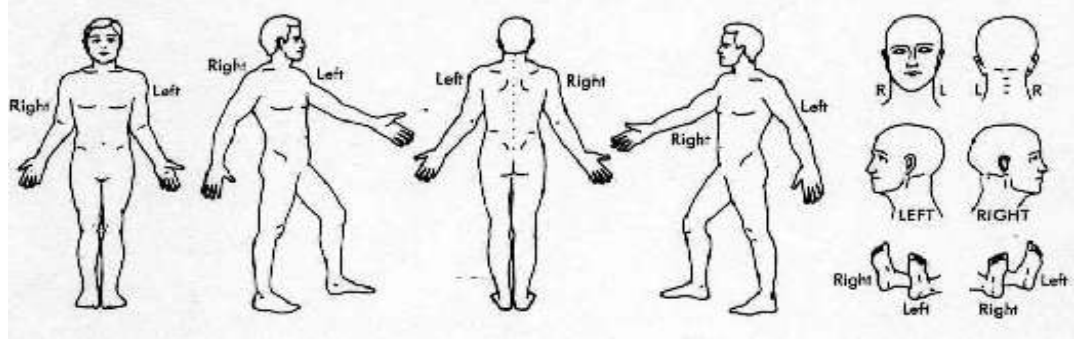
Verbal Descriptor Scale

Circle the words that best represent the intensity of your pain now.

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

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

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



History of Pain

Onset of Pain: New (within the last 7 days) Recent (within the 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, describe: _____

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days? Yes No Unknown If yes, describe the 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 Massage Relaxation Rest Repositioning Distraction Other, describe: _____

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: 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** Relief **10** Complete relief

Plan for Addressing Pain: Initiate pain management flow sheet Call Prescriber Refer to pain team Rehab referral (PT, OT, ST) Non-med intervention Medications prescribed Spiritual counseling Staff education/communication

Comments: _____

Signature/Title of person completing assessment: _____ **Date:** _____