Nursing Pain Assessment

Patient Information:

Name:

Age: Date of Birth:

Medical Record Number:

Date and Time of Assessment:

Pain Assessment:

1. Location:

Area of pain:

- 2. Intensity:
 - \Box 0 = No pain
 - □ 10 = Worst pain imaginable
 - Rate of current pain: _____
- 3. Quality:

Type of pain:

- 4. Onset and Duration:
 - When did it start?

Is it constant, or does it come and go?

How long does each episode of pain last?

5. Aggravating and Alleviating Factors:

What makes the pain worse?

What makes the pain better?

- 6. Associated Symptoms:
- 7. Impact on Activities of Daily Living (ADLs):
- 8. Pain Relief Measures Used:

9. Medication History:

10. Emotional and Psychological Impact:

11. Coping Mechanisms:

12. Patient Goals and Preferences:

Plan of Care:

Follow-up: _____