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:

   ☐ 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: _____