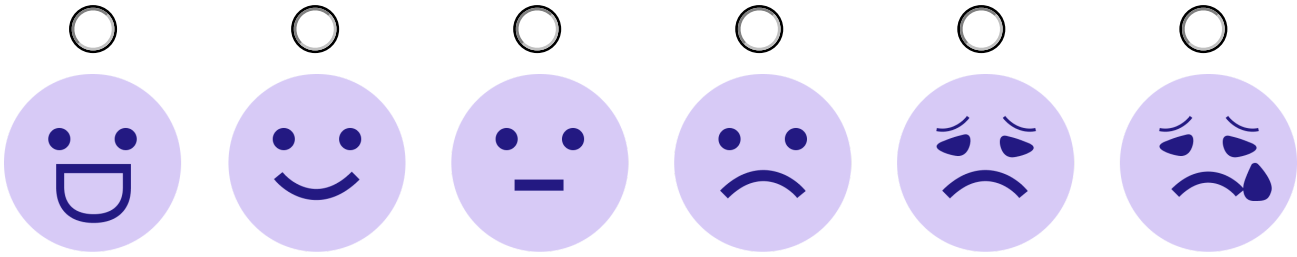
Pain Assessment

Patient information	
Name:	**Date of birth:**
Gender:	**Date of assessment:**
***Directions**: Begin by collecting the client's basic information and relevant medical history. Proceed with a structured assessment using the PQRSTU pain evaluation framework and the Wong-Baker Faces Pain Rating Scale to accurately measure and document the client's pain. Supplement this with additional questions to gain deeper insight into the pain's nature, duration, intensity, and its overall impact on the client's daily functioning.*	

Pain assessment methods	
PQRSTU	**Description/questions**
P - Provocation / palliation	What makes the pain better or worse? What activities or movements exacerbate or alleviate the pain?
Q - Quality	How would you describe the pain? Is it sharp, dull, aching, burning, or stabbing?
R - Region/radiation	Where is the pain located? Does it radiate to other parts of the body?
S - Severity	On a scale of 0-10, how severe is the pain?
T - Timing	When did the pain start? How long does it last? Does it occur at a certain time of the day or in response to specific activities?
U - Understanding	How does the pain affect your daily life and activities? What do you think is causing the pain?

Wong-Baker faces pain rating scale
Please select the face that best represents the intensity of your pain:



0
No hurt

2
Hurts
little bit

4
Hurts
little more

6
Hurts even
more

8
Hurts
whole lot

10
Hurts
worst

Additional question	
Onset	When did the pain start? Was there a specific event that triggered the pain?
Duration	How long has the pain been present? Is it consistent, or does it come and go?
Emotions	How does the pain make you feel emotional?
Medications	Have you taken any medications for the pain? If so, what and did it help?
Previous treatment	Have you had any treatments for the pain in the past? If so, what were they, and did they help?
Allergies	Do you have any allergies to medication?
Other symptoms	Are there any other symptoms that you are experiencing in addition to the pain?

Impact of activities of daily living (ADLs)	How is the pain affecting your ability to perform daily activities such as work, hobbies, and exercise?
Sleep disturbances	Is the pain causing you to have difficulty sleeping or staying asleep?
Goal of treatment	What is your goal for managing the pain?
Other concerns	Do you have any other concerns related to the pain or its management?

Notes or remarks

Healthcare professional information	
Name:	**License ID:**
Signature:	**Date of assessment:**