

# PQRST Pain Assessment

Name:		Date:
Health concern:		
PQRST Assessment	Pain Assessment Questions	Answer
<b>Provocation</b>	What triggers the pain (e.g. movement, pressure, touch, etc.)?	
<b>Quality</b>	How would you describe the pain (e.g. stabbing, burning, dull, etc.)?	
<b>Region/Radiation</b>	Does the pain stay in one region or does it radiate to other parts of your body?	
<b>Severity</b>	How would you rate the severity of your pain on a scale of 0 to 10 (0 being no pain, 10 being the worst pain imaginable)?	
<b>Time</b>	How long have you been experiencing the pain? Is it constant or intermittent?	
<b>Additional notes</b>		