Comprehensive Pain Assessment Form
Cognitively Intact

Name_____ **ID #**_____ **Room #** _____

Assessment Date _____ **Time** _____ **Health Care Provider** _____

Individual's Pain Control Goal	Individuals Pain Intensity Goal
☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Perform desired activities ☐ Other:_____	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (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

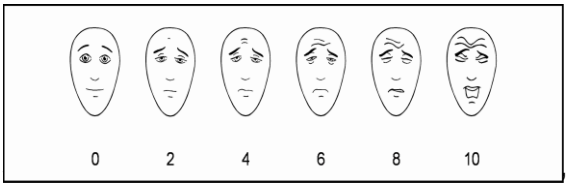
Depression (yes/no): ____ Depression Scale:_____Score:_____Date:_____

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**



counting left to right with 0= "no pain" and 10 the intensity of your pain now.

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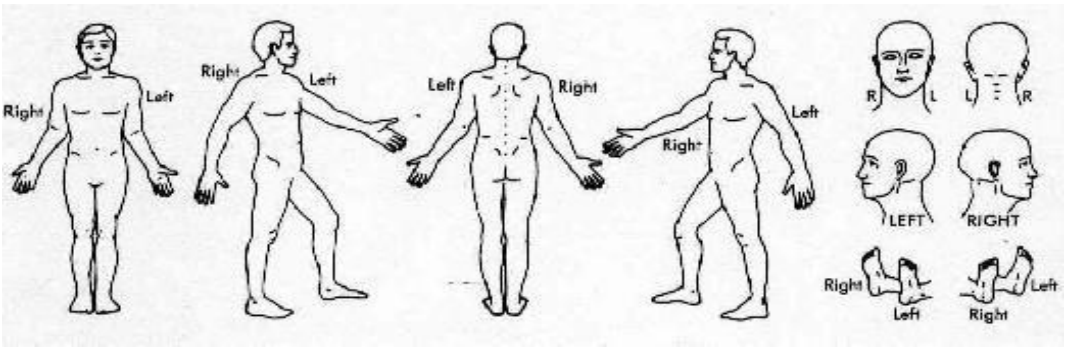
☐**Verbal Descriptor Scale**
Circle the words that best represent "worst pain possible".

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

Location: (Individual 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.

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



History of Pain

Onset of Pain: ☐New (last 7 days) ☐Recent (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: _____

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 ☐EatingOpioids ☐Non-Opioid Meds
☐Adjuvants ☐Herbals ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction
☐Other: _____

Pain Medication History: _____

_____

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
☐ Other, describe: _____

Comments: _____

_____

_____

Signature of person completing assessment: _____

Title: _____**Date**: _____