Comprehensive Pain Assessment Form
Cognitively Intact

Name_________________________ ID #________ Room #________
Assessment Date _______ Time _______ Health Care Provider ________________________

Individual’s Pain Control Goal
☐ Sleep comfortably
☐ Comfort at rest
☐ Comfort with movement
☐ Total pain control
☐ Stay alert
☐ Perform desired activities
☐ Other: _______________________

Individuals Pain Intensity Goal

<table>
<thead>
<tr>
<th>Scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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(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  ↑ Worst Possible
↑ Pain     Pain

☐ 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.

 основанewith permission from IASP; this figure may not be used or modified without express written consent from IASP
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 □ Eating Opioids □ 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: __________

Reviewed and Updated 9.7.15