

NEW PAIN ASSESSMENT

Date: _____

PAIN ASSESSMENT / STATUS:

Do you have pain now? Yes; No

What causes or increases your pain?

What relieves your pain? _____

Education:

___ verbal review of pain management.

Frequency of pain- _____

*number occurrences of pain

Nurse: _____

Location(s) of Pain: 1. _____;

Does pain radiate? Yes; No

Where does pain radiate to? _____

Pain intensity (0 - 10 or smile to crying): _____

Onset of pain (time / activity): _____

Quality of pain: burning; squeezing; tightness; crushing;
 heavy; sharp; dull; stabbing; cramping; searing/burning;
 ache; throb; other: _____

Duration: intermittent; constant

Effects of Pain: ___ on daily life _____;

physical activity: decreased; unaffected

sleep: insomnia; somnulent; unaffected

appetite: decreased; unaffected; increased

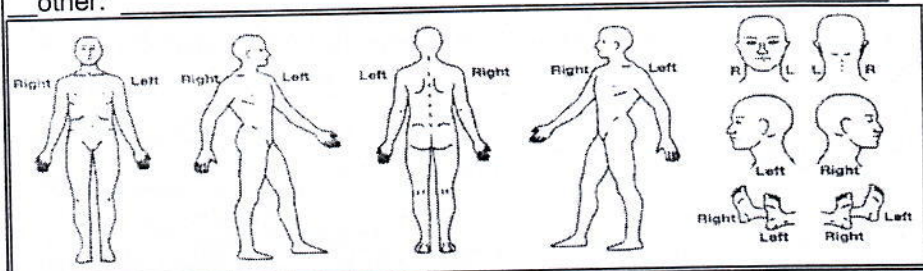
emotions: tearful; sad; angry; unaffected

concentration: decreased; unaffected

relationships with others: strained; unaffected

Patient pain goal (include intensity & goals related to function, activity, and quality of life): _____

Observation of pain site(s): no visible abnormalities;
 other: _____



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Onset of pain (time / activity): _____

Quality of pain: burning; squeezing; tightness; crushing;
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 ache; throb; other: _____

Duration: intermittent; constant *how long pain lasted

Effects of Pain: ___ on daily life _____;

physical activity: decreased; unaffected

sleep: insomnia; somnulent; unaffected

appetite: decreased; unaffected; increased

emotions: tearful; sad; angry; unaffected

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