

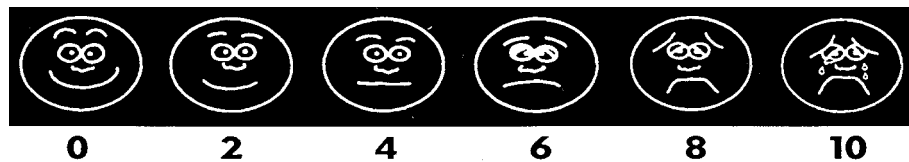
A. Pain Assessment

1. Believe the pain to be whatever the patient says it is.
2. Location of pain: Patient to point to area/areas where he/she is having pain.
Ask patient what new or unusual sensation or physical feeling he/she has had or is having.
3. Quality of pain
 - A) Somatic Pain (well localized)
Pain in skin, bone
Described as: Aching, Stabbing, Throbbing, Pressure
Use: NSAIDS
 - B) Visceral Pain (Poorly localized)
Pain in organs or viscera
Described as: Gnawing, Crampy, Aching, Sharp
Use: Steroids
 - C) Neuropathic Pain
Pain in nerves
Described as: i. Burning, tingling, allodynia (antidepressants & steroids)
ii. Shooting, lancinating, chronic neuralgias (anticonvulsants & steroids)
4. Identify intensity of pain with one of the following tools:

Verbal Pain Scale

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain		Severe pain		Very severe pain		Worst possible pain

Visual Tool



Non-Communicative Tool

VERBAL/VOCAL		BODY MOVEMENT		FACIAL		TOUCHING	
0	Positive	0	Moves easily	0	Smiling	0	No touching
2-4	Whimper/moan	5	Neutral, shifting, pacing	2-4	Neutral	5	Rubbing, patting
5-7	Repetitive comment, crying	10	Tense, not moving	5-7	Frown, grimace	10	Clenched, tight muscles
8-10	Screaming			8-10	Clenched teeth, depressed brow line		

5. Identify acceptable level of pain control.
6. History: Etiology, Onset, Duration, Course, Aggravating and Alleviating Factors
7. Assess associated symptoms: Nausea, Anorexia, Sleep disturbance
8. Psychosocial/Spiritual Pain Assessment
 - Patient/Family distress
 - Substance Abuse
 - Family Support
 - Spiritual/Religious Issues
 - Psychiatric history
 - Special Issues