

FLACC Behavioral Scale

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractable	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

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FLACC Behavioral Pain Scale

Patients who are awake: Observe for at least 2-5 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed

Patients who are asleep: Observe for at least 5 minutes or longer. Observe body and legs uncovered. If possible reposition the patient. Touch the body and assess for tenseness and tone.

Face

Score 0 point if patient has a relaxed face, eye contact and interest in surroundings

Score 1 point if patient has a worried look to face, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed

Score 2 points if patient has deep furrows in the forehead, with closed eyes, open mouth and deep lines around nose/lips

Legs

Score 0 points if patient has usual tone and motion to limbs (legs and arms)

Score 1 point if patient has increase tone, rigidity, tense, intermittent flexion/extension of limbs

Score 2 points if patient has hyper tonicity, legs pulled tight, exaggerated flexion/extension of limbs, tremors

Activity

Score 0 points if patient moves easily and freely, normal activity/restrictions

Score 1 point if patient shifts positions, hesitant to move, guarding, tense torso, pressure on body part

Score 2 points if patient is in fixed position, rocking, side-to-side head movement, rubbing body part

Cry

Score 0 points if patient has no cry/moan awake or asleep

Score 1 point if patient has occasional moans, cries, whimpers, sighs

Score 2 points if patient has frequent/continuous moans, cries, grunts

Consolability

Score 0 points if patient is calm and does not require consoling

Score 1 point if patient responds to comfort by touch or talk in ½- 1 minute

Score 2 points if patient requires constant comforting or unable to console

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decision making regarding treatment of pain requires careful consideration of the context in which the pain behaviors were observed.

Each category is scored on the 0-2 scale which results in a total score of 0-10

Assessment of Behavioral Score:

0 = Relaxed and comfortable

1-3 = Mild discomfort

4-6 = Moderate pain

7-10 = Severe discomfort/pain