

**INITIAL PAIN ASSESSMENT  
FOR PEDIATRIC USE ONLY**

**I. Location of Pain**

A. [Anatomical figure could not be reproduced.]    B. Word used for pain (eg ouchie, dolor)

**II. Intensity:** Scale used (0-10 or Wong-Baker faces) \_\_\_\_\_

Main source of information:

Parent

Child

**III. Aggravating factors**

Coughing/Deep breathing

Anxiety/Fear

Treatment/Procedure

Movement/Positioning

Parents not present

Other

**III. Alleviating factors**

Repositioning

Toileting/Feeding

Play

Parents present

Verbal support

Holding/rocking

Other

**V. Effects of pain**

Accompany symptoms

Sleep

Appetite changes

Quiet/withdrawn

Irritability/crying

Physical activity

Other

**VI. Nurses Assessment of pain**

(circle below)

A. Verbal/Vocal

0 = positive

1=other complaint, whimper

2=pain, crying

B. Body movement

0=moves easily

1=neutral shifting

2=tense, flailing arms & legs

C. Facial

0=smiling

1=neutral shifting

2=frown, grimace

3=clenched teeth

D. Touching (localizing pain)

0=no touching

1=reaching, patting

2=grabbing

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**VII. Comments and Plan for pain management**