INITIAL PAIN RATING TOOL
(Use in conjunction with Pain Flow Sheet)

Pain ❑ No Pain ❑ Date of Onset _____ \_____ \_____

Diagnosis: ____________________________________________________________

Locations: (Indicate on Drawing) _______________________________________

Pattern: Constant ___________ Intermittent ___________ Other ___________

Intensity: Patient rates the pain on 0-10 scale

At this time: 1 2 3 4 5 6 7 8 9 10
Worse pain gets: 1 2 3 4 5 6 7 8 9 10
Best pain gets: 1 2 3 4 5 6 7 8 9 10

How does patient describe pain:
❑ Shooting ❑ Prick ❑ Throb ❑ Pull ❑ Dull
❑ Ache ❑ Burn ❑ Sharp ❑ Other _________________

What relieves pain? Medication ___________________________
❑ Eating ❑ Massage ❑ Relaxation techniques
❑ Rest ❑ Heat ❑ Other ___________________________
❑ Sleep ❑ Cold ❑ Other ___________________________
❑ Repositioning ❑ Exercise ___________________________

What causes pain to increase? ___________________________________________

Indicate how pain affects:
(Note – decreased function, decreased quality of life.)

Sleep ________________________________________________________________
Mood ________________________________________________________________
Activity ______________________________________________________________
Nutrition ______________________________________________________________
Elimination _____________________________________________________________
Social Interaction ______________________________________________________
Self Image _____________________________________________________________
Sexuality ______________________________________________________________

Is there anything else you want to tell me about the pain? (Use patient’s own words)

_____________________________________________________________________

Initials of Nurse Completing Form

PainAssessTool.doc-11/92
**SEDATION SCALE**

0 = None  
1 = Mild (easy arouse: occasionally drowsy)  
2 = Moderate (frequently drowsy; easy to arouse)  
3 = Severe (somnolent; difficult to arouse)  
S = Normal sleep (easy to arouse)

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**PAIN FLOW SHEET**

<table>
<thead>
<tr>
<th>Date/Time</th>
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<tbody>
<tr>
<td>Nurse Initials</td>
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<td>Med(s) Dose</td>
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<td>Non-Med Intervention</td>
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<tr>
<td>Most Intense Pain</td>
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<td>9</td>
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<td>Use number</td>
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<td>Scale or</td>
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<tr>
<td>Patient’s Own Words</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>No Pain Sensation</td>
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<td>Respiratory Rate</td>
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<td>Sedation Rating**</td>
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<td>B.M.</td>
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<tr>
<td>Nausea/Vomiting</td>
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<td>Comments: Appetite, Activity, Depression Anxiety Other</td>
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