Pain Assessment

Resident Name________________________ Apt#__________________________

1. Does Resident have the ability to pinpoint pain? _____ Yes _____ No
   If No, Reason: ______________________________________________________

2. Location of pain: mark and assign letters to each site

3. Does the resident have a pain related diagnosis?
   Check all that apply:
   - Cancer
   - Neuropathy
   - Circulatory
   - Arthritis
   - Surgical DX
   - MI
   - CVA
   - GI

4. Intensity: Scale Used, Resident rates the pain (0-10 Numeric pain distress scale)
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Distressing Pain</td>
<td>Unbearable pain</td>
<td></td>
<td></td>
<td></td>
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   Site | Present | Worse pain gets | Best pain gets | Acceptable level

5. Does the Resident have non-verbal signs/symptoms of pain?
   Check all that apply:
   - Agitation
   - Wincing
   - Guarding
   - Depression
   - Decreased joint ROM
   - Rubbing
   - Decreased functional status
   - Redness
   - Holding
   - Change in LOC
   - Swelling
   - Weight Loss
   - Bruising
   - Facial grimacing

6. Resident description of pain: (Use resident's own words, e.g., prick, ache, burn, throb, pull, sharp)
   ________________________________________________________________________
   ________________________________________________________________________

7. What relieves the pain? ____________________________________________________

8. What causes or increases the pain? ___________________________________________

9. Effects of pain: (note decreased function, decreased quality of life)
   a. Accompanying symptoms (e.g. Nausea) _____________________________________
   b. Sleep ________________________
c. Appetite

d. Physical Activity

e. Emotions (e.g., anger, crying)

f. Other

10. Non-drug Interventions (mark "X" for interventions currently being used, mark "I" for interventions tried and proven to be ineffective):

<table>
<thead>
<tr>
<th>Heat / Cold</th>
<th>Exercise</th>
<th>Relaxation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immobilization</td>
<td>Massage / Touch</td>
<td>TENS Unit</td>
</tr>
<tr>
<td>Positioning</td>
<td>P.T.</td>
<td>Imagery</td>
</tr>
<tr>
<td>Distraction (explain)</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

11. Current Drug Interventions:

____________________________________________________________________________________

12. Other Comments:

____________________________________________________________________________________

13. Plans:

____________________________________________________________________________________

Proceed to care plan__________  Do Not Proceed__________  Date: ______________
RCM signature: ______________  Date: ______________

<table>
<thead>
<tr>
<th>Date</th>
<th>Quarterly Review</th>
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LN Sign____________________

LN Sign____________________

LN Sign____________________

Resident Name: ___________________________  Apt # __________