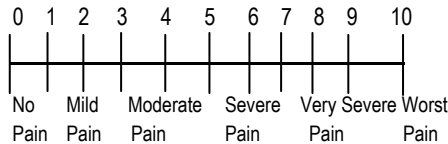


**Pain Scale Record**

Patient Name: \_\_\_\_\_ MR #: \_\_\_\_\_ Date: \_\_\_\_\_

Oriented	Nurse Observation	Pain Site / Location	Quality/Intensity (Use Patient's own words)	Current Treatment Plan of Care	Measures that alleviate pain	Factors that cause or increase pain	Effects of pain, Impact on functional ability/quality of life	Code response to treatment
<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = X 1 <input type="checkbox"/> 2 = X 2 <input type="checkbox"/> 3 = X 3	<input type="checkbox"/> Complaining <input type="checkbox"/> Crying <input type="checkbox"/> Moaning <input type="checkbox"/> Fidgeting <input type="checkbox"/> Restless <input type="checkbox"/> Muscle Rigidity <input type="checkbox"/> Resistiveness <input type="checkbox"/> Wrinkled Brow <input type="checkbox"/> Facial Grimacing <input type="checkbox"/> Sad/Worried Look <input type="checkbox"/> Frightened <input type="checkbox"/> Tense <input type="checkbox"/> Withdrawal <input type="checkbox"/> Anger <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Other	<input type="checkbox"/> Back pain <input type="checkbox"/> Bone pain <input type="checkbox"/> Chest pain <input type="checkbox"/> Headache <input type="checkbox"/> Hip pain <input type="checkbox"/> Incisional <input type="checkbox"/> Joint <input type="checkbox"/> Soft tissue <input type="checkbox"/> Stomack pain <input type="checkbox"/> Other	<input type="checkbox"/> Ache <input type="checkbox"/> Burn <input type="checkbox"/> Prick <input type="checkbox"/> Throbbing <input type="checkbox"/> Pulling <input type="checkbox"/> Sharp <input type="checkbox"/> Gnawing <input type="checkbox"/> Shock-like <input type="checkbox"/> Radiating <input type="checkbox"/> Upon movement <input type="checkbox"/> Other as discomfort soreness or pressure	<input type="checkbox"/> Pain medication <input type="checkbox"/> Routine medication dose/route interval <input type="checkbox"/> PRN time given medication dose/route <input type="checkbox"/> None <input type="checkbox"/> Other	<input type="checkbox"/> Massage <input type="checkbox"/> Cold/heat therapy <input type="checkbox"/> Repositioning <input type="checkbox"/> Deep breathing/coughing exercises <input type="checkbox"/> Relaxation techniques <input type="checkbox"/> Routine medication <input type="checkbox"/> PRN medication <input type="checkbox"/> Talking <input type="checkbox"/> Stretching <input type="checkbox"/> Music <input type="checkbox"/> Warm baths <input type="checkbox"/> Other	<input type="checkbox"/> Motion affecting incision area <input type="checkbox"/> Fear & emotional distress <input type="checkbox"/> Inflammation <input type="checkbox"/> Infection <input type="checkbox"/> Trauma or disease state <input type="checkbox"/> Position change <input type="checkbox"/> Environmental stressors <input type="checkbox"/> Fatigue <input type="checkbox"/> Inadequate pain relief measures <input type="checkbox"/> Other	<input type="checkbox"/> Affects transfers & ambulation <input type="checkbox"/> Affects appetite <input type="checkbox"/> Affects ADL's <input type="checkbox"/> Affects concentration <input type="checkbox"/> Affects mood <input type="checkbox"/> Affects attending activities <input type="checkbox"/> Affects sleep <input type="checkbox"/> Affects relationships <input type="checkbox"/> Nausea/Emesis <input type="checkbox"/> Other	<input type="checkbox"/> 0 = No pain present <input type="checkbox"/> 1 = Improved, still in pain but not bother some <input type="checkbox"/> 2 = Improved, still in pain affects/functioning activities <input type="checkbox"/> 3 = No improvement <hr/> <input type="checkbox"/> S = Sleeping, easily aroused <input type="checkbox"/> 1 = Alert and awake <input type="checkbox"/> 2 = Drowsy but arousable <input type="checkbox"/> 3 = Minimum pain or no response to stimuli <input type="checkbox"/> 4 = Coma

Intensity: The 0 - 10 rating given by the patient using Numeric Pain Ruler or Face Scale



**Narrative Notes: Nurse or Patient**

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