PAIN ASSESSMENT TOOL

PATIENT NAME

ADMISSION # DATE

PAIN LOCATION

Indicate on figures all pain sites and label (A, B, C, etc.)

DESCRIPTION OF PAIN

Pain is worse
☐ Morning
☐ Afternoon
☐ Evening
☐ Night

Onset of Pain
☐ Acute – 48 hours – 6 months
☐ Chronic – longer than 6 months

Pain feels better when _____________________________________

Pain feels worse when _____________________________________

Patient Description of Pain – check all that apply

☐ Sharp
☐ Dull
☐ Ache
☐ Tingles
☐ Stings
☐ Tender
☐ Throbbing
☐ Burning
☐ Other _____________________________________

☐ Patient unable to describe/respond

Intensity: PAIN SCALE

NO PAIN

0 1 2 3 4 5 6 7 8 9 10 SEVERE

1-3 Mild
4-6 Moderate
7-10 Severe

Pain Rating ______________________

NURSE performing pain assessment ____________________________________________

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