dacs
DEMENTIA & AGED CARE SERVICES

BRIEF PAIN ASSESSMENT	
Client Name:	**Client Date of Birth:**

Pain Assessment		
Use the Body Diagram to shade the areas where the client feels pain, mark an X on the areas that hurt the most		
1	Please rate out of 10 what best describes your pain when it was at its worst in the last week:	/10
2	Please rate out of 10 what best describes your pain when it was at its least in the last week:	/10
3	Please rate out of 10 what best describes your pain on the average:	/10
4	Please rate out of 10 what best describes how much pain you have right now:	/10
5	What kinds of things make your pain feel better (eg, heat, medicine, rest)?	
6	What kinds of things make your pain worse (eg, walking, standing, lifting)?	
7	What treatments or medications are you receiving for your pain?	
8	In the last week, how much pain relief have pain treatments or medications provided?	
9	If you take pain medication, how many hours does it take before the pain returns? (Please circle)	

Pain medication doesn't help at all	One hour	Two hours	Three hours
Four hours	Five to twelve hours	More than twelve hours	I do not take pain medication

10	I believe my pain is due to:	
	○ The effects of treatment (medication, surgery, radiation, prosthetic device)	
	○ My primary disease (meaning the disease currently being treated and evaluated)	
	○ A medical condition unrelated to primary disease (eg, arthritis)	
11	For each of the following words circle the adjective that applies to your pain	

Aching	Throbbing	Shooting	Stabbing
Gnawing	Sharp	Tender	Burning
Exhausting	Tiring	Penetrating	Nagging
Numb	Miserable	Unbearable	Other

12	Please describe how during the past week pain has interfered with your general activity
13	Please describe how during the past week pain has interfered with your mood
14	Please describe how during the past week pain has interfered with your walking ability
15	Please describe how during the past week pain has interfered with your relations with other People
16	Please describe how during the past week pain has interfered with your sleep
17	Please describe how during the past week pain has interfered with your enjoyment of life

Assessment Completion	
Name of person completing the assessment:	Designation:
Date and time assessment completed:	Signature:
Date uploaded to iCare:	