dacs
DEMENTIA & AGED CARE SERVICES

BRIEF PAIN ASSESSMENT

Client Name:	Date of Birth:

Pain Assessment

Use the Body Diagram (DACSHCP-F-135)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 (e.g., heat, medicine, rest)?

6 What kinds of things make your pain worse (e.g., 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 tick)*

☐ Pain medication does not help ☐ On 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: *(please tick)*

☐ 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 (e.g., arthritis)

11 For each of the following words tick 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 VisualCare: