

Montana Mental Health Nursing Care Center Pain Assessment

Resident _____ Physician _____ Adm. No. _____

Date _____ Diagnosis _____

Pain No Pain Date of onset _____

1. Description (descriptors offered by resident) _____

2. Location (note on drawing)

3. Severity (Scale 0-10, no pain – most intense)

4. Constant Intermittent

5. History of pain (Have they had pain like this before?) _____

6. Associated Symptoms:

Dizziness <input type="checkbox"/>	Nausea <input type="checkbox"/>	Pallor <input type="checkbox"/>	Redness <input type="checkbox"/>
Photosensitivity <input type="checkbox"/>	Diaphoresis <input type="checkbox"/>	Incontinence <input type="checkbox"/>	Swelling <input type="checkbox"/>
Feeling Faint <input type="checkbox"/>	Flushing <input type="checkbox"/>	Weakness <input type="checkbox"/>	Warmth <input type="checkbox"/>

Mood _____ Participation in ADLs _____

Sleep _____ Eating _____ Mobility _____

7. What has relieved pain? (according to resident) _____

8. Present Medications _____

9. Other methods used to relieve pain _____

10. Breakthrough Pain _____

Signature: _____