Pain Assessment

Pain Assessment is a first step in supporting a patient requiring palliative care. A pain assessment survey helps determine the characteristics of pain, including its location, intensity, duration, and impact on daily life. The survey can also identify factors influencing pain perception, such as stress and anxiety, and may explore pain management strategies and patient goals.

Questions for Patient		**Notes**
Pain Intensity	Ask the patient to rate their pain on a scale(e.g. 0-10, with 0 being no pain and 10 the worst pain imaginable)	
Pain location	Determine where the pain is located and if it radiates to other areas	
Pain quality	Ask the patient to describe the pain (e.g., sharp, dull, burning, throbbing, aching).	
Pain duration	Determine how long the pain has been present and how long each episode lasts.	
Aggravating and alleviating factors	Ask what makes the pain worse or better (e.g. movement, rest, medication, position).	
Impact on function	Assess how the pain affects the patient's ability to perform daily activities, work and social interactions.	
Observation and Physical Assessment	Look for signs of pain such as grimacing	
Nonverbal cues	Look for signs of pain, such as grimacing, moaning, guarding, or changes in posture	
Physical Examination	Conduct a physical examination to identify any underlying causes of the pain	
Range of Motion	Assess the patient's ability to move the affected area.	
Palpation	Gently palpate the area to assess for tenderness, swelling, or other abnormalities.	
Inspection	Look for any signs of inflammation, discoloration, or other abnormalities	