

# Pain—Admission Screening and Comprehensive Assessment

Resident Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_  New admission  Re-admission  Other \_\_\_\_\_

## Pain Screening *(you must attempt the interview questions with the resident and/or their representative)*

1. Do you have pain or hurting anywhere now?  Yes  No 2. Have you had any pain or hurting in the last 5 days?  Yes  No

### **Pain-related diagnoses** *(check all that apply)*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> CVA/post stroke           | <input type="checkbox"/> Lower back disorder          | <input type="checkbox"/> Other musculoskeletal   |
| <input type="checkbox"/> Amputation            | <input type="checkbox"/> Dental problems           | <input type="checkbox"/> Neuropathy                   | <input type="checkbox"/> Unspecified             |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Fracture                  | <input type="checkbox"/> Osteoporosis/osteopenia      | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Postoperative                | _____  |
| <input type="checkbox"/> Compression fractures | <input type="checkbox"/> Headache                  | <input type="checkbox"/> Pressure ulcers/skin lesions | _____  |
| <input type="checkbox"/> Contractures          | <input type="checkbox"/> Joint replacement/pinning | <input type="checkbox"/> Shingles                     |  |

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Comprehensive Pain Assessment

### I. Staff assessment of pain monitoring data collected since admission or last MDS

Review the MAR, PRN sheet, resident's self-report of pain location, quality, and intensity, resident's self-report of pain relief obtained through drug and nondrug interventions.

### II. Pain assessment interview *(you must attempt the interview questions with the resident and/or representative)*

1. Do you have pain or hurting anywhere now?  Yes  No  
2. Have you had any pain or hurting in the last 5 days?  Yes  No  
3. When you have pain, where is it? *(check all that apply)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Back pain _____                        | <input type="checkbox"/> Hip pain _____             | <input type="checkbox"/> Neck pain _____         |
| <input type="checkbox"/> Bone pain _____                        | <input type="checkbox"/> Incisional pain _____      | <input type="checkbox"/> Stomach pain _____      |
| <input type="checkbox"/> Chest pain with usual activities _____ | <input type="checkbox"/> Joint pain (not hip) _____ | <input type="checkbox"/> Unspecified _____       |
| <input type="checkbox"/> Headache _____                         | <input type="checkbox"/> Muscle pain _____          | <input type="checkbox"/> Other (describe): _____ |

4. Tell me what the pain feels like. *(check all that apply; circle R for radiating or L for localized)*

- |                                   |   |   |                                    |   |   |  |   |   |  |
|-----------------------------------|---|---|------------------------------------|---|---|--|---|---|--|
| <input type="checkbox"/> Aching   | R | L | <input type="checkbox"/> Numbing   | R | L | <input type="checkbox"/> Stabbing      | R | L | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Burning  | R | L | <input type="checkbox"/> Pressure  | R | L | <input type="checkbox"/> Throbbing     | R | L | _____ R L  |
| <input type="checkbox"/> Crushing | R | L | <input type="checkbox"/> Prickling | R | L | <input type="checkbox"/> Tingling      | R | L | _____ R L  |
| <input type="checkbox"/> Dull     | R | L | <input type="checkbox"/> Sharp     | R | L | <input type="checkbox"/> Tender        | R | L |  |
| <input type="checkbox"/> Gnawing  | R | L | <input type="checkbox"/> Sore      | R | L | <input type="checkbox"/> Uncomfortable | R | L |  |

5. How would you rate the intensity of your pain now or during the last 5 days? *(indicate which scale was used)*

- Numeric scale 1–10: \_\_\_\_\_  Numeric scale 1–5: \_\_\_\_\_  Faces scale: \_\_\_\_\_  Verbal descriptor: \_\_\_\_\_

6. How much of the time have you experienced pain or hurting in the last 5 days? *(check one)*

- Almost constantly  Daily or several times a day  Less than daily  Rarely  Unable to answer

7. When you have pain, when is it the worst? *(check all that apply)*

- Early morning  Mid-morning  Afternoon  Late evening  Night

8. How does your pain affect your everyday life? *(check all that apply)*

- |                                   |  |  |                                       |
|-----------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Sleep    | <input type="checkbox"/> Therapy or activities of choice | <input type="checkbox"/> Interaction with other people       | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Concentration                   | <input type="checkbox"/> Ability to bathe, groom, dress self | _____                                 |
| <input type="checkbox"/> Nausea   | <input type="checkbox"/> Emotions                        |  |                                       |

## Comprehensive Pain Assessment (continued)

9. What medications have relieved your pain in the past? \_\_\_\_\_  
\_\_\_\_\_

10. What nondrug approaches make your pain better?

- |   |                                     |  |  |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> Warm packs               | <input type="checkbox"/> Cold packs | <input type="checkbox"/> Repositioning | <input type="checkbox"/> Rest                    |
| <input type="checkbox"/> Breathing and relaxation |                                     | <input type="checkbox"/> Exercise      | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Distraction              |                                     | <input type="checkbox"/> Massage       | _____  |

11. What makes your pain worse? (check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Physical activity/exercises | <input type="checkbox"/> Bathing                  | <input type="checkbox"/> Feeling anxious         |
| <input type="checkbox"/> Dressing changes            | <input type="checkbox"/> Rising from a chair, bed | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Turning/Repositioning       | <input type="checkbox"/> Feeling fatigued         | _____  |

12. Since admission or the last MDS, how well has your pain been managed? (check one)

- Very poorly     Poorly     Moderately     Well     Very well

Add additional comments from the resident here:

13. What level of pain relief would you be satisfied with, in terms of function and intensity of pain? (indicate which scale was used)

- |   |   |   |                                     |   |
|---|---|---|-------------------------------------|---|
| <input type="checkbox"/> Sleep comfortably  | <input type="checkbox"/> Rest comfortably | <input type="checkbox"/> Move comfortably | <input type="checkbox"/> Stay alert | <input type="checkbox"/> Perform activities |
| <input type="checkbox"/> Total pain control | <input type="checkbox"/> Other: _____     |   |                                     |   |

- Numeric scale 1–10: \_\_\_\_\_     Numeric scale 1–5: \_\_\_\_\_     Faces scale: \_\_\_\_\_     Verbal descriptor: \_\_\_\_\_

### III. Staff observations for pain (check all that apply)

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Nonverbal sounds (crying, whining, gasping, moaning, groaning) | <input type="checkbox"/> Vocal complaints of pain ("that hurts," "ouch," "stop") | <input type="checkbox"/> Facial expressions (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaws) | <input type="checkbox"/> Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) or behaviors (yelling, resisting care, etc.) | <input type="checkbox"/> None of these signs observed |
|---|--|---|--|---|

### IV. Resident and staff goal(s) for pain management & recommendations:

Examples: Walk comfortably to dining room for evening meal; participate in 30 minutes of PT twice daily, pain 3–4 on a 10-point scale

- Continue with current plan     Update current plan of care

### V. Pain assessment interview attempted but not completed (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Staff are never or rarely able to understand resident's speech | <input type="checkbox"/> Resident is nonresponsive |
| <input type="checkbox"/> Resident does not have a representative available at this time |  |

### VI. Pain management goal for nonverbal resident    Determined by staff    Determined by resident's representative

VII. Pain Education – the following has been discussed with Resident and/or family: Completed on \_\_\_\_\_ by \_\_\_\_\_

- General Overview of pain & pain management:  Fear of addiction;  Concerns about side effects;  Fear of injections;  
 Desire to be stoic;  Desire to be a "good patient."  Medications;  Non-med interventions;  Side effects of interventions;  
 Effectiveness of interventions;  Other (state): \_\_\_\_\_

Further Comments: \_\_\_\_\_  
\_\_\_\_\_

- Continue with current plan     Update current plan of care     Other (state): \_\_\_\_\_

Completed by \_\_\_\_\_ Date \_\_\_\_\_

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