northern health
the northern way of caring

Facility

Pain Assessment

Patient's Name:
Address:
Postal Code:
Date of Birth:
Phone Number:
PHN:
(or Patient Label or Stamp)

PPS%: ____ ☐ Stable ☐ Slow Decline ☐ Rapid Decline ☐ Unknown	Location A	Location B	Location C
O **Onset:** When did it begin? How long does it last? How often does it occur?			
P **Provoking/Palliating:** What brings it on? What makes it better? What makes it worse?			
Q **Quality:** What does it feel like? Can you describe it?			
R **Region/Radiating:** Where is it? Does it spread? See body map on reverse.			
S **Severity:** (Use symptometer 0-10) At Present 1 Hour after Medication At Medication Time Worst Ever Best Ever Other symptoms that accompany pain.			
T **Treatment:** Current medications/treatments? Effectiveness? Side effects? Past medications/treatments?			
U **Understanding:** What do you believe is the cause? Effect on you and your family?			
V **Values:** **Goal for this symptom?** (0-10) Are there any other views/feelings about this that are important to you/family.			
Likely Etiology of Pain			

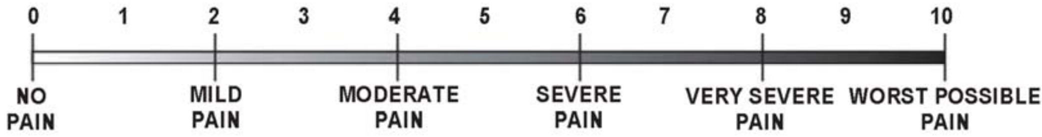
Signature: ____ Date: ____

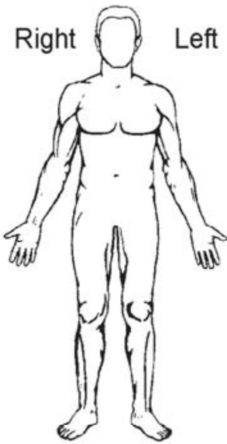
northern health
the northern way of caring

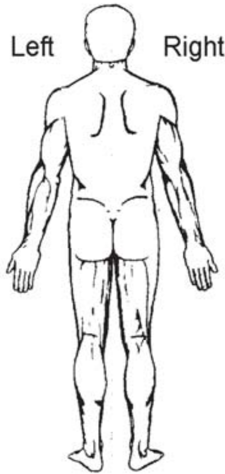
Facility ______________________________

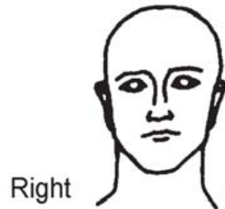
Patient's Name: ______________________
Address: ______________________
______________ Postal Code: __________
Date of Birth: ______________________
Phone Number: ______________________
PHN: ______________________
(or Patient Label or Stamp)

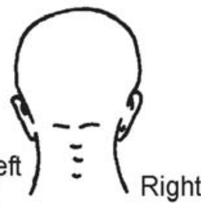
Pain Assessment

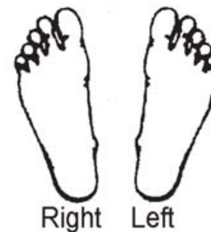












Physical Findings / Comments: ____

____

____

____

____

Signature: ______________________________ Date: ______________________