northern health
the northern way of caring

All Sites and Facilities

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

Pain Assessment

		Location A	Location B	Location C
Palliative Performance Scale %: _____ ☐ Stable ☐ Slow Decline ☐ Rapid Decline ☐ Unknown				
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? If unable to describe, ask is the pain sharp, dull, aching, burning, or do they experience pins and needles?			
R	**Region/Radiating:** Where is it? Does it spread anywhere? Use a body map to illustrate location and number of pain areas.			
S	**Severity:** How severe is this symptom? What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)? Right now? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom? If the patient has difficulty using a numerical rating scale (NRS), may use an alternative such as the verbal rating scale (VRS).			
T	**Treatment:** What medications and treatments are you currently using? Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? How effective are these? Do you have any side effects from the medications and treatments? What have you tried in the past? Do you have concerns about side effects or cost of treatments?			
U	**Understanding:** What do you believe is causing this symptom? How is it affecting you and/or your family? What is most concerning to you? What are your beliefs about opioid/narcotic medications?			
V	**Values:** Are you having to make compromises such as decreasing activities or enduring side effects to deal with your pain? What overall goals do we need to keep in mind as we manage this symptom? What is your acceptable level for this symptom (0-10)? Are there any beliefs, views or feelings about this symptom that are important to you and your family?			
Likely Etiology of Pain				

Signature / Designation: _____ Date: _____

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Pain Assessment

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

Physical findings/comments: (*Tenderness, swelling, movement, motor sensory, reflexes, edema, consciousness, abdomen, respiratory congestion, skin, fever, etc.*)

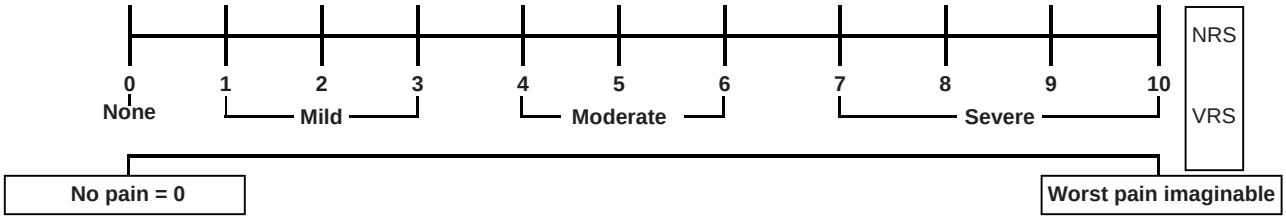
_____

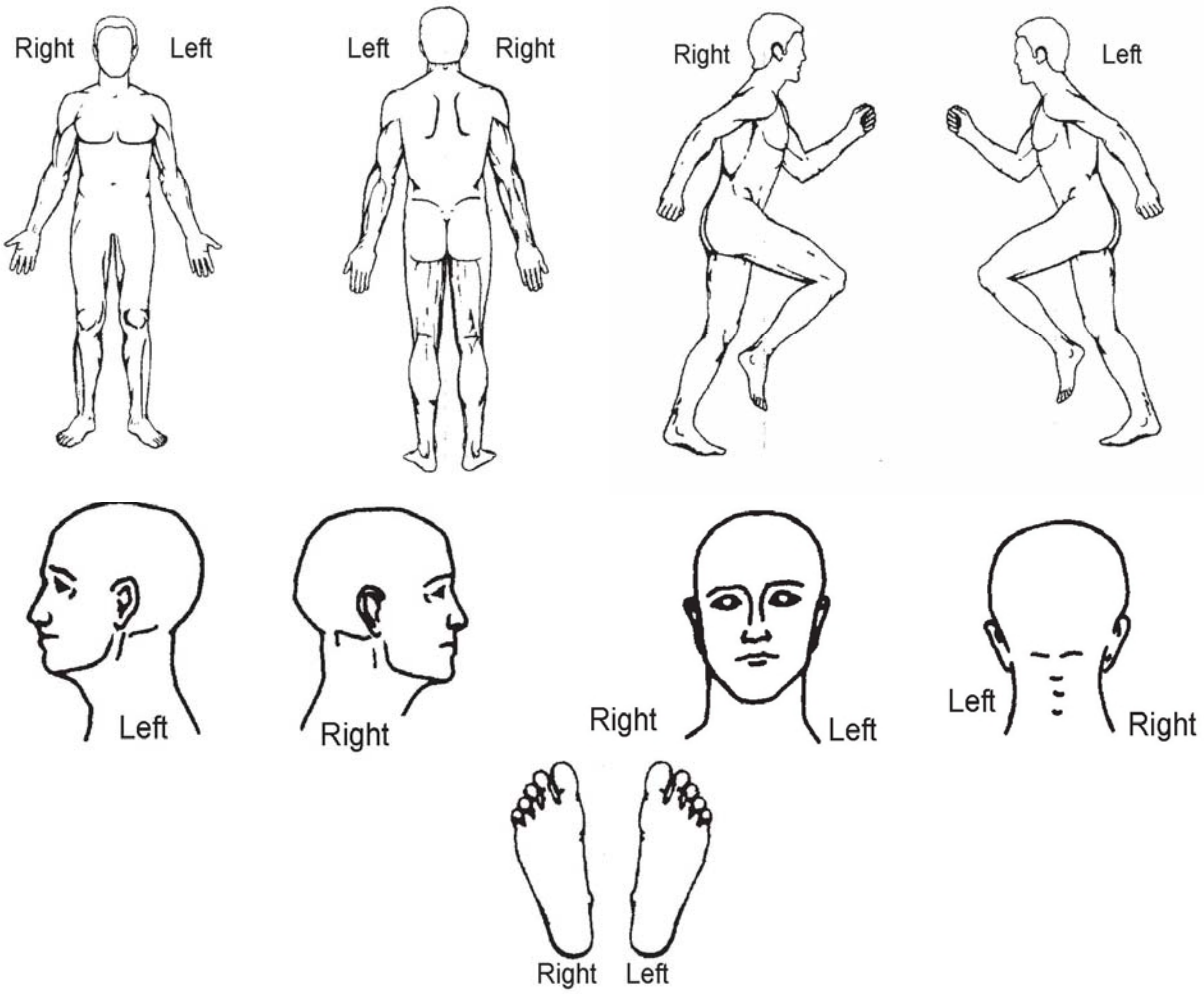
_____

_____

_____

Numerical rating scale (NRS) and verbal rating scale (VRS):





Locate and label each pain site (beginning 'A', 'B', 'C', etc.). Show area of radiation, if applicable.

Signature / Designation: _____ Date: _____