northern health
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**All Sites and Facilities**

# Palliative Care
# Pain Symptom Assessment



Patient name: _____
Address: _____
Date of birth: _____
Phone #: _____
PHN: _____
*PATIENT LABEL*

**Symptom:** _____ **PPS %:** _____

☐ **Stable** ☐ **Slow decline** ☐ **Rapid decline** ☐ **Unknown**

| | | |
|---|---|---|
| **O** | **Onset**<br>When did it begin?<br>How long does it last?<br>How often does it occur? | |
| **P** | **Provoking/palliating**<br>What brings it on?<br>What makes it better?<br>What makes it worse? | |
| **Q** | **Quality**<br>What does it feel like?<br>Can you describe it<br>(patient's own words) | |
| **R** | **Region/radiation**<br>Where is it?<br>Does it spread? | |
| **S** | **Severity**<br>What is the intensity (0 to 10) right now, at best, on average, at worst?<br>Are there other accompanying symptoms? | |
| **T** | **Treatment**<br>What treatments are you current using?<br>How effective are they?<br>Any side effects?<br>What have you used in the past? | |
| **U** | **Understanding**<br>What do you believe is causing this symptom?<br>How is this symptom affecting you/your family | |
| **V** | **Values**<br>What your goal for this symptom?<br>What is your comfort goal? | |

**Physical findings/comments:** _____

**Signature:** _____ **Date:** _____

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Patient name: _____

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PHN: _____

*PATIENT LABEL*

1. Pain assessment should be completed by the primary care provider on admission to all sites/programs and then as needed.
2. In addition, a pain assessment should be completed if there is a significant change in the pain, any modification to the pain management plan or new pain has been identified.
3. To assess pain following analgesic administration, the category of "S - severity" (0 to 10) would be the minimum assessment to monitor analgesic effectiveness.
4. Pain assessments should be documented so that all members of the care team will have a clear understanding of the pain problems. Location of documentation to be determined at each care site.
5. Begin completing the pain assessment tool by recording PPS%.
6. For each location of pain (A,B, or C) ask the patient OPQRSTUV:
   **Onset**: When did it begin? How long does it last? How often does it occur?
   **Provoking/palliating**: What brings it on? What makes it better? What makes it worse?
   **Quality**: What does it feel like? Can you describe it (patient's own words)?
   **Region/radiation**: Where is it? Does it spread? Then referring to the body diagrams on the reverse of the form, mark the location of the pain(s) on the body images. Indicate if pain radiates to other areas with arrows.
   **Severity**: What is the intensity (0 to 10) right now, at best, on average, and at worst? Goal they have for their pain? Are there other accompanying symptoms? Utilize the pain visual scales on the reverse of form for each pain location identified.
   **Treatment**: What treatments are you current using? How effective are they? Any side effects? What have you used in the past?
   **Understanding**: What do you believe is causing this symptom? How is this symptom affecting you/your family?
   **Values**: What is your goal for this symptom? What is your comfort goal?
7. Complete the likely etiology of pain.
8. Record additional comments and any physical finding in the space provided.
9. Date and sign the assessment.