

Pediatric Pain Assessment Form

Patient Name

Date of Birth

Assessment Date

Assessor Name

Pain Location

Pain Description

Pain Onset

Pain Duration

Pain Frequency

Pain Intensity (0-10)

Pain Faces Scale (Select one)

☐ 0
☐ 2
☐ 4
☐ 6
☐ 8
☐

Associated Symptoms

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Interventions/Medications Given

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Response to Interventions

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Comments/Notes

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