Pain Management Nursing Assessment Sheet

Patient Information

Name

Date of Birth

Medical Record No.

Pain Assessment

Onset

Duration

Frequency

Location

Intensity (0-10)

Quality (e.g., sharp, dull, throbbing)

Aggravating Factors

Relieving Factors

Associated Symptoms

Pain History

Previous Pain Episodes

Previous Treatments & Effectiveness

Pain Impact

Impact on Daily Living

Emotional Response

Current Pain Management

Medications

Non-pharmacological Interventions

Additional Notes