# Palliative Care Pain Assessment Form

Patient Name

Date

Assessor

Pain Location(s)

Pain Description

**Pain Intensity (0 = No pain, 10 = Worst possible pain)**

Pain Characteristics (e.g. sharp, dull, throbbing)

Onset/Timing of Pain

**Is pain constant or intermittent?**

- Constant
- Intermittent

Aggravating Factors

Relieving Factors

Current Analgesia / Pain Treatment

**Effectiveness of Pain Relief**

Side Effects (if any)

Additional Notes