

## **PAIN ASSESSMENT**

- Pain is a complex phenomenon that is difficult to evaluate and quantify because it is subjective and is influenced by attitudes and beliefs of the therapist and patient. Pain assessment is the first step in pain management.
- Pain assessment should encompass both the subjective and objective evaluations to properly document the level and amount of pain that the patient is experiencing.
- Many pain characteristics can be measured. These include intensity or magnitude of the pain; emotional unpleasantness or bothersomeness of the pain sensation; quality of the pain, such as burning, aching, lancinating, etc.; anatomical location of the pain; temporal characteristics of the pain, including variability, frequency, and duration over time; and how much pain interferes with function and everyday life.

### **TABLE 2-5 Subjective Clinical Assessment of Pain**

- What causes pain?
  - What relieves pain?
  - Where is your pain?
  - When did your pain begin?
  - What is the duration of your pain?
  - Have you ever experienced this pain before?
  - Can you describe how the pain feels?
  - Is the pain getting better or worse?
  - Does your pain increase with activity?
  - Do you have more pain after activity?
  - Do you have pain at night?
- 
- Once the subjective assessment is done, the patient's pain should be objectively evaluated using a standardized pain scale.

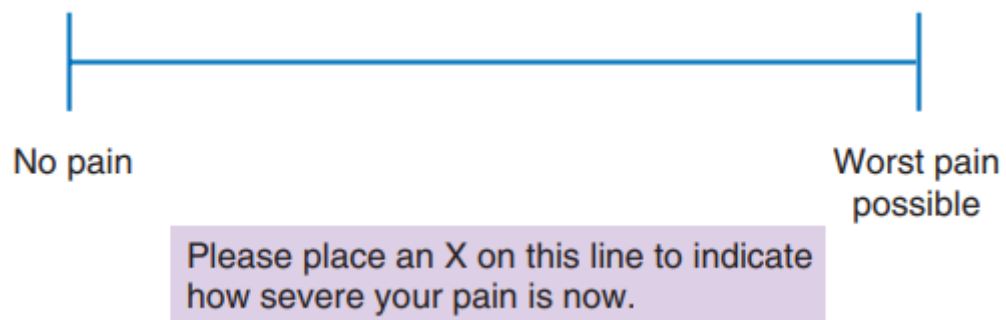
- Several standardized methods are available to measure the amount of pain in relatively objective terms.

### **Pain Assessment Scales**

The following scales are used in the evaluation of acute and chronic pain associated with illnesses and injuries.

#### **1. Visual Analog Scales (VAS)**

VAS are quick and simple tests completed by the patient. These scales consist of a line, usually 10cm in length, the extremes of which are taken to represent the limits of the pain experience. One end is defined as “No Pain” and the other as “Severe Pain”. The patient is asked to mark the line at a point corresponding to the severity of the pain. The distance between “No Pain” and the mark represents pain severity.



- The VAS has high test-retest reliability and is recommended for patients older than 8 years.
- Variations of the visual analog scale include the numeric rating scale (NRS) and the faces pain scale. The NRS uses a system that uses numbers to rate the pain. Most scales use an 11-point system (0 to 10), but variants include 21- and 101-point scales. The faces pain scale uses expressive drawings (similar to emoticons) to communicate pain and is useful with young children.

## 2. Numeric Pain Rating Scale (NPRS)

With the numeric pain rating scale the patient selects a number to represent his or her level of pain. The numbers usually range from 0 to 10 for an 11-point numeric scale. Numerical scales are typically quick and easy to administer.

### **Box 2-5. THE NUMERIC RATING SCALE**

**No Pain**

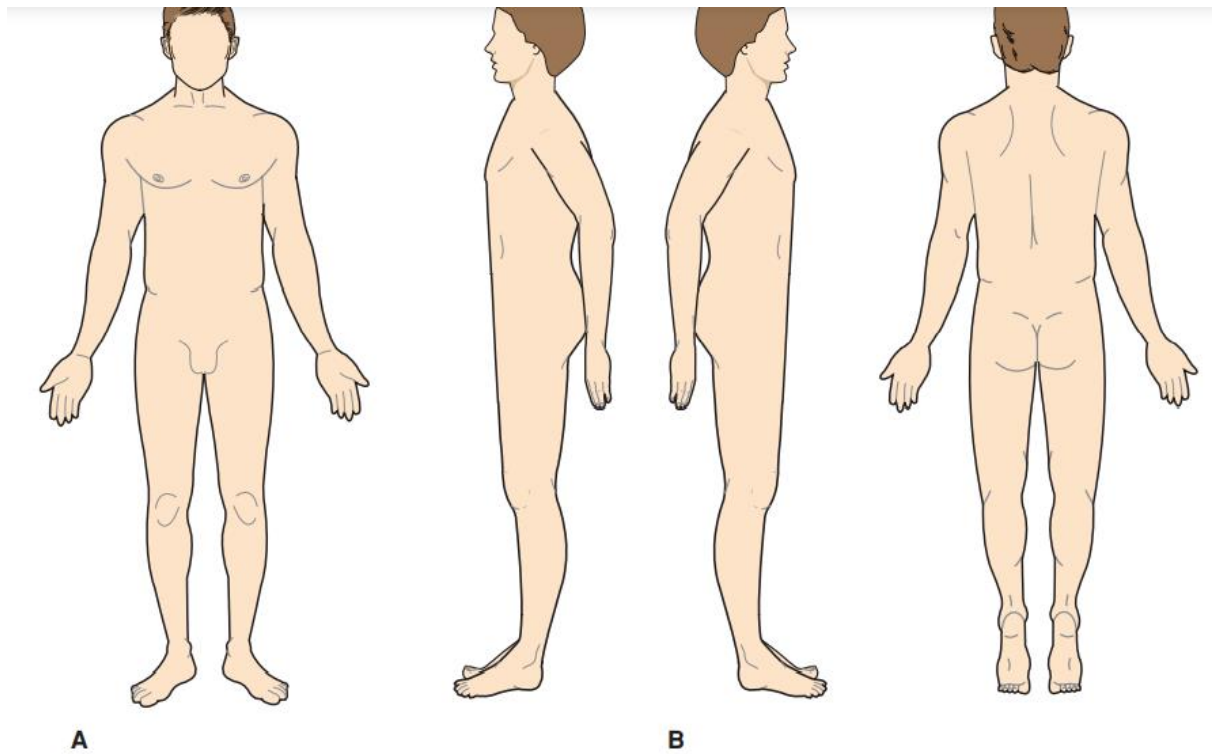
**Worst Pain Imaginable**

0      1      2      3      4      5      6      7      8      9      10

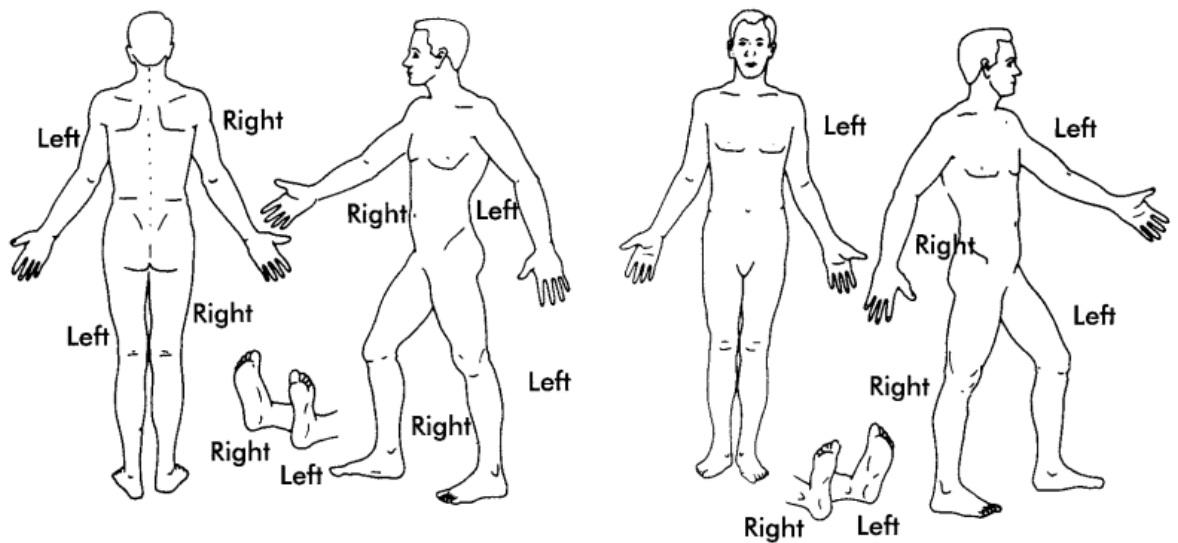
Similar to the visual analog scale (see Box 2-4), the numeric rating scale has descriptors such as No Pain on the 0 end of the scale and Worst Pain Imaginable on the high end. The patient then marks the number that best represents the level of pain. The results of this numeric rating scale should be a whole number. For instance, 7 is an acceptable result, 7.5 is not.

## 3. Body Diagrams/Pain Charts

These two-dimensional graphic portrayals are completed by the patient to assess the location of pain and number of subjective components. The patient draws or colors the pictures in areas that correspond to the pain experience. Different colors are used for different sensations. For example, blue for aching pain, yellow for numbness or tingling, red for burning pain, and green for cramping pain.



**FIGURE 4-13** Assessment of pain location on the body. **A:** Front and left side view. **B:** Right side and back view.



•**Figure 3-2** The pain chart. Use the following instructions: "Please use all of the figures to show me exactly where all your pains are and where they radiate to. Shade or draw with blue marker. Only the patient is to fill out this sheet. Please be as precise and detailed as possible. Use yellow marker for numbness and tingling. Use red marker for burning or hot areas and green marker for cramping. Please remember: blue = pain; yellow = numbness and tingling; red = burning or hot areas; green = cramping." (Used with permission from Melzack, R.: Pain measurement and assessment, New York, 1983, Raven Press.)


#### **4. McGill Pain Questionnaire**

The McGill Pain Questionnaire (MPQ) is a tool with 78 words that describe pain. These words are grouped into 20 sets that are divided into four categories, representing dimensions of the pain experience. Completion of the MPQ may take 20 minutes and is often frustrating for patients who do not speak English well. It is commonly administered to patients with low back pain. When administered every 2 to 4 weeks it has demonstrated changes in status very clearly. This allows the clinician to evaluate more comprehensive changes over the course of treatment. Some researchers have questioned the scale's practicality because it takes approximately 20 minutes to complete and another 5 minutes to score.

**McGill Pain Questionnaire**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm

PRI: S \_\_\_\_\_ A \_\_\_\_\_ E \_\_\_\_\_ M \_\_\_\_\_ PRI(T) \_\_\_\_\_ PPI \_\_\_\_\_  
 (1-10) (11-15) (16) (17-20) (1-20)

|   |  |   |       |          |            |           |          |        |           |              |          |
|---|--|---|-------|----------|------------|-----------|----------|--------|-----------|--------------|----------|
| 1 FLICKERING<br>QUIVERING<br>PULSING<br>THROBBING<br>BEATING<br>POUNDING<br>2 JUMPING<br>FLASHING<br>SHOOTING<br>3 PRICKING<br>BORING<br>DRILLING<br>STABBING<br>LANCINATING<br>4 SHARP<br>CUTTING<br>LACERATING<br>5 PINCHING<br>PRESSING<br>GNAWING<br>CRAMPING<br>CRUSHING<br>6 TUGGING<br>PULLING<br>WRENCHING<br>7 HOT<br>BURNING<br>SCALDING<br>SEARING<br>8 TINGLING<br>ITCHY<br>SMARTING<br>STINGING<br>9 DULL<br>SORE<br>HURTING<br>ACHING<br>HEAVY<br>10 TENDER<br>TAUT<br>RASPING<br>SPLITTING | 11 TIRING<br>EXHAUSTING<br>12 SICKENING<br>SUFFOCATING<br>13 FEARFUL<br>FRIGHTFUL<br>TERRIFYING<br>14 PUNISHING<br>GRUELLING<br>CRUEL<br>VICIOUS<br>KILLING<br>15 WRETCHED<br>BLINDING<br>16 ANNOYING<br>TROUBLESOME<br>MISERABLE<br>INTENSE<br>UNBEARABLE<br>17 SPREADING<br>RADIATING<br>PENETRATING<br>PIERCING<br>18 TIGHT<br>NUMB<br>DRAWING<br>SQUEEZING<br>TEARING<br>19 COOL<br>COLD<br>FREEZING<br>20 NAGGING<br>NAUSEATING<br>AGONIZING<br>DREADFUL<br>TORTURING | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">BRIEF</td> <td style="width: 33%;">RHYTHMIC</td> <td style="width: 33%;">CONTINUOUS</td> </tr> <tr> <td>MOMENTARY</td> <td>PERIODIC</td> <td>STEADY</td> </tr> <tr> <td>TRANSIENT</td> <td>INTERMITTENT</td> <td>CONSTANT</td> </tr> </table> <div style="text-align: center;">  <p>E = EXTERNAL<br/>I = INTERNAL</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>COMMENTS:</p> </div> | BRIEF | RHYTHMIC | CONTINUOUS | MOMENTARY | PERIODIC | STEADY | TRANSIENT | INTERMITTENT | CONSTANT |
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| TRANSIENT   | INTERMITTENT   | CONSTANT  |       |          |            |           |          |        |           |              |          |

•**Figure 3-3** McGill Pain Questionnaire. The descriptors fall into four major groups: Sensory, 1 to 10; affective, 11 to 15; evaluative, 16; and miscellaneous, 17 to 20. The rank value for each descriptor is based on its position in the word set. The sum of the rank values is the pain rating index (PRI). The present pain intensity (PPI) is based on a scale of 0 to 5. (Used with permission from Melzack, R.: Pain measurement and assessment, New York, 1983, Raven Press.)

## 5. Wong-Bakers Face Pain Rating Scale

This tool consists of six faces expressing different levels of pain intensity, ranging from no pain to very much pain (Hicks et al., 2001). The child is asked to point, with his or her finger, to the picture that best describes his or her current level of pain. The examiner scores this tool by reporting the number associated with the photograph identified by the suffering child on a scale ranging from 0 to 10.

## Wong-Baker FACES® Pain Rating Scale



**0**

**No  
Hurt**



**2**

**Hurts  
Little Bit**



**4**

**Hurts  
Little More**



**6**

**Hurts  
Even More**



**8**

**Hurts  
Whole Lot**



**10**

**Hurts  
Worst**

This tool was originally created with children for children to help them communicate about their pain.  
Now the scale is used around the world with people ages 3 and older, facilitating communication  
and improving assessment so pain management can be addressed.





