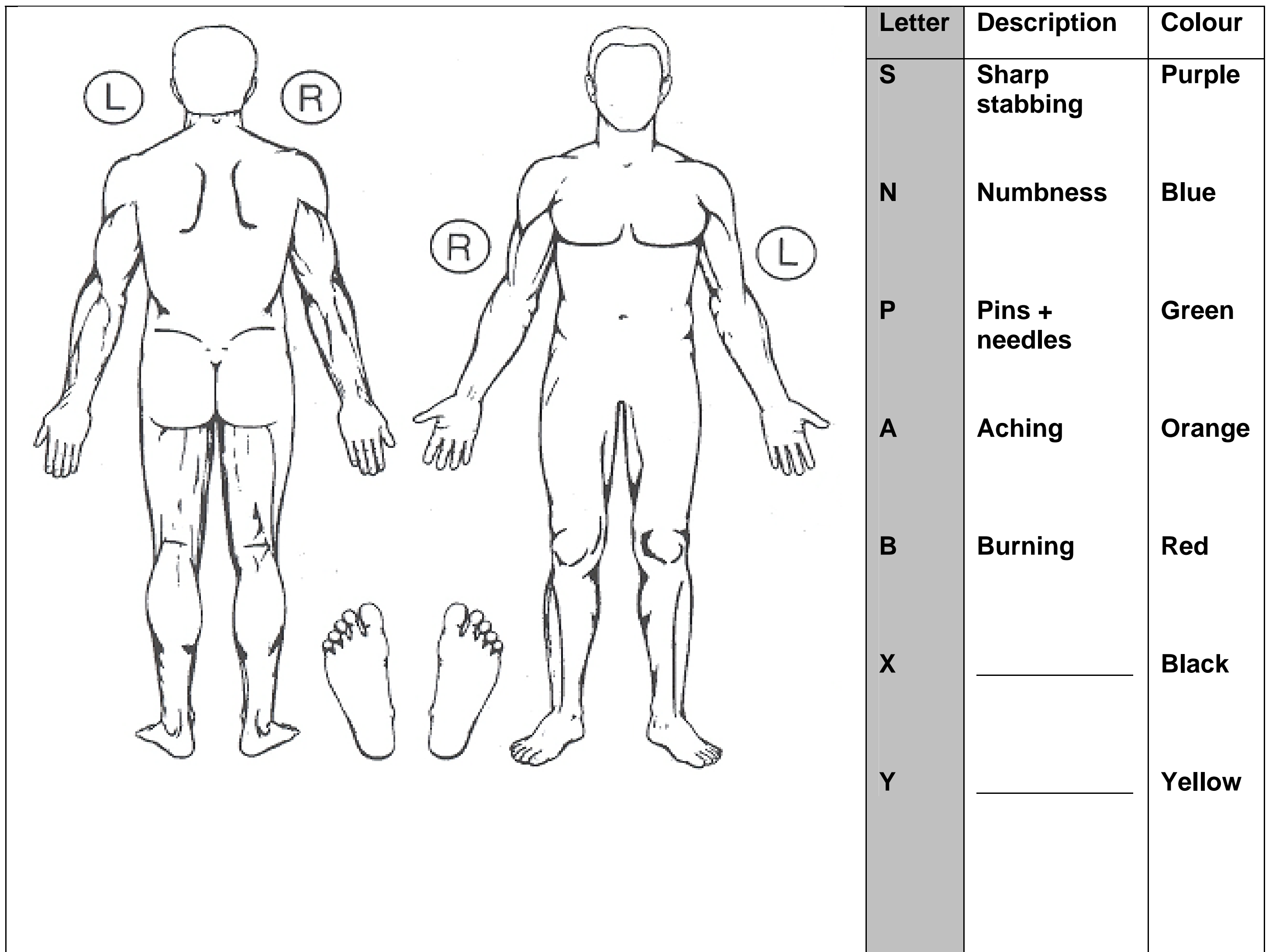
fraserhealth

Renal Program Pain Assessment Tool

Date: ___________________ Time: _______________

Information Source:
☐ Patient ☐ Spouse ☐ Child ☐ Interpreter ☐ Other ______________
Form Completed by: ________

On the diagram below mark using colours listed OR using the letters/symbols shaded in grey to show where your pain is and the best word that would describe it.



Letter	Description	Colour
S	Sharp stabbing	Purple
N	Numbness	Blue
P	Pins + needles	Green
A	Aching	Orange
B	Burning	Red
X	____________	Black
Y	____________	Yellow

NEUROPATHIC PAIN SCREENING

WOULD ANY OF THE PAIN YOU ARE HAVING BE DESCRIBED AS:

	YES	NO
BURNING……………..	☐	☐
PAINFUL COLD………..	☐	☐
ELECTRIC SHOCKS……	☐	☐

DOES THE PAIN EVER FEEL LIKE:

	YES	NO
TINGLING……………	☐	☐
PINS & NEEDLES……	☐	☐
NUMBNESS…………	☐	☐
ITCHY………………	☐	☐

DOES THE PAIN INCREASE WHEN THE AREA IS LIGHTLY TOUCHED OR BRUSHED AGAINST?

☐ YES ☐ No

DOES THE AREA WITH PAIN HAVE LESS FEELING OR SENSATION? ☐ YES ☐ No

STAFF: Neuropathic Pain indicated (Positive) by 4 or more Yes √ in this section.

On a scale of 0 to 10, how has **PAIN INTERFERED** in the last 2-3 days with your:

I--I
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — moderately — Completely interferes

Quality of Life Score	Number out of 10
General Activity	
Mood	
Walking ability	
Normal work (includes both work outside the home and housework)	
Relations with other people	
Sleep	
Enjoyment of life	

/70

Staff – Please complete
Neuropathic Pain Screen Positive YES/NO (circle)

Quality of Life Score (total number out of 70) /70

What makes your pain better?

☐ Heat ☐ Cold ☐ Massage
☐ Distraction ☐ Lying down
☐ Changing positions ☐ Physiotherapy
☐ Chiropractor

____
____

What Pain medications are you currently taking? Please include**:**
Prescription, Non-Prescription or Herbal

____
____
____
____
____
____

Rate the 3 most important goals for you if you had less pain:

____ Sleep comfortably
____ Comfort at rest
____ Comfort with movement
____ Stay alert
____ Perform activity:____________
_____ Other:__________________

Circle where you think you pain level would need to be to reach your goals:

0 1 2 3 4 5 6 7 8 9 10
I---I
No Pain — Moderate — Worst Pain

Is there anything else you would like to say about your pain?

____
____
____
____