PEDIATRIC PALLIATIVE CARE PROJECT

DETAILED PAIN ASSESSMENT: CHILDREN 8 YEARS OF AGE & UP

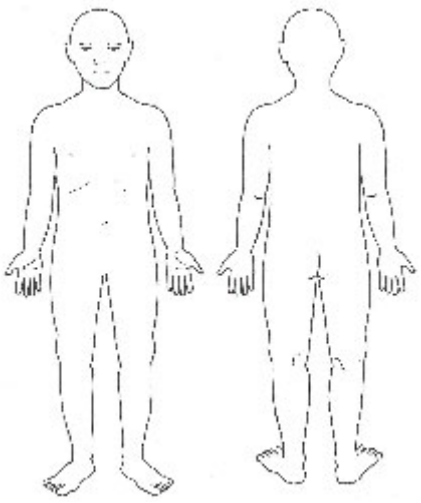
For use in as-needed home/clinic visits

Date: _____/_____/_____ Patient's Project ID# _____

***NOTE: THE MAJORITY OF QUESTIONS IN THIS SURVEY SHOULD BE COMPLETED BY CHILD/TEEN. ANY QUESTIONS FOR PARENTS &/OR NURSES WILL BE CLEARLY MARKED.*

Color in the areas on these drawings[1] to show where you have pain. Make the marks as big or as small as the place where the pain is.

Right Left Left Right



1. *PARENT, NURSES:* Sometimes children and teenagers have changes in behaviors as their illness progresses. For each of the behaviors[1] listed below, please check the behaviors that your child or teen is currently displaying:

	Parent	Nurse
1. Whine or complain more than usual?		
2. Cry more easily than usual?		
3. Play less than usual?		
4. Not do the things s/he normally does?		
5. Act more worried than usual?		
6. Act more quiet than usual?		
7. Have less energy than usual?		
8. Refuse to eat?		
9. Eat less than usual?		
10. Hold the sore part of his/her body?		
11. Try not to bump the sore part of his/her body?		
12. Groan or moan more than usual?		
13. Look more flushed than usual?		
14. Want to be close to you more than usual?		
15. Take medication when s/he normally refuses?		

☐ My child/teen is not displaying any of the above behaviors at this time.

[1] *Source:* Adolescent Pediatric Pain Tool (APPT): Savedra M, Tesler MD, 1989.
[1] *Source:* Postoperative Pain Measure for Parents: Chambers, et al. 1996.

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2. *PARENT:* Please use the colored analogue scale[3] to answer the following questions.

	Parent's Rating
1. What is an acceptable level of pain for your child/teen?	
2. How satisfied are you with the pain relief your child/teen is receiving?	

*****CHILD/TEEN SHOULD ANSWER OR FILL OUT THE REST OF THE QUESTIONS IN THIS SURVEY.*****

3. Please use the colored analogue scale to answer the following questions.

	Child/Teen Rating
1. How much pain do you have now?	
2. What is the highest level of pain you have had in the last week?	
3. What is the lowest level of pain you have had in the last week?	
4. What is an acceptable level of pain for you?	

4. What things were used to make your pain better? List up to three things in the box below.

☐ No pain has bothered me this week.

THINGS USED TO MAKE MY PAIN BETTER:	**HOW WELL THEY WORKED…** *[circle one number for each thing]*				
	Helped a little				Helped a lot
1.	1	2	3	4	5
2.	1	2	3	4	5
3.	1	2	3	4	5

5. Overall, how satisfied are you with the relief of your pain this past week?

DID IT WORK?	**LEVEL OF SATISFACTION** *[circle one number for each question]*				
	Not Satisfied		Somewhat Satisfied		Very Satisfied
1. Relief of my Pain	1	2	3	4	5

[3] *Source:* Colored Analogue Scale: McGrath PA, et al, 1996.