

RESOURCE 01 / PRACTICE WORKSHEET

Pain Assessment & Functional Goals

Practice a patient-centered interview and connect pain findings to everyday function.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Hear the pain story [1]

Onset	When did it start? Sudden or gradual? Related event? _____
Location / radiation	Where is the pain? Does it travel elsewhere? _____
Quality	Use the patient's own words: aching, burning, sharp, etc. _____
Pattern / timing	Constant or comes and goes? Duration and daily pattern? _____
Worse / better	Activities, positions, treatments, or other triggers? _____

2 Record the report and functional impact [1,2]

Measure / context	Facility-approved scale: _____ Score: _____ At rest or during which activity? _____
Patient priorities	Effect on walking, self-care, sleep, mood, or school/work: _____
Meaningful goal	"I want to be able to ..." Include a realistic task and timeframe. _____

3 Check context before planning

Treatments tried, benefit/side effects, relevant findings, and communication supports:

New/worsening concerns to report; supervisor notified and next step:

RESOURCE 01 / LEARNING NOTES & SELF-CHECK

Listen. Measure. Clarify.

Use the worksheet to learn a process, not to reduce a person to a pain score.

Start with the person, not the number [1]

Respect the person's report. Pain is a personal experience; appearance or vital signs alone do not determine how much pain someone has. Ask without judgment and use an interpreter or other communication support when needed.

Use the right method [1,3]

Use self-report when the person can communicate reliably. A 0-10 numeric rating may be appropriate: 0 = no pain; 10 = worst pain imaginable. Record the scale and whether the rating was at rest or with activity.

When reliable self-report is not possible, use a population-appropriate, facility-approved observational tool with supervision. Include caregiver knowledge and clinical findings. No verbal report does not mean no pain; do not convert a behavior score into a verbal pain rating.

Describe progress in daily life [2]

Agree on a task that matters to the patient, the assistance required, and a realistic review time. Follow mobility restrictions and the established care plan. A score change is only one part of the response.

Fictional goal-writing example

Instead of: "Pain will be zero."

Try: "By the next therapy review, the patient will walk to the dining room using the prescribed device and required staff assistance, as tolerated and consistent with the care plan."

Recognize urgent changes

New chest pain, severe breathing difficulty, sudden neurologic changes, or new bladder/bowel dysfunction with groin numbness require immediate escalation. Follow the site's emergency process and notify the supervising clinician; do not finish the worksheet first. This is not a complete warning-sign list.

Before you submit

- ☐ I recorded the patient's words and the scale/context used.
- ☐ I described at least one activity affected and one patient-chosen goal.
- ☐ I separated patient report from my observations and reported urgent changes.

Preceptor feedback / one assessment skill to improve:

Teaching sources

[1] Raja, S. N., et al. (2020). The revised IASP definition of pain: Concepts, challenges, and compromises. *Pain*, 161(9), 1976-1982. [Source](#)

[2] Dowell, D., et al. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR*, 71(RR-3), 1-95. [Source](#)

[3] Herr, K., et al. (2019). Pain assessment in the patient unable to self-report: Clinical practice recommendations in support of the ASPMN 2019 position statement. *Pain Management Nursing*, 20(5), 404-417. [Source](#)

The CDC source addresses adult outpatient prescribing; its scope excludes sickle cell disease, cancer-related pain, palliative care, and end-of-life care. Use the appropriate specialty guidance for those settings.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.