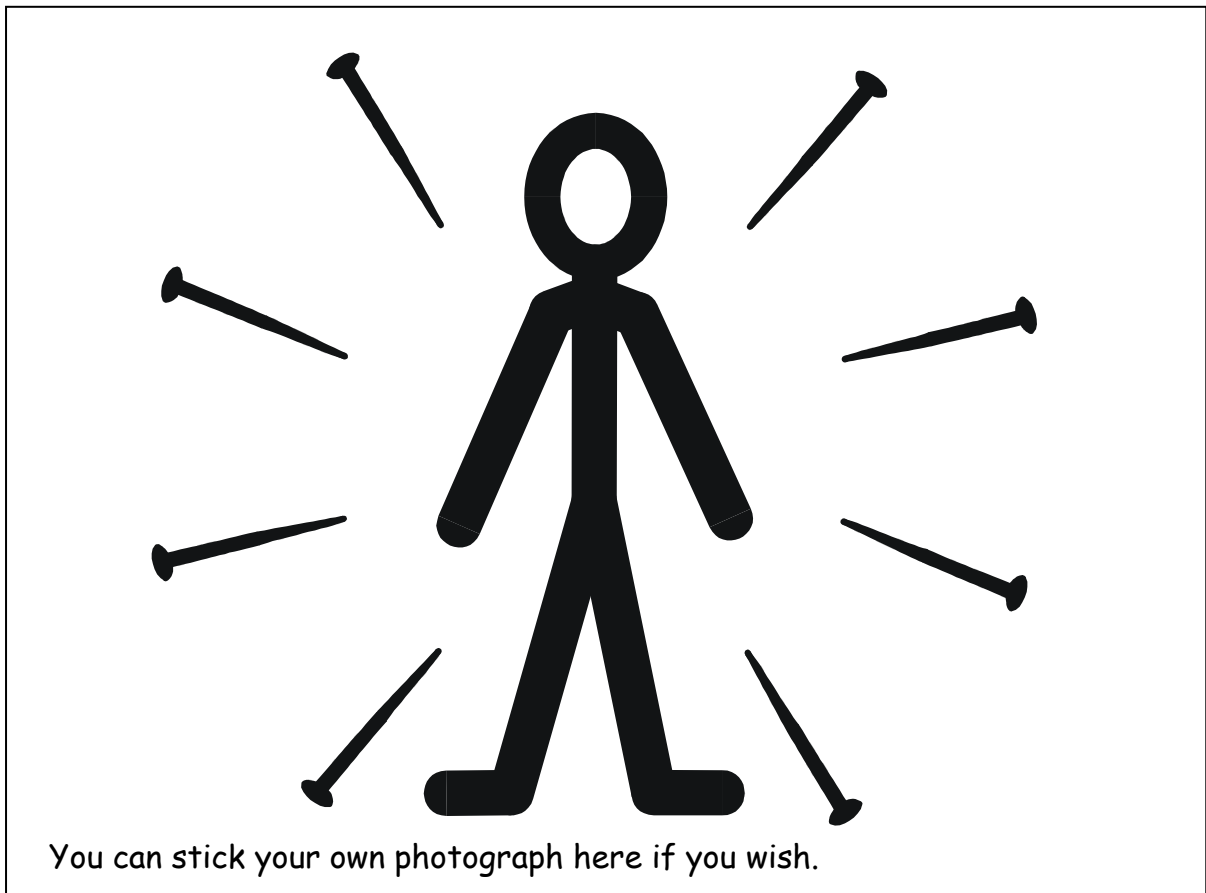


NHS Number:



# My Pain Profile



This belongs to \_\_\_\_\_  
Someone who knows me well is \_\_\_\_\_ and they can  
be contacted on \_\_\_\_\_.

NHS Number:

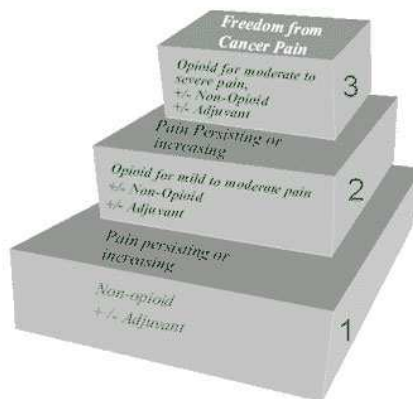
I may be in pain because;

My pain medication;



You may want to consider regular pain relief as may be more effective than PRN medication. (Rowntree)

**WHO's Pain Relief Ladder**



My other medication;



The form I take my tablets in is:

- |                   |                          |           |                          |
|-------------------|--------------------------|-----------|--------------------------|
| Tablets - whole   | <input type="checkbox"/> | Liquid    | <input type="checkbox"/> |
| Tablets - broken  | <input type="checkbox"/> | With food | <input type="checkbox"/> |
| Tablets - crushed | <input type="checkbox"/> | Other     | <input type="checkbox"/> |

# My Usual Self

(when happy and comfortable)

This section is to be used as a baseline for the assessment of my pain.



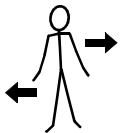
## My general appearance:

Think about: weight, skin



## My facial expressions:

Think about: appearance of face, Eyes, mouth (smiling, closed etc).



## My body language:

Think about: posture, tense/ Relaxed, mobility, positioning, sleeping position.



## My vocal sounds:

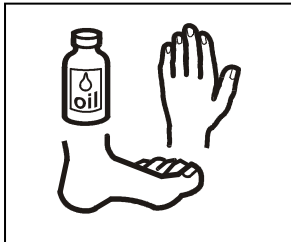
Think about: sounds, speech, Pitch, volume.



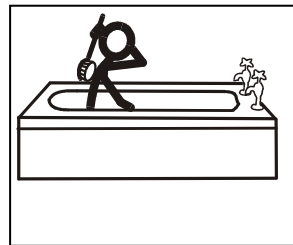
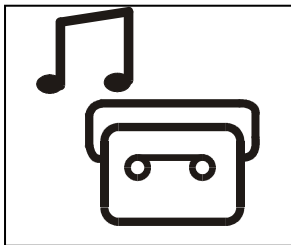
## My behaviour:

Think about: appetite, routine, activities.

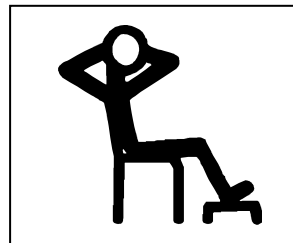
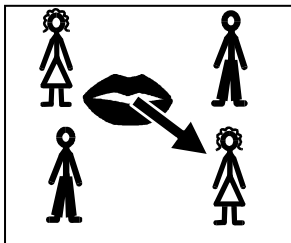
# Below is a list of things that may help to make me feel more comfortable;



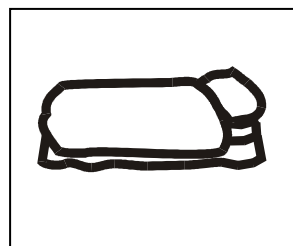
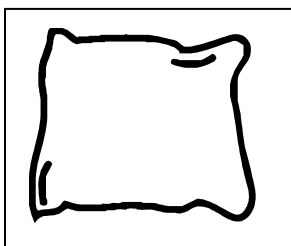
Aromatherapy  
Gentle Massage



Music  
Bubble baths



Talking  
Careful positioning



Pressure cushions  
Comforters e.g. blanket

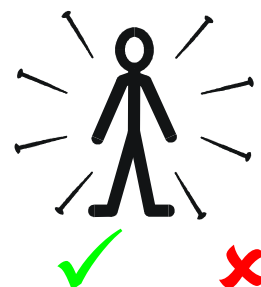
## Other things that help me relax are;

# Assessment of my pain

Name: \_\_\_\_\_

Date: \_\_\_\_\_

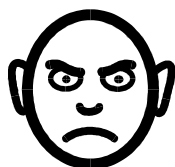
*I may not be able to tell you when I am in pain, please observe me.*



**Changes to my general appearance.**

Think about: weight loss, pressure areas, swelling, pressure areas, skin tears.

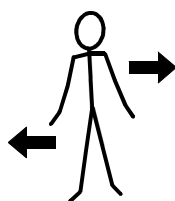
|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|



**Changes to my facial expressions.**

Think about: tense, frowning, grimacing, clenching teeth, biting lip.

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|



**Changes to my body language.**

Think about: fidgeting, rocking, guarding a part of the body, change to posture, sleeping position, purposeless movements, rubbing.

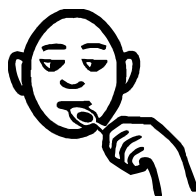
|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|



**Changes to my vocal sounds.**

Think about: whimpering, groaning, crying, pitch, volume.

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|



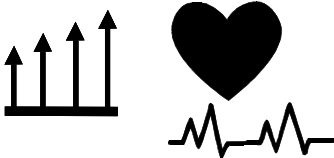
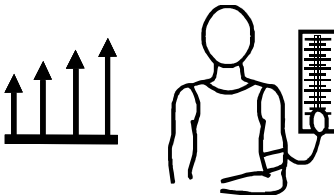

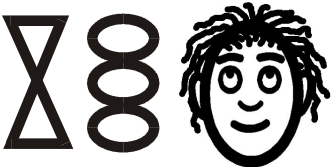


**Changes in my behaviour.**

Think about: confused, lack of appetite, alteration in usual patterns/routines.

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

# My bodily functions

Consider any physiological changes alongside any changes in usual self. (Physiological changes are supporting evidence only and are not to be used as the sole basis for the assessment of pain.)

|  |                            | ✓                        | ✗                        |
|--|----------------------------|--------------------------|--------------------------|
|    | Increased heart rate       | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Increased blood pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Increased respiration      | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Change in facial colouring | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Changed bowel movements    | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Change in urine output     | <input type="checkbox"/> | <input type="checkbox"/> |