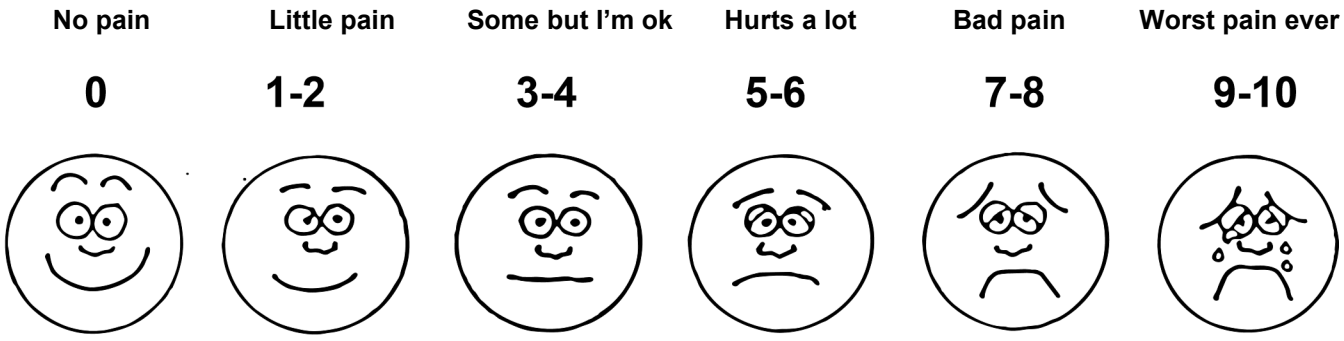
Pain Scales

1. **FUNCTIONAL PAIN SCALE:**

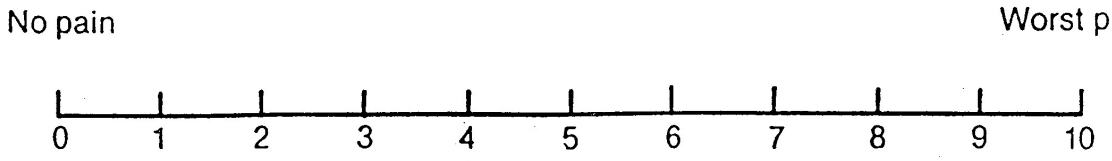
Functional Pain Scale						
No Pain	Tolerable	Tolerable	Tolerable	Intolerable	Intolerable	Intolerable
	Able to perform all activities	Prevents some active activities	Pain that becomes intolerable with movement	Pain that prevents many active, but not passive activities	Pain that prevents all active and passive activities	Unable to do anything, even speak related to pain

Mild Pain Symptoms	Moderate Pain Symptoms	Severe Pain Symptoms
Pain that is mostly tolerable and has a limited impact on function or participation in activities	Pain that may become intolerable with movement and may interfere with some active/prescribed activities	Pain that is intolerable and is having a significant impact on active/prescribed activities and passive activities

2. **FACES SCALE:** This tool consists of six cartoon faces ranging from a smiling face for "no pain" to a tearful faced for "worst pain". Explain to the child that each face is for a person who feels happy because there is no pain or sad because there is some or a lot of hurt. Ask the child to pick the face that best describes his or her pain. This scale can be used for children as young as 3 (three) years of age:



3. **NUMERIC SCALE:** This tool uses a straight line with end points identified as "no pain" and "worst pain". Divisions along the line are marked in units from 0 to 10. This scale can be used for children once they can count and understand numbers:



4. **FLACC SCALE:** The tool is a behavioral scale for scoring pain in infants and young children from 2 months to 7 years of age. The infants or children are observed and their behaviors are recorded. The corresponding numbers on the scale are totaled. The FLACC scale has a scoring range of 0 for no pain and 10 for worst pain.

	0	1	2	Score
Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant frown, clenched ja, quivering chin.	
Legs	Normal position or relaxed.	Uneasy, restless, tense.	Kicking or legs drawn up.	
Activity	Lying quietly, normal position, moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid, or jerking.	
Cry	No cry (awake or asleep).	Moans or whimpers, occasional complaint.	Crying steadily, screams or sobs, frequent complaints.	
Consolability	Content, relaxed.	Reassured by occasional touching, hugging, or talking to, distractible.	Difficult to console or comfort.	

REFERENCES:

1. Clinical Practice Guideline: Acute Pain Management: Operative or Medical Procedures and Trauma. Dept. of Health and Human Services. Agency for Health Care Policy.

2. Clinical Practice Guideline: Management of Cancer Pain. US Dept. of Health and Human Services, Agency for Health Care Policy and Research.

3. Rosing, John. "Broadening the Choices of Pain Assessment Tools". Accreditation Monthly. (Aug. 2005, Vol. 4, No. 8)

4. Pain Management Evidence-Based Tools and Techniques for Nursing Professionals JCAHO