Pain Assessment tool for the Cognitively Impaired

Assess for **changes** in the resident's activity patterns using these new behaviors as possible indicators of pain.
Please check each nonverbal behavior you observe in the resident ☑.

Verbal Expression

- Cries out with touch ☐
- Yells/Screams/shouts ☐
- Moans with turning ☐
- Volume of voice increases or becomes shrill ☐
- Becomes very quiet ☐
- Swears or calls people names ☐
- Talks without making sense ☐
- Grunts ☐

Facial Expression

- Facial grimaces such as wincing or painful look ☐
- Closes their eyes ☐
- Winces with touch ☐
- Worried expression/frowning ☐

Physical Behaviors

- Resists care ☐
- Shields or protects a certain part of their body ☐
- Rocks back and forth ☐
- Isolates self from others ☐
- Becomes physically aggressive, striking out ☐
- Stiff or rigid body ☐

Physiological Behaviors

- Vital sign changes: increased BP, Pulse, breathing (acute pain only) ☐
- Becomes pale ☐
- Becomes cold ☐
- Has a red or swollen body part ☐

Psychological Changes

- Crying/tears ☐
- Increased confusion ☐
- Irritability/agitation ☐

Adapted from VGH's 'Amy's tool' and American Geriatric Society's Clinical Practice Guideline: the management of persistent pain in older persons 2002.