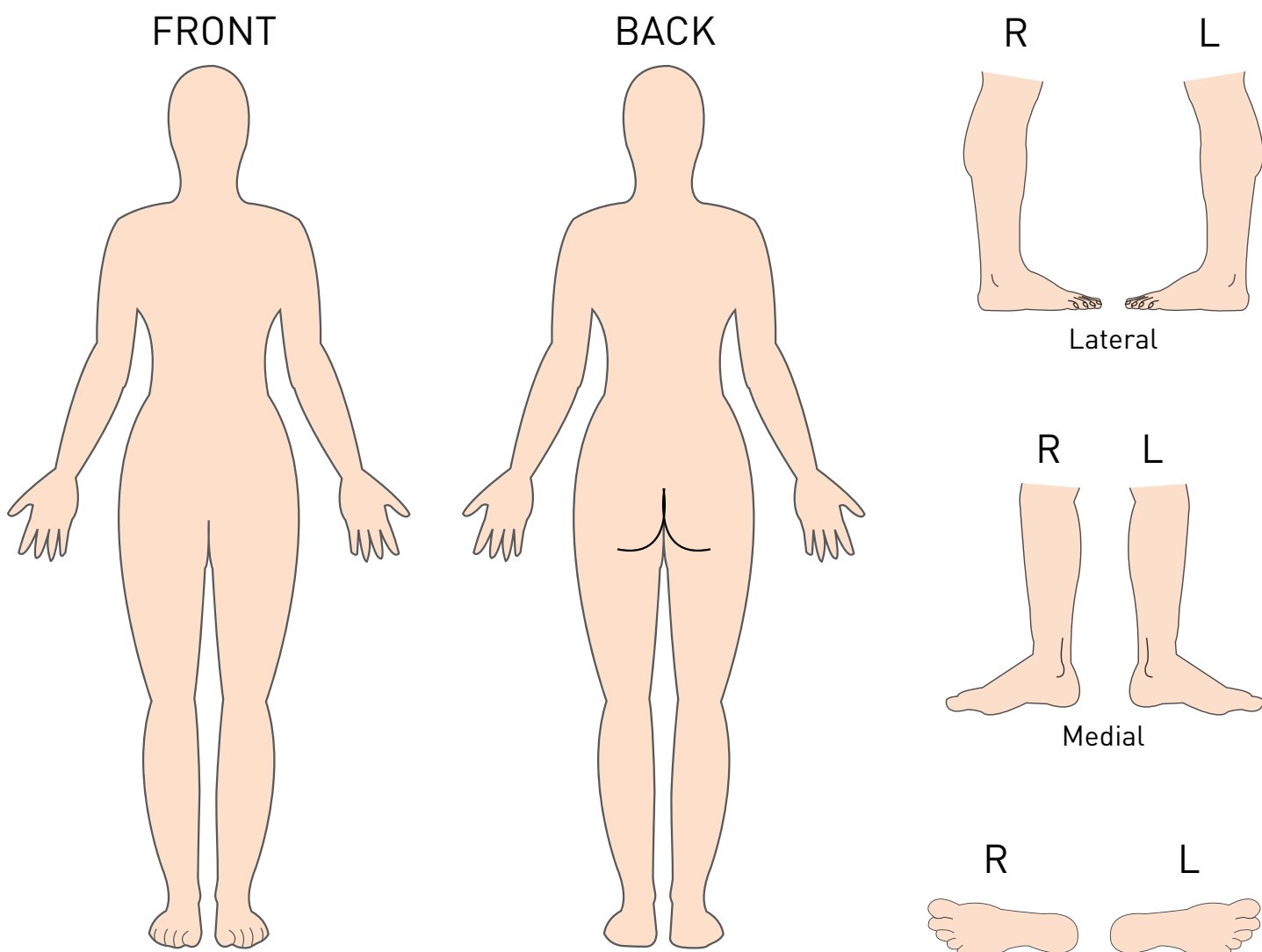


# WOUND-RELATED PAIN AT DRESSING CHANGE ASSESSMENT TOOL

Date ..... Surname ..... DOB ..... Initials .....

Medical record ..... Wound type .....

## 1. Indicate location of wound/s and number on the body map and leg/foot pictures



## 2. Do you experience pain or discomfort related to your wound/s?

Yes

No

If yes, complete the questions on the next page.

Signature .....

This pain assessment tool has been adapted by the International Pain Advisory Panel<sup>1</sup>

<sup>1</sup>Helen Hollinworth 2005. Pain at wound dressing-related procedures: a template for assessment. [www.worldwidewounds.com](http://www.worldwidewounds.com)



# WOUND-RELATED PAIN AT DRESSING CHANGE ASSESSMENT TOOL

Date ..... Initials ..... Signature.....

**3. When do you experience wound-related pain?** (May mark more than one box if applicable)

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Pain at rest (Background)                    | <input type="checkbox"/> During day                               | <input type="checkbox"/> During night |
| <input type="checkbox"/> Pain during day-to-day activities (Incident) | <input type="checkbox"/> Pain during dressing change (Procedural) |                                       |
| <input type="checkbox"/> Pain during biopsy/debridement (Operative)   | <input type="checkbox"/> Pain after dressing change               |                                       |

**4. Where is the wound-related pain?** (May mark more than one box if applicable)

- In the wound                       In the area surrounding the wound (skin)

Does the pain go anywhere. If yes where does it go? .....

**5. What words would you use to describe your pain?** (May mark more than one box if applicable)

- |                                  |                                   |                                    |                                   |                                   |                                   |
|----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Aching   | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tender   | <input type="checkbox"/> Sharp    | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stinging | <input type="checkbox"/> Shooting  | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other*   |

\*Give details: .....

**6. At dressing change, what makes the wound-related pain worse (triggers)?** (May mark more than one box)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Removing dressing | <input type="checkbox"/> Applying dressing | <input type="checkbox"/> Some dressing types* |
| <input type="checkbox"/> Cleansing         | <input type="checkbox"/> Touch             | <input type="checkbox"/> Other*               |

\*Give details: .....

**7. At dressing change, what makes the wound-related pain better (relievers)?** (May mark more than one box)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Removing dressing myself | <input type="checkbox"/> Time-outs or brief rests  | <input type="checkbox"/> Certain types of dressings* |
| <input type="checkbox"/> Warm cleansing solutions | <input type="checkbox"/> Pain-relieving medication | <input type="checkbox"/> Other*                      |

\*Give details: .....

**8. Have you been prescribed or are you currently taking pain-relieving medications (tablets, injections, topical applications, patches) for your wound-related pain?**

- Yes                       No

If yes, list name/dose and when last taken/applied/used: .....

.....

**9. Are any of the following activities negatively affected because of the wound-related pain you experience?**

- |   |   |                                 |
|---|---|---------------------------------|
| <input type="checkbox"/> Sleeping           | <input type="checkbox"/> Activities of daily living | <input type="checkbox"/> Other* |
| <input type="checkbox"/> Leisure activities | <input type="checkbox"/> Sport or exercise          |                                 |

\*Give details: .....

**10. If the wound-related pain was reduced, which activity would you look forward to the most?**

.....