PQRST Pain Assessment

Name: _____ Date: _____ dd / mm / yyyy

Health concern: _____

Provocation - What triggers the pain (e.g. movement, pressure, touch, etc.)?

Quality - How would you describe the pain (e.g. stabbing, burning, dull, etc.)?

Region/Radiation - Does the pain stay in one region or does it radiate to other parts of your body?

Severity - How would you rate the severity of your pain on a scale of 0 to 10 (0 being no pain, 10 being the worst pain imaginable)?

0 1 2 3 4 5 6 7 8 9 10

Time - How long have you been experiencing the pain? Is it constant or intermittent?

Additional Notes