Canuck Place
CHILDREN'S HOSPICE

Child's Name:
Health Care #:

Pain Assessment Acronym O,P,Q,R,S,T,U,V

Assess	Assessment Questions:
O **Onset**	When did it begin?
	How long does it last?
	How often does it occur?
P Palliating/ Provoking	What brings it on?
	What makes it better?
	What makes it worse?
Q Quality	What does it feel like?
R Radiation/ Region	Where is it?
	Does it spread anywhere?
S Severity	What is the intensity of this symptom? (scale of 0-10; 0 = none, 10 = worst ever OR appropriate pain scale) Right Now: At Best: At Worst:
	Are there other symptoms that accompany this symptom?
T Treatment	What medications/ treatments are you currently using?
	How effective are these?
	Do you have any side effects from any medications/treatments?
U Understanding/ impact on you	What do you believe is causing this symptom?
	How is this symptom affecting you/your family?
V Values	Goals and expectations of management of this symptom?

Name (person who completed the form):

Signature:

Date: