

# Charting and Vital Signs



Unit 2 Part 1

1



# Chart and Records

Some facilities will have all paper charts, paper and electronic charts, and all electronic charts

2

## Purpose of Patient Records

- Charting defined: a form of written (or electronic) communication done by the treatment team about the patient.
- Purposes
  - Communication from one team member to another
  - Protect patient from duplication and errors
  - Historical record keeping
  - Protect healthcare worker from (and during) litigation
  - Research
  - Accreditation

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## THE PATIENT CHART



- All hospital charts will contain the same standard information (some governed, some accreditation guidelines)
- The organization of each hospital's charts is determined by the individual institution

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## Rules of Documentation



- The chart is a legal document
  - Information must be
    - accurate,
    - spelled correctly,
    - concise,
    - complete,
    - factual,
    - and well organized.
- Improper charting or omissions in charting can cause legal problems.

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## General Guidelines



The chart is property of the institution/agency



Documentation is performed according to the institution guidelines.



Rule of thumb: *if it wasn't charted, it wasn't done*

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## Charting Rules

- Correct Patient/Chart/Computer Screen (double check)
- Proper spelling and grammar
- Military time
- Only approved abbreviations
- If written:
  - Neat and legible
  - Black/Blue ink
- Document promptly

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- Do your own charting. Never ask someone else to document for you. Do not document for someone else.
- Never document “ahead of time”.
- Clearly identify other staff involved in a situation.

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## DATE AND TIME ON EVERY ENTRY

- Remember to put a date and time on every entry (Computer may do that for you)
- This is very... very... very important.

**ALSO IMPORTANT...**

- Signature for every entry
- Need to identify who wrote what

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## The Patient Chart

- Never tamper with notes and try to “fix” a mistake so it is not seen.
- Do not write over previous entries.
- Do not change numbers or Right to Left/Left to Right

**Errors in documentation need to be corrected by the person who made the error**

- Draw a single line through the error
- Write “mistaken entry” next to the information
- Document the correct information
- Sign and date the correction

~~Right Foot X-ray~~

Mistaken entry

Left Foot X-ray

C. Wehr  
05/09/2021

X

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## Source of Data

- Sometimes the inpatient is not able to give complete information for a clinical history
- Important to know where to find specific information in the patient chart and on patient wrist bands (i.e. Progress Report)

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- History and Physical
- Physician/Nurse Practitioner Orders
- Hall Pass/ SBAR
- Informed Consent
- Advance Directive
- Radiology Procedure Report
  
- Legal Medical Record and Designated Record Set at RH

[Policy Manager - MCN Healthcare \(ellucid.com\)](#)

## Parts of the Patient Chart/ Documentation Important to the RT

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## H & P



History and Physical Examination



Gives general background of patient's condition and reason for admission



NOTE: Only tells condition at time of admission (not necessarily current – would need to use other sources such as Progress Notes to find out what has happened since time of admission.)

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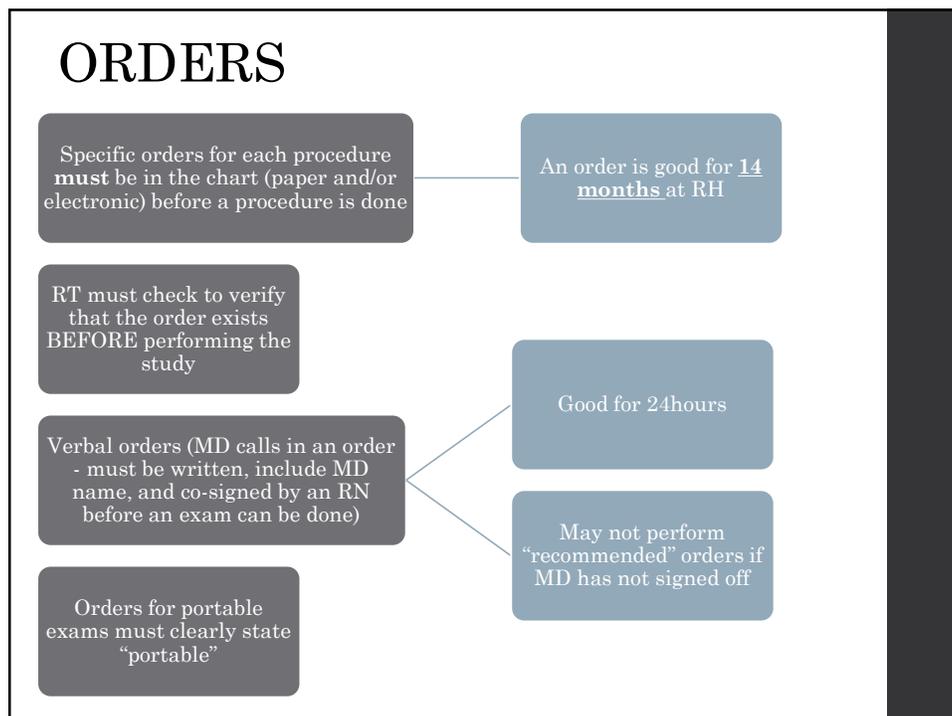
## Orders for Radiology

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- Doctor/Physician
  - Medical Doctor (MD),
  - Doctor of Osteopathy (DO)
- Medical Resident
- Nurse Practitioner

## Orders: Who can write an order?

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## PA Code (Law)

- **§ 127.32. Written orders.**
- Diagnostic radiology services shall be performed only upon the written order of a member of the medical staff, or house staff, or a physician who has been granted clinical privileges. Orders for radiology services shall, in all other respects, conform to the regulations generally applicable to written orders or the exceptions thereto. Any request for radiology services should contain a **concise statement** as to the reason for the request.

↓  
Clinical indication and/or ICD10

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All patient orders should be viewed in EPIC



If the Ordering Physician is not the same person who has entered the order, it must be authorized by a MD



RNs, PA, and nurse practitioners can place orders

At  
Reading  
Hospital

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**XR CHEST PA LATERAL [32037298]**

→ Electronically signed by: Reyner, Peter C, MD on 04/25/22 1059  
 This order may be acted on in another encounter.

→ Ordering user: Reyner, Peter C, MD 04/25/22 1059  
 Ordering mode: Standard  
 Frequency: 04/25/22 -  
 Diagnoses  
 Chronic obstructive pulmonary disease, unspecified COPD type (HCC) [J44.9]

→ Authorized by: Reyner, Peter C, MD  
 Ordered during: Office Visit on 04/25/2022

**XR ABDOMEN AP [328706680]**

→ This order may be acted on in another encounter.

→ Ordering user: Diaz, Carmen I 04/21/22 1348  
 Authorized by: Monath, James R, MD  
 Ordered during: Ancillary Orders on 04/21/2022  
 Frequency: 04/21/22 -  
 Diagnoses  
 Calculus of kidney [N20.0]

Ordering provider: Monath, James R, MD  
 Ordering mode: Transcribed Order (Use ONLY if presented with paper order)

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### HALL PASS/ “HAND OFF” COMMUNICATION/ SBAR

- Used to provide accurate information about a patient’s care, treatment or service when responsibilities are “handed off” from one care provider to another
- Patient’s chart needs to accompany her/him wherever she/he goes in the hospital
- Ensures continuity and safety of the patient’s care

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HALL PASS

PATIENT HAND OFF		
Date: _____	Time: _____	
Patient Name: _____		
RN Contact: _____	Phone Ext: _____	
<b>S Situation</b>		
Destination: _____		
Multiple Tests Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>B Background</b>		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Elopement Risk	
<input type="checkbox"/> Telemetry	<input type="checkbox"/> Language Barrier	
<input type="checkbox"/> Fall Risk	<input type="checkbox"/> Hearing Impairment	
<input type="checkbox"/> Restraints	<input type="checkbox"/> Vision Impairment	
Isolation: <input type="checkbox"/> Contact <input type="checkbox"/> Environmental <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne		
<b>A Assessment / Observation</b>		
<input type="checkbox"/> Oriented	<input type="checkbox"/> Disoriented	
<input type="checkbox"/> O2 @ _____	<input type="checkbox"/> NPO	
<input type="checkbox"/> IV Fluid @ _____	<input type="checkbox"/> Bed Rest	
Mobility: <input type="checkbox"/> Self <input type="checkbox"/> Assist 1 <input type="checkbox"/> Assist 2 <input type="checkbox"/> Total Assist		
Weight Bearing Restrictions: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>R Recommendation</b>		
Comments: _____		
Received By: _____	Dept: _____	Time: _____
Received By: _____	Dept: _____	Time: _____
Received By: _____	Dept: _____	Time: _____
Received By: _____	Dept: _____	Time: _____
NOTE: THIS FORM IS NOT PART OF THE PATIENT MEDICAL RECORD DISCARD AT THE TIME OF DISCHARGE.		

RH2110 1.07

22

11

E  
P  
I  
C

**HALL PASS** Date: 6/2/2014 Time: 1458

Name: Snyder, Susan

MRN: \_\_\_\_\_ DOB: 12/28/1964 Room/Bed: C102-2

RN Contact: Heidi Miller Phone Ext: 2568

**SITUATION**

Destination 1: <b>Radiology - Xray</b>	Destination 2: <b>Radiology - Cat Scan</b>	Destination 3:
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**BACKGROUND**

Allergies: Tylenol, Strawberries

Language Barrier: <b>No</b>	Hearing Impairment: <b>Yes</b>	Vision Impairment: <b>Yes</b>
Tale/Cardiac Monitor: <b>Yes</b>	Type of Restraints: <b>N/A</b>	Isolation: <b>Droplet</b>

**ASSESSMENT /OBSERVATION**

Orientation: <b>Oriented</b>	Diet Type: <b>Clear liquids 6/2/14</b>	IV Fluid @: <b>NSL</b>
Activity: <b>In Bed</b>	Weight Bearing Restrictions: <b>No</b>	Mobility: <b>Self Assist</b>
O2 Device: <b>Yes</b>	FIO2: <b>N/A</b>	O2 Flow Rate: <b>3 L/min</b>

**RECOMMENDATION**

Comments: \_\_\_\_\_

**POST PROCEDURE NOTE:** \_\_\_\_\_ Change \_\_\_\_\_ No Change

Comments: \_\_\_\_\_

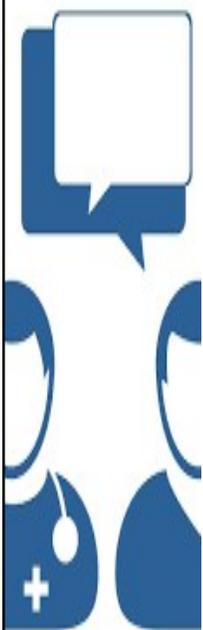
Received By: \_\_\_\_\_ Dept: \_\_\_\_\_ Time: \_\_\_\_\_

Received By: \_\_\_\_\_ Dept: \_\_\_\_\_ Time: \_\_\_\_\_

Received By: \_\_\_\_\_ Dept: \_\_\_\_\_ Time: \_\_\_\_\_

Note: THIS FORM IS NOT PART OF THE PATIENT MEDICAL RECORD.  
DISCARD AT THE TIME OF DISCHARGE.

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## HALL PASS/ "HAND OFF" COMMUNICATION/ SBAR

- Should include the patient's name, date and time
- Lists the name and phone number of caregiver (nurse)
- Person receiving chart needs to validate hall pass
  - Initials
  - Department
  - Time

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<b>S</b> <b>B</b> <b>A</b> <b>R</b>	<hr/> <b>SITUATION</b>
	<hr/> <b>BACKGROUND</b>
	<hr/> <b>ASSESSMENT/OBSERVATION</b>
	<hr/> <b>RECOMMENDATION</b>

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<b>SITUATION</b>
<ul style="list-style-type: none"><li>• What is going on with the patient?<ul style="list-style-type: none"><li>• DNR status (Allow Natural Death)</li><li>• Patient's destination</li><li>• Patient has multiple tests ordered</li></ul></li><li>• Current medical and/or nursing concerns</li></ul>


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## BACKGROUND

- Recent changes in condition or treatment
- What is the clinical background or context?
  - Isolation status and reason for isolation
  - Patient is a fall risk
  - Allergies
  - Patient recently received pain medication
  - Patient has recently had a change in level of consciousness
  - Patient speaks only Spanish and will need an interpreter



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## ASSESSMENT

- Anticipated changes in condition
- What do I think the problem is?
  - Current assessment trends
  - Current responses to treatment
    - Patient is drowsy after receiving pain medication



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## ASSESSMENT/OBSERVATION

- Patient receiving oxygen therapy
- Patient receiving IV fluids
- Patient's mobility
  - Self
  - Assist 1
  - Assist 2
  - Total Assist
- Weight bearing restrictions
- Patient is NPO



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## RECOMMENDATION

- What to watch for
- What would I do to correct the problem?
  - Information for follow-up
  - Post procedure needs
  - Patient is diabetic and has been NPO for exam; watch for signs of decreased blood sugar
  - Please give discharge instructions to spouse since patient is confused



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S  
B  
A  
R

Chapter 5 page 45

**SITUATION**

A chest x-ray has been ordered for Bertha Smith

**BACKGROUND**

Bertha Smith is a 56-year-old with congestive heart failure and multiple ED visits. She looks pale and diaphoretic. Her BP is 90/65 verified with a manual cuff. Her pulse is 110. We've got her on O2

**ASSESSMENT/OBSERVATION**

I think she may be having an MI

**RECOMMENDATION**

Bertha needs a chest x-ray STAT. Is a mobile x-ray in order due to the severity of her condition?

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Technologist Work List: RDX FLUORO - RH RAD FL WORK LIST, 17 patients, 18 appointments

Transpo	Stat	Appt	Image	Date	Appt	PT	ORDER	E-Si	P	Patient Name	Procedure	Reason for Exam
Sch				10/23/2019	7:30 AM		Transcribed				XR Abdomen Ap	Hydronephrosis with ureter

Legal Name: Schmitt, Larissa A. | MRN: 0581943 | Age: 33 y.o. | DOB: 02/08/1986 | Race: Female | Ethnicity: None | Bed: None | MONATH, J | None

Flowsheets

- File
- Add Rows
- LDA Avatar
- Cascade
- Add Col
- Insert Col
- Data Validate
- Hide Device Data
- List Filed
- Reg Doc

Procedure Verification | Procedure Pause | IV Assessment | Vital Signs | Outpatient Hall Pass ...

Accordion | Expanded

ABDOMEN, 10/23/19  
1100

OTHER

Patient present with assistive device  
 Have you fallen within the last 30 days?  
 Do you usually need something to help you walk?  
 Have you taken any medications that make you sleepy or dizzy?  
 When was the last time you ate, greater than 6 hours?  
 Are you a diabetic?  
 Do you have any special concerns, questions, or needs for today's  
 Patient Concerns:

**Radiology Hall Pass**

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## The Universal Protocol

The Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery is part of the *National Patient Safety Goals*® chapter of the Joint Commission accreditation manual.

[View National Patient Safety Goals](#)

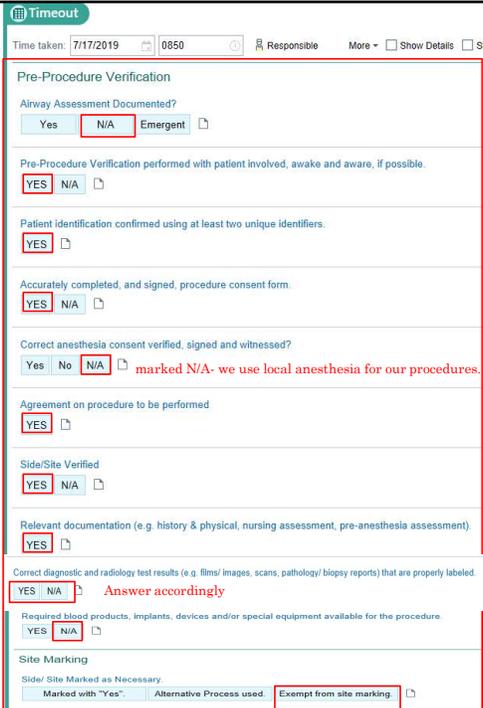


# Universal Protocol

A standard procedure with multiple checks utilized within the admission/assessment process to minimize the risk of wrong site, wrong procedure and wrong patient surgery.

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## Pre-Procedure Verification and Marking the Procedure Site



**Timeout**

Time taken: 7/17/2019 0850 Responsible: [Name] More - Show Details

**Pre-Procedure Verification**

Airway Assessment Documented?  
 Yes  N/A  Emergent

Pre-Procedure Verification performed with patient involved, awake and aware, if possible.  
 YES  N/A

Patient identification confirmed using at least two unique identifiers.  
 YES

Accurately completed, and signed, procedure consent form.  
 YES  N/A

Correct anesthesia consent verified, signed and witnessed?  
 Yes  No  N/A marked N/A- we use local anesthesia for our procedures.

Agreement on procedure to be performed  
 YES

Side/Site Verified  
 YES  N/A

Relevant documentation (e.g. history & physical, nursing assessment, pre-anesthesia assessment).  
 YES

Correct diagnostic and radiology test results (e.g. films/ images, scans, pathology/ biopsy reports) that are properly labeled.  
 YES  N/A Answer accordingly

Required blood products, implants, devices and/or special equipment available for the procedure.  
 YES  N/A

**Site Marking**

Side/ Site Marked as Necessary.  
 Marked with "Yes".  Alternative Process used.  Exempt from site marking

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## DON'T FORGET HIPAA



- Health Insurance Portability and Accountability Act (1996)
- Improve efficiency and effectiveness of the health care system by mandating confidentiality of health information
- Ensures privacy, security, and the establishment of standards and requirements for the electronic transmission of certain health information
- Governs access and usage of patient-identifiable info
- Ethical standard
- HIPAA violations may result in disciplinary actions



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- Share information **ONLY** with healthcare providers who have demonstrated a “Need to know” the information that you are releasing
- Information is shared **ONLY** for healthcare providers for the purpose of medical treatment only
- Never discuss your patient assignments with anyone except healthcare providers who need the information.
- Never look in a patient’s chart that you are not involved with!!!!

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## HIPAA applies to us all—at all times.

- Classroom
- Clinical setting
- Residence hall
- At home
- On the shuttle bus
- In the elevator
- In the cafeteria

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### PATIENT INFORMATION: RESPECT IT, PROTECT IT

Quarter 2 | 2016

Act as if  
**what you do  
makes a  
difference.  
It does.**

— William James

#### Social Media Do's and Don'ts

**Do...**

- Use privacy settings and seek to separate personal and professional information online.
- Protect patient privacy by not posting images or information regarding patients.
- Understand that a patient has a right to disclose information about themselves, BUT this does not give employees permission to engage in dialogue on a social media platform.
- Maintain professional-patient boundaries when engaging in social media.
- Check out Reading Health System's [Social Media Policy](#) located on [Policy Manager Plus](#).
- Contact the Privacy Office at 484-628-4588 with any questions, concerns or guidance needed.
- Be thoughtful in what you present on social media and understand the impact.

**Don't...**

- Assume that all communication is private based on privacy settings.
- Believe that there is no breach of confidentiality if name of patient is not disclosed.
- Engage in dialogue with a past or present patient on social media about their healthcare. Remember, information posted on a social media site can be retrieved even after being deleted and there is a great potential for it to be viewed by individuals other than its intended recipients.

#### HIPAA Reminder

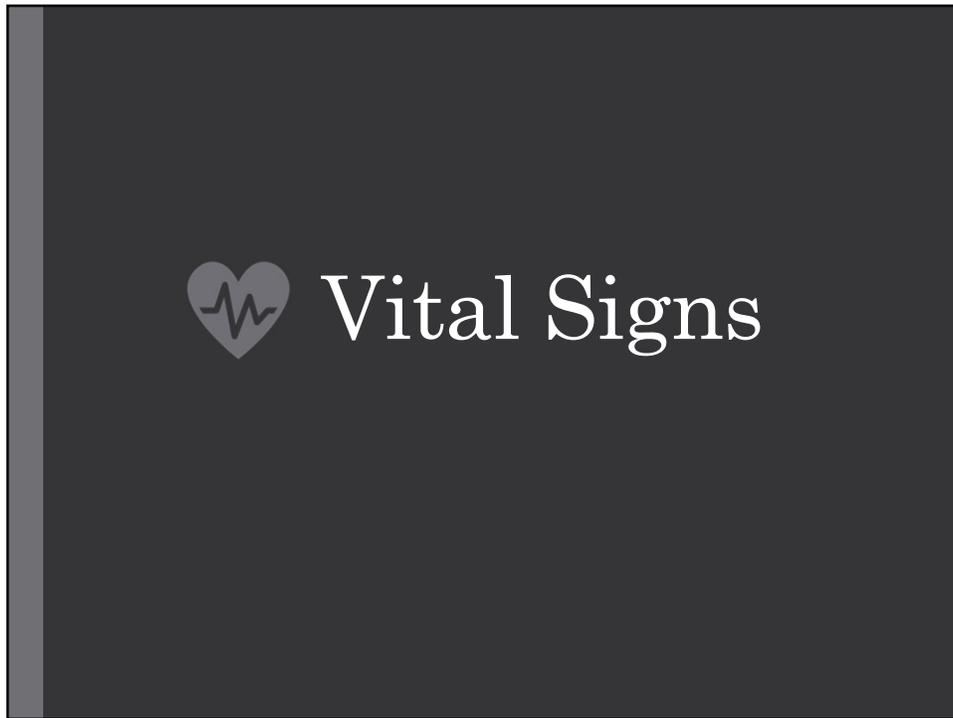
Check name on all discharge papers, prescriptions, lab requisitions, after-visit summaries, etc. before handing PHI to a patient.

*Please call  
**Carol Kriebel,  
Lisa Mondrewicz or  
Kristin Wahl**  
with any HIPAA Privacy  
questions or concerns.*

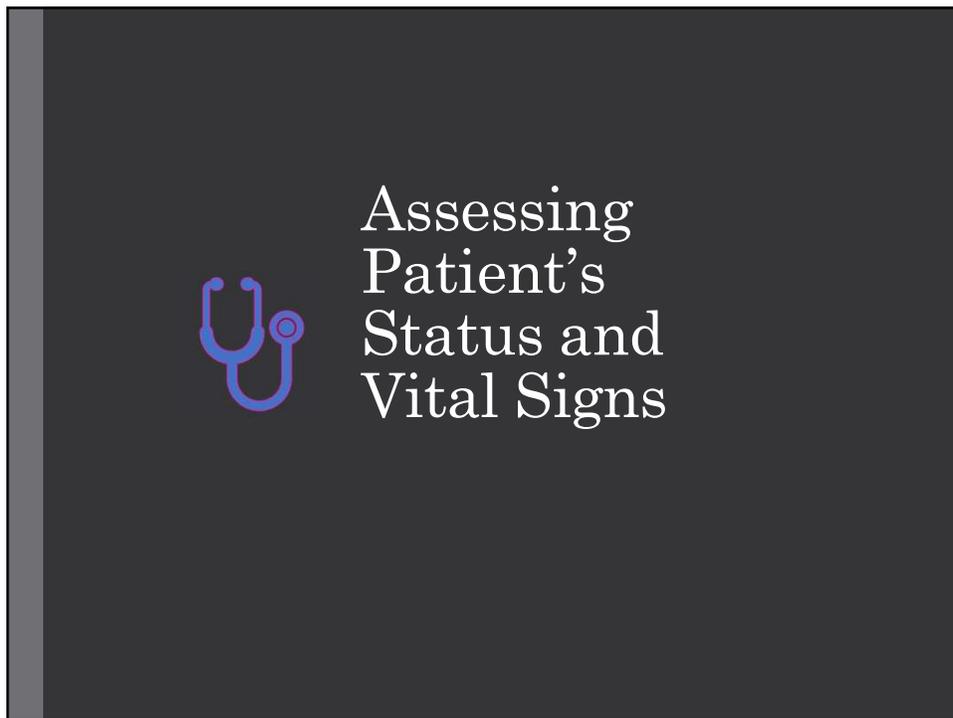


**READING HEALTH  
SYSTEM**  
Advancing Health. Transforming Lives.

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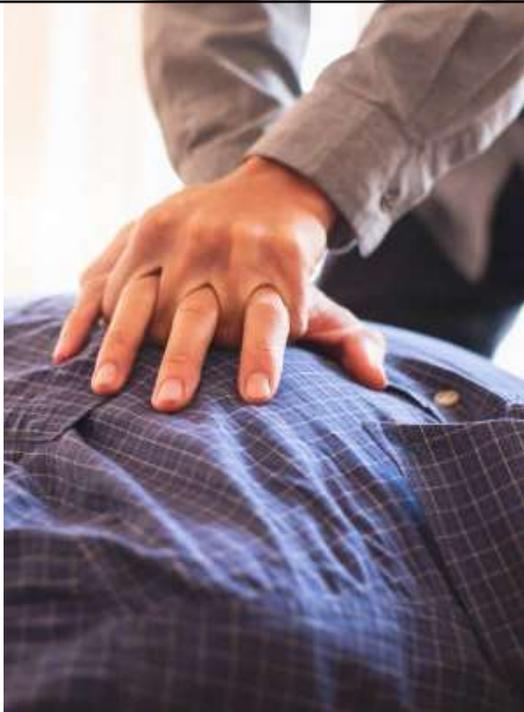


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Be aware of your patient!

Take note to the hallpass if your patient is an inpatient

Don't be afraid to take action if needed



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# Homeostasis

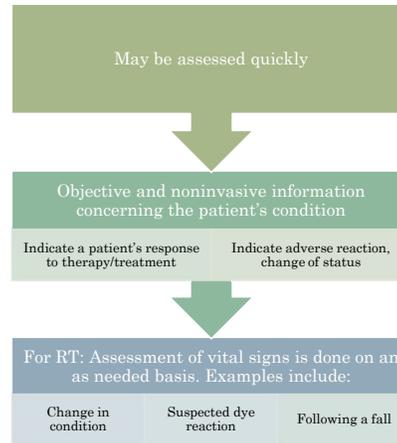
- Relative Constancy in the internal environment of the body
- Naturally maintained by adaptive responses that promote healthy survival (vital signs)
  - Heartbeat
  - Blood pressure
  - Body temperature
  - Respiratory rate
  - Electrolyte balance

Normal Vital Ranges  
pg. 168 Table15-1



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# Vital Signs



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## Body Temperature



- Measurement of degree of heat of the deep tissues of the body
  - Oral = 98.6 ° F (37° C)
  - Rectal = 99.6 ° F
    - Most accurate
  - Axillary = 97.6° F
    - Least accurate, most difficult
- Thermoregulation –body's maintenance of heat production and loss
  - Hypothalamus plays a role in preservation of heat (shivering) and regulation of heat loss (sweating)
  - Important for body temperature to remain constant (even when environment changes)

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## Five routes commonly used...

1. Oral
2. Axillary
3. Rectal
4. Tympanic
5. Temporal



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## THERE IS ONE MORE ....



## Infrared Digital Thermometers

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## Body Temperature Significance of Abnormalities

Hyperthermia – oral temperature higher than 99.5 ° F

- Otherwise known as a fever= febrile = pyrexia
- Metabolic rate changes accordingly and demands the cardiopulmonary system to also change
  - *Examples:* viral and bacterial infections, postoperative infection, injury to hypothalamus
- Reactions from patients – confusion, dizzy, comatose

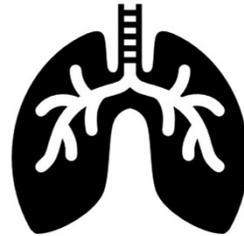
Hypothermia – temperature falls below normal range

- *Examples:* exposed to cold environmental temperatures, trauma to hypothalamus, heart surgery

Medically induced – therapeutically decrease body's need for oxygen

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## Respiratory Rate



- Ventilation
  - Mechanical movement of air into and out of the lungs
  - Respiratory system delivers O<sub>2</sub> from environment to body tissues
  - Eliminates CO<sub>2</sub> from tissues to environment
  - This gas exchange is necessary for survival
  - Diaphragm is major muscle of ventilation
    - On inspiration, diaphragm contracts
    - On expiration, diaphragm relaxes

Respiration=Combination of inspiratory and expiratory phase of breathing

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- Assessed by observing the rise (inspiration) and fall (expiration) of the chest or placing hand on the chest
  - Assess when patient is unaware so they do not alter their breathing rate and pattern
- Healthy adults – normal respirations are silent and effortless, automatically occur at regular intervals
- Measured by: breaths per minute
  - Adult at rest: 12-20
  - Children under 10: 20-30
  - Newborns: 30-60
- Counting respirations for a minimum of 1 minute is important to obtain an accurate measurement
- Can also assess the depth (shallow, normal, deep) and pattern (regular or irregular) of ventilation



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Cellular metabolism increases = demand for O<sub>2</sub> increase = production of CO<sub>2</sub> increases = increase respiratory rate

Tachypnea – respiratory rates greater than 20 breaths per minute (adult patient)

- Common causes: exercise, fever, anxiety, pain, infection

Bradypnea – decrease in the respiratory rate

- Occurs less frequently than Tachypnea
- Caused by: depression of the respiratory center of the brain
  - Example: drug overdose, head trauma, and hypothermia

## Respiratory Rate Significance of Abnormalities

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Dyspnea – difficulty breathing

Orthopnea – difficulty breathing unless sitting up or standing erect

Apnea – absence of spontaneous ventilation

## Respiratory Rate Significance of Abnormalities

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## Pulse



- Rate of contractions of the heart
- Measured by: palpating superficially located arteries
  - Common sites:
    - Radial artery (thumb side of the wrist)
    - Brachial artery (antecubital fossa of adults and upper arm of infants)
    - Carotid artery (neck)
- Additionally measured by stethoscope over heart counting each heartbeat (auscultation) = apical pulses

Auscultation - the action of listening to sounds from the heart, lungs, or other organs, typically with a stethoscope, as a part of medical diagnosis.

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## How to measure pulse?

- 2<sup>nd</sup> and 3<sup>rd</sup> digits placed over pulse point
- Counted for 60 seconds
- Assess strength and regularity
- Normal Adult Resting Pulse Rate: 60-100 BPM (beats per min)
- Children: 70-120 BPM
- During CPR: assess carotid to assess effectiveness of chest compressions
  - Adult – carotid pulse
  - Infant – brachial pulse



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## In Critical Care Settings...



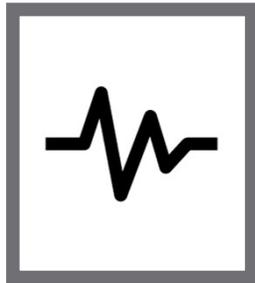
- Use pulse oximeter
- Light-emitting probe is placed on finger, foot, toe, earlobe, temple, nose or forehead of patient
- Oximeter converts light intensity into oxygen saturation and pulse rate values
- Normal Values : 95%-100% (SpO<sub>2</sub>)
- Factors can affect accuracy:
  - Movement, misplaced/loose lines, nail polish, etc.

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## Pulse Significance of Abnormalities

- Tachycardia
  - Increase of more than 20 BPM or greater than 100BPM
    - *Examples:* exercise, fever, respiratory disorder, CHF, shock
    - Also stimulated by pain, anger, fear but stimulus is from nervous system not need for oxygen
- Bradycardia
  - Decrease in heart rate
    - *Examples:* unrelieved pain, severe pain, hypothermia



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## Warning...!...Warning



- If no pulse is felt at wrist, or if cardiac arrest is thought to occur you should:
  - Assess pulse at carotid artery for a full 5 seconds while Emergency help is summoned
- If pulse irregularities are accompanied by palpitations, dizziness, or faintness:
  - Notify physician – these symptoms could be life-threatening

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## Blood Pressure

- Measure of the force exerted by blood on the arterial walls during contraction and relaxation of the heart
  - Just like water in a hose
- *Systolic* – contraction of heart (increase pressure on walls)
- *Diastolic* – relaxation of heart (constant pressure)

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## How do I measure?



- Sphygmomanometer and stethoscope
  - Sphygmomanometer – cuff, tubing, a valve, a bulb, and a manometer attached to the cuff
    - Mercury
    - Aneroid (more common)
- Patient seated and arm at level of heart
- Cuff placed on upper arm, midway between the elbow and shoulder
  - Inflated above patient's systolic pressure to stop blood flow (collapses brachial artery)
- Stethoscope placed over brachial artery in antecubital fossa of elbow
- Slowly release cuff pressure
- Blood flow returns and can be heard
- First sound corresponds to the systolic pressure
- When blood flow can no longer be heard corresponds to the diastolic pressure
- Korotkoff sounds – turbulent sound of blood flow through the arteries

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## How do I read it?

- Recorded in millimeters of mercury (mm Hg) read from manometer
- Systolic/diastolic
- Adult Normal Values:
  - Systolic: less than 120 mm Hg
  - Diastolic: less than 80 mm Hg

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**Hypertension** = persistent elevation of blood pressure above 140/90 mm Hg

- Common, but patient unaware, no symptoms exist
- Increases workload of heart and can damage brain in minutes
- Moderate degree of hypertension can cause damage to heart, brain, kidneys, lungs, and other organ systems
- Stress, medications, obesity, and smoking and contribute to hypertension
- Higher in men than women



## Blood Pressure Significance of Abnormalities

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- **Hypotension** = low blood pressure
  - Less than 95/60 mm Hg
  - Usually desirable and not problematic unless it produces symptoms
  - Concerns: dizziness, confusion, or blurred vision = ??? inadequate circulating blood volume = evaluation needed immediately
  - Shock from: severe bleeding, burns, vomiting, diarrhea, trauma, or heat exhaustion = decrease in total blood volume = immediate care needed

## Blood Pressure Significance of Abnormalities

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### Blood Pressure Significance of Abnormalities

- Orthostatic Hypotension (Postural Hypotension)
  - BP that falls 20 mm Hg or more when a patient sits or stands. Blood leaves the central organs (especially the brain) and moves to the periphery causing the person to feel faint.
  - Give the patient time and let them tell you when they are ready.

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What should  
you consider  
as a 5th Vita  
Sign.....

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## *Pain*



- A highly unpleasant and very personal sensation
- No two people experience pain in exactly the same way
- Can cause sleep loss, irritability, cognitive impairment, functional impairment, and immobility
- Pain is protective—warning us of a potential problem/injury to the body
- Assess all factors that affect the pain experience
  - Physiological, psychological, emotional, and sociocultural

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## Also Assess....



DESCRIPTION OF PAIN



INTENSITY OF PAIN



LOCATION OF PAIN



DURATION OF PAIN



AGGRAVATING AND ALLEVIATING FACTORS OF PAIN

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**Visual Analog Scale**

**Word Descriptor Scale**

- 0 = No pain
- 1 = Mild pain
- 2 = Distressing pain
- 3 = Severe pain
- 4 = Horrible pain
- 5 = Excruciating pain

**Graphic Scale**

**Verbal Scale**

"On a scale of 0 to 10, with 0 meaning no pain and 10 meaning the worst pain you can imagine, how much pain are you having now?"

**Functional Pain Scale**

- 0 = No pain
- 1 = Tolerable and pain does not prevent any activities
- 2 = Tolerable and pain prevents some activities
- 3 = Intolerable and pain does not prevent use of telephone, TV viewing, or reading.
- 4 = Intolerable and pain prevents use of telephone, TV viewing, or reading.
- 5 = Intolerable and pain prevents verbal communication

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