

## Pain Assessment using O,P,Q,R,S,T,V acronym

<b>O</b> nset,	When did it begin? How long does it last? How often does it occur?
<b>P</b> rovoking/palliating	What brings it on? What makes it better? What makes it worse?
<b>Q</b> uality	What does it feel like? Can you describe it?
<b>R</b> egion/radiation	Where is it? Does it spread anywhere?
<b>S</b> everity	What is the intensity of this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
<b>T</b> reatment	What medications and treatments are you currently using? How effective are these? Do you have any side effects from the medications and treatments? What medications and treatments have you used in the past?
<b>U</b> nderstanding/ impact on you	What do you believe is causing this symptom? How is this symptom affecting you and / or your family?
<b>V</b> alues	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you