
CHAPTER 9
Assessing Pain: The 5th Vital Sign

PRETEST

A. Choose the one best answer for each of the following multiple choice questions.

1. When assessing the client for pain, the nurse should
 - a. doubt the client when he or she describes the pain
 - b. assess for underlying causes of the pain, then believe the client
 - c. believe the client when he or she claims to be in pain
 - d. assess for the presence of physiologic indicators (such as diaphoresis, tachycardia, etc.), then believe the client

2. Acute pain can be differentiated from chronic pain because
 - a. acute pain always scores more on the visual analog scale than chronic pain
 - b. acute pain is associated with a recent onset of illness or injury with a duration of less than 6 months, whereas chronic pain persists longer than 6 months
 - c. acute pain is not treated and left to subside on its own, whereas chronic pain is referred for treatment
 - d. acute pain occurs only in persons aged less than 45 years, whereas chronic pain occurs in persons age 46 or above

3. One of the body's normal physiologic responses to pain is
 - a. hypotension
 - b. pulse rate below 50 beats/minute
 - c. diaphoresis
 - d. hypoglycemia

4. After assessing a client in pain, the nurse
 - a. documents the exact description given by the client
 - b. chooses from the list of pain descriptors what best reflects the client's description
 - c. ask the family to describe how they view the client's pain
 - d. documents how he or she best sees the client's pain

Health Assessment In Nursing Lab Manual Answers

Jean Foret Giddens, Jean Giddens



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Table of Contents Health Assessment In Nursing Lab Manual Answers

1. Understanding the eBook Health Assessment In Nursing Lab Manual Answers
 - The Rise of Digital Reading Health Assessment In Nursing Lab Manual Answers
 - Advantages of eBooks Over Traditional Books
2. Identifying Health Assessment In Nursing Lab Manual Answers
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Health Assessment In Nursing Lab Manual Answers
 - User-Friendly Interface
4. Exploring eBook Recommendations from Health Assessment In Nursing Lab Manual Answers

- Personalized Recommendations
 - Health Assessment In Nursing Lab Manual Answers User Reviews and Ratings
 - Health Assessment In Nursing Lab Manual Answers and Bestseller Lists
5. Accessing Health Assessment In Nursing Lab Manual Answers Free and Paid eBooks
 - Health Assessment In Nursing Lab Manual Answers Public Domain eBooks
 - Health Assessment In Nursing Lab Manual Answers eBook Subscription Services
 - Health Assessment In Nursing Lab Manual Answers Budget-Friendly Options
 6. Navigating Health Assessment In Nursing Lab Manual Answers eBook Formats
 - ePub, PDF, MOBI, and More
 - Health Assessment In Nursing Lab Manual Answers Compatibility with Devices
 - Health Assessment In Nursing Lab Manual Answers Enhanced eBook Features
 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Health Assessment In Nursing Lab Manual Answers
 - Highlighting and Note-Taking Health Assessment In Nursing Lab Manual Answers
 - Interactive Elements Health Assessment In Nursing Lab Manual Answers
 8. Staying Engaged with Health Assessment In Nursing Lab Manual Answers
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Health Assessment In Nursing Lab Manual Answers
 9. Balancing eBooks and Physical Books Health Assessment In Nursing Lab Manual Answers
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Health Assessment In Nursing Lab Manual Answers
 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
 11. Cultivating a Reading Routine Health Assessment In Nursing Lab Manual Answers
 - Setting Reading Goals Health Assessment In Nursing Lab Manual Answers
 - Carving Out Dedicated Reading Time
 12. Sourcing Reliable Information of Health Assessment In Nursing Lab Manual Answers

- Fact-Checking eBook Content of Health Assessment In Nursing Lab Manual Answers
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
- Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
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