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## CHAPTER 9

### Assessing Pain: The 5<sup>th</sup> Vital Sign

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#### 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

**R Sanford**



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