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 then chronic pain
 - 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
 - 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
 - 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

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