

Resources for the Comprehensive Geriatric Assessment based Proactive and Personalised Primary Care of the Elderly

FLACC pain scale (F) Face, (L) Leg, (A) Activity. (C) Cry, (C) Consolability

Purpose : Evaluation of severity of pain in individuals who are unable to communicate
Admin time : 5-10 min
User Friendly : High
Administered by : Primary Carer or Self-administered
Content : scoring of 0-2 for (F) Face, (L) Leg, (A) Activity. (C) Cry, (C) Consolability
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https://www.cgakit.com/m-5-flacc

FLACC pain scale

Name

Date

Score

Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested [appears sad or worried]	Constant grimace or frown Frequent to constant quivering chin, clenched jaw [Distressed-looking face: Expression of fright or panic]
INDIVIDUAL BEHAVIOURS			
Legs	Normal position or relaxed	Uneasy, restless, tense [Occasional tremors]	Kicking, or legs drawn up [Marked increase in spasticity, constant tremors or jerking]
INDIVIDUAL BEHAVIOURS			
Activity	Lying quietly, normal position moves easily	Squirming, shifting back & forth tense. [Mildly agitated (e.g head back and forth, aggression); shallow, splinting, respirations, intermittent sighs]	Arched, rigid or jerking [Severe agitation head banging; Shivering (not rigors); Breath holding, gasping or sharp intake of breath; Severe splinting]
INDIVIDUAL BEHAVIOURS			
Сгу	No cry, (awake or asleep)	Moans or whimpers; occasional complaint [Occasional verbal outbursts or grunts]	Crying steadily, screams or sobs, frequent complaints [Repeated outbursts, constant grunting]
INDIVIDUAL BEHAVIOURS			
Consolability	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractible	Difficulty to console or comfort [Pushing away caregiver, resisting care or comfort measures]
INDIVIDUAL BEHAVIOURS			



FLACC pain scale

Scoring

The FLACC scale is based on observations, with zero to two points assigned for each of the five areas.

Patients who are awake : Observe for at least 1-3 minutes. Patients who are asleep : Observe for at least 5 minutes or longer.

Observe legs and body uncovered. Reposition patient or observe activity. Assess body for rigidity and tone. Initiate consoling interventions if needed, then assess again.

Interpretation

- 0: Relaxed and comfortable
- 1 to 3: Mild discomfort
- 4 to 6: Moderate pain
- 7 to 10: Severe discomfort/pain

By recording the FLACC score periodically, healthcare providers can evaluate and document whether someone's pain is increasing, decreasing, or stable.

