### FLACC Behavioral Pain Assessment Scale

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No particular expression or smile</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
</tr>
</tbody>
</table>

**How to Use the FLACC**

**In patients who are awake:** observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

**In patients who are asleep:** observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

**Face**

- Score 0 if the patient has a relaxed face, makes eye contact, shows interest in surroundings.
- Score 1 if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed.
- Score 2 if the patient has deep furrows in the forehead, closed eyes, an open mouth, deep lines around nose and lips.

**Legs**

- Score 0 if the muscle tone and motion in the limbs are normal.
- Score 1 if patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of the limbs.
- Score 2 if patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, tremors.

**Activity**

- Score 0 if the patient moves easily and freely, normal activity or restrictions.
- Score 1 if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, pressure on a body part.
- Score 2 if the patient is in a fixed position, rocking; demonstrates side-to-side head movement or rubbing of a body part.

**Cry**

- Score 0 if the patient has no cry or moan, awake or asleep.
- Score 1 if the patient has occasional moans, cries, whimper, sighs.
- Score 2 if the patient has frequent or continuous moans, cries, grunts.

**Consolability**

- Score 0 if the patient is calm and does not require consoling.
- Score 1 if the patient responds to comfort by touching or talking in 30 seconds to 1 minute.
- Score 2 if the patient requires constant comforting or is inconsolable.

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decisions regarding treatment of pain require careful consideration of the context in which the pain behaviors are observed.

**Interpreting the Behavioral Score**

Each category is scored on the 0–2 scale, which results in a total score of 0–10.

- 0 = Relaxed and comfortable
- 1–3 = Mild discomfort
- 4–6 = Moderate pain
- 7–10 = Severe discomfort or pain or both

From Merkel, S. I., Voepel-Lewis, T., Shayevitz, J. R., & Malviya, S. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3), 293–297. The FLACC scale was developed by Sandra Merkel, MS, RN, Terri Voepel-Lewis, MS, RN, and Shobha Malviya, MD, at C. S. Mott Children’s Hospital, University of Michigan Health System, Ann Arbor, MI. Used with permission.