## FLACC Behavioural Pain Assessment Scale

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Face</strong></td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown; withdrawn, disinterested</td>
<td>Frequent to constant frown, clenched jaw, quivering chin</td>
</tr>
<tr>
<td><strong>Legs</strong></td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid, or jerking</td>
</tr>
<tr>
<td><strong>Cry</strong></td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimpers, occasional complaint</td>
<td>Crying steadily, screams or sobs; frequent complaints</td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or being talked to; distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

### How to score

**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, whimpers, 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.

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

---