**FLACC Behavioral 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Occasional grimace or frown; withdrawn, disinterested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>
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<tr>
<td><strong>Legs</strong></td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
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<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>
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<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>
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<tr>
<td><strong>Consolability</strong></td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or being talked to; distractable</td>
<td>Difficult to console or comfort</td>
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</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, 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.

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.*