

## Pain Assessment

### 1. Site of pain

- Primary location: description ± body map diagram - use questionnaire if appropriate eg) Brief Pain Inventory (BPI) or numerical rating scale (NRS)
- Radiation of pain from primary location

### 2. Circumstances associated with pain onset

- Including details and history of trauma or surgical procedures

### 3. Character of pain

- Intensity
- Sensory descriptors, e.g. sharp, throbbing, aching
- Temporal nature, aggravating factors
- Assess neuropathic pain characteristics (e.g. DN4)

### 4. Intensity of pain

- a) At rest
- b) On movement
- c) Temporal factors eg) duration, current or past pain over a time period, continuous or intermittent, aggravating or relieving factors
- Use a questionnaire eg) Brief Pain Inventory (BPI) or numerical rating scale (NRS)

### 5. Associated symptoms (e.g. nausea)

### 6. Effect of pain on activities and sleep

- Use questionnaire eg) Brief Pain Inventory (BPI) or numerical rating scale (NRS)

### 7. Treatment

- Current and previous medications (including OTC) dose, frequency of use, efficacy, side effects
- Other treatment (current or previous)
- Healthcare professionals consulted

### 8. Relevant medical history

- Prior or coexisting pain conditions and treatment outcomes
- Prior or coexisting medical conditions
- Substance abuse

### 9. Factors influencing the patient's symptomatic treatment

- Belief about the causes of pain
- Knowledge, expectations and preferences for pain management
- Expectations of outcome of pain treatment
- Reduction in pain required for patient satisfaction or to resume 'reasonable activities'
- Typical coping response for stress or pain
- Presence of anxiety or psychiatric disorders (e.g. depression or psychosis) already diagnosed or assess presence using questionnaire (e.g. Kessler 10)
- Family expectations and beliefs about pain and stress