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
