II. CLINICAL APPROACH

HISTORY TAKING IN THE PATIENT WITH PAIN

Howard S. Smith, MD, FACP, and Andrew Dubin, MD

1. What are the key elements in taking the clinical history of a patient with a complaint of pain?

The first step in taking the clinical history of a patient with a complaint of pain is to evaluate the pain complaint. Important factors are location; radiation; intensity; characteristics and quality; temporal aspects; exacerbating, triggering, and relieving factors; circumstances surrounding the onset of pain; and potential mechanisms of injury. Additionally, the clinician should ascertain if the pain is constant and steady, intermittent or sporadic, or constant with exacerbating circumstances by gathering information regarding the occurrence and characteristics of any breakthrough pain. Furthermore, one should ascertain the patient’s perception of why he or she has persistent pain, the duration of the pain, and changes in pain since its onset (e.g., any gradual or rapid progression in intensity or “spread” of location).

The patient should specifically be asked about any perceived exacerbation of pain with innocuous light touch, with sheets or clothes on the painful body part(s), with the wind blowing on the pain, and with external temperature changes (e.g., is the pain worse in winter?). Patients should be asked about any specific clothing they wear, aides they use, or behaviors or activities they engage in to function optimally with the pain.

The patient should be questioned about the function of the specific painful area and resultant changes in global physical functioning. Information should also be obtained regarding perceived restriction of range of motion; stiffness; swelling; muscle aches, cramps, or spasms, color or temperature changes; changes in sweating; changes in skin; changes in hair; nail growth; perceived changes in muscle strength; perceived positive (dysesthesias/itching) or negative (numbness) changes in sensation—including what may trigger these changes (if they are not constant) and when they are likely to occur.

Many aspects of the patient’s current life and perceived quality of life along with how this has changed because of pain should be questioned. Include the following:

- Social functioning
- Recreational functioning (e.g., how often the patient goes out to the movies, spectator sports concerts, to play cards, etc.)
- Emotional functioning
- Mood/affect, anxiety
- Identification of family members/significant others/friends and their relationships with the patient
- Occupation (if any)—last time worked and why stopped

2. If pain is a purely subjective phenomenon, how can its intensity be measured?

The only reliable measure of pain’s intensity is the patient’s report. Measures of pain intensity are not meant to compare one person’s pain with another’s; rather, they compare the intensity of one patient’s pain at any given time with its intensity at another given time. Thus, physicians and patients can judge whether pain intensity is increasing or decreasing with time and treatment. It is sometimes helpful to have the patient compare the intensity of the current pain experience with prior experiences.
3. How should pain intensity be recorded?
There are a number of different measurements for pain intensity (see Chapter 6, Pain Measurement), and it is not clear that any particular scale is universally better than any other. Some patients have greater ease with a verbal scale, some with a numerical, and some with a visual analog scale. It is, however, a good idea to use the same measure across time. Thus, verbal descriptors, such as “no pain, mild pain, moderate pain, severe pain, unbearable pain,” or numerical scales can be graded on each visit.

4. Can pain intensity be measured in children, the older person, and the cognitively impaired?
Once children reach an age of verbal skills, pain intensity can usually be quantified on a verbal scale. However, a number of scales work even for preverbal children (see Chapter 30, Pain in Children). Once children reach the preteen years, the same tools used in adults can be applied.

The older person may present more difficult problems. If the patient is cognitively impaired, it is often difficult to assess pain intensity on a precise scale, and it becomes more valuable to judge the functional impairments resulting from pain. Furthermore, medications used to treat pain may increase cognitive impairment and make assessment even more difficult. Older patients may tend to be more stoic about pain and are reluctant to report high intensities. One of the most helpful factors when assessing pain in children, older patients, and/or cognitively impaired patients is eliciting from the caregivers any changes from the patient’s baseline behavior.

5. What information can be gathered from the character of the pain?
The McGill Pain Questionnaire contains numerous descriptors for pain. Certain words that patients choose may help to infer a specific pathophysiology. For example, a burning, dysesthetic, or electric shock–like pain usually implies neuropathic pain. An aching, cramping, waxing and waning pain in the abdomen usually indicates visceral, nociceptive pain.

6. Why are the temporal characteristics of pain important?
The onset of pain is extremely important. The approach to pain of relatively recent onset should follow more closely the medical model, that is, a search for underlying cause. Acute pain usually indicates a new pathologic process, correction of which will relieve the pain. Chronic pain of long duration is less likely to be amenable to a standard medical model and requires a biopsychosocial approach (see Chapter 44, Physical Modalities: Adjunctive Treatments to Reduce Pain and Maximize Function). Chronic pain often outlives the initial cause and develops a life of its own; however, the events that initially resulted in the onset of pain may help guide potential therapeutic approaches to chronic pain.

7. Why is the temporal course of the pain important?
Certain pain syndromes have classic temporal patterns. For example, cluster headaches may occur at the same time of the day, every day, during only certain months of the year. Rheumatoid arthritis is characteristically worse early in the morning on rising (morning stiffness). Similarly, chronic, daily abdominal pain that has persisted in an unchanging way for years is unlikely to have a clear medical cure, whereas episodic abdominal pain that allows long pain-free intervals punctuated by severe bouts of pain is more likely to be due to focal pathology. The intensity of pain over time is also of significance. Acute, severe back pain that gradually improves probably should be followed expectantly, assuming that there are no signs of tumor or infection. On the other hand, pain that increases over days to weeks is of more concern.
8. **What is the best way to elicit the time course of a pain syndrome if the patient is having difficulty being specific?**

For the onset, ask the patient what he or she was doing when the pain started. If the patient can give a specific act or time of day, it is likely that the pain was of acute onset. To judge whether the pain is worsening or improving, look for functional signs; that is, ask the patient what he or she cannot do that he or she could do a few months ago. Also, ask what can they do. If functional ability is decreasing, the pain probably is increasing. The patient and clinician should attempt to construct a timeline of the pain, as well as precisely what patients did themselves in attempts to help the pain and any treatment designed by clinicians, including pharmacologic, interventional, neurophysical medicine techniques and modalities, behavioral medicine techniques, and neuromodulation techniques.

9. **What is the importance of ascertaining exacerbating and relieving factors?**

Specific pain syndromes have specific exacerbating and relieving factors. For example, tension headache is often relieved by alcohol, whereas cluster headache is characteristically exacerbated by alcohol intake. Back pain from a herniated disc is usually relieved by recumbency, whereas back pain from tumor or infection is either unrelieved or exacerbated by recumbency.

10. **A patient complains of back and leg pain but has trouble describing the exact distribution. What can you do to clarify the matter?**

Pain maps (body maps) are often useful for patients who have difficulty with verbal expression. A front and rear view of the body is presented on paper, and the patient simply pencils in the location of the pain. The patient may use different colors or different types of lines to describe different types of pain. This technique helps to define whether pain is in a nerve distribution or simply somatic. Also, having patients map out the pain distribution on their own body may be helpful for determining somatic versus nerve distributions.

11. **A patient has a rather nondescript headache that is getting worse over days to weeks. What should you consider?**

This patient’s pain—a temporal pattern of vague onset with rapid acceleration in symptoms—should raise suspicion that a space-occupying lesion could be present. Even in patients with back pain, one should consider tumor or infection as a possibility.

12. **An 80-year-old woman complains of severe pain in the chest wall after having a rash in that area. You made the diagnosis of postherpetic neuralgia and plan to use a tricyclic antidepressant. What questions should you ask in the history?**

Before prescribing any medication, a careful history of prior medication use and prior medical illnesses is imperative. Particularly in an older person in whom we consider using a tricyclic antidepressant, these matters are of maximal importance. Tricyclic antidepressants have anticholinergic properties. Therefore, they can exacerbate glaucoma, cause urinary retention, and increase confusion (factors that are fairly common in the older person). Orthostatic hypotension and other anticholinergic side effects are also more common in older patients than in young patients.

13. **What specific questions should be asked about the medical history in patients with complaint of pain?**

Questions should be directed at ascertaining comorbid medical conditions, including at least the following three major factors: (1) Has the patient had other painful illnesses? The response to these illnesses helps to guide current therapy. (2) How has the patient responded to medications or treatments in the past? This information should include the following: how long it was tried and at what level/dose (e.g., celecoxib 200 mg for 3 weeks and then celecoxib 400 mg for 6 weeks); perceived effectiveness; perceived adverse side effects at various doses; and all testing/imaging and visits/evaluation by any health care professionals (with clinician
addresses and phone numbers). Attempts should be made to obtain all records from clinician offices, hospitals, imaging centers/laboratories, pharmacies, etc. The patient’s current primary care physician and other involved health care specialists, along with current pharmacy/pharmacies, medication list (including complementary and alternative medications [e.g. herbal vitamins and over-the-counter agents]), and diet should be recorded. This information may limit the drugs that can be prescribed. For example, in patients with a history of hypersensitivity to a given medication, any medication in the same group should be avoided. If the patient has an aspirin allergy, nonsteroidal antiinflammatory drugs (NSAIDs) cannot be used without great caution. If patients tend to develop orthostatic hypotension or confusion easily, the tricyclics probably should be avoided. (3) Medical conditions that may limit treatment should be investigated. For example, glaucoma, benign prostatic hypertrophy, and cognitive impairment are relative contraindications to the use of tricyclic antidepressants because their anticholinergic properties may precipitate crises. In patients with a history of opioid abuse, the opioids may be used with great caution. In patients with active peptic ulcer disease, aspirin and NSAIDs may have limited utility. In patients with renal disease, NSAIDs and gabapentin may need to be “dose-adjusted” and used with caution. In patients with significant hepatic dysfunction acetaminophen, NSAIDs, antiepileptic medications, antidepressants, opioids, and muscle relaxants should be used with caution.

14. How does the family history affect a patient with pain?
Aside from the obvious issue of familial diseases, role models are often found in the family. A careful history should be taken to determine whether either parent or older siblings have suffered from a chronic pain syndrome. In addition, the family’s reaction to the pain syndrome should be noted.

15. Is history of disability benefits of any importance?
The issue has caused a great deal of argument in the literature, but there is no clear resolution. The general wisdom is that patients receiving significant compensation for illness are reinforced in their chronic pain. This has been called compensation neurosis. However, the evidence is somewhat tenuous at best, and such patients are probably best treated in the rehabilitative fashion.

16. Are there any helpful clues in the history taking of a patient with ischial bursitis “weaver’s bottom” that help support the diagnosis?
The following clues, if uncovered during history taking, will help point to an ischial bursitis diagnosis: In patients with this condition (known as “weaver’s bottom”), pain invariably occurs when they sit and always goes away when they stand up or lie on their side. However, when the patient resumes a seated position, the pain returns. They can point to the spot where it hurts and pressure reproduces their pain. Additionally, most patients with weaver’s bottom are able to say “it hurts right here,” and consistently point with their finger to the precise location of the painful spot.

17. What are some elements that could help to determine residual function?
- Is the patient ambulatory? If yes, do they need an assist device? (e.g., cane, brace, walker, crutch)
- How far can the patient ambulate?
  - Room distances
  - House distances
  - Limited community distances (150 to 200 feet)—able to walk length of driveway to mailbox
  - Community distances (e.g., mall walking)
- How fast can the patient walk? (e.g., How long does it take the patient to get from the parking lot to your office? Compare this with your own time.)
What capacity do the patients have to mobilize themselves in the community? (Know the environmental barriers they will encounter coming from parking lot to your office.)

Is the patient able to dress himself/herself? Ask the following questions:
- Can you put your own shoes and socks on with assist devices?
- Do you use slip-on shoes?
- Can you put a shirt on yourself?
- Can you put on a pullover by yourself?

For women with shoulder injuries:
- If you wear a bra, are you able to put it on by yourself?
- Do you fasten it in the back or do you fasten it in the front and then rotate it around?

Are you able to do activities of daily living such as household duties and chores? (Can you brush your teeth? comb your hair?)

Are you able to drive a car?
- Can you get in and out of a car with relative ease in a reasonable time period?

Are you able to get up and down from sitting on the toilet?
- Do you have a sitting or standing or lying intolerance?
- Are you able to bathe yourself?
- Are you able to toilet yourself?

**KEY POINTS**

1. Taking an appropriate history is essential for the assessment and treatment of patients with acute and chronic pain.

2. Detailed history taking of non–pain-related issues may lead to more effective treatment of the pain by identifying potential adverse treatment interactions prior to their prescription.

3. Detailed history taking may also lead to improved functional outcome in patients with chronic pain by identifying more completely the true needs of the patient.

**BIBLIOGRAPHY**


**SUGGESTED READINGS**
