

The art of history taking in patient with pain: An ignored but very important component in making diagnosis

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ABSTRACT

History taking in patient suffering from pain is dealt like an art by emphasizing the multimodal experience of pain which is ignored in modern sophisticated investigations era. For clinical diagnosis, we need proper history, targeted clinical examination and support by investigation with or without diagnostic intervention. Ignoring history part in clinical assessment can lead to wrong diagnosis and unnecessary experience and expenses for patient. History part of patient evaluation can be divided into present pain as chief complaint, ruling out red flags or warning signals, past history, personnel history including sleep and bladder and bowel history, treatment history and family history. Present pain history can be divided into quantity assessment, quality assessment, mode of onset and location, duration and chronicity, provocative and relieving factors, special characters, timing of pain, relation to posture and associated features. Quantity and quality of pain can be assessed by different tools with different sensitivity and specificity. These tools give idea about the multimodal experience of pain which cannot be assessed by any physical examination and investigation. This helps us in diagnosing and planning for multimodal approach of pain management. We can conclude that proper history with adequate tools which is supported by physical examination and investigation with or without diagnostic intervention helps in diagnosing exact nature of pain.

Key words: Pain, history taking, assessment tools, quality of pain, quantity of pain, neuropathic questionnaire, multidimensional assessment

Diagnosis is the most important part in any branch of clinical practice for management of patient's complaints. Similarly we cannot choose the correct treatment modality unless we identify the pain generator correctly and understand the pathophysiology behind it. In modern medicine with the advent of sophisticated imaging, there are tendencies of ignoring history part in clinical examination. Many times we jump directly into the magnetic resonance imaging (MRI) or other scans ignoring the importance of proper history in diagnosis of pain. But we must remember that some abnormality in MRI may not be indicative of the source of pain.

In making a clinical diagnosis there are three essential steps: History taking, clinical examination, and investigations. In establishing diagnosis of painful conditions, there is another special subheading under investigation part, called diagnostic interventions or diagnostic nerve blocks, which help us in finding pain generators.

Proper targeted history taking may help us in avoiding unnecessary costly investigations. History taking is an art, which makes physician and patients to have a good rapport and helps us to find the pain generator. Sufficient time should be given to the patients who are anxious, depressed, or overtly frightened, feels hopeless from medical science that their pain can be treated and may not be able to express the present situation. Repeated

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history taking of more patients gives us experience and teaches us to handle situation, which may confuse us at the beginning.

Analysis of history is also very important in making many other decisions such as history suggestive of red flags in back pain or headache prompt us to go for more invasive investigations or management. For example, history of bladder and bowel dysfunction, weakness of legs, increasing numbness, history of malignancy, and history of trauma in low back pain and leg pain, all point to the red flags of low back pain.

The history part of patient evaluation can be divided as follows:

- Pain at different locations as chief presenting complaints.
- Ruling out red flags or warning signals.
- Past history.
- Personal history, including sleep, bladder/bowel habit.
- Treatment history.
- Family history.

During history taking we must remember the following:

- Adequate time must be given to express their problems and the reasons for seeking advice from pain clinic care.
- We need to listen carefully without distractions in order to obtain and interpret the clinical information provided by the patient.
- Physician should be empathetic.
- Patient should believe that my physician is accepting my complaint.

Comprehensive history taking is usually done on first consultation. This will be more time consuming and laborious. Preconsultation questionnaire can help in overcoming this problem. This can be used as baseline reference about the patient in all aspects of pain. While taking history we should concentrate to get answers for two questions. First is to find out the source of pain and other to find out the type of pain.

Pain History

The chief complaint can be dealt with in the following steps:

1. Quantity or severity of pain.
2. Quality or nature of pain.
3. Mode of onset and location.
4. Duration and chronicity.
5. Provocative and relieving factors.
6. Special character.
7. Timing of pain.
8. In relation to posture.
9. Associated complaints.

Quantity or Severity or Intensity of Pain

Pain is a subjective experience. Like many diseases, such as hypertension or diabetes, there is no objective measurement for a patient's pain intensity. Unfortunately we do not have thermometer-like device to measure pain so we need to rely on the patients' statements. Pain is a complex neurobehavioral problem affected by psychological, cultural, and environmental factors. The variables to be measured are current pain intensity and average pain intensity over a specified period of time, for example, last 1 week or 4 weeks. It is the average pain intensity, which is the usual target for pain treatment both by the clinician and the patient. The goal of treatment in chronic pain is to reduce pain intensity as much as possible while avoiding side effects. Numerous pain scales for practical assessment of pain intensity in clinical studies have been developed. The chosen one should be appropriate for patient's abilities and preferences. These scales are more appropriate for detecting change within individuals rather than comparison between individuals.

Types of Pain Intensity Assessment

Pain can be assessed in two ways, by either unidimensional or multidimensional instruments. Pain should be assessed upon movement, not just like that when the patient is lying still to minimize discomfort.

Unidimensional instruments

1. Verbal Rating Scales (VRS)

In VRS, pain is described as none, mild, moderate, or severe. This is the usual way a patient express pain. This scale is short, easy to administer, and understand especially in elderly patients. Lack of reproducibility makes this one less suitable for research purposes.^[1]

2. The Binary Scale:

The patient is asked to answer for the question like — is your pain 60% relieved? “Yes or No.” This is short, easy to administer, and easy to understand. This can mislead the patient; along with lack of reproducibility make this less suitable for research purposes.

3. The Numerical Rating Scale (NRS):

It is the most commonly used. In this the two extremes of the pain experience is noted and has a numerical scale between “no pain” and “worst pain imaginable.” “Zero” corresponds to no pain and “10” corresponds to the worst pain imaginable [Figure 1].

The advantage of this scale is that it easy for the patients to understand. The disadvantage is that the digital scale

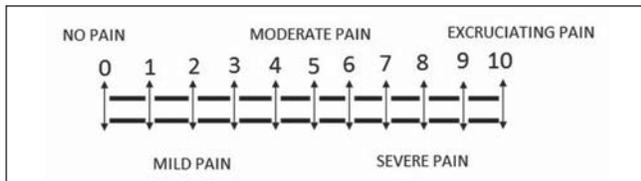


Figure 1: Numerical rating scale

reduces the capacity to detect subtle changes as the digits act as anchoring points. A reduction of 30% or 2 points and more from baseline in patient on treatment indicates positive response for treatment.

4. The Faces Rating Scale:

It is commonly used. The patient is asked to point to various facial expressions ranging from a smiling face (no pain) to an extremely unhappy one (the worst possible pain). It can be used in patients with whom communication may be difficult.

5. The Visual Analog Scale (VAS):

It is similar to the numerical rating scale. There is a 10-cm horizontal line labeled “no pain” at one end and “worst pain imaginable” on the other end. The patient is asked to mark on this line where the intensity of the pain lies. The distance from “no pain” to the patient’s mark numerically indicates the severity of the pain. Slide rule-like devices are also available that make measurement easier. The device has a line on the patient side and a numeric score on the clinician side. The VAS is a simple, efficient, valid, and minimally intrusive method that correlates well with other reliable methods.

The disadvantage is it is more time consuming than other instruments. There is some difficulty in using and understanding this scale in elderly patients.

Multidimensional Instruments

1. The McGill Pain Questionnaire (MPQ)^[2,3]

It was developed by Melzack and Torgerson. It is a checklist of words describing symptoms. Unlike other scales, it attempts to define the pain in three major dimensions by 20 sets of descriptive words divided as follows:

- Ten sets describe sensory — discriminative (nociceptive pathway).
- Five sets describe motivational — affective (reticular and limbic structures).
- One set describes cognitive — evaluative (cerebral cortex).
- Four sets describe miscellaneous dimensions.

The patient selects the sets that apply to his or her pain, and circles the words in each set that best describe the

pain. The words in each class are given rank according to severity of pain. It is translated to multiple languages. The advantage is that it is reliable and can be completed in 5-15 min and it helps in the diagnosis as the choice of descriptive words that characterize the pain correlates well with pain syndromes. The disadvantage is that high levels of anxiety and psychological disturbance can obscure the MPQ’s discriminative capacity.

2. Brief Pain Inventory (BPI)^[4]

It measures both the intensity of pain (sensory dimension) and the interference of pain in the patient’s life (reactive dimension).

It is translated to multiple languages.

Advantages:

- It is a reliable and valid for the cancer pain and many pain syndromes and can be completed in 5-15 min.
- It shows good sensitivity to treatment effects (mostly in pharmacological treatments).

3. West Haven-Yale Multi-dimensional Pain Inventory (WHYMPI)^[5,6]

Technique:

It is composed of 56 items with three parts:

- Five dimensions covering the experience of pain and suffering, interference with family, social and work functions.
- The patient’s perception of the pain with determining the responses or significant other displays to pain.
- The degree to which the patient engages in common daily activities.

Patients respond to the questions on a 7-point scale.

Advantages:

- It is valid in many pain syndromes.
- It shows good sensitivity to treatment effects.

4. Medical Outcome Study 36-item Short-form Health Survey (SF-36)^[7,8]

It consists of eight subscales including

- Physical functioning.
- Limitations due to physical problems.
- Social functioning.
- Bodily pain.
- Role limitations due to emotional problems.
- General mental health.
- Vitality.
- General health perceptions.

Advantages:

- a) It is the most widely used instrument to measure multiple dimensions of quality of life.
- b) It is used in almost every diseases or conditions imaginable.
- c) It is easy to administer, taking about 10 min to complete.

Assessment of Quality or Nature of Pain

It is one of the most important components in making diagnosis, particularly if we want to diagnose the nature or character of pain whether it is nociceptive or neuropathic or a mixed variety. There are different validated questionnaire-based tools, which helps us in identifying neuropathic pain conditions. And most of these tools are based on analysis of history. Even when we are not using such tools, proper history can guide us in making diagnosis of neuropathic pain. Simple questions like whether there is burning sensation, tingling, numbness, sensations such as crawling of ants, cramping, electric shock-like pain, and so on, can guide us to understand whether there is neuropathic component in pain. Allodynia can also be assessed by history, when touching parts of body with clothes or simple touch with fingers is evoking the pain. Nociceptive pain is somewhat easy to manage. Neuropathic pain if it is not diagnosed and treated properly in time, then it can lead to catastrophic stage where no options are available to treat.

Neuropathic pain has been defined by the Special Interest Group on Neuropathic Pain (*NeuPSIG*) as “*pain arising as a direct consequence of a lesion or disease affecting the somatosensory system.*”^[9] It is a common type of pain associated with suffering, depression, anxiety, disturbed sleep, and impaired quality of life. Because these components require different pain management strategies, correct diagnosis is highly desirable.^[10] The presence of validated tools to diagnose neuropathic pain is therefore required as improper assessment is frequently associated with undertreatment, underdiagnosis, and increased cost to the patient and society as a whole. A number of screening tools in the form of questionnaires have been developed and validated in the past decade to address the above purpose.

Screening tools for neuropathic pain

1. Leeds Assessment of Neuropathic Symptoms and Signs (LANSS)

LANSS, first described in 2001,^[11] was the first screening test to identify pain of neuropathic origin. It is a simple tool consisting of five symptoms addressing pain quality and triggers and two signs [Table 1]. Each item is a binary response (yes or no) to the presence of symptoms (five

items) or clinical signs (two items). It is easy to score in clinical settings and has been tested and validated in a number of neuropathic pain conditions since then with a sensitivity and specificity ranging from 82% to 91% and 80% to 94%, respectively.^[12-15]

Score < 12/24 indicates that the pain is unlikely to be neuropathic in origin and Score ≥ 12/24 indicates that the pain is likely to be neuropathic in origin. The need for clinical examination and pin prick testing limits its use in clinical setting. To overcome this drawback, a self-report tool, *S-LANSS* has been developed and validated to identify patients whose pain is dominated by neuropathic mechanisms.^[17]

2. Neuropathic Pain Questionnaire (NPQ)

It was administered to 382 patients of whom 149 had neuropathic pain and 233 patients had nonneuropathic pain.^[18] It is a *self-questionnaire* consisting of 12 items: 10 related to sensations and two related to affect [Table 2]. Each item is scored on a scale of 0 (*no pain*) to 100 (*worst possible pain*). The sensitivity and specificity have been demonstrated to be 66% and 75%, respectively, compared with clinical diagnosis. A *short form* of NPQ has been described consisting of three items: numbness, tingling, and pain increase in response to touch.^[19]

3. Douleur Neuropathique en 4 questions (DN4)

It consists of seven items related to symptoms and three items related to physical examination [Table 3].^[20] Each item is scored 1 (yes) or 0 (no) and sum of all 10 items is taken as total score with a score of ≥4 as neuropathic pain. It was developed in 160 patients: 89 with nerve lesions and 71 without nerve lesions. Sensitivity and specificity of 83% and 90%, respectively, has been demonstrated,

Table 1: Leeds Assessment of neuropathic symptoms and signs^[16]

Symptoms	Signs
Pricking, tingling, pins and needles sensation [5]	Brush allodynia [5]
Electric shocks or shooting [2]	Raised pin prick threshold [3]
Skin color change [5]	
Pain evoked by light touch [3]	
Skin temperature – hot or burning [1]	

Scores in square brackets.

Table 2: Neuropathic pain questionnaire

Burning pain	Squeezing pain
Overly sensitive to touch	Freezing pain
Shooting pain	Unpleasant (affect)
Numbness	Overwhelming (affect)
Electric pain	Increased pain to touch
Tingling pain	Increased pain to weather changes

respectively. The seven sensory descriptors can be used as a self-reported questionnaire with similar results.

4. Pain DETECT

It is a simple patient-based self-report questionnaire consisting of nine items: seven sensory descriptors and two related to spatial (radiating) and temporal characteristics [Table 4].^[21,22] The sensory descriptors are scored on a scale of 0 (no) to 5 (very strongly) and radiating pain as 1 (yes) or 0 (no). A score of ≥ 19 indicate neuropathic pain likely and ≤ 12 neuropathic pain unlikely. It does not require a clinical examination. It was validated in 392 patients: 228 with predominantly neuropathic origin and 164 with nociceptive origin.^[23] Sensitivity and specificity of 85% and 80%, respectively, has been demonstrated.

5. ID-Pain

It is a self-questionnaire consisting of five sensory descriptors and one item regarding pain located in the joints (to identify nociceptive pain) and does not require a clinical examination [Table 5].^[24] Scoring is from 1 to 5 with higher score indicating neuropathic pain. It was validated in 307 patients: 105 with neuropathic pain, 104 mixed, and 98 with nociceptive pain.

Table 3: Douleur neuropathique en 4 questions

Symptoms	Signs
Burning	
Painful cold	
Electric shocks	Hypoesthesia to touch
Tingling	Hypoesthesia to prick
Pins and needles	Pain caused or increased by brushing
Numbness	
Itching	

Table 4: PainDETECT

Symptoms	Pain course: four items
Burning (stinging nettles)	Persistent pain with slight fluctuations
Tingling or pricking	Persistent pain with slight attacks
Is light touching painful?	Pain attacks without pain between them
Sudden pain attacks such as electric shocks	Pain attacks with pain between them
Is cold or heat occasionally painful?	Radiation
Numbness	Radiating pain
Does slight pressure trigger pain?	

Table 5: ID-Pain

Pins and needles	Electric shocks
Hot/burning	Is the pain made worse with touch of clothing or bed sheets?
Numb	Is the pain limited to your joints? (-1)

Mode of Onset and Location

Mode of onset and location is very important for the etiology of pain. It may be sudden or gradual onset. Sudden onset of severe pain without any provocation, for example, severe intolerable headache may be due to subarachnoid hemorrhage and sudden severe pain on patients with pre-existing pain, for example, severe back pain in elderly patients with pre-existing back pain may be due to spinal carcinoma metastases. Both these conditions indicate red flag, considered. Site of onset gives better idea in finding out primary reason, for example, lumbar facet joint arthropathy patient gives history of pain on lower back, buttock, and thigh but on enquiry they will show onset on paramedial region and later distributed to other regions. It is not uncommon for patient to link pain to trauma in the past or present, which may not be relevant. Detailed enquiry may reveal pain-free period after trauma.

Chronicity (Duration and Frequency)

The duration is important to an extent, if patient is having chronic pain of 20 years duration; it is not risky, in other aspect if new symptoms or sudden increase of pain occurs in already existing problem warrant's exclusion of malignancy or metastasis. Duration and frequency history plays a vital role in the diagnosis, for example, in migraine, the unilateral pain is frequently throbbing and may last for hours to days. Cluster headaches, in contrast, are named for their periodicity. In short, duration and frequency history ease our diagnosis. Patient with long history of pain, physical provocative test may become negative, for example, straight leg raise test in lumbar radiculopathy may be negative on long course. In this case, history of pain in leg with neuropathic character, exaggerated on exertion and relieved by rest may be only clue for its diagnosis. Very important in chronic pain conditions, always remember that sympathetic system (central sensitization) will become the main pain mediator, which may explain diffuse the nature of pain in patient and failure to respond to conventional (interventional) treatment.

Provocative and Relieving Factors

Assessing what provokes or relieves the pain provides valuable clues to the diagnosis. Leg and back pain due to spinal stenosis has a characteristic pattern of worsening with walking or standing, with the pain being totally relieved with sitting or lying down for less than 10 min. Neuropathic pain can present with spontaneous pain or pain can be provoked by different stimuli such as cold, light touch, or the brushing of sheets. It is usually improved with heat, often the opposite of inflammatory pain. Patient with

pain generator very near to each other, for example, lower lumbar facet and sacroiliac joint may have similar history but provocative and relieving factors will give good idea for diagnosis as sitting relieve pain in facet joint syndrome not in sacroiliac joint arthropathy in which sitting may provoke pain.

Special Character

Between pain character and severity, considerable overlap can be identified. For examples, in cluster headache the pain usually will be deep, boring, wrenching, and the pain is most severe while vascular headache tends to be throbbing, pulsatile, and severe in intensity. For facial pain the character and severity tends to be different for different conditions, in idiopathic trigeminal neuralgia pain tends to be unilateral, paroxysmal, sharp, shooting, and lancinating along one or more branches of trigeminal nerve, whereas the pain of temporomandibular joint dysfunction tends to be unilateral, dull aching, and around the affected joint. It is exacerbated by bruxism, eating, and yawning. Postherpetic neuralgia pain may be burning and aching superimposed on paroxysms of shocks and jabs. It is associated with dysesthesias, and allodynia (unpleasant sensation even with the slightest touch over the skin).

Timing of Pain

Pain and stiffness felt in the morning hours persisting for more than hours may be inflammatory arthropathy, whereas pain after any inactivity persisting less than half an hour or after prolonged activity goes more in favor of degenerative arthropathy. Severe headache occurring regularly at a particular time, particular season may give clue for cluster headache. Neuropathic pain can be more severe in the night.

Relation with Posture

Pain on sitting on floor may be because of sacroiliac(SI) joint arthropathy, whereas cross-legged sitting may be painful in piriformis syndrome, and others. Pain on change of posture such as turning in bed, standing from sitting position goes more in favor facet joint syndrome. Prolonged sitting produces more pain in discogenic pain. Patients with spinal canal stenosis have more pain on standing and walking.

Associated Complaints

Associated complains such as weakness, numbness may indicate neurologic deficits. Fever may indicate infections, nausea/vomiting also have diagnostic value in migraine, space occupying lesion of brain, and so on.

Understanding Red Flags or Warning Signals

We must be very cautious in dealing certain painful conditions, which can be potentially dangerous. We must be having multidisciplinary approach to deal with these patients. These vary in different anatomical locations, but the following features (not limiting to the followings) in general can be serious.

- Pain with major trauma
- Suspecting tumor
- Suspecting infection with fever, rigor, vomiting, and so on
- Unconsciousness
- Motor weakness
- Progressive sensory deficit
- Loss of vision
- Loss of bladder control with retention and incontinence
- Loss of bowel control with inability to force to pass stool
- Sudden onset pain, which is progressing rapidly
- Not relieved by analgesic within few days.

Past History

Past history includes any pain events mimicking present, ask for progress, diagnosis, and any treatment taken and procedure/operation done. Past history help in making diagnosis, for example, history of rash, vesicles in the same dermatome as of present neuropathic pain can confirm postherpetic neuralgia. Some diseases have periodic occurrence and they can have multiple same type of previous episodes before presenting to us at present, for example, cluster headache. Patient with multiple episodes of pain can have associated significant cognitive disturbance. Patient can have some disease, which can influence the manifestation of pain (eg, dementia) or it can interfere with treatment (organ damage). History targeted on finding etiology of pain can help in finding other pain manifestations of a disease (eg, multiple sclerosis). Diabetes, hypertension, thyroid disorder, dementia, parkinsonism, liver and kidney compromise, inflammatory disorders should be given more importance on its presence.

Personal History Including Sleep, Bladder/Bowel Habit

Patient with pain can have some psychological disorders, such as anxiety and depression, which occurs primarily because of pain, leads to patient's less tolerance to pain and decreased coping capacity and some disorders, such as dementia, bipolar disorder, Post Traumatic Stress Disorder (PTSD) and Attention Deficit Hyperactivity Disorder

(ADHD). A lot of tools are available for mental status assessment, which includes

- PHQ-9
- Beck Depression Inventory^[25]
- Hamilton Depression Scale^[25,26]
- Zung Self-Rating Depression Score^[25]
- Hospital Anxiety and Depression Scale (HADS)^[27]
- Pain Catastrophizing Scale (PCS)^[28]
- The Tampa Scale of Kinesophobia.^[29]

1. PHQ-9

	Not at all	Several days, but less than half a month	Several days, more than half a month	Nearly everyday
A. Little interest or pleasure in doing things	0	1	2	3
B. Feeling down, depressed, or hopeless	0	1	2	3
C. Trouble falling or staying asleep or sleeping too much	0	1	2	3
D. Feeling tired or having little energy	0	1	2	3
E. Poor appetite or overeating	0	1	2	3
F. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
G. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
H. Moving or speaking so slowly or so restlessly that other people could have noticed	0	1	2	3
I. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	0	1	2	3

Maximum score is 27. Score 1-4/27 indicates minimal depression, 5-9/27 indicates mild depression, 10-14/27 indicate moderate depression, 15-19/27 indicate moderately severe depression, and 20-27/27 indicate severe depression.

2. Beck Depression Inventory^[25]

This have 21 parameters and each are graded from 0 to 3 thus have total score of 63. Result will be inferred as below

- 1-10 — Ups and downs are considered normal.
- 11-16 — Mild mood disturbance.
- 17-20 — Borderline clinical depression.
- 21-30 — Moderate depression.
- 31-40 — Severe depression.
- >40-Extreme depression

3. Hamilton Depression Scale.^[25,26]

It includes 17 parameters with score grade of 4 items (symptom is absent, mild, moderate, severe and very severe), 2 items (symptom is absent, mild and definite). Total score of 0-7, 8-13, 14-18, 19-22, ≥ 23 indicates normal, mild, moderate, severe and very severe depression accordingly.

4. Zung Self-Rating Depression Score.^[25]

It includes 20 parameters with grading ranging from 1 to 4, thus a total score of 20-80. Some parameters are given score from 1 to 4 for symptoms increasing in time duration and some are given in reverse.

5. Hospital Anxiety and Depression Scale (HADS).^[27]

It includes 14 parameters with 2, 4, 6, 8, 11, 12, 14 for anxiety and 1, 3, 5, 7, 9, 10, 13 for depression.

Scoring is done as 3, 2, 1, 0 (for item 7 and 10 scoring is reversed). Score of 0-7 indicates noncase; 8-10 indicate borderline case; and 11 or above indicate case.

Pain Catastrophizing Scale (PCS)^[28] and The Tampa Scale of Kinesophobia^[29] helps in assessing personality disorder.

Sleep disorder and pain is highly interlinked together. Pain can cause sleep disorder in over 70% of patient. Pain may be interrupted, for example, posttraumatic stress disorder or patient can feel inadequate sleep on waking up, for example, in fibromyalgia. Some disorders associated with sleep such as obstructive sleep apnea can interfere with treatment and result, for example, treatment with opioids. Effective treatment of sleep disturbance will involve assessing and treating all of the contributing factors. Chance of pregnancy should be ruled out in women of child-bearing age. Bladder and bowel disturbance may be an associated component or etiology for present pain complaint. For example, history of inflammatory bowel disease may be a reason for seronegative inflammatory arthropathy, and irritable bowel disease may be an associated disease of fibromyalgia.

Treatment History

The initial questionnaire should allow the patient to list all the therapeutic modalities they are currently using or have used in the past. Chances of drug addiction should be ruled out before prescribing any drugs. Any drug allergy, any side effect/complication to past treatment or comorbid condition (renal, hepatic compromise) should be taken into consideration before prescribing medicine.

Family History

History of pain and diseases in family members can support in getting diagnosis as some diseases run among families, for example, rheumatoid arthritis, fibromyalgia, and others. History of family dispute should be ruled out in patients having disproportionate, irrelevant, and unusual manifestations.

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