Initial Adult Pain Complaint Assessment

- Medical History
  - Onset, Character, Progression
  - New (acute) or chronic (present for at least than 90 days)
  - Associated Symptoms
  - Prior treatments and response
  - Assess pain impact on daily activities and functioning
    - May use a Pain Assessment such as PEG
      - PEG: Pain, Enjoyment, General Activity
  - Assess prior or current Mental Health; consider using commonly validated tools such as
    - PHQ-2 (Patient Health Questionnaire)
    - PHQ-9
    - GAD (General Anxiety Disorder)
    - PC-PTSD (Primary Care-PTSD4)
  - Examination
    - Mental Status Exam
    - Physical Exam:
      - Thorough exam of suspected/identified source of pain (See examples below)
        - Neurological
        - Musculoskeletal
        - Systemic/Inflammatory
        - Multiple etiologies
        - "Red Flags" present → Outside of this algorithm
    - Determine possible etiology of pain and contributing co-morbidities
    - Review diagnostic tests if available or consider testing dependent upon findings

Neurological	Musculoskeletal/Mechanical	Inflammatory	Multiple Etiologies
-Nerve root compression/Sciatica -Neuropathies (DM, Post-herpetic, Trigeminal)	-Degenerative Arthritis -Degenerative Disk Disease -Compression Fracture -Neck & Back pain -Myofascial Pain	-Arthropathies (Rheumatoid Arthritis) -Tissue Injury	-Central Pain Syndromes (Post CVA, Complex Regional Pain Syndrome) -Fibromyalgia -Behavioral, PTSD/ACE

Acute Pain

(Less than 90 days)

See Acute Pain Management Protocol

Chronic Pain

(More than 90 days)

See Chronic Pain Management Protocol

Appendix A

PEG Pain Screening Tool

1. What number best describes your pain on average In the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has Interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your **general activity?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instrument, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

Appendix B

The Patient Health Questionnaire-2 (PHQ-2) • Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ--2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ 2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric: Properties[1]

Major Depressive Disorder (7% Prevalence)				Any Depressive Disorder (18% Prevalence)			
PHQ-2 score	Sensitivity	Specificity	PPV	PHQ-2	Sensitivity	Specificity	PPV
1	97.6	59:2	15 .4	1	90.6	65.4	36.9
2	92.7	73.7	21.2	2	82.1	80.4	48.3
	82.9	90.0	38.4	3	62.3	95.4	75.0
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

" *Because* the *PPV varies with the prevalence* of *depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with, a lower prevalence.*

1. Kroenke K, Spitzer RI, Williams JB. The *Patient Health Questionnaire-2: validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.*

The Patient Health Questionnaire-2 (PHQ-2.)

Patient Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?		**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Appendix C

Patient Health Questionnaire (PHQ-9)

Patient Name:_____ **Date:** _ _ _

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any often following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual .	☐	☐	☐	☐
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For clinician use only

Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____	X 0 = _____
Several days	(#) _____	X 1 = _____
More than half the days	(#) _____	X 2 = _____
Nearly every day	(#) _____	X 3 = _____

Total score: _____

Interpreting PHQ-9 Scores		Actions Based on PH9 Score	
		Score	**Action**
Minimal depression	0-4	<4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27 20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Appendix D

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHO). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbla.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from O to 21.

0-4: minimal anxiety

5-9**:** mild anxiety

10-14: moderate anxiety

15-21: severe anxiety

Appendix E

Post-Traumatic Stress Disorder Test - PC-PTSD-4 Screen

In your life, have you ever experienced any event(s) that was/were so frightening or upsetting that, in the past month you have...	No (0)	Yes (1)
1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?		
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?		
3. Been constantly on guard, watchful, or easily startled?		
4. Felt numb or detached from people, activities, or your surroundings?		

Scoring:
The results of the PC-PTSD should be considered "positive" if a patients answers "yes" to any three items. Those screening positive should then be assessed with a structured interview for PTSD. The screening tool does not include a list of traumatic events.

Reference
Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., et al., The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5): Development and Evaluation Within a Veteran Primary Care Sample. *J Gen Intern Med,* 2016. **31(10):** p. 1206-11. PMC5023594.