

OPQRST

O	Onset of event	• What was the patient doing when it started? Were they active, inactive, and or stressed? • Did that specific activity prompt or start the onset of pain? • Was onset of pain sudden, gradual or part of an ongoing chronic problem
P	Provocation and palliation of symptoms	• Is the pain better or worse with: • Activity. Does walking, standing, lifting, twisting, reading, etc... have any effect of the pain? • Position. Which position causes or relieves pain? Provide examples to the patient-- sitting, standing, supine, lateral, etc... • Adjuvant. Which type of medication relieves the pain (Tylenol, Ibuprofen, etc..)? Does the use of heat or ice packs alleviate pain? What type of alternative therapy (massage, acupuncture) have you used before? • Does any movement, pressure (such as palpation) or other external factor make the problem better or worse? This can also include whether the symptoms relieve with rest.
Q	Quality	• Ask the patient to describe the quality of pain – is it throbbing, dull, aching, burning, sharp, crushing, shooting, etc...? • Questions can be open ended "Can you describe it for me?" or leading • Ideally, this will elicit descriptions of the patient's pain: whether it is sharp, dull, crushing, burning, tearing, or some other feeling, along with the pattern, such as intermittent, constant, or throbbing.

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R	Region and radiation	- Where pain is on the body and whether it radiates (extends) or moves to any other area? Referred pain can provide clues to underlying medical causes. <i>Location</i>: body diagrams may help patients illustrate the distribution of their pain. <i>Dermatome map</i> – may help determine the relationship between sensory location of pain and spinal nerve segment (see figure next slide). <i>Referred vs Localized</i>: referred pain (also known as reflective pain) is feeling pain in a location other than the original site of the painful stimulus. Localized pain is when pain typically stays in one location and does not spread.
S	Severity	- Ask the patient to describe the intensity of pain at baseline and during acute exacerbations. - The pain score (usually on a scale of 0 to 10) where 0 is no pain and 10 is the worst possible pain. This can be comparative (such as "... compared to the worst pain you have ever experienced") or imaginative ("... compared to having your arm ripped off by a bear"). If the pain is compared to a prior event, the nature of that event may be a follow-up question.
T	Timing	- Identify when the pain started, under what circumstances, duration, onset (sudden/gradual), frequency, whether acute/chronic. - How long the condition has been going on and how it has changed since onset (better, worse, different symptoms)? - Whether it has ever happened before, and how it may have changed since onset, and when the pain stopped if it is no longer currently being felt?