Scenario 1: Participant Information

Learning Objectives:

1. Learners will identify at least 3 of the correct domains of the biopsychosocial assessment of pain including attitudes/beliefs, physical function, sleep, school, emotional, family, social
2. Learners will demonstrate effective interviewing skills to complete the assessment of the above domains for both patient and caregiver
3. Learners will demonstrate a collaborative interprofessional team approach to complete a subjective assessment

History of Presenting Illness/Situation

Hanna is a 16-year-old female presenting with pain in different locations. She cannot remember when the pain started exactly, but it has aggravated over the past 18 months. The pain started in her lower extremities, and currently she has pain in bilateral ankles, knees, hips, lower and middle back, neck, right wrist and elbow and left shoulder. She was seen by her pediatrician, who referred her to a rheumatologist and neurologist. Hanna had extensive medical work-up done before she was seen in your clinic: she had a whole-body MRI, blood work with inflammatory markers and an electromyography (or EMG = measurement of normal nerve stimulation of the muscles). All previous tests came back normal. There is no follow up scheduled in rheumatology or neurology clinics. Hanna was previously healthy, with no relevant medical history. There is a positive family history for chronic pain: Hanna's mother has a medical history of migraines, and there is a paternal aunt with the diagnosis of fibromyalgia.

You suspect Hanna has chronic primary MSK pain that is widespread.

You have started your assessment with her and have obtained the following information (see below). Please take a couple of minutes to plan as a team for what other information you need to retrieve using a biopsychosocial approach. Once you are ready, please articulate that you would like to connect with Hanna and her mother to obtain the remainder of the information from them. Consider the impact of pain on Hanna's overall life. You've met Hanna and her mother once before. Hanna is at the clinic with her mum (June). Hanna lives with her mum, 13-year-old sister (Chloe) and maternal grandparents (Anna - grandmother and Charles - grandfather). Dad (Thomas) lives out of the country and is not involved.

Past Medical History/Background

Weight: 45 kg
PMHx: Healthy
Allergies: NKA
Medications: Acetaminophen, ibuprofen
Imaging: Whole-body MRI: normal findings, no signs of inflammatory disease, arthritis, enthesitis or myositis.
Pain location: Bilateral ankles, knees, hips. Lower and middle back, neck area. Right wrist and right elbow. Left shoulder.
Intensity (Numerical Pain Rating Score): Currently 7/10, Range 4-9/10, Average 7/10
Quality: Aching, hurting, shooting, tingling, uncomfortable, annoying.
Aggravating factors: All physical activities and movements, being in one position for a longer period of time: sitting, standing.
Easing factors: Resting, a warm bath feels comforting in the moment
24-hour pattern: Constant pain, seems random, worse at end of day
Associated symptoms: sleep difficulties, 'cracking of joints'
Treatments tried: ibuprofen, acetaminophen, rest, ice, heat, elevation, massage therapy

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Scenario 2: Participant Information

Learning Objectives

1. Learners will demonstrate a pain focused physical examination.
2. Learners will review the limits of confidentiality with patient
3. Learners will demonstrate an assessment of substance use and psychosocial function with the adolescent on their own.

History of Presenting Illness/Situation

You've just completed a comprehensive subjective pain assessment of Ella who is a 14-year-old female with chronic left ankle/foot pain. She fell during a dance class 3 months ago and had immediate pain in her left ankle and it became swollen. She was seen in the emergency department and diagnosed with a grade 2 ankle ligament sprain. She was recommended to wear an Aircast for comfort for 3 weeks. Her pain worsened after she stopped using the Aircast and she was referred to the pain clinic. This is her first assessment in the pain clinic.

Ella was referred to the pain clinic by orthopedics. The referring physician states that she has normal healing and no activity restrictions. You have completed the interview with Ella and her parents. Now you and two other team members have brought Ella into an exam room alone for the pain focused physical examination and psychosocial function.

Past Medical History/Background

Weight: 55kg
PMHx: Healthy
Allergies: None
Medications: Acetaminophen, ibuprofen as needed
Pain location: L anterior ankle, radiating up to calf and down to mid foot.
Intensity (Numerical Pain Rating Score): Currently 7/10, Range 4-9/10, Average 7/10
Quality: sharp, shooting, tingling, burning, throbbing, aching, uncomfortable, annoying
Aggravating factors: touch – even light touch, moving it, standing on it, walking.
Easing factors: Rest, elevation with a pillow
24-hour pattern: Constant pain, random worsening of pain, worse at the end of the day.
Associated symptoms: Left leg feels cooler and has purplish discoloration.
Sleep: Not sleeping well, difficulty falling asleep and waking up at night due to pain.
Referral history: Referred by orthopedics, Xray did not show any fracture – pain is out of keeping with expected healing. Ella and her family have been very frustrated by this persistent pain and its impact on her daily life.

As a team, you will perform a pain focused physical exam, a confidential assessment regarding alcohol/drug use and psychosocial stressors of the teen.