

Understanding and Describing Your Pain

The words that help your clinician recognise the pattern and ask the right questions

KEY MESSAGE

Your pain is real, and the right words are clues that guide assessment rather than a way to diagnose yourself.

This sheet gives you the language of pain medicine, explains the mechanisms behind it, and helps you prepare for an appointment. The clearer your description, the easier it is for a clinician to recognise the pattern and investigate it properly.

1 First, your pain is real

The international definition of pain describes it as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage, and it states that a person's report of their pain should be respected.¹ Pain is both a physical and an emotional experience, and biological, psychological and social factors all influence it.

2 Pain is not the same as tissue damage

Pain and tissue damage are related but not the same. You can have significant damage with little pain, and significant pain with little or no damage a scan can find. Pain is produced by the nervous system in response to signals it judges as threatening, so it reflects the system's assessment rather than a direct readout of harm. This is why the amount of pain does not always match what imaging shows.

3 Acute and chronic pain

Acute pain comes on recently, usually in response to injury, illness or a clear event, and it tends to settle as the body heals. Chronic pain is pain that lasts longer than three months, and it can continue after the original injury has healed or arise without a clear injury at all.² Chronic pain is not simply acute pain that has gone on longer, because the nervous system itself changes over time, which is part of why it needs a different approach to assessment and treatment.

4 Three mechanisms can contribute to pain

These are mechanisms, and more than one can be present at the same time.

Nociceptive pain: from tissue

Pain arising from actual or threatened damage to non-neural tissue and the activation of pain receptors called nociceptors.¹ It can come from mechanical loading, inflammation, injury, osteoarthritis, fracture or the internal organs. It may be provoked by movement or load, and depending on the cause it can also be present at rest or overnight, as with inflammatory joint conditions.

Neuropathic pain: from nerve

Pain caused by a lesion or disease of the somatosensory nervous system.³ It often burns, shoots or feels electric, and may bring tingling, pins and needles, numbness or altered sensation in a pattern that follows a nerve. These features raise suspicion of neuropathic pain; they do not confirm it, because that requires clinical assessment of the history, the distribution and examination.

Nociplastic pain: from altered processing

Pain arising from altered nociception that is not fully explained by nociceptive or neuropathic mechanisms.⁴ The clinical criteria require pain for more than three months, a regional, multifocal or widespread distribution, pain not fully accounted for by the other mechanisms, and clinical signs of pain hypersensitivity. Fibromyalgia is one example, though widespread pain with normal imaging does not by itself establish nociplastic pain.

The mechanisms overlap

A single person can have more than one mechanism at once, such as osteoarthritis with added nociplastic amplification, or nerve pathology alongside tissue pain. The balance can also change over time. A normal scan does not establish nociplastic pain, and an abnormal scan does not exclude it.

5 Describe your pain like a clinician

Pain intensity is only one dimension. A structured description tells a clinician far more than a number alone. Before your appointment, note each of these.

WHAT YOU NOTICE	WORDS YOU MIGHT USE
Tissue or loading pattern	Aching, sore, tender, stiff, pulling, throbbing
Nerve-type symptoms	Burning, electric, shooting, tingling, pins and needles, numb
Sensory hypersensitivity	Painful to touch, clothing hurts, light pressure or temperature hurts
Deep or visceral	Cramping, pressure, deep ache
Pain behaviour	Constant, intermittent, episodic, flaring
Distribution	Localised, radiating, regional, widespread, shifting

These descriptions help identify patterns. They do not diagnose the mechanism by themselves.

The seven things worth recording

- **Where:** exact location, which side, how deep, one site or several.
- **What it feels like:** use the words above, and note if it changes character.
- **When:** morning, evening, during or after activity, overnight, or linked to your cycle if you still have one.
- **How long:** seconds, minutes, hours, constant or intermittent.
- **What changes it:** movement, rest, load, touch, temperature, sleep, stress.
- **What happens afterwards:** settles immediately, later that day, the next morning, or lasts several days.
- **What it stops you doing:** walking, stairs, exercise, work, sleep, sex, driving, lifting.

6 Intensity is not the same as interference

Two women can both rate their pain 6 out of 10. One still works, exercises and sleeps; the other cannot do any of those. Clinically these are very different, so describe both.

Rating intensity, with context

When asked to rate pain out of 10, don't give the number alone, because tolerance varies from person to person. Anchor it: it is a 6, and it stops me sleeping, or it is a 4 at rest but an 8 on the stairs. The context is what a clinician can act on.

Describing interference

Say plainly what the pain is stopping you from doing, across sleep, work, exercise, relationships and daily activities. Pain interference is one of the most useful things you can report, and it is often what treatment is aiming to change.

7 The sensitivity terms worth knowing

- **Hyperalgesia:** increased pain from a stimulus that would normally cause pain.
- **Allodynia:** pain from a stimulus that does not normally cause pain, such as light touch or clothing.
- **Central sensitisation:** increased responsiveness of pain-processing neurons within the central nervous system.⁴ In everyday terms, the system can become more sensitive, rather like turning up the volume on pain signals.
- **Peripheral sensitisation:** increased responsiveness of nerve endings in injured or inflamed tissue, making the area tender and reactive.
- **Referred pain:** pain felt away from the structure generating it, because sensory information converges within the nervous system. For example, pain from the hip may be felt in the groin or thigh.

Allodynia and hyperalgesia are clinical descriptions. Neither tells you the mechanism on its own.

8 What menopause changes

Pain becomes more common around the menopause transition

A 2026 review of 93,021 women found muscle or joint pain in about 40% of premenopausal, 57% of perimenopausal and 59% of postmenopausal women. The risk was higher in peri- and postmenopause than before it, though the studies varied widely and the design cannot prove menopause is the cause.⁵ A separate decade-long review of menopause-associated pain reaches the same broad picture, that pain patterns shift across the transition while the determinants remain incompletely understood.⁶ Menopause may alter the biological context in which pain is experienced. It is one possible contributor, not an explanation for every pain.

This works in both directions. It means midlife pain deserves to be taken seriously rather than dismissed as ageing, and it means pain should still be assessed properly rather than assumed to be hormonal.

9 Do not assume it is just menopause

Some pain needs assessment rather than explanation. See a GP promptly if your pain is any of the following.

When pain warrants assessment

- New, rapidly worsening, severe or persistent.
- With significant swelling, redness or warmth in a joint.
- With fever, feeling generally unwell, or unexplained weight loss.
- With progressive weakness, numbness or other neurological symptoms.
- Following significant injury or trauma.
- Consistently waking you at night, or changing substantially in character.
- With persistent morning stiffness or several swollen joints.
- With any change in bladder or bowel control.
- Interfering significantly with your ability to function.

A normal scan does not mean your pain is not real. A normal scan also does not tell you which mechanism is responsible.

10 What treatment depends on

The pain pattern helps a clinician decide which treatments are most appropriate. Treatment depends on the condition, the mechanisms involved, the person and their goals, and how the pain affects function, rather than on a single label. Many people have more than one mechanism, and the balance can shift over time.

Exercise

Exercise is consistently beneficial for chronic musculoskeletal pain, though the best type and dose are individual.⁷ For tissue-related pain, progressive loading helps restore capacity, and some discomfort during rehabilitation is not necessarily harmful. For persistent pain, graded activity and function-based goals are useful, and pain does not have to be gone before movement can progress. The right programme is matched to your condition, capacity and response, rather than to a rule.

11 Take this to your appointment

Fill this in before you see your GP, physiotherapist or specialist.

My pain started:

Where it is:

It feels like:

It is worst:

It is better with:

It is worse with:

It affects:

☐ Sleep

☐ Walking

☐ Exercise

☐ Work

☐ Lifting

☐ Sex

☐ Mood

☐ Daily activities

Other symptoms:

MY MAIN QUESTION

Could there be more than one contributor to my pain, and what assessment would help tell them apart?

SOURCES

1. Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain. *Pain*. 2020;161(9):1976–1982.
2. Treede RD, Rief W, Barke A, et al. Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). *Pain*. 2019;160(1):19–27 (chronic pain defined as pain persisting or recurring for longer than three months).
3. Themistocleous AC, Schmid A, Sierra-Silvestre E, et al. Identifying neuropathic pain in the clinic: a guide for clinicians. IASP Global Year 2026 (IASP definition of neuropathic pain as pain caused by a lesion or disease of the somatosensory nervous system).
4. Kosek E, Clauw D, Nijs J, et al. Chronic nociplastic pain affecting the musculoskeletal system: clinical criteria and grading system. *Pain*. 2021;162(11):2629–2634 (nociplastic criteria; central sensitisation as a distinct neurophysiological process).
5. Kruse C, et al. Musculoskeletal manifestations of perimenopause: a systematic review and meta-analysis of 93,021 women. *JBJS Open Access*. 2026 (muscle/joint pain 40% pre, 57% peri, 59% post; high heterogeneity; observational, not causal).
6. Ertmane E, Lulle A. Menopause-associated pain: a decade review of patterns, determinants, and research priorities. *Menopause*. 2026 Jul 7. doi: 10.1097/GME.0000000000002842. Epub ahead of print. PMID: 42412599.
7. Smith BE, et al. Should exercises be painful in the management of chronic musculoskeletal pain? *British Journal of Sports Medicine*. 2017;51(23):1679–1687 (small short-term benefit from painful exercise; no clear long-term superiority; individualise).
8. National Institute for Health and Care Excellence. Menopause: identification and management. NICE guideline NG23. Published 2015, updated 2024.

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