screen for pain that has a neuropathic component, the risk associated with a false positive is low, as screening a patient for neuropathic pain only suggests the potential use of therapies for this condition. With a false negative, however, a patient who could potentially benefit from one or more of these therapies for neuropathic pain might never be considered for them. Since ‘limited to joints’ is associated with nociceptive pain, endorsing this item alone would give a negative score. Non-negative scores are associated with reporting at least one item related to non-nociceptive pain.

The predictive accuracy of the final tool in the study sample participating in the phase 1 study was estimated using the concordance \( c \) index and by evaluation of the corresponding ROC curve. The final six items provided a \( c \) index of 0.73. The ROC curve for this analysis is depicted in Figure 3. Each point on the ROC curve represents the ratio of ‘false alarms’ to ‘hits’, which is the trade-off between sensitivity and 1-specificity.

**Phase 2: evaluation of validity and reliability**

Table 3 shows the distribution of the scores overall and by the three pain types designated by the pain specialists during phase 2 of the study. Scores ranged from –1 to 5, with a higher score indicative of pain that contains a neuropathic component. For these data, the

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**Figure 2.** *ID Pain* questions and scoring. If patients have more than one painful area, they are to consider the one area that is most relevant to them when answering the *ID Pain* questions. Scoring was from –1 to 5. Higher scores are more indicative of pain with a neuropathic component.