TPT Toolkit®

2026

Targeted Pain Treatment®
Resources and References

compiled by
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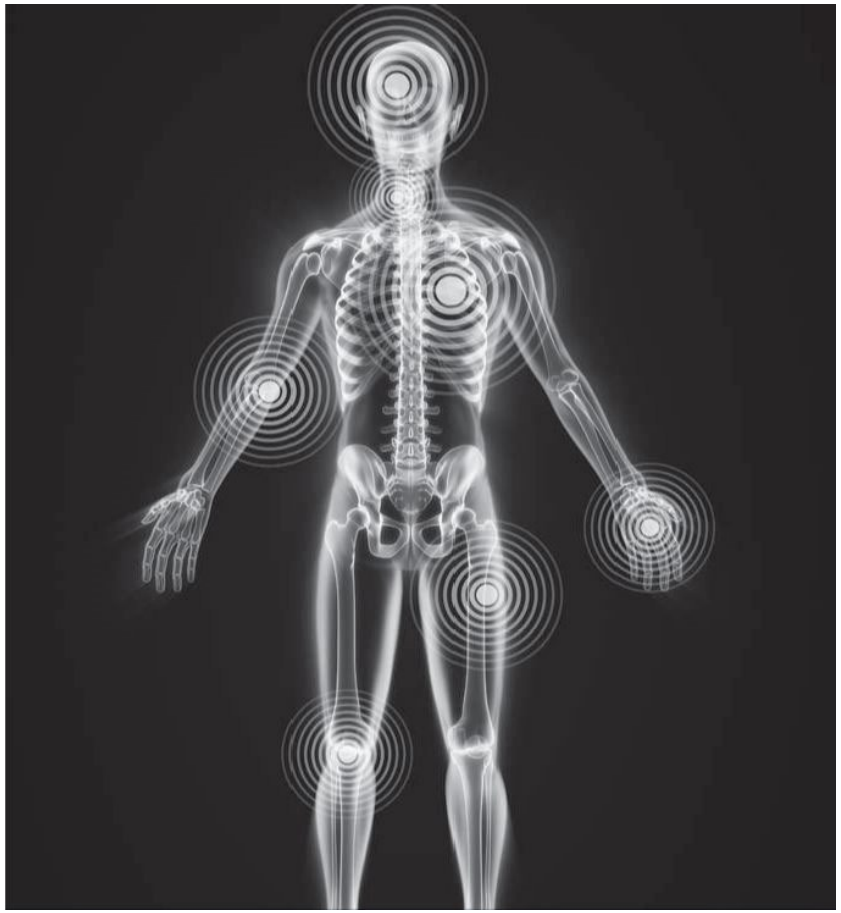
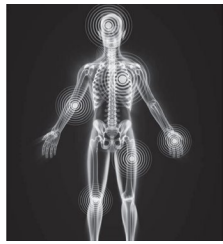
Targeted Pain Treatment

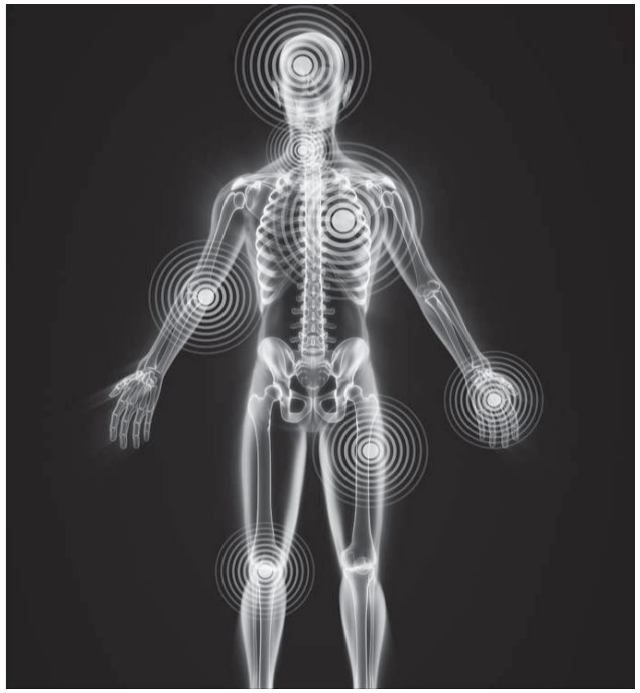
"accurate diagnosis and targeted treatment of pain"



TARGETED PAIN TREATMENT®

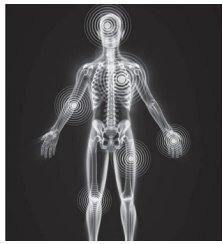


Accurately **diagnose the** ***CAUSE(s)*** **of the pain**



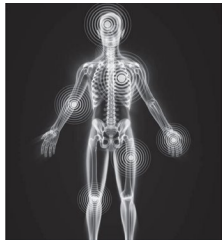
Target **the treatment to the** ***CAUSE(S)*** **of the pain**

4 Components of Targeted Pain Treatment



- 1. **Accurate Diagnosis:** Identify ALL of the causes of pain that are present
- 2. **Targeted Treatment:** Target the causes of pain in a way that is specific, *strategic, and safe*
- 3. **Focus on Function:** work with patients to continue to optimize their function
- 4. **Engagement & Empowerment:** engage the patient in the treatment process. Empower them to decide and do what is best for their function and quality of life.

TPT Toolkit® - Overview



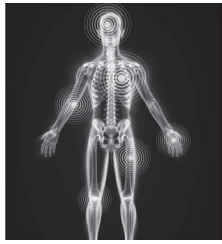
ACCURATE DIAGNOSIS

1. Causes of Pain
2. Pain States and Mechanisms
3. Common Anatomic Causes of Pain (by pain complaint)
4. S.C.R.I.P.T. History
5. Pain RED Flags

TARGETED TREATMENT

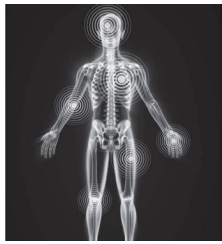
1. M.I.P.S. – Multimodal approach to treating pain
2. TPT Pain Assessment Template
3. Function Optimization Template
4. Targeted Medications – “Specific, Strategic, Safe”
5. Targeted Medications – Examples
6. Targeted Interventions - “Specific, Strategic, Safe”

TPT Toolkit® - Overview



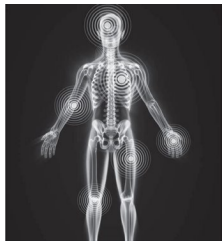
RESOURCES

1. TargetedPainTreatment.com
2. Targeted Pain Treatment Documentary – Hope for Patients with Pain
3. Tennessee Functional Status Questionnaire (TFSQ) – Index (Scoring)
4. 4E's of Patient Education
5. ABCD's of Pain Advocacy
6. HHS Pain Management Best Practices Report – Link/Highlights
7. Tennessee Chronic Pain Guidelines – Link/Highlights



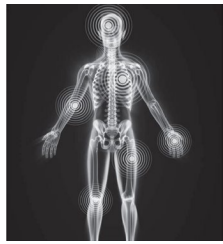
ACCURATE DIAGNOSIS

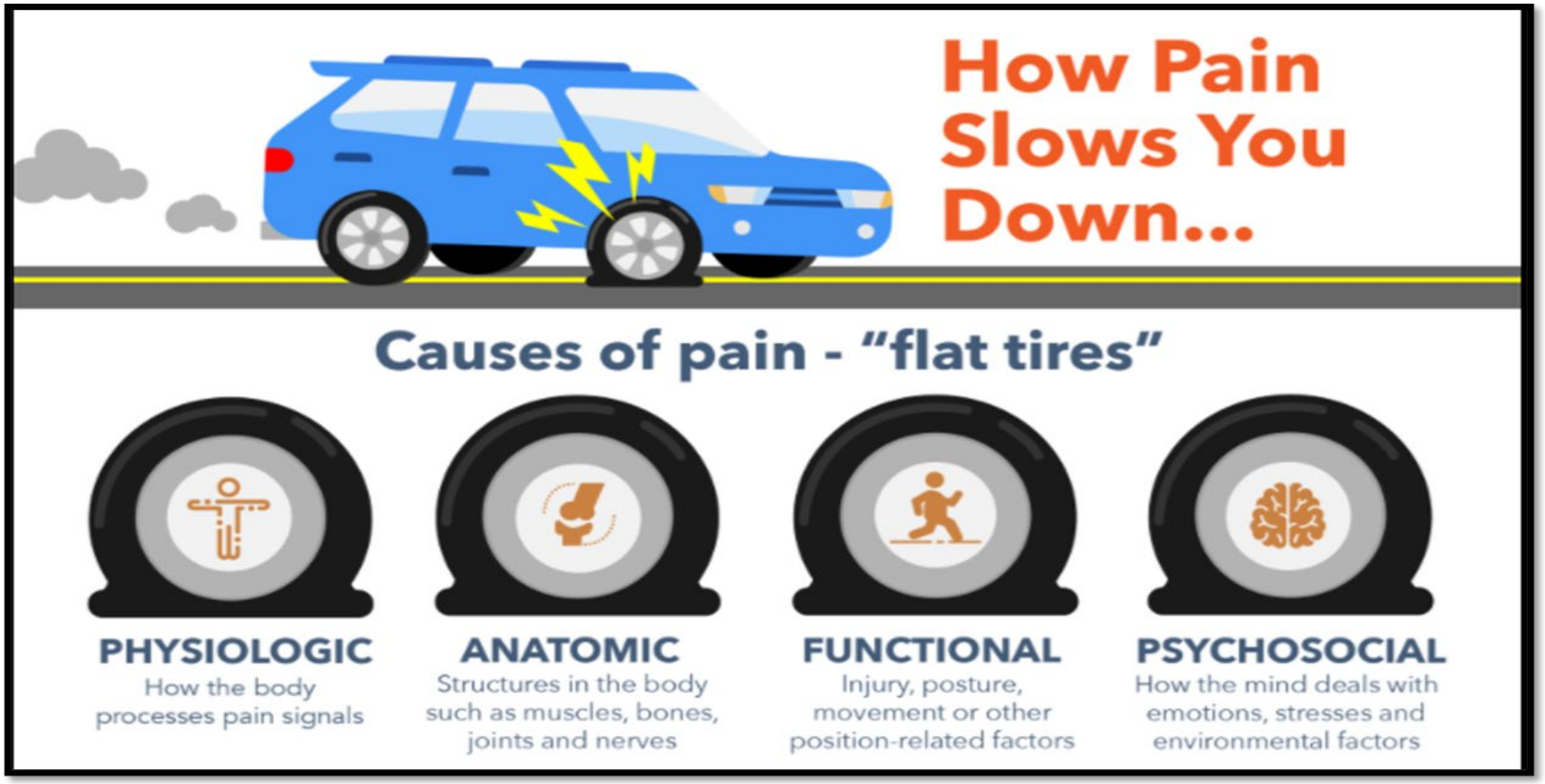
TPT Toolkit ® - Accurate Diagnosis



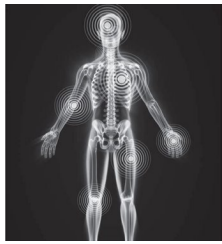
1. Causes of Pain (“Flat Tires”)
2. Pain States and Mechanisms
3. Common Anatomic Causes of Pain (by pain complaint)
4. S.C.R.I.P.T. History
5. Pain RED Flags

Accurately Diagnose the CAUSE(s) of Pain





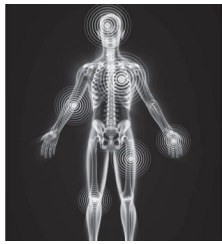
Pain States



PAIN STATE	PATHOLOGY	SYMPTOMS
Nociceptive 	Evidence of noxious (mechanical, thermal, chemical) insult	Pain localized to area of stimulus/joint damage
Inflammatory 	Evidence of inflammation (sterile or infectious)	Redness, warmth, swelling of affected area
Neuropathic 	Evidence of sensory nerve damage	Burning, tingling or shock-like, spontaneous pain; paresthesias, dysesthesias
Dysfunctional/ centralized 	Pain in the absence of detectable pathology	No identifiable noxious stimulus, inflammation or neural damage; evidence of increased amplification or reduced inhibition

*Modified from Table 1. in Vardeh D, et.al. *J Pain. 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review. (used with permission)*

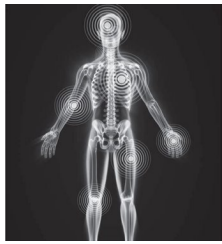
Pain Mechanisms



PAIN MECHANISM	CLINICAL DIAGNOSTIC CRITERIA	CLINICAL EXAMPLE	SPECIFIC TREATMENT EXAMPLE
Nociceptive Transduction	Proportionate pain in response to identifiable noxious stimulus	Mechanical nerve root compression	Remove mechanical stimulus
Peripheral Sensitization	Primary hyperalgesia due to decreased transduction threshold of nociceptor terminal	Rheumatoid arthritis, Cellulitis	Anti-inflammatory (e.g. NSAID, coxibs); immunosuppressant
Ectopic activity	Spontaneous pain in the absence of obvious trigger, relieved by local nerve block	Trigeminal neuralgia	Na Channel Blockers, Ca Channel Blockers
Central sensitization	Secondary hyperalgesia; temporal summation, allodynia	Complex Regional Pain Syndrome (CRPS)	NMDA Antagonists (e.g. Ketamine)
Central disinhibition	Secondary hyperalgesia, allodynia	Fibromyalgia	GABA-A subunit agonists Dual amine uptake inhibitors (e.g. SNRI)

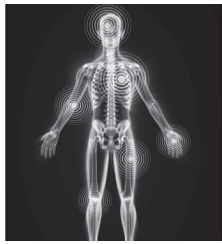
*Adapted from Table 2. in Vardeh D, et.al. *J Pain. 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review. (used with permission)*

Common Anatomic Causes of Pain (1 of 3)



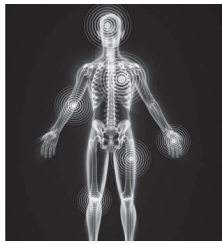
Area of pain	Possible Anatomic Cause
Head	occipital nerve (posterior), myofascial trigger points (trapezius, levator scapula, cervical paraspinous muscles, other neck muscles, cervical facet joints, cervical degenerative disc disease (DDD)
Neck	myofascial trigger points, cervical DDD, cervical facet joints
Shoulder	myofascial trigger points, cervical DDD, cervical facet joints
Upper Arm pain	myofascial trigger points, cervical DDD with radiculopathy, cervical facet joints
Lower arm pain/Hand/Finger pain	cervical DDD with radiculopathy, nerve entrapment, myofascial trigger points,
Thoracic back pain	myofascial trigger points, intercostal nerves, thoracic facet joints, thoracic DDD

Common Anatomic Causes of Pain (2 of 3)



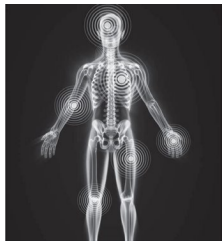
Area of pain	Possible Anatomic Cause
Low back pain (above lumbosacral junction)	myofascial pain without trigger points (spasm), lumbar facet joints, lumbar DDD with or without radiculopathy, myofascial trigger points
Low back/Buttock pain (below lumbosacral junction)	lumbar facet joints (L5/S1), lumbar DDD with or without radiculopathy, sacroiliac joint arthropathy, piriformis muscle syndrome, sacral pain (responding to caudal ESI),
Lower abdominal Wall	Ilioinguinal or iliohypogastric neuralgia (especially after hernia repair) Scar, nerve entrapment, abdominal wall trigger points
Groin Pain	Referred from SI joint, Referred from L1/2 nerves, Ilioinguinal neuralgia, genitofemoral neuralgia
Hip pain	greater trochanteric bursitis, sacroiliac joint arthropathy, hip joint (degeneration), lumbar ddd with radiculopathy (L2/3 or L3/4), myofascial trigger points in the lumbar region with peripheral radiation

Common Anatomic Causes of Pain (3 of 3)



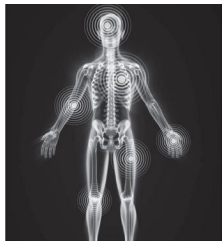
Area of pain	Possible Anatomic Cause
Thigh pain - Lateral	greater trochanteric bursitis, intra articular hip, ddd with radiculopathy, sacroiliac joint arthropathy
Thigh pain - posterior	sacroiliac joint arthropathy, DDD with radiculopathy (usually L5/S1), Lumbar spondylosis (L4/5, L5/S1), piriformis syndrome,
Thigh pain - anterior	DDD with radiculopathy (L2/3, L3/4), Lumbar facet joints (L3/4, L4/5) Sacroiliac joint arthropathy, intra articular hip
Knee pain	knee joint, DDD with radiculopathy (L3/4 and L4/5)
Lower leg pain	Knee joint, DDD with radiculopathy (L4/5, L5/S1)
Ankle/Foot pain	DDD with radiculopathy (L4/5 (medial, dorsal aspect), L5/S1 (lateral, plantar aspect), Ankle joint, metatarsal joints, neve entrapments, Neuromas

The S.C.R.I.P.T. History Template

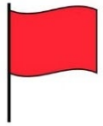


S.C.R.I.P.T.	Information to Gather
Story	- Circumstances of Onset (acute, trauma, insidious, etc) - Details, Details, Details
Current Symptoms	-Pain location -Pain description -ROM -Aggravating Factors -Alleviating factors
Rx (Relevant Meds)	-Anti-inflammatories, Muscle relaxers, Nerve pain medication
Interventions	-Previous injections to the area (what was injected, what type of injection was done?)
Physical Therapy	-Previous PT, Massage, chiropractic, other
Tests	-Imaging of the affected area, NCS/EMG, etc (if done)

Pain RED Flags (1 of 2)



- Pain RED Flags
  - Findings on patient assessment that should trigger you to look for a more accurate cause of the pain

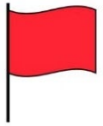


Outside the Expected Location

- E.g. Patient with LEFT leg pain, but RIGHT L4/5 disc bulge

Out of Proportion to Diagnosis

- E.g. Patient with cervical radiculopathy, but completely unable to abduct right shoulder due to pain

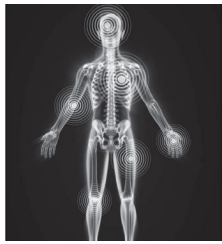


"Something's not right"

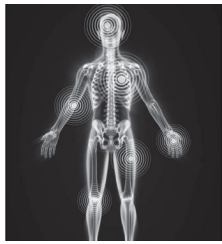
- E.g. patient with previous well-healed hip fracture, now with new pain in same area, negative imaging, no trauma

PAIN RED FLAG? Prompt to identify the Accurate Dx and treat the *CAUSE* of the pain

Pain RED Flags (2 of 2)

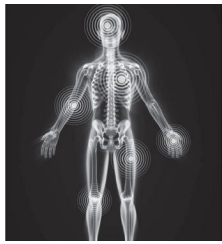


- *Resolving* Pain RED Flags
  - Step 1. Re-visit the Story – make sure you're not missing anything.
  - Step 2. Clarify the current symptoms – location, radiation, sensation, etc
  - Step 3. Repeat the physical exam
  - Step 4. Evaluate existing tests
  - Step 5. Order new tests if needed.

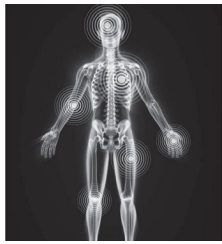


TARGETED TREATMENT

TPT Toolkit® - Targeted Treatment

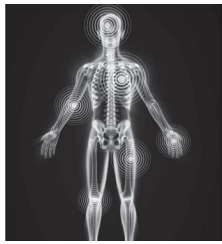


1. M.I.P.S. – Multimodal approach to treating the cause(s) of pain
2. TPT Plan - Pain Assessment Template*
3. Function Optimization Template *
4. Targeted Medications – “Specific, Strategic, Safe”
5. Targeted Medications – Examples
6. Targeted Interventions – “Specific, Strategic, Safe”



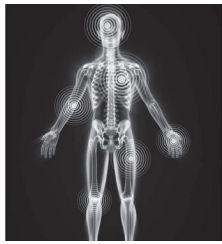
Target the Treatment to the Cause(s)
"Multimodal" Approach – M.I.P.S.

TPT Plan – Pain Assessment Template



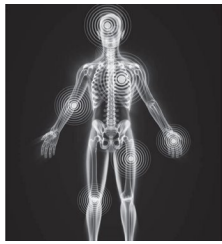
Patient ID:	Patient descriptor (name, age, relevant clinical background)
Pain complaint:	Location and chronicity
Pain State(s) present:	(Select all that apply): Nociceptive, Inflammatory, Neuropathic, Central/dysfunctional
Pain Mechanism(s) present:	(Select all that apply): nociceptive transduction, peripheral sensitization, ectopic activity, central sensitization, central disinhibition
Cause(s) of pain:	(select all that apply) Physiologic, Anatomic, Functional, Psychosocial (specify and elaborate as needed- e.g Anatomic, post-surgical pain after total hip arthroplasty, or Physiologic and anatomic pain due to disc herniation with radicular symptoms and ectopic activity of the nerve.
Rationale for treatment plan:	Address each cause, state and mechanism with the comprehensive, multimodal treatment plan (M.I.P.S): – Medications (target the physiologic cause) – Interventions (target the anatomic cause) – Physical therapy (target the functional limitation) – psychosocial Treatment (target the psychosocial comorbidity)

Function Optimization Template



Component	Documentation	Notes
Current Functional Status	Functional Performance Functional Capacity Potential for future functional decline	May use the Tennessee Functional Status Questionnaire, or other validated function assessment tool.
What is limiting function the most?	List the principal pain/function-limiting diagnosis	May have more than one CAUSE of pain – physiologic, anatomic, functional, psychosocial
Functional Micro-goal	S.M.A.R.T. functional goal that is reasonably achievable in 1 month (micro-goal)	Specific, measurable, attainable, relevant, time-bound. Maintain motivation
MIPS treatment plan	(See TPT Plan - Pain assessment template)	Remember SSS ("specific, strategic, safe") for medications and interventions
Accountability plan	Follow up timing. How progress will be measured	Get buy-in of patient and family members.

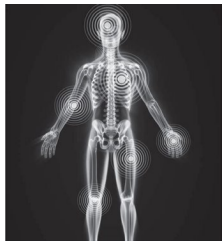
Specific-Strategic-Safe….for Medications!



Medication Selection

Specific	Strategic	Safe
Target identified pain mechanism(s)	What's limiting function the most?	Drug-drug interactions
Mode of delivery (oral, injectable, topical, etc)	Initiation and titration of multiple medications	Physiologic considerations
	Strategic consideration of side-effect profile	Warnings on sedation, driving, operating heavy equipment, etc.

Targeted Medications - Examples

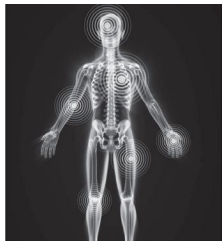


Goal: Target the physiologic cause of pain

Cause	Medication Class	Examples
Muscle Spasm	Muscle Relaxer	Cyclobenzaprine, Methocarbamol, Metalaxone, Orphenadrine, Tizanadine
Neuropathic (Nerve) Pain	Neuromodulator ("Nerve Pain Medication")	Gabapentin, Pregabalin
Inflammation	Anti-inflammatory ("NSAID")	Ibuprofen, celecoxib, Meloxicam, Etodolac, Diclofenac
Central Sensitivity	Certain antidepressants	Duloxetine, Minalcipram

- Remember – opioids do not target the *cause* of the pain.

Pain Medications (non-opioids)



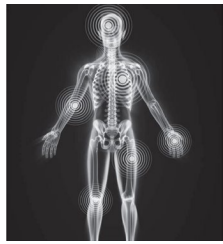
Inflammatory Pain	NSAIDs (non-steroidal anti-inflammatory drugs) • ibuprofen (PO) • naproxen (PO) • ketorolac (PO, IM, IV) • diclofenac (PO, topical gel) • etodolac (PO) • meloxicam (PO) • methyl salicylate/menthol (topical) Steroids (oral, intra-articular, peri-neural, epidural, IM, IV)
Neuropathic Pain & Central Pathologic Pain** **(evidence for efficacy for pain treatment is mixed and limited for many of these medications)	Anticonvulsants • gabapentin, pregabalin SNRIs (serotonin, norepinephrine reuptake inhibitors) • duloxetine, milnacipran Tricyclic anti-depressants • amitriptyline, nortriptyline Na^+ channel blockers • lidocaine (topical cream, topical patch, IM, IV), mexilitine, topiramate TRPV1 ion channel blocker • capsaicin (topical cream/ointment, topical patch) NMDA receptor antagonists • ketamine (IV), memantine (PO), dextromethorphan
Nociceptive Pain	Antispasmotics (muscle spasm related pain) • cyclobenzaprine, tizanidine, baclofen, diazepam/lorazepam Acetaminophen and NSAIDs also effective, especially if inflammatory pain is also present
Non-specific Pain	Acetaminophen Alpha agonists • clonidine (PO, patch), dexmedetomidine

Edwards DA, Acute Pain Management. In Urman & Ehrenfeld editors. Pocket Anesthesia. 3rd Ed, Lippincott William & Wilkins, 2016. (used with permission)

Common Nonopioid Adjuvant Dosage for Adult Patients				
Group	**Drug**	**Route**	**Dose**	**Side Effects**
COX-1, 2 Inhibitors	Aspirin	PO	325–650 mg	Urticaria, angioedema, Reye's syndrome (avoid in children <12 y)
	Ibuprofen	PO, IV	PO: 200–800 mg tid IV: 400–800 mg tid	GI pain, dyspepsia, bone fracture
	Ketorolac	IV/IM	15–30 mg q6h (max 120 mg daily)	GI pain, dyspepsia Caution in elderly and with renal impairment
	Diclofenac	IV, IM, PO, topical	50–100 mg	GI pain, dyspepsia
	Meloxicam	PO	7.5–15 mg q24h	GI pain, dyspepsia
	Naproxen	PO	250–500 mg q6–8h (max 1,000 mg daily)	GI pain, dyspepsia
	Celecoxib	PO	100–200 mg daily	Reduced GI side effects (short-term)
	Acetaminophen (CNS COX-1,2)	PO, PR, IV	PO: 500–1,000 mg IV: 500–1,000 mg q4–6h; max 4 g/d	Hepatotoxicity, GI upset
Anticonvulsants	Gabapentin	PO	300 mg PO tid titrated to range of 600–1,200 mg tid	Sleepiness, confusion, bloating, leukopenia, thrombocytopenia
	Pregabalin	PO	25–150 mg PO daily, titrate to tid as tolerated	Sleepiness, confusion, bloating
Alpha2 agonists	Tizanidine	PO	2–4 mg qhs, titrate to 2–12 mg tid as tolerated	Hypotension, bradycardia, sleepiness, dizziness, nausea, dry mouth, anxiety, blurred vision, ↑ LFT
	Clonidine	PO, IV, epidural, topical	PO: 0.3–0.4 mg epidural: 30–40 mcg/h	Hypotension, bradycardia, sleepiness, dizziness, dry mouth, decreased bowel motility
TCA's	Amitriptyline	PO	10–25 mg qhs, titrate up to 25–150 mg qhs over several days	Sleepiness, dry mouth, ↑ HR, blurred vision, urinary retention, constipation
	Nortriptyline	PO	10–25 mg qhs, titrate up to 25–150 mg qhs over several days	Sleepiness, dry mouth, ↑ HR, blurred vision, urinary retention, constipation
SNRI	Duloxetine	PO	30–60 mg/d	Nausea, dry mouth, headache, sleepiness

Edwards DA, Acute Pain Management. In Urman & Ehrenfeld editors. Pocket Anesthesia. 3rd Ed, Lippincott William & Wilkins, 2016. (used with permission)

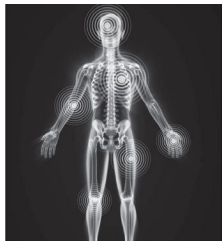
Targeted Interventions – S.S.S.



Specific, Strategic, Safe

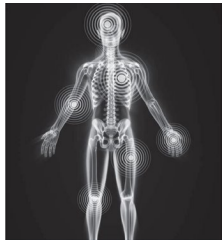
Specific	***Strategic (choice)***	***Safe***

• Where exactly is the pathology?
  • E.g shoulder pain Shoulder joint versus subacromial bursa?
• What technique will target it the best?
  • The more specific the injection to the identified anatomic cause, the better (once all other factors are considered for safety, etc).
	• 1. Start with the "worst pain" first
	  • Get a quick win, move to the next cause
	  • "don't work on the roof if the kitchen is on fire"
	• 2. Start "from the inside out"
	  • If pain is all in the same general location (e.g. low back) address the deeper structures first
	  • "don't patch the drywall if the pipe is still leaking"
		• Cumulative Steroid Dose
		  • Risk/benefit of steroid
		• Imaging Guidance
		  • Fluoroscopy
		  • Ultrasound
		• Anatomic considerations
		  • Abnormal anatomy
		  • Severe pathology
		• Pharmacologic considerations
		  • Anticoagulants
		  • Contrast dye allergies



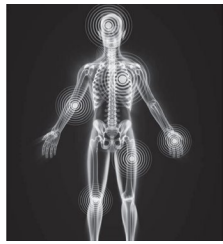
RESOURCES

TPT Toolkit® - Resources

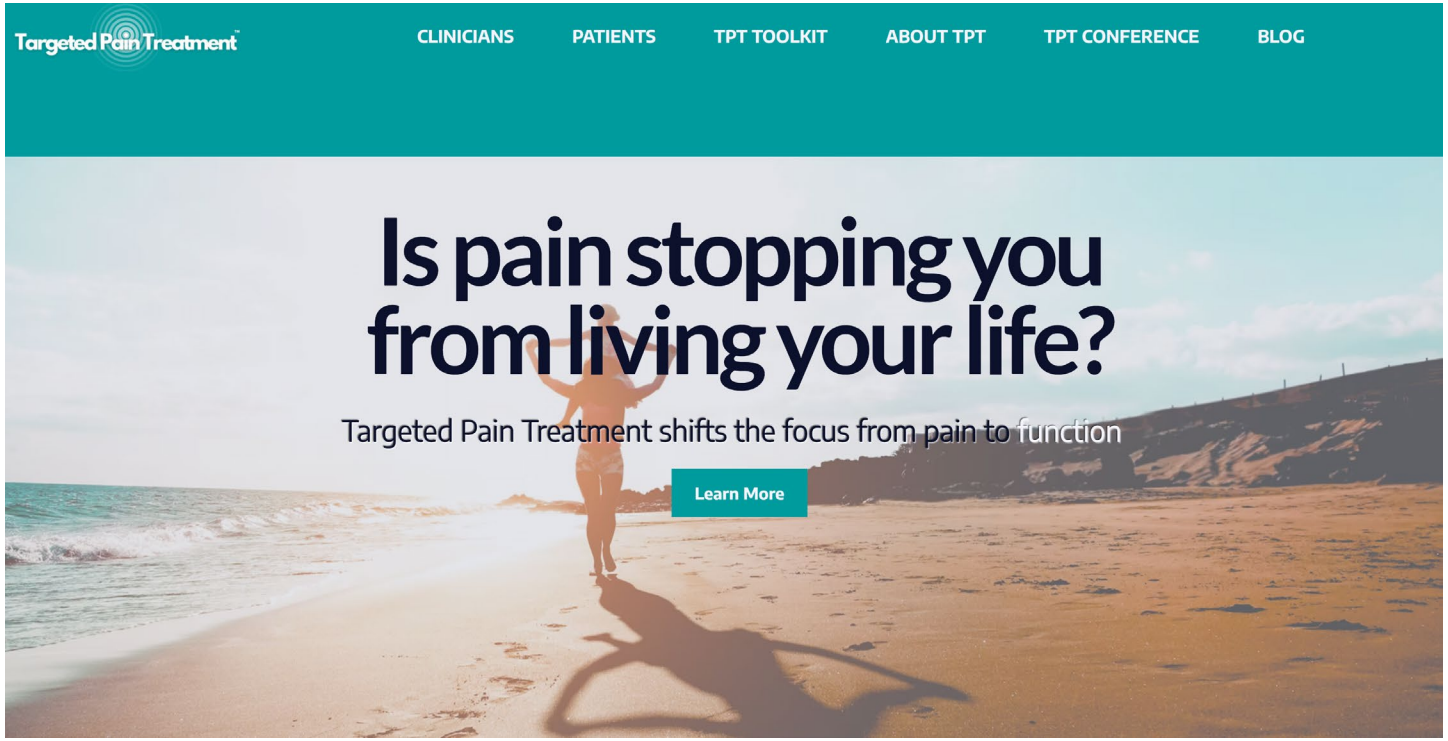


1. TargetedPainTreatment.com
2. Targeted Pain Treatment Documentary – Hope for Patients with Pain
3. Tennessee Functional Status Questionnaire (TFSQ) – Index (Scoring)
4. 4E's of Patient Education
5. ABCD's of Pain Advocacy
6. HHS Pain Management Best Practices Report – Link/Highlights
7. Tennessee Chronic Pain Guidelines – Link/Highlights

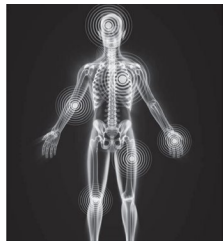
TargetedPainTreatment.com



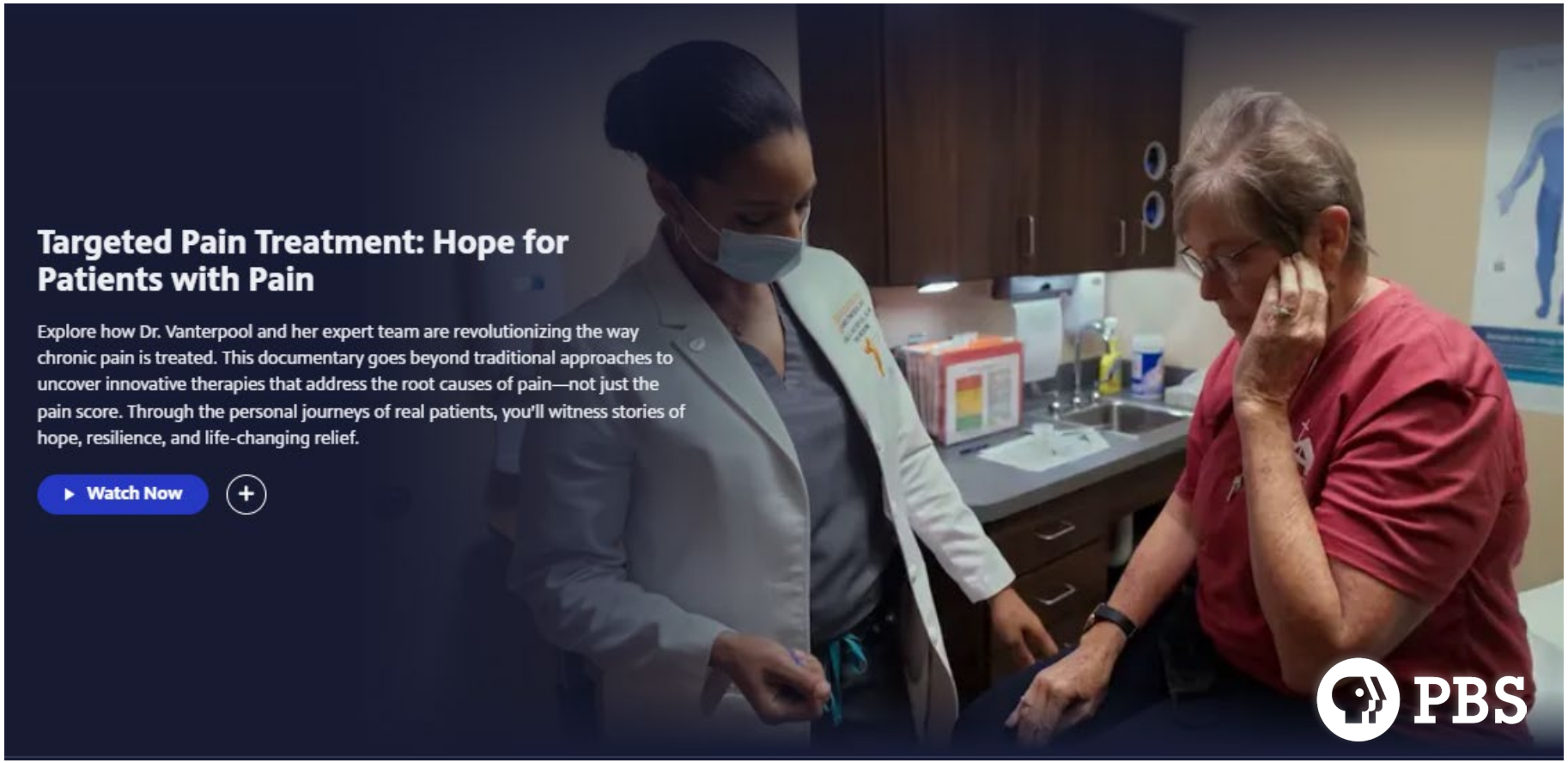
- Resources for Clinicians
- Resources for Patients
- Frequently Asked Questions
- Conference Updates
- Blog



Targeted Pain Treatment Documentary (PBS)



https://www.pbs.org/video/targeted-pain-treatment-hope-for-patients-with-pain-pdtmd6/



TFSQ

A: <3 METS
B: 3 to <4 METS
C: 4 to <5 METS
D: 5 to <6 METS
E: >= 6 METS

Tennessee Functional Status Questionnaire Index Scoring System Guideline

Question Number (1-5)	Score (1-13 total possible score)
TFSQ 1 (2-6 possible points)	A=2 points B=3 points C=4 points D=5 points E=6 points
TFSQ 2 (2-6 possible points)	A=2 points B=3 points C=4 points D=5 points E=6 points
TFSQ 3 (+1, -1 or 0 possible points)	a= +1 points b= -1 points c= 0 points
TFSQ 4 (-1 or 0 possible points)	a= -1 points b= 0 points
TFSQ 5 (-1 or 0 possible points)	a= -1 points b= 0 points

Minimum score 1

Maximum score 13

Higher score = higher functional status

Tennessee Functional Status Questionnaire (TFSQ) -Version 9 (9/19/2020)

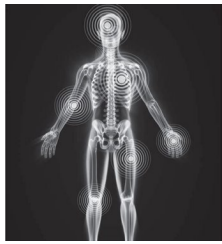
Please use the table below to answer Questions 1 and 2:

A	B	C	D	E
• Self-Care – shower/wash, dress, use bathroom, Eat • Shop at store, make food • Walk around house • Sit at computer • Ride mower, water grass	• Activities in Column A, **and** at least one activity below: • Child care – lift a child • Sweep/Vacuum/Clean inside house • Walk the Dog/ Walk on flat firm surface • Trim shrubs or trees, use leaf blower	• Activities in Column B, **and** at least one activity below: • Elder care, care for disabled adult • Sweep outside house, sidewalk, or garage. • Push a wheelchair/ Walk fast while holding less than 25 lbs • Push a power mower, Rake lawn, Play Golf (walk and pull clubs)	• Activities in column C **and** at least one activity below: • Walk/run - play with children - vigorous only active periods • Carry 1-15lb load upstairs; • Walk fast on a flat surface (4mph) (walk a mile in 15 minutes) • Softball or baseball; Tennis, doubles; Health club/gym work out	• Activities in column D **and** at least one activity below: • Move Furniture, household items, carry boxes • Walk 3.5mph (very fast) up hill • Jog, singles tennis, basketball game, hard work out (high impact aerobics)

1. Choose the column that best matches what you **usually** do in a day (your usual activity level) (circle one)
   Column: A B C D E
2. Choose the column that best matches what you **can** do on your **best** day (circle one)
   Column: A B C D E
3. In the last 60 days, has your **usual** activity level **changed**? (circle one)
   a. I am now **more** active than I was 60 days ago.
   b. I am now **less** active than I was 60 days ago.
   c. My activity level is the **same** as it was 60 days ago.
4. In the last 60 days, have you had **pain** that affects your activity level?
   a. Yes
   b. No
5. In the last 60 days, have you gone to the **emergency room** (ER)/**hospital** or had a **surgery**?
   a. Yes
   b. No

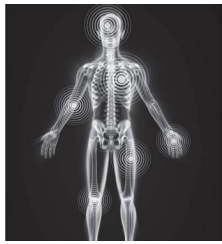
Vanterpool SG, Heidel RE, Snyder K, et al. Developing and Validating a Novel Tool to Enhance Functional Status Assessment: The Tennessee Functional Status Questionnaire (TFSQ). J Am Board Fam Medicine. 2023;36(1):4-14. doi:10.3122/jabfm.2022.220261r1

The 4 E’s of Patient Education



- #1. Engage
  - Connect, Compassion, Comedy, Compliments
- #2. Empathize
  - 5 empathy skills
- #3. Explain
  - Start with Why
- #4. Empower
  - Power to choose

ABCDs of Pain Advocacy



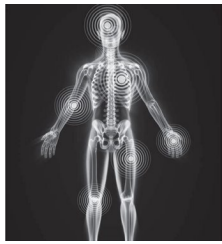
A. Ask questions *(WHAT's causing my pain? WHAT can we do about it?)*

B. Be optimistic/open to treatment options

C. Clarify the plan *(WHY are we doing it?)*

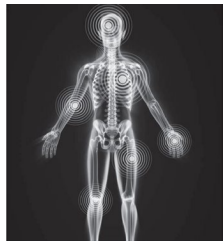
D. Do your part *(Focus on function)*

HHS Pain Management Best Practices Report



- Link:
  - https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
- Highlights
  - 2.1 Approaches to Pain Management
  - 2.2 Medications
  - 2.3 Restorative therapies
  - 2.4 Interventional procedures
  - 2.5 Behavioral health Approaches
  - 2.6 Complementary and Integrative Health
  - 2.7 Special Populations

Tennessee Chronic Pain Guidelines – 4th Ed.



- Link:
  - https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf
  - Appendices
    - CSMD: Controlled Substance Monitoring Database
    - Urine Drug Testing
    - **OPIOID CONSENT***
    - **CONTROLLED SUBSTANCE AGREEMENT**
    - Naloxone
    - Perioperative management
    - Useful links