MARVIX AI

INTERVENTIONAL PAIN MEDICINE SOAP NOTE TEMPLATE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

REFERRAL SOURCE

VISIT TYPE: INTERVENTIONAL PAIN MEDICINE CONSULTATION / FOLLOW-UP / PROCEDURE FOLLOW-UP / MEDICATION MANAGEMENT

CARE SETTING: OUTPATIENT / PAIN CLINIC / PROCEDURE CENTER / TELEHEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING SPECIALIST, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY PAIN CONCERN

Primary pain-related reason for the visit in the patient's own words when possible — neck pain, back pain, radicular pain, joint pain, neuropathic pain, chronic pain, post-procedure follow-up, medication management, injection evaluation, or functional limitation due to pain...

S SUBJECTIVE

3 PAIN HISTORY, PRIOR TREATMENT & FUNCTIONAL IMPACT

3a REASON FOR EVALUATION & PAIN CHARACTERIZATION

Reason for Interventional Pain Medicine Evaluation (initial pain evaluation, follow-up, procedure planning, post-injection follow-up, medication management, chronic pain management, worsening pain, new neurologic symptoms, review of imaging or testing):

Pain Location and Distribution (exact location, laterality, radiation pattern, dermatomal or non-dermatomal distribution, focal joint involvement, axial versus radicular symptoms, unilateral or bilateral):

Pain Onset and Course (onset, duration, inciting event, injury, surgery, trauma, work-related event, progression, frequency; improving, worsening, stable, recurrent, or intermittent):

Pain Character and Severity (sharp, dull, aching, burning, throbbing, stabbing, shooting, cramping, electric, pressure-like, or numbness-associated; current, best, worst, and average pain score; severity trend):

Aggravating and Alleviating Factors (activity-related triggers, posture, standing, walking, sitting, bending, lifting, twisting, coughing or sneezing, sleep position, weather, stress, rest, medications, heat or ice, physical therapy, injections):

Associated Neurologic Symptoms (numbness, tingling, weakness, gait difficulty, balance problems, falls, bowel or bladder dysfunction, saddle anesthesia, sensory changes, progressive neurologic deficits):

Functional Impact (walking, standing, sitting, lifting, bending, driving, work duties, household tasks, exercise, sleep, mood, activities of daily living, quality of life):

3b PRIOR TREATMENT, MEDICATIONS & SAFETY HISTORY

Prior Conservative Treatment (physical therapy, home exercise program, chiropractic care, acupuncture, massage, bracing, activity modification, weight loss efforts, behavioral therapy, pain psychology):

Prior Interventional Treatment (epidural steroid injections, facet injections, medial branch blocks, radiofrequency ablation, sacroiliac joint injections, trigger point injections, nerve blocks, joint injections, spinal cord or peripheral nerve stimulation, intrathecal therapy — with dates, level and laterality, percent relief, duration of relief, complications):

Medication History and Response (analgesics, anti-inflammatories, neuropathic agents, muscle relaxants, opioids, topical agents, steroids, anticoagulants, sedatives, adherence, side effects, benefit, refill needs, access issues):

Opioid / Controlled Substance History, if applicable (use, dose, frequency, benefit, side effects, aberrant medication behaviors if discussed, naloxone availability, PDMP review, urine drug screening, opioid agreement status, overdose risk factors, safe storage counseling):

Surgical / Spine History (prior spine surgery, orthopedic surgery, hardware, fusion, decompression, joint replacement, fracture, implantable pain device, surgical recommendations):

Relevant Medical History (diabetes, anticoagulation use, infection risk, immunosuppression, cancer history, osteoporosis, renal disease, liver disease, pregnancy status when relevant, psychiatric comorbidities):

Recent Imaging / Testing (X-ray, MRI, CT, EMG/NCS, ultrasound, prior procedure reports, operative reports, other diagnostic results reviewed):

Pertinent Negatives (fever, chills, unexplained weight loss, cancer history red flags, progressive weakness, bowel or bladder dysfunction, saddle anesthesia, acute trauma, infection signs, severe rapidly worsening pain):

ROS PAIN MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Neck pain, back pain, joint pain, limb pain, radicular pain, or neuropathic pain	
Numbness, tingling, weakness, gait difficulty, balance issues, or falls	
Bowel or bladder dysfunction, saddle anesthesia, fever, chills, or unexplained weight loss	
Sleep disturbance, mood symptoms, anxiety, depression, or pain-related distress	
Medication side effects, sedation, constipation, nausea, dizziness, or cognitive effects	
Bleeding or bruising, anticoagulant use, diabetes-related concerns, or infection risk	
Functional limitations in work, ADLs, mobility, exercise, or sleep	

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT

WEIGHT

BMI

PAIN SCORE

5a FOCUSED MUSCULOSKELETAL & NEUROLOGIC EXAMINATION

General Appearance (distress level, body habitus, pain behaviors, mobility, assistive device use):

Inspection / Posture (posture, spinal alignment, scoliosis or kyphosis, guarding, antalgic positioning, asymmetry, swelling, deformity, scars, muscle atrophy, skin changes):

Gait (normal, antalgic, Trendelenburg, foot drop, balance impairment, assistive device use, heel and toe walking, tandem gait, transfer difficulty):

Range of Motion (cervical, thoracic, lumbar, shoulder, hip, knee, or other joint as relevant — pain limitation and planes of movement affected):

Palpation (tenderness, trigger points, paraspinal tenderness, facet loading tenderness, sacroiliac joint tenderness, joint line tenderness, bursal tenderness, muscle spasm, allodynia or hyperalgesia):

Motor Examination (strength by region and laterality, focal weakness, myotomal deficits, atrophy, functional weakness):

Sensory Examination (light touch, pinprick, dermatomal sensory loss, peripheral neuropathy findings, allodynia, hyperalgesia, numbness distribution):

Reflexes (deep tendon reflexes, asymmetry, hyperreflexia, hyporeflexia, clonus, pathologic reflexes):

Special Tests (straight leg raise, crossed straight leg raise, Spurling, facet loading, FABER, FADIR, Gaenslen, thigh thrust, compression/distraction, Tinel, Phalen, slump test, Patrick test, other condition-specific maneuvers):

Neurologic / Safety Findings (mental status, focal deficits, coordination, gait safety, bowel or bladder red flags, signs requiring urgent escalation):

PS PROCEDURE SITE / POST-PROCEDURE EXAMINATION, IF APPLICABLE

6 PROCEDURE-RELATED FINDINGS

PROCEDURE PERFORMED AND DATE

INJECTION OR DEVICE SITE LOCATION

TENDERNESS, BRUISING, SWELLING, OR ERYTHEMA

WARMTH, DRAINAGE, BLEEDING, OR HEMATOMA

INFECTION SIGNS

NEUROLOGIC STATUS AFTER PROCEDURE

PAIN RELIEF PERCENTAGE

DURATION OF RELIEF

FUNCTIONAL IMPROVEMENT AFTER PROCEDURE

ADVERSE EFFECTS OR COMPLICATIONS

PATIENT TOLERANCE AND RECOVERY STATUS

FA PAIN AND FUNCTIONAL ASSESSMENT TOOLS

7 MEASURES USED & INTERPRETATION

NUMERIC PAIN RATING SCALE

OSWESTRY DISABILITY INDEX

NECK DISABILITY INDEX

PEG SCALE

PROMIS PAIN INTERFERENCE SCORE

BRIEF PAIN INVENTORY

PAINDETECT / NEUROPATHIC PAIN SCREENING

PHQ-9 / GAD-7, WHEN RELEVANT

OPIOID RISK TOOL, SOAPP-R, COMM, OR OTHER OPIOID RISK ASSESSMENT

Score, interpretation, comparison to prior scores, limitations, and functional goals and progress since prior visit:

L LABORATORY AND DIAGNOSTIC RESULTS

8 RESULTS REVIEWED OR ORDERED

Imaging (X-ray, MRI, CT, ultrasound, fluoroscopic imaging, bone scan, other imaging relevant to pain generator localization):

Electrodiagnostic Testing (EMG/NCS findings, radiculopathy, neuropathy, plexopathy, nerve entrapment results):

Laboratory Studies (CBC, CMP, renal function, liver function, inflammatory markers, coagulation studies, HbA1c, infection-related labs, medication-monitoring labs):

Medication / Safety Monitoring (urine drug screen, toxicology results, PDMP review, opioid agreement status, pill count, medication compliance documentation):

Procedure Reports Reviewed (prior injections, ablations, operative reports, implant records, fluoroscopy reports, response documentation):

Prior Records Reviewed (primary care, orthopedic, neurology, neurosurgery, and physical therapy notes, imaging reports, emergency records, medication history, prior pain clinic records):

A ASSESSMENT

9 INTERVENTIONAL PAIN MEDICINE CLINICAL INTERPRETATION

Primary pain diagnosis or working diagnosis. Suspected pain generator. Differential diagnoses considered. Pain severity and chronicity. Neurologic status and presence or absence of red flags. Functional limitation and quality-of-life impact. Response to prior conservative, medication, and interventional treatments. Imaging and test correlation with symptoms and exam. Medication benefit, side effects, and safety concerns. Opioid or controlled substance risk assessment when applicable. Procedure candidacy, risks, contraindications, and expected benefit. Need for further imaging, electrodiagnostic testing, injections, ablation, neuromodulation, medication adjustment, therapy, surgical referral, or urgent escalation...

P PLAN

10 INTERVENTIONAL PAIN MANAGEMENT BY PROBLEM

Conservative management plan (physical therapy, home exercise program, activity modification, ergonomics, bracing, weight management, heat or ice, behavioral therapy, pain psychology). Medication plan (continuation, initiation, dose adjustment, discontinuation, refills, side effects, monitoring, education). Interventional procedure plan (injection type, target level and site, laterality, image guidance, diagnostic versus therapeutic purpose, sedation plan, expected goals). Anticoagulation and antiplatelet management plan (peri-procedural hold instructions, coordination with prescribing provider, bleeding risk counseling). Diabetes or infection-risk plan (steroid-related glucose counseling, infection screening, procedure timing, post-procedure monitoring). Opioid management plan (risk and benefit discussion, opioid agreement, PDMP review, urine drug screening, naloxone, tapering plan, safe storage, refill policy). Neuromodulation plan (spinal cord or peripheral nerve stimulation, trial planning, psychological evaluation, imaging review, implant follow-up). Diagnostic plan. Referral or coordination plan. Patient education on diagnosis, expected course, procedure risks and benefits, medication risks, activity precautions, red flags, and when to seek urgent or emergency care...

F FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up timeframe and purpose (medication reassessment, procedure scheduling, post-procedure response review, imaging or test review, functional goal reassessment, opioid monitoring, escalation planning):

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

COUNSELING / COORDINATION OF CARE TIME

RECORDS REVIEW TIME, IF APPLICABLE

PROCEDURE PLANNING TIME, IF APPLICABLE

MEDICATION MANAGEMENT TIME, IF APPLICABLE

E/M LEVEL: 99203 / 99204 / 99205 / 99213 / 99214 / 99215

PROCEDURE CODE(S), IF APPLICABLE

IMAGING GUIDANCE CODE(S), IF APPLICABLE

MEDICATION MANAGEMENT / CONTROLLED SUBSTANCE MONITORING, IF APPLICABLE

BASIS FOR BILLING: TIME-BASED / MEDICAL DECISION MAKING / PROCEDURE-BASED / IMAGING GUIDANCE / MEDICATION MANAGEMENT

PRIMARY PAIN DIAGNOSIS CODE + DESCRIPTION

SECONDARY DIAGNOSIS CODE(S), IF APPLICABLE

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY: INTERVENTIONAL PAIN MEDICINE	DATE	TIME