

Pain has a way of shrinking life. People stop traveling because the car ride is too hard on their back. They stop sleeping through the night because shoulder pain wakes them every time they roll over. They stop gardening, lifting grandchildren, working full shifts, or even sitting through dinner. By the time many patients arrive at a pain clinic, they are not just dealing with discomfort. They are dealing with lost function, poor sleep, irritability, fear of movement, and the quiet frustration of not feeling like themselves.

A good pain clinic is not simply a place that prescribes medication. At its best, it is a setting where the cause, pattern, and impact of pain are examined carefully. That distinction matters because pain is not one condition. It is a symptom that can come from joints, nerves, discs, muscles, inflamed tissues, scar tissue, or the central nervous system itself. Two people can say, “My back hurts,” and need very different care.

The range of conditions treated at a pain clinic is broad, but certain problems show up again and again. Some are common because they track with aging and wear. Others are common because they follow surgery, injury, diabetes, cancer treatment, or long-standing inflammation. What ties them together is persistence, complexity, or severity that goes beyond what routine self-care can reasonably fix.

What a pain clinic actually treats

Most people think of a pain clinic when pain has lasted for months, but time is only part of the story. Clinics also see severe acute pain after surgery or injury, cancer-related pain, and flares of known chronic conditions. In practice, pain specialists often treat pain that is interfering with work, mobility, sleep, or basic daily tasks, even if the calendar does not yet say “chronic.”

Pain can be grouped a few different ways. Some of it is mechanical, such as pain from an irritated spinal joint or a worn knee. Some is neuropathic, meaning it comes from damaged or malfunctioning nerves and often burns, tingles, shocks, or stabs. Some is inflammatory, as in certain arthritic conditions. Some is mixed, which is common and one reason treatment can be less straightforward than patients expect.

The goal is usually not a single dramatic cure. Sometimes that happens, especially when a specific pain generator is identified and treated well. More often, the work is to reduce pain, restore function, improve sleep, and make day-to-day life more manageable. That may sound modest on paper, but for someone who has been unable to stand long enough to cook a meal or walk through a grocery store without stopping, those changes are significant.

Back pain and the many problems hiding under that label

Low back pain is one of the most common reasons people seek care at a pain clinic. It is also one of the most misunderstood. “Back pain” can mean a strained muscle, a bulging disc, arthritic facet joints, sacroiliac joint dysfunction, spinal stenosis, vertebral compression fractures, or pain radiating from compressed nerves. The treatment depends on what is actually driving the symptoms.

One patient may describe a dull ache across the beltline that worsens after standing and improves when sitting. That pattern often points in a different direction than the patient who reports pain shooting from the buttock down the leg, with numbness in the foot. The first raises questions about joints or muscular support. The second often raises concern for lumbar radiculopathy, commonly called sciatica, where a spinal nerve is irritated or compressed.

Disc-related pain is common in adults who lift, twist, sit for long hours, or simply accumulate years of spinal wear. Not every abnormal MRI causes pain, which is an important point. Many people have disc bulges or degeneration on imaging and feel fine. A careful clinic does not treat a scan in isolation. It matches symptoms, physical findings, and imaging before deciding what matters and what may be incidental.

Spinal stenosis is another frequent diagnosis, especially in older adults. Patients often describe leg pain or heaviness when walking, with relief when leaning forward onto a shopping cart or sitting down. That pattern can be quite characteristic. Facet joint arthritis, on the other hand, often causes pain with extension, prolonged standing, or twisting. Sacroiliac joint pain can mimic low back pain but often sits lower and off to one side, sometimes after pregnancy, altered gait, or prior lumbar fusion.

Pain clinics commonly manage all of these conditions because they often require more than rest, a heating pad, and time.

Neck pain, arm pain, and cervical spine problems

Neck pain deserves its own discussion because the cervical spine produces a distinct set of problems. Some patients have localized neck pain and stiffness, often from degenerative changes, poor ergonomic load, or a whiplash-type injury. Others develop cervical radiculopathy, where a nerve root in the neck becomes irritated and sends pain, numbness, tingling, or weakness down the shoulder and arm.

The pattern matters. Pain into the thumb side of the hand points in one direction, while symptoms into the ring and little fingers point in another. Head position can aggravate it. Looking up to wash hair, turning while backing out of the driveway, or sleeping with the neck slightly extended can trigger symptoms. That kind of history is often more useful than patients realize.

Cervical facet pain is also common, particularly after rear-end collisions or in older adults with arthritis. These patients often say the pain settles at the base of the skull or into the upper shoulders rather than shooting below the elbow. They may have headaches that start in the neck and wrap upward. A pain clinic often sees these cases after months of “just neck strain” that never quite resolved.

Arthritis pain, from knees and hips to the spine

Arthritis is one of the largest categories of pain clinic referrals, though the term covers several different problems. Osteoarthritis is the familiar wear-related joint degeneration that affects knees, hips, shoulders, hands, and spinal joints. It often builds gradually. Patients notice morning stiffness that eases with movement, soreness after activity, creaking joints, or reduced range of motion. Later, pain can become constant and interfere with sleep.

Knee arthritis alone can change a person's whole body mechanics. When a knee hurts, people limp. When they limp, they stress the opposite hip, strain the low back, and reduce activity. Reduced activity leads to deconditioning, which makes the next flight of stairs harder, which leads to even less movement. This cycle is one reason pain clinics spend time asking about function rather than pain scores alone.

Hip arthritis is another frequent culprit that is missed more often than expected. Not every patient with groin pain recognizes it as hip pain. Some describe buttock discomfort, thigh pain, or a vague inability to put on socks. Others are treated for "back pain" for months before the hip is properly evaluated. Pain specialists often sort through these overlaps.

Arthritic pain in the spine, particularly the facet joints, is also common. It tends to be worse with standing, arching backward, or rotational movements. Patients may say they can walk only a certain distance before the pain builds, then have to sit for relief. Again, the pattern tells a story.

Inflammatory arthritis, such as rheumatoid arthritis or psoriatic arthritis, is usually managed primarily by rheumatology, but a pain clinic may become involved when pain remains significant despite disease-focused treatment. In those cases, the challenge is balancing symptom control without losing sight of the underlying inflammatory process.

Nerve pain, often described as burning, shocking, or electric

Neuropathic pain behaves differently from joint or muscle pain. Patients rarely call it a simple ache. They use words like burning, zapping, pins and needles, stabbing, icy, crawling, or hypersensitive. Clothing may hurt. Bed sheets may feel intolerable on the feet. A light touch that should be harmless can register as painful. These are clues that the nerves themselves are part of the problem.

Peripheral neuropathy is a common example. Diabetes is a leading cause, but it is not the only one. Chemotherapy, alcohol misuse, vitamin deficiencies, certain autoimmune conditions, and idiopathic causes all show up in clinic. Patients often describe numbness and burning in the feet first, especially at night. Sleep suffers quickly when feet feel as if they are on fire at 2 a.m.

Radiculopathy, whether from the neck or low back, is another nerve pain problem. So is postherpetic neuralgia, the lingering pain that can follow shingles. Some patients recover from the rash but continue to have severe skin sensitivity and stabbing pain for months or longer. A pain clinic often treats this because it can be surprisingly debilitating, especially when the chest wall or face is involved.

Nerve pain can be especially frustrating because standard anti-inflammatory measures may do little. People sometimes think they have "failed treatment" when the real issue is that the wrong type of treatment was aimed at the wrong type of pain. Distinguishing nerve pain from inflammatory or mechanical pain is basic to good care.

Headaches and facial pain that cross into pain medicine

Not every headache belongs in a pain clinic, but many do. Chronic migraine, cervicogenic headache, occipital neuralgia, and certain facial pain syndromes often bring patients in after repeated urgent care visits, inconsistent

relief, or a long string of medications that never solved the bigger pattern.

Cervicogenic headaches start in the neck and radiate upward, often on one side. Patients may feel they can put a finger on the spot where the headache begins. Occipital neuralgia causes sharp or electric pain in the back of the head, sometimes with scalp tenderness so intense that hair brushing becomes uncomfortable. These conditions are often mistaken for “just tension headaches” for far too long.

Facial pain syndromes, including trigeminal neuralgia, are among the most severe pain conditions many clinicians encounter. The pain can be brief but excruciating, triggered by chewing, speaking, brushing teeth, **pain treatment clinic** or even cool air on the face. Patients are sometimes afraid to eat or wash their face. This is a condition where precise diagnosis matters tremendously because the pain quality and trigger pattern are so distinctive.

Complex regional pain syndrome and why early recognition matters

Complex regional pain syndrome, often shortened to CRPS, is less common than back pain or arthritis, but it is one of the conditions pain specialists are trained to recognize. It typically follows an injury, fracture, surgery, or other trauma, though the initial event may seem relatively minor compared with the severity of the later pain.

The hallmark is pain that is out of proportion to the original injury, along with changes in color, temperature, swelling, sweating, hair growth, nail growth, or sensitivity in the affected limb. A hand may become too painful to tolerate a sleeve brushing against it. A foot may look dusky, feel warmer or colder than the other side, and become stiff because the patient is understandably afraid to move it.

Timing matters with CRPS. Delayed recognition can make recovery harder. In practical terms, if someone has persistent severe pain, swelling, and sensitivity after what should have been routine healing, a pain clinic evaluation can be important. This is one area where experience really shows. Seasoned clinicians learn not to dismiss disproportionate pain as “just anxiety” when the physical findings and course suggest something more.

Pain after surgery, even when the procedure was technically successful

Surgery can fix structural problems and still leave pain behind. That reality surprises many patients, who assume a good operation guarantees a pain-free result. Sometimes lingering pain reflects slow healing. Sometimes it reflects scar tissue, nerve irritation, altered mechanics, or an entirely different pain generator that surgery did not address.

Post-laminectomy syndrome, often called failed back surgery syndrome, is one example commonly seen in a pain clinic. The name is unfortunate because it sounds like blame, and that is usually not the right frame. Many people have surgery for the correct reason and still develop persistent back or leg pain afterward. The challenge then is to identify whether the issue is recurrent nerve compression, epidural scarring, adjacent level disease, persistent nerve injury, sacroiliac pain after fusion, or something else.

Pain after joint replacement can also be complex. A knee replacement may improve arthritis pain yet leave neuropathic symptoms, stiffness, or pain from surrounding soft tissues. Shoulder surgery can resolve one lesion and uncover another issue in the neck. Pain medicine often steps in when the expected healing timeline has passed and symptoms are still limiting function.

Cancer pain and pain related to cancer treatment

Cancer pain deserves careful, individualized attention. It may come from the tumor itself, from treatment, or from both. Bone metastases, nerve compression, post-surgical pain, chemotherapy-induced neuropathy, and radiation-related tissue changes all fall within the scope of pain management.

What makes cancer pain different is not only the source, but the clinical context. The goals may be comfort, function, sleep, preservation of appetite, the ability to tolerate further treatment, or support in advanced illness. There is no one-size-fits-all approach. Someone undergoing active chemotherapy with severe neuropathy in the hands may need a very different plan than someone with focal bone pain from metastatic disease.

Pain clinics that work closely with oncology and palliative teams can make a real difference here. Even relatively small improvements, such as reducing pain enough to let a patient lie flat for radiation treatment or walk from bed to bathroom with less distress, matter enormously.

Abdominal, pelvic, and musculoskeletal pain syndromes that are harder to categorize

Some of the most difficult cases in a pain clinic do not fit neatly into one box. Chronic pelvic pain, abdominal wall nerve entrapment, intercostal neuralgia, myofascial pain syndromes, and pain related to prior trauma often require slower, more nuanced assessment.

Myofascial pain is a good example. Patients may have taut bands in muscle, focal trigger points, and referred pain patterns that mimic nerve or joint problems. A desk worker with shoulder blade pain may have a mix of cervical strain, postural overload, and myofascial trigger points. A runner with persistent buttock pain may turn out to have gluteal trigger points layered on top of a spinal issue. These are not throwaway diagnoses. They can be functionally limiting and surprisingly stubborn.

Pelvic pain is another area where patients often bounce between specialties. Gynecologic, urologic, gastrointestinal, musculoskeletal, and neuropathic causes can overlap. By the time these patients reach a pain clinic, they are often exhausted from feeling unheard. Careful listening is not a soft skill in these cases. It is part of the diagnostic process.

When pain becomes chronic, the nervous system changes too

One reason pain clinics exist is that persistent pain does not remain a simple signal from one injured body part. Over time, the nervous system can become sensitized. Pain may spread. Harmless movement may feel threatening. Sleep deprivation, stress, depression, and inactivity can magnify the experience without making it imaginary. This is one of the hardest ideas for patients to hear because they fear it means the pain is “all in their head.” It does not. It means the biology of chronic pain is more layered than an injured knee or irritated disc alone.

A person with long-standing low back pain, for instance, may start with a disc flare and later develop guarded movement, weak hip stabilizers, poor sleep, and fear of bending. Months later, even after the original tissue irritation has improved, the pain system remains on high alert. That is why effective pain care often needs more than one tool and more than one visit.

What usually prompts referral to a pain clinic

There is no perfect timeline, but certain patterns suggest the need for a more focused evaluation:

- pain lasting beyond expected healing time, often several weeks to months

- symptoms that disrupt sleep, mobility, work, or self-care
- nerve-type pain such as burning, numbness, tingling, or shocks
- pain that persists after surgery or follows a significant injury
- pain that remains poorly controlled despite standard treatment

These situations are common, not rare. The referral does not necessarily mean surgery is coming, nor does it mean medication is the only answer. More often, it means the problem has become specific enough, persistent enough, or impactful enough to benefit from specialty care.

The conditions may be common, but the treatment plans rarely are

A patient with knee arthritis who still walks two miles a day, sleeps well, and mainly wants help before a vacation is different from a patient with the same X-ray findings who cannot get out of a chair without assistance. A patient with diabetic neuropathy and mild nighttime burning is different from one who dreads bedtime because the sheets feel painful. This is why a pain clinic worth its name takes history seriously.

There is also a practical side to treatment that patients appreciate once they see it. A retired teacher with cervical radiculopathy may be able to rest, attend therapy during the day, and tolerate slower progress. A warehouse worker with the same diagnosis may need a plan built around lifting demands, shift schedules, and the reality that missing six weeks of work is not financially feasible. Medicine that ignores context tends to disappoint.

Some conditions overlap so heavily that diagnosis unfolds in stages. A patient may arrive for back pain and eventually learn the primary driver is hip arthritis. Another may think they have migraine and turn out to have occipital neuralgia. A careful pain clinic expects that possibility and adjusts rather than forcing every symptom into the first available label.

A better question than “what hurts?”

The most useful pain assessments go beyond location. They ask what the pain feels like, when it started, what worsens it, what eases it, where it travels, how it affects sleep, whether there is numbness or weakness, what treatments have already failed, and what the patient is trying to get back to doing. That last point matters. Someone who wants to play 18 holes of golf has a different functional target than someone who wants to stand long enough to shower without help.

Common conditions treated at a pain clinic include back and neck pain, arthritis, nerve pain, chronic headaches, post-surgical pain, cancer-related pain, CRPS, and several harder-to-classify syndromes involving muscles, scar tissue, or sensitized nerves. The list sounds broad because pain itself is broad. What unifies these conditions is the need for careful differentiation and a practical plan.

For patients, that often comes as a relief. They do not need another generic answer that everything “looks normal enough.” They need someone to sort out whether the pain behaves like joint pain, nerve pain, inflammatory pain, or a mixture of several. They need a clinician who understands that severe pain is rarely just a physical sensation and rarely just a number on a scale. It is a force that changes movement, mood, identity, and routine. A skilled pain clinic treats that reality, not only the symptom.

Denver Pain Management Clinic
455 Sherman St #450, Denver, CO 80203

(720) 405-2330

FAQ About pain clinic

Do I need a referral to go to the pain clinic in Denver?

Denver Pain Management Clinic accepts referrals. Contact the clinic and your insurance plan before booking to confirm whether a referral is required for your visit.

Do pain management clinics give pain meds?

Some pain clinics include medication management as part of an individualized plan. At Denver Pain Management Clinic, a clinician reviews your medical and treatment history and discusses options after an evaluation.

What medication is used for chronic pain?

Medication choices depend on the cause of the pain, your health history, and any medicines you already take. A clinician can discuss the benefits and risks of medication and whether other approaches, such as physical therapy, may be appropriate.