



Last Name: _____ First Name: _____ Middle Init: _____

Preferred Name: _____ Sex: M F DOB: ____/____/____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Cell Phone: () _____

May we leave a voice message to remind you about appointments on your home and/or cell phone number? Yes No

Email address: _____@_____

Marital Status: Single Married Divorced Separated Widowed Primary Language: English Spanish Other

Race: African/American Caucasian Hispanic Other _____ Ethnicity: Not Hispanic/Latino Hispanic/Latino

Occupation: _____ Work Phone: () _____

Address _____

Referring Physician: _____

Primary Care Physician: _____ Phone Number: () _____

Pharmacy Name: _____ Phone Number: () _____

How did you hear about Atlantic Coast Pain Management? Referred Commercial Webpage Other

Emergency Contact Name: _____ Relationship: _____

Home Phone: () _____ Cell Phone: () _____

Insurance

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

WC or MVA Insurance Name: _____

WC or MVA Address: _____

Adjuster/Case Mgr Name: _____ Claim #: _____

Phone #: _____ Ext. _____ Date of Accident: ____/____/____

Body part(s) injured? _____

Attorney Name: _____

Address: _____

Phone #: _____ Fax #: _____

Health Insurance: _____ Effective Date: ____/____/____

Health Ins. Address: _____

Member ID #: _____ Group #: _____

Policyholder's Name: _____ Referral required: Y N

Policyholder's DOB: ____/____/____ SSN#: _____ Deductible \$ _____

Co-Pay \$ _____ Relation to Insured: _____

Policyholder's Employer: _____

The above information is true to the best of my knowledge. I authorize Atlantic Coast Pain Specialist to furnish information to insurance carriers required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand fully that I am responsible for any amount not covered by the insurance, or any collection fees, or interest required.

Signature

Date



R. Blake Kline, MD

Rita Cagle, APRN

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

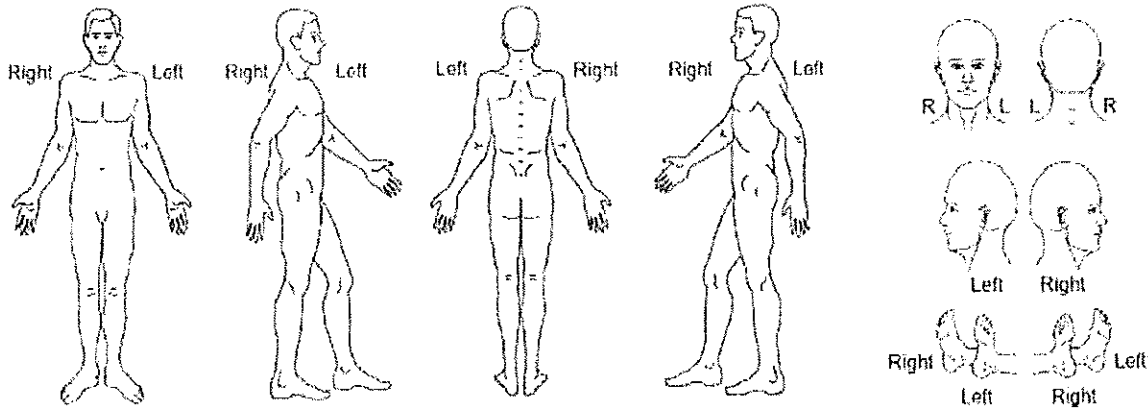
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? Gradually Suddenly

Since your pain began how has it changed? Improved Worsened Stayed the same

Height: _____

Weight: _____

Pain Description

Check all of the following that describe your pain:

- Dull/Aching Hot/Burning Shooting Stabbing/Sharp
- Cramping Numbness Spasming Throbbing
- Squeezing Tingling/Pins and Needles Tightness

When is your pain at its worst?

- Mornings Daytime Evenings Middle of the night
- Always the same

How often does the pain occur?

- Constant Changes in severity but always present
- Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best It Gets _____ The Worst It Gets _____

Mark the effect each of the following have on your pain level -

	Increases	Decreases	No Change
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking upward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
Weakness in the arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark all of the following treatments you have used for pain relief:

	<u>When</u>	<u>Where</u>
Spine Surgery	_____	_____
Physical Therapy	_____	_____
Chiropractic Care	_____	_____
Psychological Therapy	_____	_____
Brace Support	_____	_____
Acupuncture	_____	_____
Hot/Cold Packs	_____	_____
Massage Therapy	_____	_____
Medications	_____	_____
TENS Unit	_____	_____
Other	_____	_____

Interventional Pain Treatment History

- Epidural Steroid Injection - (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection - Joint(s) _____
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- MILD (Minimally Invasive Lumbar Decompression) - _____
- Nerve Blocks - Area/Nerve(s) - _____
- Radiofrequency Nerve Ablation - (circle levels) - Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator - Trial Only/Permanent Implant _____
- Trigger Point Injections - Where? _____
- Vertebroplasty/Kyphoplasty - Level(s) _____
- Other - _____

Which of these procedures listed above have helped with your pain? _____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

- MRI of the: _____ Date: _____ Where: _____
- X-Ray of the: _____ Date: _____ Where: _____
- CT Scan of the: _____ Date: _____ Where: _____
- EMG/NCV study of the: _____ Date: _____ Where: _____
- Other Diagnostic Testing: _____ Date: _____ Where: _____
- I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- Acupuncturist Neurosurgeon Psychiatrist/Psychologist
- Chiropractor Orthopedic Surgeon Rheumatologist
- Internist Physical Therapist Neurologist
- Other _____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past? _____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- Cancer - Type _____
- Diabetes - Type _____

Head/Ears/Eyes/Nose/Throat

- Headaches
- Migraines
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Glaucoma

Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Coronary Artery Disease
- High Blood Pressure
- Peripheral Vascular Disease
- Stroke/TIA
- Heart Valve Disorders

Respiratory

- Asthma
- Bronchitis/Pneumonia
- Emphysema/COPD

Gastrointestinal

- GERD (Acid Reflux)
- Gastrointestinal Bleeding
- Stomach Ulcers
- Constipation

Musculoskeletal/Rheumatologic

- Bursitis
- Carpal Tunnel Syndrome
- Fibromyalgia
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Chronic Joint Pains

Urological

- Chronic Kidney Disease
- Kidney Stones
- Urinary Incontinence
- Dialysis

Other Diagnosed Conditions

- _____
- _____
- _____
- _____
- _____
- _____

Neuropsychological

- Multiple Sclerosis
- Peripheral Neuropathy
- Seizures
- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

- 1) _____ Date? _____
- 2) _____ Date? _____
- 3) _____ Date? _____
- 4) _____ Date? _____
- 5) _____ Date? _____

I have NEVER had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? YES No

If YES, which ones? Aspirin Plavix Coumadin Lovenox Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Allergies

Do you have any drug/medication allergies? Yes No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: Latex Iodine Tape IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

- Arthritis Cancer Diabetes
- Headaches/Migraines High Blood Pressure Kidney Problems
- Liver Problems Osteoporosis Rheumatoid arthritis
- Seizures Stroke

Other Medical Problems: _____

I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

Temporary Disability Permanent Disability Retired Unemployed

Are you currently under worker's compensation? No Yes

Is there an ongoing lawsuit related to your visit today? No Yes

Alcohol Use:

Social Use History of alcoholism Current alcoholism Never

Daily use of alcohol

Tobacco Use:

Current user Former user Never used

Packs per day? _____ How many years? _____ Quit Date: _____

Illegal Drug Use:

Denies any illegal drug use Currently uses illegal drugs

Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? Yes No

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Easy bruising
	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Unexplained Weight Gain		<input type="checkbox"/> Weakness
	<input type="checkbox"/> Unexplained Weight Loss		

Eyes:	<input type="checkbox"/> Recent Visual changes
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Ears/Nose/Throat/Neck:	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Earaches	<input type="checkbox"/> Hearing Problems
	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus problems	

Cardiovascular:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Clots
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling in feet
	<input type="checkbox"/> Shortness of breath during sleep		

Respiratory:	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath
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Gastrointestinal:	<input type="checkbox"/> Constipation	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Abdominal Cramps
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Hernia

Musculoskeletal:	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pains	<input type="checkbox"/> Joint Stiffness
	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> Neck Pain

Genitourinary/Nephrology:	<input type="checkbox"/> Flank Pain	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Decreased Urine Flow/Frequency/Volume		

Neurological:	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Numbness/Tingling		<input type="checkbox"/> Seizures

Psychiatric:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Feeling Anxious	<input type="checkbox"/> Stress Problems
	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Suicidal Planning	
	<input type="checkbox"/> Thoughts of Harming Others		

All other review of systems negative

Reviewer _____

Notice of Privacy Practices
Acknowledgement Form

I acknowledge receiving Atlantic Coast Pain Specialists Notice of Privacy Practices. This notice provides in detail and in plain language the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by, this practice. If changes occur to the policy, this practice will provide me with a revised Notice of Privacy Practices upon request.

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Name (Please Print) Date of Birth

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Signature Today's Date

Relationship to patient (If signed by a personal representative):

HIPAA Consent Form

I authorize Atlantic Coast Pain Specialists, 1500 Main Street,
Conway, SC 29526 to disclose or provide protected health
information about me to the individual(s) listed below.
(Please list each family member, friend or other individual
permitted to receive this information).

Name _____
Home Phone _____ Cell Phone _____
Relationship _____
Information to disclose ___All ___Appointment ___Financial ___Health

Name _____
Home Phone _____ Cell Phone _____
Relationship _____
Information to disclose ___All ___Appointment ___Financial ___Health

Name _____
Home Phone _____ Cell Phone _____
Relationship _____
Information to disclose ___All ___Appointment ___Financial ___Health

Name (Please Print) _____

Signature _____

Date of Birth _____

Today's Date _____



Request for Medical Records

I, _____
authorize the release of my medical records.....

To: _____

From: _____

...including, but not limited to: office notes, lab results, special test results, letters, diagnostic imaging reports and/or any information related to the above named patient.

Signature _____

Date of Birth _____

Today's Date _____

1500 Main Street
Conway, SC 29526
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