Medical Record#_____

1500 Main Street
Conway, SC 29526
Phone: (843) 438-8470
Fax: (843) 438-8480

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 acquired.

_____ _____

Signature Date

Medical Record#_____

ATLANTIC COAST PAIN SPECIALISTS

R. Blake Kline, MD

1500 Main St.

Conway, SC 29526

843-438-8470

Patient Information

Today's date: _____

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

Referring Physician: _____ Primary Care Physician: _____

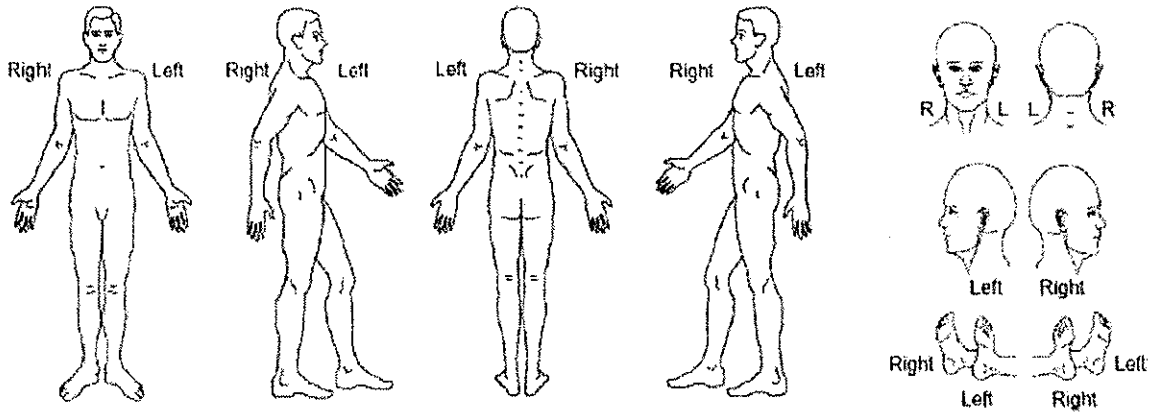
Pain History

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:_____

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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	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

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

_____

_____

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☐	Where? _____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

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

	When	Where
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 _____

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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_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

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

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

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

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

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Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

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

	Medication Name	Allergic Reaction
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

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Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐ Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		

Eyes:	☐ Recent Visual changes		

Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	

Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		

Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath

Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐ Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ muscle spasms	☐ Neck Pain

Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		

Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures

Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☐ All other review of systems negative ☐ Reviewer _____

Atlantic Coast Pain Specialists

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Notice of Privacy Practices Acknowledgement Form

The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

I acknowledge receiving Atlantic Coast Pain Specialists, Notice of Privacy Practices.

_____ _____/_____/_____
Patient Name (Please PRINT) Date of Birth

_____ _____/_____/_____
Signature Date

I authorize Atlantic Coast Pain Specialists to disclose or provide protected health information about me to the individual(s) listed below (list each family member, friend, or other individual to receive PHI):

Name: _____ Phone: _____

Relationship: _____ ☐ All information ☐ Appointment ☐ Financial ☐ Health

Name: _____ Phone: _____

Relationship: _____ ☐ All information ☐ Appointment ☐ Financial ☐ Health

Name: _____ Phone: _____

Relationship: _____ ☐ All information ☐ Appointment ☐ Financial ☐ Health

_____ _____/_____/_____
Signature Date

R. BLAKE KLINE, MD

REQUEST FOR MEDICAL RECORDS

I, _____

authorize the release of my medical records....

To:

_____

_____

_____

From:

_____

_____

_____

.....including, but not limited to, office notes, lab results, tests and special test results, letters, x-ray reports, MRI reports and/or any information related to the above named patient.

Signature_____ Date_____

D.O.B._____SS#_____

1500 MAIN STREET • CONWAY, SC 29526
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