DR. BLAKE KLINE
DR. MICHAEL WARDEN

Please complete the following information:

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: Male Female DOB: _____SSN: _____

Address: _____

Home phone: _____ Cell phone: _____

May we contact you to remind you of your appointments via home/cell phone, or both? _____

Patient Email: May we contact you via email? Yes No

If yes, please provide email address_____@_____

Race/Ethnicity: ____Caucasian ____ African American ____Latino/Hispanic _____non-Hispanic ____Other

Marital Status: _____Married _____Single _____Divorced _____Separated _____ Widowed

Occupation: _____ Work Number: _____

Pharmacy name and phone: _____

Referring Provider: _____ Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Contact Number for emergency person: _____

2767 CULTRA ROAD • CONWAY, SC 29526
PHONE (843) 438-8470 • FAX (843) 438-8480
WWW.ATLANTICCOASTPAIN.COM

ATLANTIC COAST
SPINE & PAIN CENTER

DR. BLAKE KLINE
DR. MICHAEL WARDEN

Insurance

Primary Insurance: _____ ID#: _____

Are you the policy holder? _____If no, policy holder name: _____

DOB: _____ SSN: _____ Phone Number: _____

Secondary Insurance: _____ ID#: _____

Are you the policy holder? _____If no, policy holder name: _____

DOB: _____ SSN: _____ Phone Number: _____

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

Signature: _____Date: _____

Worker's Compensation

Type of accident (circle one) Worker's Comp Motor Vehicle Other

Adjustor / Case Manager Name: _____

Phone Number:_____ Fax#: _____

Claim#: _____ Case#: _____

Do you have an attorney representing you in this matter? Yes No

Name: _____

Address: _____

Phone#: _____ Fax#: _____

Date of injury: _____

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

Signature: _____Date: _____

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NEW PATIENT — PAIN ASSESSMENT

Atlantic Coast Spine & Pain

Patient Name: _____ **DOB:** _____

Reason for today's visit: _____

Pain Characteristics:

1. Where is the pain located? _____

   And where does the pain radiate? _____

2. How long have you had this pain (number of days/months/years)? _____

3. Was there an injury or event that started the pain? _____

   If so, what happened? _____

4. Since starting, have symptoms: (circle one) **improved** **worsened** **remained the same**

5. How would you describe the pain? (circle all that apply)

   sharp **stabbing** **shooting** **burning** **tingling** **dull** **aching** **throbbing** **cramping**

6. Docs the pain ever go away? **Yes, the pain comes and goes.** **No, the pain is always there.**

7. How much does it hurt today?

   No pain | ——|——|——|——|——|——|——|——|——|—— | Worst Possible Pain

8. Any other symptoms? (circle all that apply) **numbness** **tingling** **weakness** **other**_____

9. What makes the pain better? (circle all that apply)

   rest **sitting** **lying down** **medications** **ice** **heat** **other**_____

   What makes the pain worse? (circle all that apply)

   Sitting **standing** **walking** **bending** **lifting** **getting up from sitting** **other**_____

10. Symptoms have interfered with: (circle all that apply)

    physical activity **work** **sexual relations** **walking** **sleeping** **bathing** **social activities**

11. Do you have any of the following? (circle all that apply)

    bowel or bladder dysfunction **weight loss** **personal history of cancer** **recent injury**

Past Treatments & Imaging:

12. Have you had other professional care? (circle all that apply)

    physical therapy **chiropractor** **acupuncture** **TENS unit** **pain management**

Pati+

13. What pain medications have you tried? _____

    What are you currently taking for pain? _____

14, Did you have previous injections/surgeries for pain? _____

15. Did you have any imaging of your painful areas or spine? _____

If so, where and when was it done? _____

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_____ **Patient Name:**_____ **DOB:** _____

Past Medical History

Please list the names of other physicians you are seeing:

_____

_____

Please mark the following conditions /diseases you have been treated for in the past:

General Medical

_____Cancer – type _____

_____Diabetes – type _____

Cardiovascular / Hematological

_____Anemia

_____Heart Attack

_____Coronary Artery Disease

_____High Blood Pressure

_____Peripheral Vascular Disease

Gastrointestinal

_____ GERD (acid reflux)

_____ Gastrointestinal Bleeding

_____ Stomach Ulcers

_____ Constipation

Urology

_____ Chronic Kidney Disease

_____ Kidney Stones

_____ Urinary Incontinence

_____ Dialysis

Respiratory

_____Asthma

_____Bronchitis / Pneumonia

____ Emphysema / COPD

Neuropsychological

_____ Multiple Sclerosis

_____ Peripheral Neuropathy

_____Seizures

_____ Depression

_____ Anxiety

_____Schizophrenia

_____ Bipolar Disorder

Head / Ears / Eyes / Nose / Throat

_____ Headaches

_____ Migraines

_____ Head injury

_____ Hyperthyroidism

_____ Hypothyroidism

_____ Glaucoma

Musculoskeletal / Rheumatologic

_____ Bursitis

_____ Carpal Tunnel Syndrome

_____ Fibromyalgia

_____ Osteoarthritis

_____ Osteoporosis

_____ Rheumatoid Arthritis

_____ Chronic Joint Pain

Other: _____

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Patient Name: _____ DOB: _____

Past Surgical History

Please list any surgical procedures you have had performed including the 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 and over the counter.

Medication Name	Dose	Frequency

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_____ **Patient Name:** _____ **DOB:** _____

Allergies

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

If so, please list them

Medication	Allergic Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please check all the appropriate diagnosis as they pertain to your first-degree relatives

_____ Arthritis _____ Cancer _____ Diabetes _____ Headaches / Migraines

_____ High Blood Pressure _____ Kidney _____ Liver _____ Osteoporosis

_____ Seizures _____ Rheumatoid Arthritis _____ Stroke

_____ Other_____

_____ Other_____

Social History

Occupation: _____ When was the last time worked? _____

Who is currently in your household? _____

Are there any stairs in your home? Yes No If so, how many? _____

Are you currently under Workman's Compensation? Yes No

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

Alcohol Use: _____Social _____ History of alcoholism _____ Daily _____ Never

Tobacco Use: _____ Current User _____ Former User _____ Never _____ Vape

_____ Packs per day _____ Former User 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 narcotics or prescription medication? **Yes** **No**

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Patient Name: _____ **DOB:** _____

Review of Symptoms

Check the symptoms from which you currently suffer:

Constitutional: _____ Chills _____ Difficulty sleeping _____ Night sweats _____ Fatigue

_____ Insomnia _____ Low sex drive _____ Fevers _____ Tremors

_____ Weakness _____ Unexplained weight loss _____ Unexplained weight gain

_____ Easy bruising

Eyes: _____ Recent visual changes

Ears/ Nose / Throat / Neck: _____ Dental problems _____ Earaches _____Hearing problems

_____ Nose bleeds _____ Sinus problems

Cardiovascular: _____ Chest pain _____ Fainting _____ Shortness of breath during sleep

_____ Bleeding disorder _____ Palpitations _____ Blood clots

_____ Swelling in feet

Respiratory: _____ Cough _____ Wheezing _____ Shortness of breath

Gastrointestinal: _____ Constipation _____ Diarrhea _____Acid reflux _____ Abdominal cramps

_____ Nausea / vomiting _____ Hernia

Musculoskeletal: _____ Back pain _____ Joint swelling _____Joint pains _____Neck pain

_____ Muscle spasms _____ Joint stiffness

Genitourinary / Nephrology: _____ Flank pain _____ Blood in urine _____Painful urination

_____ Decreased urine flow / frequency / volume

Neurological: _____ Dizziness _____ Numbness _____ Headaches _____ Tremors

_____ Seizures _____ Tingling

Psychiatric: _____ Depressed mood _____Feeling anxious _____ Stress problems

_____ Suicidal thoughts _____ Suicide planning _____ Thoughts of harming others

_____**All other review of symptoms negative**

Reviewer: _____