IRWIN J. ISAACS, M.D.
PRP REGENERATIVE PAIN INSTITUTE, P.C.
4163 Montgomery BLVD NE
Albuquerque, NM 87109
Office (505) 503-6990
FAX (505) 554-2452

PATIENT DEMOGRAPHICS:

FIRST NAME: _____ MI: _____ LAST NAME: _____

DOB: _____ SS#: _____

MARITAL STATUS: _____ RACE: _____ GENDER: _____

MAILING ADDRESS: _____ Zip code: _____

PHYSICAL ADDRESS: _____ Zip code: _____

EMAIL: _____

CELL PH #: _____ HOME PH #: _____

OCCUPATION: _____ EMPLOYER: _____

HOW WERE YOU REFERRED TO US: _____

PRIMARY CARE PHYSICIAN (With Phone #): _____

PHARMACY (With Phone #): _____

EMERGENCY CONTACT & RELATIONSHIP: _____

EMERGENCY CONTACT PHONE #: _____

ALLERGIES: _____

SPOUSE'S INFORMATION *(if applicable)*:

FIRST NAME: _____ MI: _____ LAST NAME: _____

CELL PH #: _____ HOME PH #: _____

RESPONSIBLE PARTY INFORMATION *(if different from Patient)*:

FULL NAME: _____ RELATIONSHIP: _____

SS#: _____ DOB: _____

CELL PH #: _____ HOME PH #: _____

INSURANCE INFORMATION: *(Not necessary if card is scanned)*

PRIMARY: _____

SECONDARY: _____

PAYMENT OF CO-PAY, SELF-PAY, OR CO-INSURANCE IS EXPECTED AND DUE UPON CHECK-IN.

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT:

I acknowledge that I am legally responsible for all charges relating to the medical care and treatment provided by representatives of the PRP Regenerative Pain Institute, P.C.

I assign and authorize payments to the PRP Regenerative Pain Institute, P.C.

I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity.

I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

I give permission to leave phone message(s).

_____

Patient Signature and or/Guardian Date

PRP Regenerative Pain Institute, P.C.

4163 Montgomery Blvd., NE

Albuquerque, NM, 87109

New Patient Form Email:

Name of patient:

Date of birth: **Age:**

Where is your pain? (Please circle) back legs upper back head neck arms shoulder hip knee other

When did your pain first start? (Duration)_____

What started the pain? (Please circle) just came on without cause fall car accident work injury other

The quality of pain is: (Please circle) sharp dull burning aching stabbing throbbing tingling shooting pressure-like other

The timing of the pain is: (Please circle) comes and goes constant

Highest pain level is: (Please circle) 0 1 2 3 4 5 6 7 8 9 10 (Highest)

Average pain level is: (Please circle) 0 1 2 3 4 5 6 7 8 9 10

Lowest pain level is: (Please circle) 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? (Please circle) bending standing lying walking reaching lifting cold weather sitting neck rotation twisting back climbing stairs other

What makes the pain better? (Please circle) ice heat medications walking sitting physical therapy lying acupuncture chiropractor other

Associated signs and symptoms: (Please circle) shooting pain tingling numbness

weakness headaches muscle spasms balance problems walking problems

bowel dysfunction bladder incontinence other

Pain medications tried: (Please circle) **Tylenol** (helped, no relief) **ibuprofen, aleve** (helped, no relief)

Opioids (helped, no relief) **muscle relaxers** (helped, no relief) **0ther**

Treatments tried: (Please circle)

Physical therapy (helped, no relief)

Massage (helped, no relief)

Acupuncture (helped, no relief)

Chiropractor (helped, no relief)

Spine surgery (helped, no relief)

Injections (helped, no relief)

Another pain clinic (helped, no relief)

List any tests you have had related to your pain: (Please circle) X-rays MRI

CT scan EMG other

List any medications you are currently taking including vitamins, herbs and supplements. Include dose and frequency:

Medication:_____ Dose and Frequency_____

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Medication:_____ Dose and Frequency_____

Medication:_____ Dose and Frequency_____

Medication:_____ Dose and Frequency_____

Medication:_____ Dose and Frequency_____

Medication:_____ Dose and Frequency_____

Blood thinners: (Please circle) yes no

Allergies: (Please circle) None List allergies_____

Past medical history: (Please circle)

Diabetes bleeding disorder HIV or AIDS stroke Heart murmur stroke heart attack heart problems aneurysm circulation problems DVT (deep venous thrombosis) High cholesterol seizures cancer kidney problems high blood pressure atrial fibrillation Asthma thyroid problems ulcers liver problems heartburn pacemaker hepatitis Sleep apnea defibrillator fibromyalgia rheumatoid arthritis osteoarthritis lupus pulmonary embolus PTSD Depression Anxiety other immune disorder

Past surgical history: (Please list any previous surgery you have had)

_____

_____

_____

_____

FAMILY HISTORY

Does anyone in your family suffer from chronic illness: ☐No/☐Yes:

Relationship (e.g. father, sister, etc.) Illness

_____

_____

SOCIAL HISTORY

What was the highest level of education you completed?
☐ High school ☐ College ☐ Graduate school

What is you marital status?
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children do you have? _____

Do you smoke? ☐No/☐Yes:
If yes, how many packs/day _____ *How many years have been smoking?* _____

Do you drink alcohol? ☐No/☐Yes:
If yes, how much and often do you drink? (e.g. 2 glasses of wine/day) _____

Do you use recreational drugs? ☐No/☐Yes: *If yes, please describe* _____

Do you exercise regularly? ☐No/☐Yes: *If yes, how often?* _____

WORK HISTORY

Are you currently working? ☐No/☐Yes: *If yes, who is your current employer:* _____

_____

What is your occupation? _____

Are you disabled? ☐No/☐Yes: *If yes, how long have you been disabled?* _____

What caused you to become disabled? _____

PSYCHOSOCIAL HISTORY

Have you ever been treated for emotional/behavioral disorder? ☐No/☐Yes: *If yes, please describe:* _____

Have you ever been treated for depression? ☐No/☐Yes: *If yes, when:* _____

Have you ever attempted suicide? ☐No/☐Yes: *If yes, when:* _____

Do you currently have suicidal thoughts? ☐No/☐Yes

REVIEW OF SYSTEMS

Please circle any of the following problems that you are now experiencing:

Constitutional: weight change ◦ weakness ◦ fatigue ◦ fever

Eyes: change in your eyeglass prescription ◦ eye pain ◦ tearing ◦ double vision

Ear, Nose, Throat: hearing loss ◦ nasal congestion ◦ ringing in your ears ◦ dizziness ◦ sore throat

Cardiovascular: shortness of breath ◦ chest pain ◦ palpitations ◦ ankle swelling

Respiratory: cough ◦ sputum ◦ coughing up of blood ◦ difficulty breathing ◦ wheezing

Gastrointestinal: heartburn ◦ nausea or vomiting ◦ abdominal pain ◦ constipation ◦ diarrhea ◦ bowel incontinence ◦ bloody stool

Genitourinary: pain with urination ◦ bladder incontinence ◦ urgency ◦ blood in urine

Musculoskeletal: joint pain ◦ stiffness ◦ neck or backache

Skin: rash ◦ lumps ◦ itching ◦ hair changes ◦ nail changes

Neurological: headache ◦ weakness ◦ numbness ◦ seizures ◦ blackouts ◦ memory loss

Psychological: nervousness ◦ tension ◦ depression ◦ anxiety

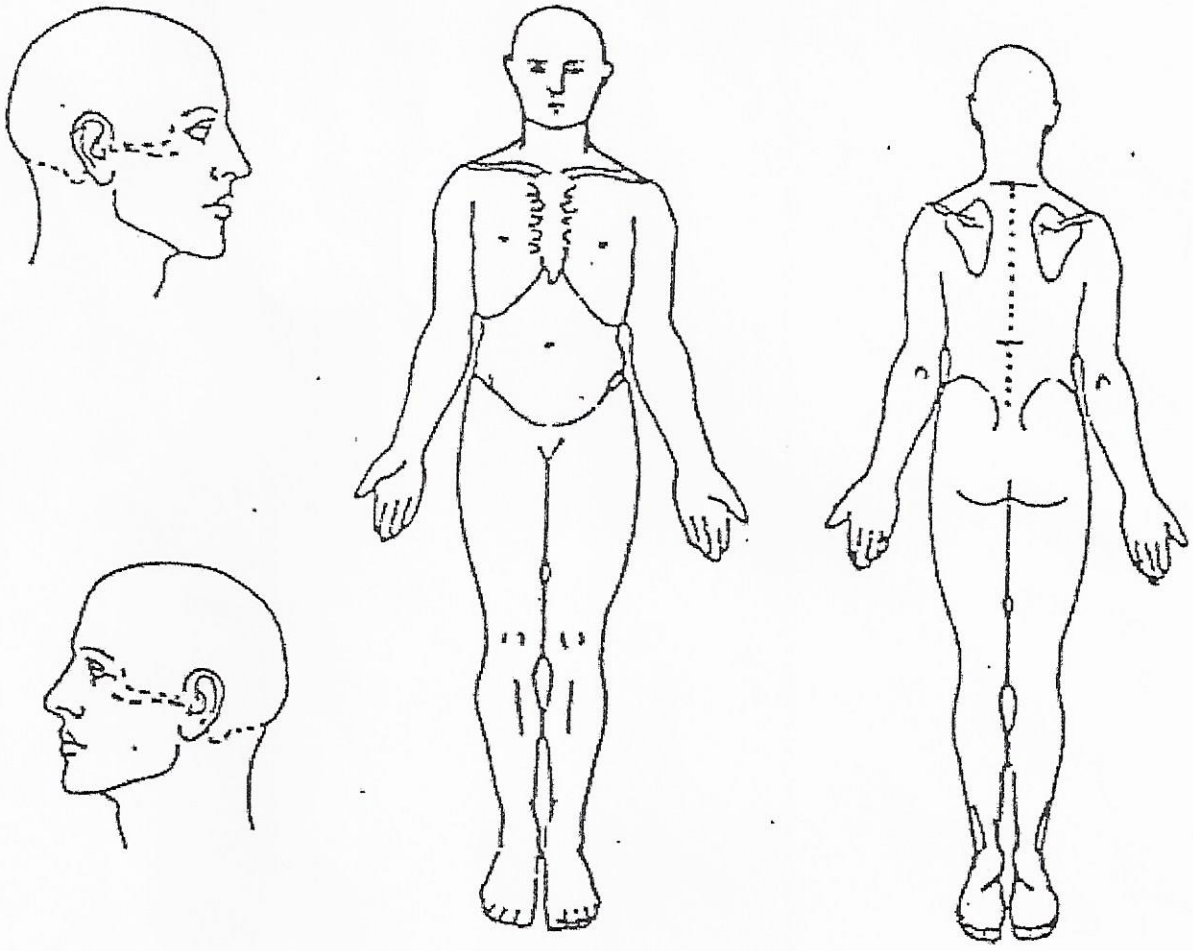
Endocrine: heat or cold intolerance ◦ sweating ◦ thirst ◦ hunger ◦ change in urination

Hematologic: bruising ◦ bleeding

Is there any chance you could be pregnant? ☐No/☐Yes

WHERE IS YOUR PAIN?

Please shade the areas of your pain in the diagrams below.



I, the undersigned, have completed this form to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Physician Signature _____ Date _____