Primary Care

Welcome to Rehabilitation Partners

Rehabilitation Partners has now opened a primary care clinic at 501 14th Street, NW Albuquerque, NM 87104. (On the corner of 14th St. and Lomas)

- We make healthcare simple.
- If you ever have a medical emergency, **please CALL 911**.
- For Non-Emergent medical matters, please call our office at **(505)-503-8806** to schedule an appointment and depending on the issue we will do our best to schedule a visit as soon as possible.
- **Please know that we are not an Urgent Care service.**
    - Office Hours vary at this time; please leave a message and we will try to get back to you within a 24 hour turn around.

We have a few providers that see patients here. They are:

- Angela Baumeister, PA-C
- Debra Green, CNP
- Mark Gould, PA-C
- Ben Lohr, PA-C
- Dr. Bette Allen – Medical Director

Please fill out the requested information below, this will help us manage your care and we will then schedule your appointment with a provider.

Please send packet back to our scheduler: tina@rehab-partners.com

Or

Our main office at: 1524 Eubank Blvd, Suite 6, Albuquerque, NM 87112

or

fax 888-503-8511

Rehabilitations Partners - Primary Care

The more information we have about our patients the better care we can provide.

Patient Name: _____ **DOB:** _____

Physical Address: _____ City: _____ Zip: _____

Gender: _____ Cell: _____ Email: _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone X Email ☐ Mail

Preferred Language: _____ **Marital Status:** _____ _____

Ethnicity (Choose one or more)

☐ American Indian or Alaska Native
☐ Black or African American
☐ Prefer Not to Answer
☐ White
☐ Hispanic or Latino
☐ Native Hawaiian or other Pacific Islander
☐ Asian

Preferred Pharmacy Name: _____

Phone#: _____ Fax#: _____

Address: _____

Insurance Information: *(Please include copies of insurance cards, if available)*

Primary: _____ Name of Policy Holder: _____

Member ID: _____ Group #: _____

Secondary: _____ Name of Policy Holder: _____

Member ID: _____ Group #: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible for our patients. Feel free to use additional pages to write any information not included here that you think is important.

1. Current/ Past Medical/Behavior Problems: Example; Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye Problems, etc.

Current or Past Medical Problem	Approximate Date of Onset or Diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

2. Past Surgeries: Example; Gall Bladder removed, Appendectomy, Hysterectomy, Cataract surgery, Prostate surgery, Heart Surgery, Angioplasty, Colonoscopy, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	
4.	
5.	

3. Recent Hospitalizations: Please list the reason for any recent hospitalizations during the past 2 years and the name of the hospital you were admitted to.

Reason for Hospitalization	Name of Hospital	Date
1.		
2.		
3.		
4.		
5.		

4. Allergies and Reaction: Example; rash, swelling, trouble breathing, etc.

Allergic To	Reaction
1.	
2.	
3.	
4.	

5. List of medications

Medications.	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

6. Family History: Please list medical problems of close family members (example; Dementia, Cancer and what type, Heart Disease, Stroke, Diabetes, Hypertension, Depression, etc.), if anyone has died, the age of death and the cause of death.

Underneath "Mother" list any brother(s)/sister(s) and their medical problems.

Family Member	**Age Died** (if applicable)	**Cause of Death or any Medical Problems**

7. Social History:

- **Tobacco Use:** Never □ Quit □ Current User □

  Packs per day on average: _____ Years Smoked: _____

  Type: Cigarette □ Cigar □ Pipe □ Chew □ Quit Date: _____

  Would you like information about quitting tobacco? Yes □ No □

- **Alcohol Use:** Never □ Quit □ Current Drinker □

  Number of drinks per week: _____

  Quit Date: _____

Was drinking too much alcohol ever a problem for you? Yes □ No□

- **Illegal Drug Use:** No □ Yes □ Type: _____
- **Sexually Active:** Not Currently □ No □ Yes □

Tell us something the patient is proud of in their lifetime:

_____

_____

_____

- **Past Occupation:** _____
- **Years of Education**: _____
- **Does your religion/faith affect your healthcare decisions?** Yes □ No

8. Advanced Directives:

Does the patient have a Durable Power of Attorney for Healthcare? Yes □ No □

Name and Relationship: _____

Does the patient have a Living Will? Yes □ No □

Does the patient have a Do Not Resuscitate Form? Yes □ No □

If you answered yes to any of the above questions, please provide us with a copy for the patient's chart.

9. Dietary Restrictions: _____

10. Activities of Daily Living: Please mark the appropriate box below.

Activities of Daily Living	No Assistance	Total Assistance	Partial Assistance: Please Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

11. Immunizations: Please mark the appropriate box below and list dates if known. If unknown, please contact your primary care doctor before our visit and ask if you are up to date with your immunizations.

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumococcal (Pneumonia)					

12. Durable Medical Equipment: Please list any medical equipment you have in the home such as a bedside commode, wheelchair, walker, hospital bed, tube feeding pump, suction machine, etc. Please also list the name of the medical supplier and their phone number.

Name of Equipment	Supplier Name	Supplier Phone #
1.		
2.		
3.		
4.		
5.		

13. Do you have care from the following? If yes, please provide Agency name and phone # in the space provided below.

Home Health Agency: Yes No

Agency Name: _____ Phone #: _____

Physical Therapy: Yes No

Agency Name: _____ Phone #: _____

Occupational Therapy: Yes No

Agency Name: _____ Phone #: _____

Speech Therapy: Yes No

Agency Name: _____ Phone #: _____

14. Recent Doctors: Please list any recent doctors, their specialties (e.g., Primary doctor, cardiologist, neurologist, etc.), their phone number and fax number.

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			

Rehab-Partners LLC
Homebound Solutions
1524 Eubank Blvd NE Ste 6
Albuquerque, NM 87112

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____0_____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016.
See website for additional information and translations.