NexGen HEALTHCARE LLC

New Patient Information

Date: _____

Name: _____, _____ _____
LAST FIRST PREFERRED NAME

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

Phone Numbers: (Home) _____ (Cell) _____ (Work) _____

Email Address: _____ Date of Birth: _____

SSN: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated

Occupation: _____ Retired? Y N Disabled? Y N

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our practice? _____

What brings you in today? _____

Please list all medications and supplements you are currently using, including dosages and frequencies.

MEDICATION	DOSAGE	FREQUENCY

Please list all surgeries and/or procedures you have already undergone or are planning on undergoing.

SURGERY/PROCEDURE	DATE OF SURGERY/PROCEDURE

Please check to indicate if you are currently experiencing or have ever experienced any of the following conditions:

- ❑ Abdominal Pain
- ❑ Ability to Exercise
- ❑ Aching Pain
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arm Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Attempted Suicide
- ❑ Autoimmune Disease
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulging Disc
- ❑ Bulimia
- ❑ Burning Feeling in Limbs
- ❑ Cancer
- ❑ Carotid Artery Blockage
- ❑ Carpal Tunnel
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Hands and/or Feet
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Cramping
- ❑ Dead Feeling
- ❑ Degenerative Disc
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Electric Shocks
- ❑ Emphysema
- ❑ Excessive Thirst/Urination
- ❑ Fainting
- ❑ Fatigue
- ❑ Food Allergies
- ❑ Food Cravings
- ❑ Foot Numbness
- ❑ Foot Pain
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Hand Numbness
- ❑ Hand Pain
- ❑ Headaches
- ❑ Heart Disease
- ❑ Heavy Feeling
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hip Pain
- ❑ Hot Sensation
- ❑ Implanted Cord/Bladder
- ❑ Insomnia
- ❑ Jaundice
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Knee Pain
- ❑ Light Bothers Eye(s)
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Back Pain/Stiffness
- ❑ Low Body Temperature
- ❑ Low Libido
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Morton's Neuroma
- ❑ Nausea
- ❑ Neck Pain/Stiffness
- ❑ Nervousness/Anxiety
- ❑ Neuropathy
- ❑ Numbness
- ❑ Oral Contraception
- ❑ Osteoporosis
- ❑ Pacemaker/Defibrillator
- ❑ Palpitations
- ❑ Permanent Weight Loss
- ❑ Pinched Nerve
- ❑ Pins and Needles
- ❑ Plantar Fasciitis
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Circulation
- ❑ Poor Wound Healing
- ❑ Post-Surgery Joint Pain
- ❑ Prostate Problems
- ❑ Psychiatric Care
- ❑ Sciatica
- ❑ Seasonal Allergies
- ❑ Sharp Pain
- ❑ Shortness of Breath
- ❑ Shoulder Pain
- ❑ Sinus
- ❑ Skin Rash
- ❑ Sleeping Difficulties
- ❑ Spinal Stenosis
- ❑ Stabbing Pain
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Swelling
- ❑ Throbbing Pain
- ❑ Thyroid Problem
- ❑ Tingling
- ❑ Tiredness
- ❑ Triglyceride > 300
- ❑ Tuberculosis
- ❑ Tumor/Growth
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Vitamin D Deficiency
- ❑ Weight Gain Stimulator

Please list any other medical conditions you currently have or have had in the past that are not listed on the previous page.

_____

_____

What do you think is causing your problem? _____

_____

How long have you been experiencing symptoms? _____

Do you smoke? Y N If so, how many cigarettes per day? _____

Do you drink? Y N If so, how many drinks per week? _____

Do you exercise regularly? Y N If so, please describe the type and list how often. _____

_____

In order of importance, please list the health problems you are most interested in getting resolved.

1. _____
2. _____
3. _____

Is your condition interfering with any of the following? (Please mark all that apply.)

❑ Sleep ❑ Work ❑ Daily Activities

❑ Recreational Activities ❑ Walking ❑ Standing

How has your life been impacted by your illness? _____

_____

Current Pain Levels

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Patient's Name: _____

Patient's Signature: _____ Date: _____