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**Dr. Anthony M. Alphonso DC**

**NEW PATIENT INFORMATION FORM**

**PLEASE PRINT CLEARLY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APT. #\_\_\_\_\_\_\_\_\_\_\_**

**CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_\_ Weight:\_\_\_\_\_\_\_**

**Marital Status: (circle one): S M D W**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse/Partner’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. Children\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you see your overall health: (circle one) Excellent / Good / Fair / Poor**

**Are you currently taking any medication? (list)**

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**Are you currently under a physicians care? (if yes, please give name and date of last visit)**

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**Are you taking any nutritional supplements? (list)**

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**HEALTH HISTORY:**

**HOW WERE YOU BORN? (circle one) C-SECTION / NATURAL / BREACH**

**Were you breast-fed or bottle-fed? (circle one)**

**Were you vaccinated? (circle all that applies) as a child as an adult**

**Childhood Illnesses:**

**Did you have any sickness/broken bones/accidents/surgeries as a child? (list and approx. date)**

 **Problems: Date:**

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**Adult Illnesses:**

**Did you have any surgeries/ broken bone/ accidents as an adult: (list and approx. date)**

 **Problem: Date:**

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**Do you smoke, drink coffee, or drink alcohol? (circle any that apply)**

**Indicate how much? Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Coincident Scars:**

**Ask yourself if you had any symptoms arise AFTER you received a scar somewhere on your body. This includes an episiotomy, tearing, c-section, any surgery and piercings.**

**List Scars: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIST YOUR TOP 5 HEALTH SYPMTOMS IN ORDER OF IMPORTANCE:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What occurred just before you started to lose your health that may be contributing or causing your current health condition? For example, any specific physical trauma or life stress? Dental work? Vaccine? Bad diet? Too much alcohol or medications?**

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