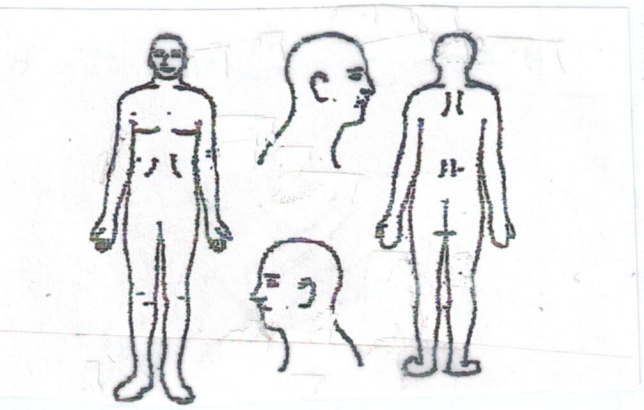
Where Healing Begins Naturally, L.L.C.
Dr. Sophie Jacob, D.C.

Last Name: _____ First Name: _____ Middle: _____
Address: _____ City/State: _____ Zip: _____
Phone Home: _____ Cell: _____ Work: _____
Email: _____ Date of Birth: _____ Age: _____
Occupation: _____ Employer: _____
Referred by: _____ Emergency Contact: _____
What is your major complaint?: _____
_____
_____
Other complaints?: _____
How long have you had this condition? _____ Have you had this or a similar condition in the past? _____
Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes and Goes _____
Please mark your areas of pain on the figure below:



__Neck Problems
__Shoulder Problems
__Arm Problems
__Numbness/Arms
__Tiredness/Fatigue
__Low Back Problems
__Leg Problems
__Numbness/Legs
__Headaches
__Depression
__Vision Problems
__Ear Pain/Noises
__Diabetes
__Blood Pressure High/Low

__Sore Muscles
__Walking Problems
__Broken Bones
__Muscle Cramps
__Weak Muscles
__Dizziness
__Fainting
__Forgetfulness
__Diarrhea
__Constipation
__Kidney Infection
__Menstrual Cramps
__Frequent Colds

__Allergies
__Hay Fever
__Asthma
__Exzema
__Shingles
__Nausea
__Poor Digestion
__Ulcers
__Loss of Feeling
__Stiff Joints
__Painful Joints
__Ear Infections
__Hearing Loss
__Pain Between Shoulder

This a new/old illness. It was not ____/was____ treated before.
If Treated before, what was done? _____

Name of Doctor(s): _____

Have you ever had surgery or been hospitalized? ___Yes ___No
List surgeries: _____

Have you ever had chiropractic care before? ___Yes ____No
Name of Doctor: _____ Date: _____

Last time you had spinal x-rays or other x-rays: _____

Female: Are you pregnant at this time?
____Yes Due Date: _____ No ____

From birth to present please list by date describe car accidents_____
_____
_____

Falls/Injuries (including sports):
_____
_____
_____

Medications you now take: _____
_____

Signature: _____ Date: _____