**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 \_\_Sore Muscles \_\_Allergies

\_\_Shoulder Problems \_\_Walking Problems \_\_Hay Fever

\_\_Arm Problems \_\_Broken Bones \_\_Asthma

\_\_Numbness/Arms \_\_Muscle Cramps \_\_Eczema

\_\_Tiredness/Fatigue \_\_Weak Muscles \_\_Shingles

\_\_Low Back Problems \_\_Dizziness \_\_Nausea

\_\_Leg Problems \_\_Fainting \_\_Poor Digestion \_\_Numbness/Legs \_\_Forgetfulness \_\_Ulcers

\_\_Headaches \_\_Diarrhea \_\_Loss of Feeling

\_\_Depression \_\_Constipation \_\_Stiff Joints

\_\_Vision Problems \_\_Kidney Infection \_\_Painful Joints

\_\_Ear Pain/Noises \_\_Menstrual Cramps \_\_Ear Infections

\_\_Diabetes \_\_Frequent Colds \_\_Hearing Loss

\_\_Blood Pressure High/Low \_\_Pain Between Shoulder

This a new/old illness. It was not \_\_\_\_/was\_\_\_\_ treated before. Female: Are you pregnant at this time?

If Treated before, what was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Yes Due Date: \_\_\_\_\_\_\_ No \_\_\_\_

Name of Doctor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From birth to present please list by date

describe car accidents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery or been hospitalized? \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had chiropractic care before? \_\_\_Yes \_\_\_\_No Falls/Injuries (including sports):

Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last time you had spinal x-rays or other x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications you now take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_