Prokopec Chiropractic, LTD. 533 Auburn Dr. Island Lake, IL 60042
Patient Intake

Name _____ Date _____
Address _____ City _____ Zip _____
Cell number _____ Email _____
Marital Status: S M W D
Date of birth _____ Age _____ Occupation _____
What do you do at work: sit____ stand____ computer____ manual labor____
Emergency contact (name & phone #) _____
Who can we thank for referring you? _____
If you're submitting to insurance, are you the policyholder Yes No
If you are not the policyholder, what is the name & date of birth of the policyholder?
_____

Major Complaint and symptoms _____

When did it start? _____ **How did it start?** _____

On a scale of 0 to 10 (10 being the worst pain) what is your current pain level? _____

Is this condition getting... _____ Worse _____ Better _____ Staying the same?

Is the pain... _____constant _____come and go

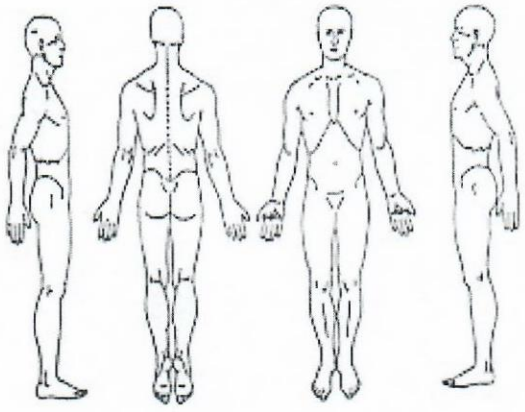
Does the pain radiate (travel) anywhere? Arm R L Leg R L other ____

What makes it worse (circle all that apply)?

Sitting Rising out of chair Standing Walking Lying down Bending over
Climbing stairs Using a computer Getting in/out of a car Driving a car Lifting
Looking over shoulder When I wake up

What have you done to relieve the symptoms?

__ Ice __ Heat __ Ibuprofen __ Rest __ Stretches __ Nothing



***Please circle on the illustration where your pain is.**

What does it feel like? (Check all that apply)

____ Numbness ____Tingling ___Stiffness
____ Dull ____ Aching ___ Cramps ____ Sharp
____ Guarded ____ Nagging ____ Burning
____ Shooting ____ Throbbing ____ Stabbing
Other: _____

What else should Dr. Prokopec know about your current condition? _____
_____
_____

Prokopec Chiropractic, LTD. 533 Auburn Dr. Island Lake, IL 60042
Patient Intake

Is this condition due to a car accident? Y N

Did this happen at work? Y N

Have you ever been to a chiropractor Y N
If so, for what condition? _____

Date of your last x-ray or MRI _____

Medical History----------

List medications that you're currently taking _____
_____

Medical History	YES	NO	Medical History	YES	NO
Arthritis			Cancer		
Diabetes			Heart Condition		
Vascular Condition			High Blood Pressure		
Lung Condition			Sinus/Allergies		
Pregnant			Exercise		
Alcohol			Smoker		
Auto Accident			Major Illness		
Injury/Fall			Surgeries		

If you have answered yes to the above conditions please explain further_____
_____
_____

Are there any other illnesses not listed above that you have? _____
_____
_____