Wilkinson Clinic of Chiropractic
115 E. Waverly Street, Morris, IL 60450
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Date_____
Account # _____
X-ray #_____

Patient Demographics Form

Please note: Our new extensive entrance form is necessary for compliance with the Health Care Financing Administration and the National Committee for Quality Assurance's new standards. Please fill it out completely.

Name_____ Preferred Phone [Home/Cell] ( ) _____

Address_____ City_____ State_____ ZIP_____

Age _____ Birthdate _____/_____/_____ Social Security # _____ Email_____

Gender M / F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Occupation _____ Employer _____ Work Phone ( ) _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Date of Last Physical Exam _____ Referred By _____

Patient's Primary Care Physician _____ Permission to Contact Yes / No

Insurance Information

Policy Holder Name_____ Birthdate _____/_____/_____ Phone ( ) _____

Address_____ City_____ State_____ ZIP_____

Relationship to Patient _____ Policy Holder's Social Security # _____

Employer Name_____ Work Phone ( ) _____

Insurance Company Name _____ Insurance Co. Phone ( ) _____

Insured's ID Number _____ Group Number _____

Is patient covered under any other insurance? Yes / No If yes, please complete the following:

Secondary Insurance

Policy Holder Name_____ Birthdate _____/_____/_____ Phone ( ) _____

Address_____ City_____ State_____ ZIP_____

Relationship to Patient _____ Policy Holder's Social Security # _____

Employer Name_____ Work Phone ( ) _____ ext.____

Insurance Company Name _____ Insurance Co. Phone ( ) _____

Insured's ID Number _____ Group Number _____

History of Current Problem:

Please describe your current problem._____

Is your current problem the result of: Auto Accident? Yes / No Work Accident? Yes / No

How did your problem begin? _____

Date problem began _____ Other doctors seen for this condition_____

List other treatments or tests you've had for this condition_____

Have you been treated by a physician for any other health condition in the last year? Yes / No If yes, please explain:

_____

How often are your symptoms present? __Constantly __ Frequently __ Occasionally __ Intermittently

Describe your current paint/symptoms: __Sharp __Burning __Throbbing __ Shooting
__Soreness __Numbness/Tingling __Weakness

Since it began, is your problem: __Improving __Getting Worse __No Change

What makes the problem better? __Nothing __Lying Down __Standing __Walking __Sitting
__Movement __Exercise __Inactivity/Rest __Other_____

What makes the problem worse? __Nothing __Lying Down __Standing __Walking __Sitting
__Movement __Exercise __Inactivity/Rest __Other_____

Can you perform your daily <u>home</u> activities? __Yes __Only with help __Not at all

Do you exercise? __Yes, almost daily __Yes, occasionally __Not at all

Describe your job requirements: __Mainly Sitting __Light Labor __Heavy Labor

Can you perform your daily <u>work</u> activities? __Yes __Only with help __Not at all

Describe your stress level: __None to mild __Moderate __High

Please list all allergies, including allergies to medications._____

List all medications you are presently taking, including vitamins and supplements. _____

_____

List any surgeries, fractures, serious illnesses or hospitalizations. _____

_____

Family Health History

Circle if a family member has had any of the following:

Cancer	Lupus	Heart Problems	High Blood Pressure	Epilepsy
Diabetes	Lung Problems	Chronic Back Problems	Rheumatoid Arthritis	Chronic Headaches

If circled any of the above conditions, please indicate all relations that apply:_____

_____

Social History *Indicate your use of the following: (L= Light, M= Moderate, H= Heavy)*

Alcohol	L M H	Tobacco	L M H	Drugs	L M H
Sugar	L M H	Salty Foods	L M H	Caffeine	L M H
Sleep	L M H	Exercise	L M H	Water	L M H

Past Health History Please check if you have experienced any of the following conditions at any point.

___Anorexia
___Arthritis
___Asthma
___Bladder Infection
___Blood Disorder
___Breast Lump
___Chronic Cough
___Chronic Sinusitis
___Colitis
___Convulsions
___Digestive Disorders
___Dizziness
___Epilepsy
___Fainting
___Headache
___Herniated Disk
___Jaw Pain
___Kidney Disorders
___Loss of Bladder Control
___Nervousness
___Pain-Neck
___Pain- Mid Back
___Pain- Low Back
___Pain- Arm/Elbow
___Pain-Hand
___Pain- Wrist
___Pain- Shoulder
___Pain- Ankle/Foot
___Pain-Leg
___Pain- Knee
___Rapid Heartbeat
___Rheumatic Fever
___Pregnancies
___Scoliosis
___Tinnitus (Ear Noise)
___Vision Disturbance
___Venereal Disease

Detailed Review of Systems

Cardiovascular: __N/A	**Now**	**Past**
Poor circulation	**N**	**P**
High Blood Pressure	**N**	**P**
Aortic Aneurysm	**N**	**P**
Heart Disease	**N**	**P**
Vascular Disease	**N**	**P**
Heart Attack	**N**	**P**
Chest Pain	**N**	**P**
High Cholesterol	**N**	**P**
Pace Maker	**N**	**P**
Jaw Pain	**N**	**P**
Irregular Heartbeat	**N**	**P**
Swelling of Legs	**N**	**P**
Stroke	**N**	**P**

Hematologic/Lymphatic: __N/A	**Now**	**Past**
Hepatitis	**N**	**P**
Blood Clots	**N**	**P**
Cancer	**N**	**P**
Easy Bruising	**N**	**P**
Easy Bleeding	**N**	**P**
Fevers/Chills/Sweats	**N**	**P**

Eyes: ___N/A	**Now**	**Past**
Glaucoma	**N**	**P**
Double Vision	**N**	**P**
Blurred Vision	**N**	**P**
Red/Itchy (allergy)	**N**	**P**

Genitourinary: __N/A	**Now**	**Past**
Kidney Disease	**N**	**P**
Lower Side Pain	**N**	**P**
Burning Urination	**N**	**P**
Frequent Urination	**N**	**P**
Blood in Urine	**N**	**P**
Kidney Stone	**N**	**P**
Bet Wetting/Enuresis	**N**	**P**
Prostate Problems	**N**	**P**

Gastrointestinal: __N/A	**Now**	**Past**
Acid Reflux	**N**	**P**
Bowel Problems	**N**	**P**
Constipation	**N**	**P**
Upset Stomach	**N**	**P**
Gas Pains	**N**	**P**
Ulcers	**N**	**P**
Gallbladder Prob.	**N**	**P**
Liver Prob.	**N**	**P**
Diarrhea	**N**	**P**
Nausea/Vomiting	**N**	**P**
Poor Appetite	**N**	**P**
Bloody Stools	**N**	**P**

Itegumentary: __N/A	**Now**	**Past**
Eczema	**N**	**P**
Rashes	**N**	**P**
Psoriasis	**N**	**P**
Skin Ulcers	**N**	**P**
Skin Disease	**N**	**P**

Respiratory: __N/A	**Now**	**Past**
Asthma	**N**	**P**
Shortness of Breath	**N**	**P**
Upper Respir. Infec.	**N**	**P**
Cold/flu	**N**	**P**
Pneumonia	**N**	**P**
Cough/Wheezing	**N**	**P**
Emphysema	**N**	**P**
RSV	**N**	**P**
Tuberculosis	**N**	**P**

Allergic/Immun.: __N/A	**Now**	**Past**
Autoimmune	**N**	**P**
Chronic Allergies	**N**	**P**
Seasonal Allergies	**N**	**P**
Food Allergies	**N**	**P**
Environmental Allerg.	**N**	**P**
Allergy Shots	**N**	**P**
Cortisone Use	**N**	**P**
HIV/AIDS	**N**	**P**
Hives	**N**	**P**

Endocrine: __N/A	**Now**	**Past**
Hyperthyroid	**N**	**P**
Hypothyroid	**N**	**P**
Type 1 Diabetes	**N**	**P**
Type 2 Diabetes	**N**	**P**
Hair Loss	**N**	**P**
Menopausal	**N**	**P**
Menstrual Prob.	**N**	**P**
Endometriosis	**N**	**P**
Hot Flashes	**N**	**P**

Ear/nose/throat: __N/A	**Now**	**Past**
Sinus Congestion	**N**	**P**
Sinus Infection	**N**	**P**
Nosebleed	**N**	**P**
Sore Throat	**N**	**P**
Difficulty Swallowing	**N**	**P**
Ear Ache	**N**	**P**
Ear Infections	**N**	**P**
Dizziness	**N**	**P**
Hearing Loss	**N**	**P**
Bleeding Gums	**N**	**P**

Musculoskeletal: __N/A	**Now**	**Past**
Poor Posture	**N**	**P**
Neck Pain	**N**	**P**
Back Pain	**N**	**P**
Arthritis	**N**	**P**
Rheumatoid Arth.	**N**	**P**
Joint Stiffness	**N**	**P**
Muscle Weakness	**N**	**P**
Osteoporosis	**N**	**P**
Broken Bones	**N**	**P**
Joint Replacement	**N**	**P**
Gout	**N**	**P**

Psychiatric: __N/A	**Now**	**Past**
Depression	**N**	**P**
Anxiety Disorder	**N**	**P**
Unusual Stress	**N**	**P**
OCD	**N**	**P**
Bipolar Disorder	**N**	**P**
SAD	**N**	**P**