ONKELS
CHIROPRACTIC

471 W 800 S, Bountiful, UT 84010
(801) 298-9190 · Fax (801) 298-2451
info@onkels.us · www.onkels.us

Patient Case History

Returning this form. Please print it, complete it, and bring it with you, or fax it to **(801) 298-2451**. Please do not send completed forms by email. Email is not a secure way to send health information or a Social Security number. If you have questions, call us at (801) 298-9190 and we will help.

PERSONAL INFORMATION

NAME | DATE

ADDRESS | CITY | STATE | ZIP

TELEPHONE | SOCIAL SECURITY NO. | DRIVER'S LICENSE NO.

AGE | BIRTHDATE | SEX | MARRIAGE STATUS | NO. CHILDREN

HEIGHT | WEIGHT | REFERRED BY

EMPLOYMENT

OCCUPATION | EMPLOYER | WORK PHONE

EMPLOYER'S ADDRESS | SPOUSE'S NAME | SPOUSE'S OCCUPATION | SPOUSE'S EMPLOYER

YOUR CONDITION

PRESENT COMPLAINT OR ILLNESS

DURATION

EVENTS PRECEDING ONSET

HOW LONG SINCE YOU'VE BEEN WELL

PERSONAL HEALTH GOALS

Have you had any of the following? If yes, briefly describe:

ACCIDENTS

SURGERY

VACCINATIONS

WOMEN ONLY

ONSET MENSTRUATION | NO. OF CHILDREN | COMPLICATIONS | NO. OF MISCARRIAGES | C-SECTIONS | MENOPAUSE

- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity

DATE OF LAST PERIOD

☐ Are you now pregnant? how long

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History, Habits & Family Health

HISTORY & HABITS

IF YOU HAVE HAD ANY X-RAYS IN LAST 2 YEARS, PLEASE LIST BY WHOM, WHEN, AND WHAT PART OF THE BODY

LIST TYPES OF EXERCISE YOU NORMALLY DO

HOURS OF SLEEP YOU USUALLY HAVE

ARE THEY INTERRUPTED?

WHAT POSITION IS YOUR BODY IN DURING SLEEP?

HAVE YOU SEEN A DOCTOR OF CHIROPRACTIC BEFORE? WHO?

ARE YOU SKEPTICAL OF SEEING A CHIROPRACTOR?

ALCOHOL PER DAY

PER WEEK

PER MONTH

CIGARETTES PER DAY OR WEEK

GLASSES OF WATER PER DAY

CUPS OF COFFEE PER DAY

NUMBER OF BOWEL MOVEMENTS PER DAY

DO YOU USE WHITE SUGAR?

ARE YOU ENCOUNTERING OUTSIDE STRESSES FROM FAMILY, WORK, ETC. WHICH MAY BE ADVERSELY AFFECTING YOU?

CURRENT CARE & MEDICATIONS

HAVE YOU SEEN ANYONE ELSE ABOUT THIS PROBLEM? WHO, WHEN, AND WHAT WERE THE FINDINGS?

PRESCRIPTION, OVER-THE-COUNTER, OR RECREATIONAL DRUGS YOU CURRENTLY USE

MEDICATIONS YOU HAVE TAKEN IN THE PAST

EVER UNDER PSYCHIATRIC OR PSYCHOLOGICAL CARE?

ANY HEALTH PROBLEMS ASSOCIATED WITH TIME SPENT IN OTHER COUNTRIES

FAMILY MEDICAL HISTORY

Check any condition that you or a relative has had.

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Heart disease / stroke	High blood pressure	Hypothyroidism	Kidney disease	Neurological disease	Stomach ulcer	Periodontal disease	Tuberculosis	Atherosclerosis	Obesity
You																	
Father																	
Mother																	
Brothers																	
Sisters																	
Spouse																	
Children																	
Grandparents																	

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Insurance & Areas of Pain

HOW YOUR VISITS WILL BE PAID

- ☐ **I will pay for my visits myself**
- ☐ **Please bill my health insurance**
- ☐ This is an **auto accident** injury
- ☐ This is a **work related** injury

INSURANCE COMPANY NAME

CERTIFICATE / MEMBER NO.

GROUP NUMBER

INSURANCE COMPANY ADDRESS

IF AN ATTORNEY IS INVOLVED

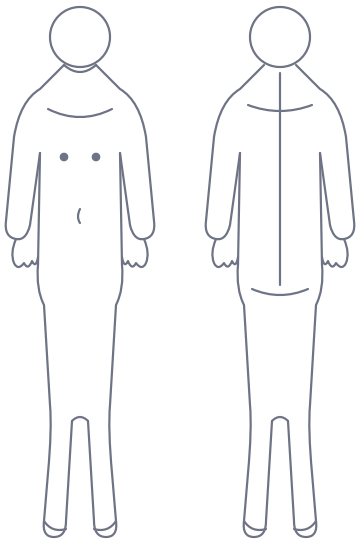
ATTORNEY NAME

ADDRESS

PHONE

WHERE IT HURTS

Mark the areas of pain or injury on the drawings, then describe what you feel in those areas.



DESCRIBE YOUR SYMPTOMS IN THOSE AREAS

SIGNATURE

PRINTED NAME

DATE

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Other Conditions & Payment Agreement

OTHER CONDITIONS

Check anything you have now or have had in the past.

- ☐ Abscesses
- ☐ Acne
- ☐ AIDS / HIV
- ☐ Alcohol addiction
- ☐ Allergies
- ☐ Alopecia
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Back problems
- ☐ Bleeding gums
- ☐ Bronchitis
- ☐ Candida
- ☐ Cataracts
- ☐ Chest pains
- ☐ Chicken pox
- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diphtheria
- ☐ Diverticulosis
- ☐ Drug addiction
- ☐ Ear infections
- ☐ Eczema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Excessive fatigue
- ☐ Eye disease
- ☐ Fainting or dizziness
- ☐ Gall stones
- ☐ Gastritis
- ☐ Gingivitis
- ☐ Goiter
- ☐ Hay fever
- ☐ Hearing problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated disc
- ☐ Herpes
- ☐ High blood pressure
- ☐ Hives
- ☐ Insomnia
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Major surgery
- ☐ Malaria
- ☐ Measles
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Myopia
- ☐ Nervous breakdown
- ☐ Nervousness
- ☐ Neuralgia
- ☐ Night blindness
- ☐ Numbness
- ☐ Pancreatitis
- ☐ Persistent cough
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Scarlet fever
- ☐ Sciatica
- ☐ Skin ulcers
- ☐ Skipped heartbeats
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Syphilis
- ☐ Thyroid disease
- ☐ Ulcerative colitis
- ☐ Vision problems

ANYTHING ELSE NOT LISTED ABOVE

PATIENT NAME _____ **DATE** _____

WHAT YOU ARE AGREEING TO

I understand that services provided to me by **Dr. Michael Onkels, DC** and/or **Dr. Eveline Onkels, DC** are to be paid on the same day treatment is provided, unless other arrangements are made before my appointment.

Accounts that require billing are subject to a **$5.00 per month service charge**. Any unpaid balance over 60 days is subject to **1% interest per month**.

Once I have made an appointment, it is my responsibility to be on time. If I need to reschedule, **24 hours notice** is required. I understand I am responsible for a **$25.00 missed appointment charge** if less than 24 hours notice is given.

Emergency visits on weekends outside of the office are **$350.00**, payable at the time of service.

All supplements are to be paid for at the time of purchase.

If Drs. Onkels bill my health insurance, I understand that I am responsible for any deductible and co-payment percentage the insurance does not cover. I understand that I am **ultimately responsible for payment of all services** provided in this office if my insurance does not pay.

> **Questions about any of this?** Please ask the front desk before signing. We are glad to walk through anything that is unclear, including what your insurance is likely to cover.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ **PRINTED NAME** _____ **DATE** _____

IF REPRESENTATIVE, RELATIONSHIP TO PATIENT _____ **STAFF INITIALS & DATE RECEIVED** _____

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Communication Preferences

PATIENT

FULL NAME | DATE OF BIRTH | TODAY'S DATE

HOW WE MAY REACH YOU

Check every method we may use. Leave blank anything you would rather we not use.

- ☐ **Mobile** _____
- ☐ **Home** _____
- ☐ **Work** _____
- ☐ **Email** _____
- ☐ **Fax** _____
- ☐ **Mail** to address on file

I PREFER TO BE CONTACTED BY | BEST TIME OF DAY

TEXT MESSAGES

- ☐ **Yes, you may text me** at the mobile number above.

Texts may include appointment reminders, scheduling changes, occasional practice updates such as a change of hours or location, and an invitation to leave a review. Message and data rates may apply, and frequency varies. Reply **STOP** to opt out or **HELP** for help. **Consent is not required to receive care** and declining anything here will not affect your treatment. Text messaging is not a secure method of communication.

VOICEMAIL

- ☐ Leave a **detailed message** — appointment times, billing, account matters
- ☐ Leave a **brief message only** asking me to call back
- ☐ **Do not leave voicemail**

EMAIL

- ☐ **Appointment reminders** and scheduling
- ☐ **Practice updates** — hours, location, new services
- ☐ **Billing and account** information

OTHERS WE MAY SPEAK WITH

Anyone we may discuss your appointments or care with. Leave blank if none.

NAME | RELATIONSHIP | PHONE

NAME | RELATIONSHIP | PHONE

A note on email. Standard email is not fully secure, and we will not send detailed health information by email unless you ask us to. **Your rights.** You may change or withdraw any preference at any time by telling the front desk, calling (801) 298-9190, or writing to us at the address above. Changes take effect as soon as we can process them and may not apply to messages already scheduled. Your choices here never affect the care you receive.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE | PRINTED NAME | DATE

IF REPRESENTATIVE, RELATIONSHIP TO PATIENT | STAFF INITIALS & DATE RECEIVED