BACK TO HEALTH WELLNESS CENTER

1

APPLICATION FOR TREATMENT

Pt #____________

Date____________

Patient____
First Middle Last

Address____

____
City State Zip

Phone (H)_________________ (W)________________

Cell_______________ Email______________________

Best time and place to reach you__________________

May we leave a medical message at home? ❑ Yes ❑ No

May we leave a medical message at work? ❑ Yes ❑ No

May we leave a medical message on cell? ❑ Yes ❑ No

Sex: ❑ M ❑ F Age_____ Birthdate________________

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

❑ Right-handed ❑ Left-handed ❑ Ambidextrous

Name & Age of Children__________________________

Native Language_________________________________

Patient SS#_____________________________________

❑ Employed ❑ Full-time student ❑ Part-time student

Occupation_____________________________________

Employer/School_________________________________

Employer/School Address_________________________

____

Whom may we thank for referring you?______________

____

Where have you heard or seen us?

❑ TV ❑ Radio ❑ Billboard ❑ Health Fair ❑ Internet

❑ Yellow Pages –Tulsa ❑ Yellow Pages –Broken Arrow

2

YOUR MEDICAL DOCTOR

Doctor________________________________MD/DO
First Last

Location____

We like to coordinate care with your medical doctor.

May we send reports to this doctor? ❑ Yes ❑ No

3

Spouse's Name__________________________________

Spouse's Birthdate___________ SS#_______________

Spouse's Occupation_____________________________

Spouse's Employer_______________________________

Spouse's Phone (if different)______________________

4

IN CASE OF EMERGENCY, CONTACT

❑ Spouse OR contact:

Name__________________ Relationship____________

Phone (H)__________________ (W)________________

5

CONSENT & POLICIES

1) I understand and agree to allow Back to Health Wellness Center to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease**.

2) I hereby authorize Back to Health Wellness Center including Dr. Michael K. Van Antwerp and his assigns to examine, test, x-ray, and administer treatment to me as they deem necessary.

3) I understand that all first visit charges are payable when services are rendered.

4) I realize that the fee paid for x-rays is for technical and professional charges only. The x-ray films themselves are the property of this office. Copies can be made if necessary for a fee.

5) I will be taking care of today's charges by:

❑ Cash ❑ Check ❑ Credit Card ❑ Voucher

❑ Auto insurance assignment

______________________________ ________________
Patient's/Guardian's Signature Date

______________________________ ________________
Witness Signature Date

6

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Back to Health Wellness Center including Dr. Michael K. Van Antwerp and his assigns to examine, test, x-ray, and administer treatment as they deem necessary to my child ____________________. This is to serve as long-term authorization and is to apply to all occasions of service until it is revoked in writing.

______________________________ ________________
Guardian's Signature Authorizing Care Date

______________________________ ________________
Witness Signature Date

Back to Health Wellness Center • 2433 N Aspen Ave • Broken Arrow, OK 74012 • 918-259-3000

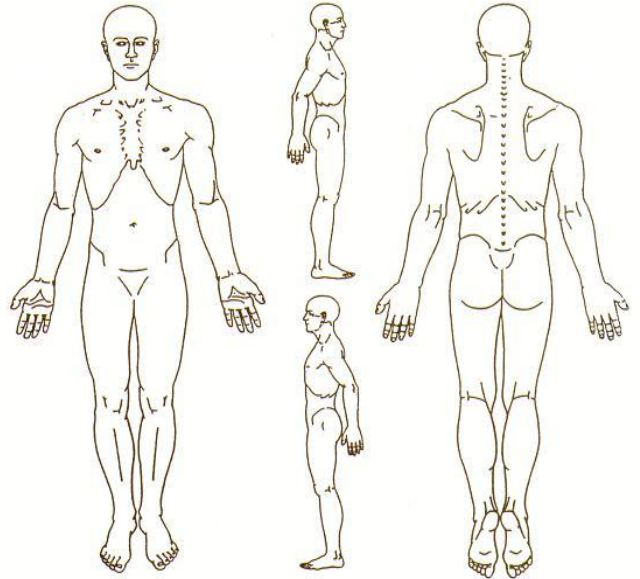
Patient___________________________________ Pt #___________ Date_________________

UNWANTED HEALTH CONDITIONS: Check any problems you might be having. Circle **L** if it is left or **R** if it is right,
Constant (75-100%) **F**requent (50-75%) **I**ntermittent (25-50%) **O**ccasional (0-25%),
0 = no pain **10**= worst possible pain

❑ Head	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Jaw	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Neck	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Shoulder: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Elbow: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Wrist: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Mid Back	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Low Back	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Hip: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Knee: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Ankle: L R	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Other_________	C F I O	0 1 2 3 4 5 6 7 8 9 10
❑ Other_________	C F I O	0 1 2 3 4 5 6 7 8 9 10

Mark all problem areas

Numbness OOOOO
Pins&Needles -----
Burning XXXXX
Aching *****
Stabbing /////



1. How would you describe your Chief Unwanted Health Condition?____

2. When did your Condition start bothering you?_______________________________ Was it ❑ Gradual ❑ Sudden

3. What started your Condition?____

4. Is Condition related to ❑ Work Injury ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other:________________________

5. What makes it better?_____________________________________ worse?____________________________________

6. Which time of day is harder for you? ❑ In Bed – AM ❑ Morning ❑ Noon ❑ Evening ❑ In Bed – PM ❑ Sporadic ❑ All

7. Is your Condition: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numb ❑ Aching ❑ Shooting ❑ Burning ❑ Stabbing ❑ Tingling ❑ Cramping ❑ Stiff ❑ Swelling ❑ Deep ❑ Superficial ❑ Upon Movement ❑ Upon Touch

8. Does it radiate into an extremity? ❑ Yes ❑ No

9. Does your Condition interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

10. Have you lost workdays? ❑ Yes ❑ No If yes, how many?________

11. Have you had a similar condition before? ❑ Yes ❑ No If yes, when?___________

12. Activities that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

13. Name other doctors/clinicians/therapists/hospitals you have seen for this condition_________________________________

Previous Chiropractic Care? ❑ Yes ❑ No Were you given a spinal hygiene/maintenance program? ❑ Yes ❑ No

What did you like?_____________________________ What did you not like?________________________________

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Patient___________________________________ Pt #___________ Date_________________

DISEASES: Mark any of the following you have had:

❑ Pneumonia	❑ Measles	❑ Heart Disease	❑ Mental Disorders
❑ Rheumatic Fever	❑ Mumps	❑ Thyroid – High/Low	❑ Lumbago
❑ Polio	❑ Small Pox	❑ Influenza	❑ Eczema/Psoriasis
❑ Tuberculosis	❑ Chicken Pox	❑ Pleurisy	❑ AIDS, HIV
❑ Whooping Cough	❑ Diabetes – Type:_______	❑ Arthritis – Type:_______	❑ Marfan Syndrome
❑ Anemia	❑ Cancer – Type:________	❑ Epilepsy	❑ _____________

REVIEW OF SYSTEMS: Mark any of the following you have had in the past 6 months:

MUSCULOSKELETAL
- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficulty Chewing/Jaw Click
- ❑ General Stiffness

NERVOUS SYSTEM
- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting

Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

GENERAL
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

GASTROINTESTINAL
- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heart Burn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITOURINARY
- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

C-V-R
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure – High/Low
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

MALES
- ❑ Prostate/Sexual Dys.
- ❑ Breast Pain/Lumps

FEMALES
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Breast Pain/Lumps

Last Period?__________

Pregnant? ❑ Yes ❑ No

FAMILY HISTORY: Mark if family such as grandparents, parents, siblings, or children have had any of the following:

❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Thyroid Disease ❑ Kidney Disease ❑ Migraines ❑ Spinal Disorder

____

____

EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy **WORK HABITS**: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

HABITS: ❑ Smoking, Packs/Day_______ ❑ Alcohol, Drinks/Week_______ ❑ Coffee, Cups/Day_______ ❑ Sugar

❑ High Stress Level Reason____________________ Hobbies/Activities/Interests____________________

INJURIES/SURGERIES you have had Description (write the **date** in parentheses for each)

Auto Accidents ____

Falls ____

Head Injuries ____

Broken Bones ____

Dislocations ____

Surgeries ____

Implants/Replacements____

MEDICATIONS: ____

____

ALLERGIES: ____

VITAMINS/HERBS/MINERALS:____

I am interested in seeing the following financial agreements:

❑ Time of Service ❑ 17 and under/Student ❑ 65 and over/Disabled ❑ Employee/Independent Contractor

BACK TO HEALTH WELLNESS CENTER

Michael K. Van Antwerp, DC • 2433 N Aspen Ave • Broken Arrow, Oklahoma 74012 • 918-259-3000

Dear Patient:

State law requires us to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

ASSOCIATES AND ASSISTANTS

In this office we use trained staff personnel to assist Dr. Michael K. Van Antwerp (hereinafter, “doctor”) with portions of your consultation, examination, and treatment. Occasionally when the doctor is unavailable another clinic doctor might treat you.

EXAMINATIONS

Physical Examination: Certain orthopedic, neurological, and chiropractic tests are designed to aggravate a condition in order to identify it properly. These tests have the possibility of making your condition more painful, sore, or worse at least temporarily. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

X-ray: Concerning x-ray examination, this office uses highly sensitive screens that provide the highest quality with the least exposure. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The only noteworthy inherent risk with taking x-rays deals with pregnancy. If there is a possibility that you are pregnant, inform this office prior to x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

TREATMENT

The Chiropractic Adjustment: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible “pop” or “click” much as you have experienced when you “crack” your knuckles.

Acupuncture: The doctor and/or his assigns will use an electrostimulation device, low level laser, scraping tool, percussion tool, finger pressure, or very fine needles to stimulate certain acupuncture points.

There are some material risks involved in doing these, and they are as follows:

INHERENT RISKS

Pain: It is common for an adjustment as well as traction, massage therapy, exercises, acupuncture, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscles may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term effects. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might “crack” a rib. This can happen with anyone; however, it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis that is severe enough can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that we have not been able to find any available statistics to quantify their probability.

Disc Herniations: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that we have not been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. This is so rare that you have the same chance of getting hit by lightning, which is around one in a million. However, this office feels that these great odds can be further reduced by tests performed in this office. Prior to treatment you will be given such tests to further reduce your risk.

Physical Therapy Burns: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that we have not found any statistics to quantify their probability.

Infection: Needle acupuncture has the potential to cause infection. However, we adhere to clean needle technique including sealed sterile disposable needles which greatly reduce the risk of infection. The literature is still unclear about risk, but it has been estimated at the low rate of less than 1 in 10,000.

Puncture: Needle acupuncture has the potentional to cause mechanical injury to the lungs, heart, blood vessels, muscles, spine, and/or nerves. Penetration has to be fairly deep to cause damage which is why we use shallow needle technique and avoid contraindicated areas. Risk statistics are still unclear, but it has been estimated at the low rate of less than 1 in 10,000.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., other than noted above. Temporary nausea, dizziness, fainting, pain, and bruising might occur from chiropractic treatment. Temporary nausea, dizziness, fainting, pain, bruising, and local bleeding might occur from acupuncture treatment. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

OTHER AVAILABLE TREATMENT

Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of a person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger, and ineffectiveness of such treatment is more a probability than a possibility.

NON TREATMENT

Remaining untreated, results in adhesions, pain, and reduction in associated joint mobility. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

PATIENT HEALTH INFORMATION ("PHI")

Our office uses open adjusting and treatment rooms. The possibility that one's adjustment, treatment, and/or name may incidentally be observed and the possibility that conversations and/or names may incidentally be overheard are terms and conditions that the patient agrees to in this office. We try to limit incidental disclosures as much as possible and adhere to minimum necessary and reasonable safeguard requirements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If private room adjusting is requested, arrangements will be made. We do respect your privacy, so a private room is available for conversations if needed. Your chart notes might be handed to you to fill out. It is your responsibility to guard these as you see fit while they are in your possession.

I UNDERSTAND THE UNDESIRED RESULTS OF EXAMINATION AND TREATMENT AND HAVE GONE OVER ANY QUESTIONS I MIGHT HAVE.

I hereby authorize and direct the above named physician and assigns to provide such additional services as they may deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM.

A photocopy of this Informed Consent shall be considered as effective and valid as the original.

____________________	____________________	__________
Patient's Printed Name	Patient's Signature	Date
Guarantor's/Guardian's Printed Name if any	Guarantor's/Guardian's Signature	Date
Witness's Printed Name	Witness's Signature	Date

BACK TO HEALTH
WELLNESS CENTER
Michael K. Van Antwerp, DC • 2433 N Aspen Ave • Broken Arrow, Oklahoma 74012 • 918-259-3000

RELEASE AND ASSIGNMENT

The following agreements are necessary because insurance is an arrangement between you and the insurance company. The doctor and the clinic are not part of this arrangement, and thus need your release, assignment, and authorization.

1) I authorize the request, release, and disclosure of any medical, health care, or other information necessary to process my insurance claims, to secure the payment of benefits, and to manage my care including communication with insurance companies, claims adjusters, case nurses, claims reviewers, employers, hospitals, clinics, healthcare providers, and attorneys. This is to serve as a long-term authorization card. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease**. This language is included as required by 63 O.S. § 1-502.2.

2) I directly assign my rights and benefits under my policy and authorize payment of all benefits directly to Dr. Michael K. Van Antwerp (hereinafter, “doctor”) and Back to Health Wellness Center (hereinafter, “clinic”). This payment will not exceed my indebtedness to the above-mentioned doctor and clinic, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. This authorization is to apply to all occasions of service until it is revoked in writing.

3) If my current policy prohibits direct payment to doctor and clinic then I hereby instruct and direct the insurance company to make check to me as a patient and to mail it to me as follows:
Back to Health Wellness Center
2433 N. Aspen Ave.
Broken Arrow, OK 74012

4) I do hereby designate Dr. Michael K. Van Antwerp and Back to Health Wellness Center to the full extent permissible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the goods and/or services I receive from the above named doctor and clinic. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the goods and/or services I received from my doctor and clinic.

5) I agree that a photocopy of this agreement shall be effective and valid as the original.

_______________________________, “I” in above agreements
Patient’s Printed Name

____
Patient’s Signature

____
Date

____
Guarantor’s/Guardian’s Printed Name (if any)

____
Guarantor’s/Guardian’s Signature

____
Date

____
Witness’s Printed Name

____
Witness’s Signature

____
Date