

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

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

Spouse's Name _____

Spouse's Birthdate _____ SS# _____

Spouse's Occupation _____

Spouse's Employer _____

Spouse's Phone (if different) _____

IN CASE OF EMERGENCY, CONTACT

Spouse OR contact:

Name _____ Relationship _____

Phone (H) _____ (W) _____

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

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

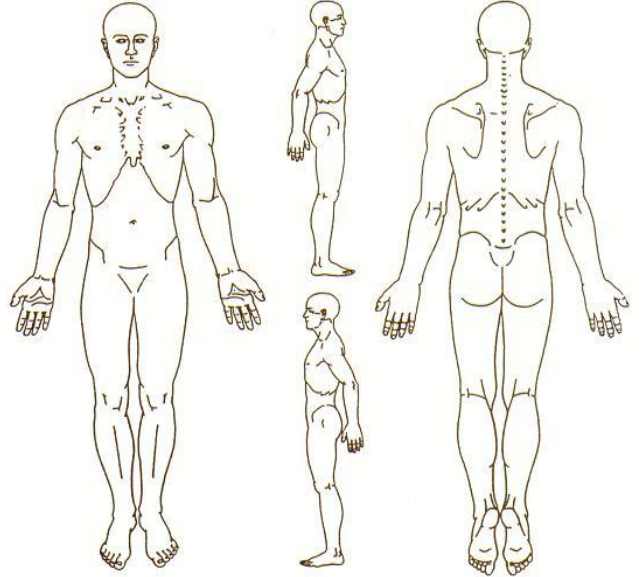
Patient _____ Pt # _____ Date _____

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%) **Frequent (50-75%)** **Intermittent (25-50%)** **Occasional (0-25%),**
0 = no pain **10= worst possible pain**

- | | | |
|--|---------|------------------------|
| <input type="checkbox"/> Head | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Jaw | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Neck | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Shoulder: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Elbow: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Wrist: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Mid Back | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Low Back | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Hip: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Knee: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Ankle: L R | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Other _____ | C F I O | 0 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> 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 /////



- How would you describe your Chief Unwanted Health Condition? _____
- When did your Condition start bothering you? _____ Was it Gradual Sudden
- What started your Condition? _____
- Is Condition related to Work Injury Auto Accident Home Injury Fall Other: _____
- What makes it better? _____ worse? _____
- Which time of day is harder for you? In Bed – AM Morning Noon Evening In Bed – PM Sporadic All
- Is your Condition: Sharp Dull Throbbing Numb Aching Shooting Burning Stabbing Tingling
 Cramping Stiff Swelling Deep Superficial Upon Movement Upon Touch
- Does it radiate into an extremity? Yes No
- Does your Condition interfere with your: Work Sleep Daily Routine Recreation
- Have you lost workdays? Yes No If yes, how many? _____
- Have you had a similar condition before? Yes No If yes, when? _____
- Activities that are painful to perform Sitting Standing Walking Bending Lying Down
- 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? _____

Patient _____ Pt # _____ Date _____

DISEASES: Mark any of the following you have had:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid – High/Low | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> AIDS, HIV |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes – Type: _____ | <input type="checkbox"/> Arthritis – Type: _____ | <input type="checkbox"/> Marfan Syndrome |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer – Type: _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> _____ |

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

- | | | | |
|---|--|--|---|
| MUSCULOSKELETAL | <input type="checkbox"/> Stress | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low Back Pain | | <input type="checkbox"/> Gas/Bloating After Meals | |
| <input type="checkbox"/> Pain Between Shoulders | GENERAL | <input type="checkbox"/> Heart Burn | EENT |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Black/Bloody Stool | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Colitis | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Loss of Sleep | GENITOURINARY | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Fever | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Difficulty Chewing/Jaw Click | <input type="checkbox"/> Headaches | <input type="checkbox"/> Painful/Excessive Urination | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> General Stiffness | | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Stuffed Nose |
| NERVOUS SYSTEM | GASTROINTESTINAL | C-V-R | MALES |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Prostate/Sexual Dys. |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Short Breath | <input type="checkbox"/> Breast Pain/Lumps |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Blood Pressure – High/Low | FEMALES |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Breast Pain/Lumps |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Varicose Veins | Last Period? _____ |
| Convulsions | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ankle Swelling | Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Gall Bladder Problems | | |
| | <input type="checkbox"/> Weight Trouble | | |

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

PATIENT MOTOR VEHICLE CRASH HISTORY FORM

Name _____ Date _____

Date of Loss/Onset (Accident): _____ Claim Number: _____

Describe Accident:

Specifics of Accident (Mark each that applies to the accident):

Job or Work Related injury () Yes () No

Your were the Driver Passenger
Sitting Front seat Back seat

Impending Collision Braced Not braced
Head Did Strike Object Not strike Object
Did you experience Shock
 Flash of Light Seen Upon Impact
 Air bag Deployed

Immediately Following the Accident

Ambulance – Paramedics Called
 Treated at Scene
 Transported to Hospital by Ambulance
 Went to Hospital on his/her Own
 Diagnostics Preformed at Hospital
 Medication Prescribed
 Treatment at Hospital
 Follow-up Recommended

Time Loss

- NO time loss from work due to injury. I am currently working with No limitations.
- NO time loss form work due to injury BUT I do have limitations*.
- I have experienced time loss from work due to injury. Indicate number of days, weeks, etc
- N/A

*Describe Limitations: _____

Mechanism of Injury

- Were you surprised by the impact? Yes No
- In relation to the back of your head, was your headrest set: Low Middle High None
- Where was your head facing at the time of impact? Left Forward Right Unknown
- Were you leaning forward at the time of impact? Yes No
- Were you wearing a seatbelt/harnser? Yes No
- Were you rendered unconscious as a result of the accident? Yes No
- Did you feel pain immediately after the accident? Yes No
- Year and type of vehicle were you in? _____
- Size of your vehicle? Small Mid Large Unknown
- Year and type of other vehicle involved in the accident? _____
- Size of other vehicle? Small Mid Large Unknown
- What was the approximate speed of your vehicle when the accident occurred? _____
- What was the approximate speed of the other vehicle when the accident occurred? _____

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 potential 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 UNDESIRE 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

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

AUTO INJURY POWER OF ATTORNEY

An auto injury irrevocable healthcare power of attorney is often necessary to secure benefits, to make sure an insurance company pays fully and promptly, and to pursue an insurance company for benefits of the patient if they fail to pay.

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____ County, State of _____, do appoint my healthcare provider, Dr. Michael K. Van Antwerp (hereinafter, "Attorney"), as my agent and true and lawful Attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

- 1) Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any automobile, medical payments, personal injury protection, uninsured motorist, underinsured motorist, health, or third party liability insurance companies which relate to healthcare goods and services provided by Attorney to Principal (or members of Principal's family) over to Attorney.
- 2) Demand and direct any and all automobile, medical payments, personal injury protection, uninsured motorist, underinsured motorist, health, or third party liability insurance companies, during the course of Principal's (or members of Principal's family) claim for healthcare goods and services with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such goods and services payable to Attorney and to send such checks directly to Attorney.
- 3) File complaints with the insurance commissioner on Principal's (or members of Principal's family) behalf.
- 4) File suit or seek arbitration on Principal's (or members of Principal's family) behalf if any situation presents itself as necessary in regards to an insurance company, attorney, or other.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare goods and services provided and shall be irrevocable throughout the duration of the claim for healthcare goods and services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said Attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said Attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

A photocopy of this power of attorney shall be effective and valid as the original.

Principal's Printed Name

Principal's Signature

Date

Guarantor's/Guardian's Printed Name (if any)

Guarantor's/Guardian's Signature

Date

Witness 1's Printed Name

Witness 1's Signature

Date

Witness 2's Printed Name

Witness 2's Signature

Date