CASE HISTORY

Name: ______ Age: ______ Date: ______ Case Number: ______
Address: ______ City: ______ State: ______ Zip: ______
Phone:(H) ______(C)______ Fax: ______ E-mail: ______
Date of Birth: ______ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: ______
Occupation: ______ Employer: ______ Telephone (Work): ______ Ext. ______
Insured's Name: ______ Phone: ______ Insured's Date of Birth: ______
Spouse's Name: ______ Spouse's Occupation: ______
Spouse's Employer: ______ Spouse's Telephone (Work): ______
Past Chiropractic Care: ❑ Yes ❑ No When? ______ Doctor's Name: ______
Results: ______ Referred by: ______
Insurance Company: ______ Telephone: ______
Social Security Number: ______ Driver's License Number: ______ State: ______
Spouse's Insurance Company: ______ Telephone: ______
Spouse's Social Security Number: ______ Spouse's Driver's License Number: ______
Emergency Contact: ______ Relationship ______ Contact Number ______

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: ______
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other: ______
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When? ______ Why? ______
Have you retained an attorney? ❑ No ❑ Yes Name & Address: ______

Pain Symptoms: (in order of severity)
1. ______ Began-(Mo/Yr): ______ Previous Episodes: ______
2. ______ Began-(Mo/Yr): ______ Previous Episodes: ______
3. ______ Began-(Mo/Yr): ______ Previous Episodes: ______

Please mark the intensity of your pain today.
0 - NO PAIN
10 - INTENSE PAIN
Example ______ Neck ______
O 1 2 3 ④ 5 6 7 8 9 10
1. ______
O 1 2 3 4 5 6 7 8 9 10
2. ______
O 1 2 3 4 5 6 7 8 9 10
3. ______
O 1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness
P-Pain
A-Ache
ST-Stiffness

Left
Left

DOCTORS USE ONLY

______
______
______
______

HABITS

❑ Smoking Packs/Day: ______
❑ Drinking Alcohol: ______
❑ Caffeine Cups/Day: ______

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other	
Mother	❑	❑	❑	❑	❑	______
Father	❑	❑	❑	❑	❑	______
Brother,# of: ____	❑	❑	❑	❑	❑	______
Sister,# of: ____	❑	❑	❑	❑	❑	______

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS	
❑	❑	❑	995.3	Allergy (What)____
❑	❑	❑	490	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.39	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.79	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Sweats
❑	❑	❑	786.07	Wheezing
❑	❑	❑	311	Depression

Never	Previously	Presently	GASTRO-INTESTINAL	
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

Never	Previously	Presently	GENITO-URINARY	
❑	❑	❑	788.36	Bed Wetting
❑	❑	❑	599.7	Blood in Urine
❑	❑	❑	788.4	Frequent Urination
❑	❑	❑	788.3	Lack of Bladder Control
❑	❑	❑	590.9	Kidney Infection
❑	❑	❑	788.1	Painful Urination
❑	❑	❑	601.9	Prostate Trouble

Never	Previously	Presently	MUSCLES/JOINTS/BONES	
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors/Twitching
❑	❑	❑	782	Arm Trouble

Never	Previously	Presently	CARDIO-VASCULAR	
❑	❑	❑	401.9	High Blood Pressure
❑	❑	❑	458.9	Low Blood Pressure
❑	❑	❑	786.51	Pain Over Heart
❑	❑	❑	785.9	Poor Circulation
❑	❑	❑	438	Previous Heart Trouble
❑	❑	❑	785.0	Rapid Heart
❑	❑	❑	427.89	Slow Heart
❑	❑	❑	436	Strokes
❑	❑	❑	719.7	Swelling Ankles
❑	❑	❑	454	Varicose Veins

Never	Previously	Presently	SKIN OR ALLERGIES	
❑	❑	❑	680.9	Boils
❑	❑	❑	924.9	Bruising Easily
❑	❑	❑	701.1	Dryness
❑	❑	❑	691.8	Eczema
❑	❑	❑	708.9	Hives or Allergy
❑	❑	❑	698.9	Itching
❑	❑	❑	782.0	Sensitive Skin
❑	❑	❑	782.1	Skin Eruptions

Never	Previously	Presently	FOR WOMEN ONLY	
❑	❑	❑	625.3	Cramps or Backaches
❑	❑	❑	626.2	Excessive Flow
❑	❑	❑	627.2	Hot Flashes
❑	❑	❑	626.4	Irregular Cycle
❑	❑	❑	634.9	Miscarriage
❑	❑	❑	625.3	Painful Periods
❑	❑	❑	623.5	Vaginal Discharge
❑	❑	❑	611.79	Lump in Breast

❑ Yes ❑ No Pregnant at this time?

❑ Yes ❑ No Have you had a mammogram?

__________ Last Pap Smear Date

__________ By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
__________	Vaccinations	__________	Tubes in Ears	__________	Sinus
__________	Tonsillectomy	__________	Appendectomy	__________	Hernia
__________	Gall Bladder	__________	Female Organs	__________	Thyroid
__________	Back Operation	__________	Rectal Surgery	__________	Stomach
__________	Other: __________	__________	Other: __________	__________	Other: __________

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:__________ ❑ Recreation: __________

❑ Sports:__________ ❑ School:__________ ❑ Other:__________

List any broken bones (fractures) or dislocations: __________

Ever on crutches? ❑ Yes ❑ No Why?__________

Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No

Have you ever had a lapse of memory? ❑ Yes ❑ No

Have you ever had X-rays taken? ❑ Yes ❑ No When?__________ By Whom?__________

For what ailments were these X-rays made?__________

Do you suffer from any condition other than that for which you are now consulting us? __________

Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs?__________

____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X__________ Date:__________

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Dr. Rebecca Pearson LLC dba Health Back Center

Continuity of Care Document / PQRS Data Sheet

(Please Circle)

Visit Date: ________________ Initial Update

Patient Name: ________________________________ Patient DOB:____________

Patient Demographics (Please circle)

Sex:	Male	Female				
Preferred Language:	English	Other:				
Ethnicity:	None	Hispanic/Latino	Not Hispanic/Latino	Unknown by Patient	Not Given	
Race:	White	American Indian/ Alaskan Native	Asian	Black/African American	Native Hawaiian/ Pacific Islands	Other
Marital Status:	Single	Married	Divorced	Widowed	Unknown	
Smoker?	Never	Former	Smoker	Daily	Some	Not Given

Vitals (For Physician Use Only)

Height: ________________

Weight: ________________ BMI ________________

Blood Pressure: ________________ Temperature ________________

Pulse: ________________ SP02 ________________

Medication Information

Medication Allergies:

(Please Circle)

Do you have any known medication allergies: No Yes

If yes, please list each medication on Page 2

Medications: (___list from patient attached)

(Please Circle)

Are you currently taking any medications? No Yes

If yes, please list each medication on Page 2 or provide current medication list.

(See Page 2)

MEDICATIONS

Are you currently taking any medications: No Yes

Medication 1

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Medication 2

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Medication 3

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Medication 4

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Medication 5

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Medication 1

Medication Name: ______________________ Dosage: ______________

Prescriber: ______________________ Start Date: ______________

Do you have any known medication allergies: No Yes

Medical Allergy 1

Medication Name: ______________________________

Reaction: ______________________________

When did you first notice this allergy?______________________

Medical Allergy 2

Medication Name: ______________________________

Reaction: ______________________________

When did you first notice this allergy?______________________

Thank you for completing this Health History Questionnaire!

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:____

Address:______________________________ ___________ ____ ___________

Date of Birth:______________________________Date of Request:____________________

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize Dr Rebecca Pearson, LLC dba Health Back Center, and any of its employees to use or disclose my Patient Health Information to the following persons(s), entity(s), business associates of this office (insurance carrier(s) or other listed entity (s):

Any insurance company or other entity I have requested claims be filed to as a courtesy and on my behalf and:

____

Patient Health Information authorized to be disclosed:

Personal, Financial & Medical Records
All information collected in patient record necessary to verify, process and submit insurance claims

For the specific purpose of (describe in detail):

Care of patient, management of records, billing and insurance processing

Effective dates for this authorization: From: ___/___/___through ___/___/___.
This authorization will be continuous unless expiration date indicated above. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information. However, I do understand that refusal to sign this document may prevent this office from assisting with the filing of my insurance claims.

____ ____________________
Signature of Patient or Patient's Authorized Representative *Date*

____ ____________________
Authorized signature of Facility *Date*

HIPPA CONTACT FORM
REQUEST FOR CONFIDENTIAL COMMUNICATION BY
ALTERNATIVE MEANS OR ALTERNATE LOCATION

I, ____________________________________, Date of Birth______________authorize/request an alternative means of communication of my health information (e.g., regular mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by Health Back Center and disclosure by alternative means may not be protected and could endanger me. I understand that request for alternative means of communication may be intercepted by others and Health Back Center is not responsible if such intercepts occur.

Please indicate in detail your authorized alternative means or alternate location for receiving communications from Health Back Center.

☐ Email Reminders: ____

☐ Phone Call Reminders: ____

☐ Permission to leave message on voicemail/recorder: ☐ Yes ☐ No

☐ Alternate Mailing Address:

____ __________ __________

☐ Use mailing address provided on initial paperwork or by written update.

☐ Alternate Phone Number

☐ Alternate Means of Contact (Please specify):

This request applies to the following information:
☐ Today's Date of service only
☐ From:____________ ☐ To:______________
☐ From:____________ Until Further Notice

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (If Personal Representative, state relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

FOR HBC USE ONLY

☐ Request Approved ☐ Denied
If denied, reason (check one):
☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided
☐ Failure to provide information on how payment will be made (if applicable)
☐ Other (please explain):____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice:	October 22, 2013
Contact Person:	Dr. Rebecca Pearson
Phone Number:	417-337-7100

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."

____

Patient or Representative Name (please print)

____ ______________

Patient or Representative Signature *Date*

☐ Patient refused to sign ☐ Patient was unable to sign because

____