Karen Erickson, DC, FACC
127 West 79th Street, Suite 4, New York, NY 10024
Phone: 212.721.0177 | Fax: 212-579-6236

ERICKSON HEALING ARTS

Name: _____ Age: _____ DOB: _____ Gender: ___

Height: _____ Weight: _____ Social Security: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

The best time to contact me is: □_____A.M. □_____P.M. Contact me on my: □Home phone □Work phone □ Cell phone

Do you have children? □Yes □No, Ages: _____ Referred by: _____

□Single □Married □Widowed □Separated □Divorced Name of Spouse/Significant other:_____

Emergency Contact: _____ Emergency Contact Phone: _____

Present Health

Specific areas of focus:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

What aggravates this condition? □Standing □Sitting □Lying □Bending □Other_____

How frequent is this condition? □Constant □Daily □Intermittent □Night only □Changing positions

Current level of pain on a scale of 1-10: _____ Is this due to: □ Auto □Work □Accident □Other_____

Is this condition interfering with: □Work □Sleep □Daily Routine □Other _____

_____

_____

_____

Health History

Childhood Health Issues: _____

Chronic Health Issues: _____

Surgery/Procedures: _____

Allergies (Food & Environmental):_____

Food Sensitivities:_____

Symptoms

Muscle/Joint/Bone
Pain, weakness, numbness in:

- ☐ Neck
- ☐ TMJ
- ☐ Arms
- ☐ Shoulder/ Elbow
- ☐ Wrist/Hand/Fingers
- ☐ Upper Back/Shoulder Blades
- ☐ Low Back
- ☐ Hip
- ☐ Sciatica
- ☐ Legs
- ☐ Knee
- ☐ Ankles/ Feet

General

- ☐ Depression
- ☐ Dizziness | Vertigo
- ☐ Fainting
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Anxiety
- ☐ Numbness
- ☐ Night Sweats

Headaches

- ☐ Side of Head (Temples)
- ☐ Frontal (Above Eyes)
- ☐ Base of Skull (Back)
- ☐ Top of Head
- ☐ Entire Head
- ☐ Migraines

Genito-Urinary

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Gastrointestinal

- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Ulcer

Cardiovascular

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eyes, Ears, Nose & Throat

- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Eyeglasses/Contacts
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Congestion

WOMEN only

- ☐ PMS
- ☐ Bleeding between Periods
- ☐ Menstrual Pain
- ☐ Hot Flashes
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Infertility
- ☐ Fibrocystic Breast

MEN only

- ☐ Prostate Enlargement
- ☐ Prostate Cancer
- ☐ Sexual Dysfunction

Conditions

- ☐ Addiction Issues
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Candida
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Bowel Inflammation
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Parasites
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate
- ☐ Psoriasis
- ☐ Scoliosis
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other_____

WOMEN only

Menstrual History: Cycle Length_____Menst Length_____Date of last Menstrual Period_____

Do you experience pain/cramping? ☐Yes ☐No Do you do breast self-examinations? ☐Yes ☐No

Are you or is there a possibility that you are pregnant? ☐Yes ☐No

Have you been pregnant before? ☐Yes ☐No If so, number of pregnancies? _____ Miscarriages ? _____

Number of deliveries: _____ Delivery interventions? _____

Specialty	Name
Primary Care Physician/Internist	
OB/GYN	
Urology	
Physical Therapy	
Physical Training	
Psychotherapy	
Acupuncture & Oriental Medicine	
Other Holistic Therapy	
Other Specialist:	
Previous Chiropractic Care?	

Medications & Supplements (Please feel free to attach a list)

Medication	Dose	For how long?	Reason for medication

Supplements/Vitamins	Dose	For how long?	Reason for supplement

Wellness Lifestyle

What is your health philosophy? (What are you currently doing to be healthy?) _____

_____

How many hours do you exercise weekly? _____ Do you belong to a gym? □Yes □No

Aerobic Exercise: _____ Duration and Frequency_____

Strength Training: _____ Duration and Frequency_____

Stretch/Yoga: _____ Duration and Frequency_____

Other: _____ Duration and Frequency_____

How many glasses of water do you drink per day? _____How many servings of vegetables do you eat per day? _____

Do you eat super foods or take antioxidant vitamins? □Yes □No List: _____

Are you at your ideal body weight? _____ I am about the right weight.

_____ I would like to lose weight.

_____ I am more than 20 pounds over my ideal weight.

_____ I am under weight.

Have you ever dieted (cleanse or another type)? □Yes □No If yes, type: _____

Average hours of sleep per night? _____ Trouble falling asleep? □Yes □No Staying asleep? □Yes □No

Would you say your energy level is: □Excellent □Mostly Okay □Often Fatigued □Always Fatigued

Do you snore? _____ Do you have Sleep Apnea? _____ Age of Mattress: _____

Do you notice memory loss? □Yes □No Do you sense diminishing mental acuity? □Yes □No

Do you have decreased libido? □Yes □No Are you on an anti-aging/life-extension program? □Yes □No

Do you have a skincare regime? □Yes □No Please describe: _____

Hours at computer per day: _____ Good chair? □Yes □No Keyboard on (circle): Tray | Desk

On a scale of 1-10 describe your stress level: (1 = least/ 10 = extreme) Occupational _____ Personal _____

Do you meditate? □Yes □No Other MindBody practices? □Yes □No_____

How many drinks of alcohol you have per day/week? _____

Do you smoke now? □Yes □No If yes, how many per day/week? _____

Did you smoke in the past? □Yes □No If yes, how many per day/week? _____ Year stopped: _____

Authorization

I authorize Erickson Healing Arts to share diagnosis, examination, test results, and treatment records to my insurance company for the purpose of filing claims and/or appeals, and as appropriate to other healthcare providers.

Name **Signature** **Date**

Karen Erickson D.C

127 West 79th Street, Ste 4 NY, New York 10024

Tel: (212) 721-0177 Fax: (212) 579-6236

Notice of Privacy Practices

We are required by law to protect the privacy of health information that may reveal your identify and to provide you with a copy of this notice. This notice describes how medical information about you may be used and disclosed and details your rights about your Protected Health Information (PHI). Please review it carefully and sign the back of this page.

This practice, in accordance with this Notice and without asking for your express consent or authorization may use and disclose your Protected Health Information (PHI) in the following ways:

General State of Privacy Practices

We will not use or disclose your PHI except for treatment, payment, or health care operations or as otherwise described in this notice.

Examples of Disclosure

Treatment: We may use your healthcare information for treatment purposes. Example: information obtained by our healthcare team will be recorded in your record and used to determine the course of treatment that will work best for you. Dr. Erickson will record the actions she took, her observations, and her assessment. In that way. she will know how you are responding to treatment.

We may also provide your other physicians or a subsequent healthcare provider with copies of various reports that should assist them in treating you, as well as to people who may be involved in your care, such as family members, clergy, significant others, or others we use to provide services that are part of your case.

Payment: We will use your healthcare information for payment purposes. For **example:** A bill may be sent to a third party payer/insurance company. The information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. If requested, we will provide copies of the applicable portions of your medical record to your insurance company or governmental programs, such as Medicare or Medicaid, in order to validate your claim. We may also use your PHI to appeal denial of coverage on your behalf.

Regular Health Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the services we provide.

Other Possible Disclosures Permitted or Required by Law

Telephone or Email Contact/Appointment reminders: We may contact you to provide appointment reminders or information about treatments and test results or other health related benefits and services that may be of interest to you.

Personal Representative: The Practice may use and disclose your PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

De-Identified Information: The Practice may use and disclose health information that may be related to your care **but** does not identify you and cannot be used to identify you.

Disaster Relief: We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend, significant other of your location and general condition.

Workers' Compensation: We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling diseases, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institute or agents thereof health information necessary for your health and the health and safety of other individuals.

Funeral Director or **Coroner:** We may disclose health information to funeral directors or coroners consistent with **applicable** law to car **y out** their duties.

Organ Procurement: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged with procurement, banking, or transplantation of organs for the **purpose** of tissue donation and transplant.

Law **Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member of business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and potentially endangering one or more patients, workers, or the public.

Special Government Functions: If you are a member of the Armed Forces, we may release your PHI as required by military command authorities.

Your Rights

You have certain rights with respect to your Protected Health Information.

You have the right **to Revoke Authorization:** You have the right to revoke any authorization or consent you have given to the Practice, at any time. To request revocation, you must submit a written request to the Practice's Privacy Officer. Also you have the right to:

1. Request Restrictions: You have the right to request, in writing that we agree to restrictions on the uses and disclosures of your PHI for treatment, payment and health care operations. However, we are not required to agree to your requested restrictions.
2. **Confidential Communication:** You may request, in writing, that we send confidential **communication** of your protected health information to alternate locations and by alternate means, and we must abide by your request if reasonable.
3. Inspect **your PHI:** You have the right to request, in writing, that we allow you to inspect and copy your protected health information.
4. **Amend:** You have the right to request, in writing, an amendment to your health information. However, we are not required to make the amendment if we do not believe the amendment is justified.
5. **An accounting** of **Disclosures:** You have the right to receive an accounting of any disclosures of your protected health information that are not made either for treatment, payment, or health care operations purposes or pursuant to your authorization.
6. **Paper copy:** You have the right to request a paper copy of this notice.
7. File a **Complaint:** You have the right to complain to the Practice or to the United States Secretary of Health if you believe your rights have been violated. See below for the address to write to.

Our Duties

With respect to your Protected Health Information that is created or maintained here, we are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of this notice.

We reserve the right to change our practices and make the new provisions effective for all health information we maintain. Should our information practices change, you will receive a revised copy from us in person or by mail the next time we provide treatment to you.

For more **information or to** report a **problem:**

If you believe that your privacy rights have been violated, you can file a complaint in writing with our Privacy Officer in person, or directly with the Secretary of Health and Human Services, Office for Civil Rights, US Department of Health and Human Services , 200 Independence Avenue, SW, Washington, DC. There will be no retaliation against you for filing a complaint.

Signature _____ Date_____

Karen Erickson D.C

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Acknowledgement of Receipt of Notice of Privacy Practices

This *form will be retained in your medical record.*

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:** _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Karen Erickson, DC.

I understand that the Notice describes the uses and disclosures of my protected health information by Karen Erickson, DC and informs me of my rights with respect to my protected health information (PHI).

Patient's Signature or Legal Representative_____

Printed Name of Patient or Legal Representative_____

Today's Date; _____If Legal Representative, Indicate Relationship:_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ❑ The patient refused to sign.
- ❑ Due to an emergency situation it was not possible to obtain an acknowledgement
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ Other (please specify):

*Employee Name:*_____ *Today's Date* _____

Erickson Healing Arts

Welcome to our practice! We appreciate being part of your healthcare team!

We want to make everything about your visit as healing and stress-free as possible. To that end, we want to inform you of the office scheduling policy.

Travel in NYC can be challenging. Feel free to arrive a few minutes early to relax, read, even enjoy a cup of tea.

You are welcome to schedule a 15-minute infrared session before or after your appointment. It is best to schedule these in advance, but we will do everything we can to accommodate spur of the moment sessions. These sessions involve lying on a warm infrared massage table in our beautiful Zen-like massage room. Infrared detoxifies, boosts metabolism, relaxes muscles, and profoundly reduces stress. Our patients emerge looking like they have just been on retreat!

We are meticulous about appointment date and times. Once an appointment is made, it is considered confirmed. We do not call to confirm appointments.

When an appointment is scheduled, that time is reserved just for you. We do not overbook our schedule, and strive to see our patients on-time. If we are running a few minutes late, you will be given the full appointment time scheduled.

If you are late for an appointment, you will be given the remaining time available. If you schedule a 30-minute appointment and arrive10 minutes late, you will have a 20-minute session, and be charged for 30 minutes. Please call us if you will be late. Not only do we appreciate it, but occasionally we are able to juggle the schedule.

Our office has a 24-hour cancellation policy. You may notify us of an appointment cancellation by phone or email, even when the office is closed. We will always phone or email back to confirm we received your cancellation. All appointments missed or cancelled with less than 24-hours notice will be charged the full fee.

Our goal is to make every visit a deeply relaxing, clinically meaningful, and healing experience. Thanks so much for your cooperation and understanding.

Yours in health,

The Erickson Healing Arts Team

I hereby acknowledge the above appointment and 24-hour cancellation policy:
(please sign below)

Name: _____Date: _____