Erickson Healing Arts

Karen Erickson, DC

DATE:_____

Personal Information

Child's Name_____

Child's Address:_____

City_____State_____Zip_____

Birth Date_____ Age_____Gender_____

Height _____ Weight _____

Child's Home Phone #_____

Mother's Name_____

Mother's Cell #_____

Mother's Email_____

Mother's Employer_____

Work Phone_____

Father's Name_____

Father's Cell #_____

Father's Email_____

Work Phone_____

Number of Siblings_____Ages_____

Referred by_____

Is this a wellness visit? ☐ YES ☐ NO

Primary Concern/s:

_____

_____

_____

_____

How long has your child been experiencing this?

_____

How often? ☐Constantly ☐Intermittently

Other_____

Other Physicians who provide care:

_____Specialty:_____

_____Specialty:_____

_____Specialty:_____

Sports/Exercise? ☐ YES ☐ NO _____

Screen Time? ☐ YES ☐ NO, Hours/day:_____

Sitting Time? Hours/day:_____

Wear a heavy backpack? ☐ YES ☐ NO

Please check if your child has any of the following:

- ☐ Asymmetrical Facial Features
- ☐ Neck Pain/Back Pain/Growing Pains
- ☐ Head Tilt/ Torticollis
- ☐ Head Distortion/ Plagiocephaly
- ☐ Ear Aches/ Ear Infections
- ☐ Behavior Concerns/Frequent Tantrums
- ☐ GERD/Acid Reflux
- ☐ Constipation/Diarrhea/Digestive Issues
- ☐ Difficulty Nursing/ Eating
- ☐ Difficulty Sleeping, **Avg Hours of Sleep: _____**
- ☐ Back Arching / Tension
- ☐ Autism Spectrum Disorders/Neuro-Sensory Dysfuntion
- ☐ Problems Crawling or Walking
- ☐ Seizures/Neurological Ticks
- ☐ Appears Clumsy/Poor Coordination
- ☐ Abnormal Sleep Patterns
- ☐ Skin Problem/ Rash/ Eczema
- ☐ Allergies/Intolerances to Foods or Formula:

_____

_____

_____

Child's Name_____ **Date**_____

Pregnancy and Peri-Natal History

Please provide us with information as it related to your pregnancy with this child by checking all that apply:

- Accident while pregnant
- Alcohol consumption
- Amniocentesis
- Abnormal Fetal Position or Breach
- Chemical Exposure
- Frequent Ultrasounds #_____
- Genetic Testing
- Gestational Diabetes
- Group-B Strep Positive
- Hypertension
- Bacterial or Viral Infection
- Yeast/Fungal Infection
- Morning Sickness/Nausea
- Placenta Abruptio
- Placenta Privia
- Poor Nutrition
- Pre-Eclampsia
- Prescription Medication
- Radiation Exposure
- Recreational Drug Use
- Rhogam Injection
- Swelling/Edema
- Pre-Natal Vitamins
- Unknown/Adopted

Please check all that apply regarding your child's vaccine history:

- Up-to-date
- Partial
- Delaying
- Conscientious Objector
- Concerned/Unknown
- Vaccine Reactions

Choose all that apply to your child as a newborn:

- Premature
- Poor Sleeping
- Jaundice
- Low APGAR score
- Failure to thrive
- Colic
- Resuscitation required
- Prolonged cranial distortion
- Difficulty nursing/latching
- Meconium aspirated
- Antibiotic administered
- Circumcised
- Breast fed
- Formula fed

Development & Neurosensory

Please answer the following questions as they pertain to your child's behaviors:

	Frequently	Occasionally	Rarely
1a. Avoids busy places/crowds			
1b. Dislikes tags/tight clothes			
1c. Unaware of being banged into			
1d. Unable to keep hands to self			
2a. Dislikes strong-smelling things			
2b. Constantly smells everything			
3a. Covers ears to avoid noises			
3b. Seems to ignore you often			
4a. Has difficulty/avoids reading			
4b.Hesitates to climb/use stairs			
4c. Dislikes/avoids bright lights			
4d. Squints/turns head to see			
5a. Gets motion sickness easily			
5b. Loves to spin, jump & swing			
6a. Difficult to hop/skip/jump			
6b. Appears clumsy			
7a. Likes heavy blankets			
7b. Kicks/taps things			
8a. Dislikes playing in groups			
8b. Doesn't express needs well			
8c. Is advanced academically			

Treatment History

Please list any additional care or relevant services your child has received:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any supplements and/or vitamins your child is taking now:_____

_____
_____
_____
_____
_____
_____
_____
_____

Child's Name_____ **Date**_____

Child's Health History (ROS)

Constitutional
- o Fever
- o Headache
- o Recent Trauma
- o Stressed/anxiety
- o Fatigue/lethargy
- o Poor Sleep
- o Loss of Appetite
- o Weight Loss

EENT
- o Excessive tearing
- o Eye infections
- o Poor eye control
- o Poor hearing
- o Ear aches/infection
- o Discharge from ear
- o Poor smell
- o Nasal congestion
- o Gags easily
- o Difficult speech
- o Spots on tongue
- o Gum disease
- o Tooth decay

Respiratory
- o Difficulty breathing
- o Shortness of breath
- o Asthma/wheeze
- o Sputum
- o Chronic Cough

Genital
- o Testicular problems
- o Gonadal Mass
- o Genital rash
- o Yeast infections
- o Vaginal discharge
- o Breast Mass
- o Early onset puberty

Skin
- o Jaundice
- o Skin rash/hives
- o Eczema
- o Bruises easily
- o Scars
- o Skin masses/bumps
- o Skin/hair/nail changes

Musculoskeletal
- o Swelling of muscles/joints
- o Limited range of motion
- o Chronic injury/complaint

Neurological
- o Seizures/convulsions
- o Neurological ticks
- o Lightheaded/dizziness
- o Tremors
- o Clumsy/poor balance

Cardiovascular
- o Poor circulation
- o Chest Pain
- o Extremity Swelling
- o Abnormal Heart Rhythm

Immunological
- o Food intolerance
- o Environmental intolerance
- o Lymph node enlargement
- o Allergy
- o Meningitis/serious infection
- o Weak immune system

Gastrointestinal
- o Bloating
- o Constipation
- o Diarrhea
- o Stomach Tenderness/aches
- o Weight loss/loss of appetite
- o Vomiting
- o Bloody/tarry stools
- o Irritable Bowel Syndrome
- o Chrohn's/Ulcerative Colitis
- o Eating disorder

Endocrine
- o Neck or thyroid mass
- o Abnormal growth patterns
- o Excessive sweating

Urinary
- o Difficult urination
- o Foul-smelling urine
- o Blood in urine
- o Painful urination
- o Kidney problems

Child's Medical History

Please list any **Prescription Medications** your child takes:

_____

_____

_____

Please list any **Surgical Procedures** your child has had:

_____

_____

_____

Has your child ever needed **Emergency Services?**

_____

_____

List any known **Allergies** your child has:

_____

_____

_____

Minor Consent

CONSENT FOR EVALUATION AND TREATMENT OF A MINOR CHILD:

I hereby authorize the Doctor to treat my child's conditions as s/he deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I hereby authorize the Doctor and whomever s/he may designate as his/her associate to administer chiropractic care as s/he deems necessary to my child.

Child's name_____

Legal Representative: _____

Relationship to Patient: _____

- 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 carry 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.

Guardian's Signature _____ Date_____

Karen Erickson D.C

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

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

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: _____