



Dr. Sandy Baird, D.C.  
 3409 Grand Avenue #5  
 Oakland, CA 94610  
 P: 510.465-2342

**Patient Intake Form**

Kindly fill out the following information as completely as possible so that we may better serve you.

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex (at birth): \_\_\_\_\_ Gender (if different than sex): \_\_\_\_\_

Email Address: \_\_\_\_\_ May we add you to our newsletter(no spam) Y \_\_\_ N \_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

Are you seeking help today as a result of an auto injury or workplace accident? No \_\_\_\_\_ Yes (specify) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's/Partner's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact/Phone #: \_\_\_\_\_ Who can we thank for referring you? \_\_\_\_\_

**Payment Information**

Person Responsible for Payment: \_\_\_\_\_

Driver's License # and state: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Previous Chiropractic (DC name/last visit):** \_\_\_\_\_

**What services do you seek?**

- Chiropractic
- A.R.T. (Active Release Techniques)
- Graston
- Exercises
- Physical Therapy

**Main complaint(s) today:** \_\_\_\_\_

**How is this issue affecting you?** \_\_\_\_\_

**What are your goals for treatment?**  Get out of pain  Return to activity  Balance body/mind



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### Office Hours:

The doctor is available to see patients Monday, Tuesday, Wednesday, and Friday by appointment only.

### Rescheduling an Appointment:

In order to provide the best care to all patients, please **provide 24 hours notice** if you are unable to make your appointment. We do not double-book, your appointment slot is held for you, and you only. We do our very best to start all appointments on time, and a missed appointment means someone else was not able to receive care during that timeslot. Special circumstances aside, an \$70 missed appointment/late cancellation fee will be charged if we do not receive 24 hours notice.

### Terms of Acceptance of Care

**Assignment & Release** - *By signing below, I authorize Dr. Sandy Baird to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr. Sandy Baird and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goals. It is important that each patient understand both the objective and the method that will be used to attain these goals. This will prevent any confusion, misunderstanding or disappointment with your care in this office. **Adjustment:** An adjustment is the specific application of forces to facilitate the correction of joint restrictions. Our chiropractic method of correction is by specific adjustments of the spine and extremities.*

**By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.**

I, \_\_\_\_\_, have read and fully understand the above statements.  
(print name of patient)

Signed \_\_\_\_\_ Date \_\_\_\_\_

### **Please read and sign:**

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I hereby authorize Sandy Baird, D.C. to prepare any necessary reports or forms and release any information concerning my condition to any insurance company, attorney or adjuster so as to process claims for reimbursement of charges incurred by me. Payment toward my account by any insurance company, attorney or adjuster is hereby directed to be paid directly to Riverstone Chiropractic, or Sandy Baird, D.C., and applied to my account for services rendered. However, I clearly understand and agree that all services rendered to me are charged directly to me, that direct billing to my insurance company is done as a courtesy, and that I am personally responsible for payment of the full amount of my charges if not covered by my insurance benefits. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Dr. Sandy Baird, D.C. is hereby authorized to treat me when I present myself for treatment. I agree to pay all collection costs including, but not limited to: reasonable attorney fees, late charges, litigation costs in the event of any breach, including failure to timely make any required payments. A copy of this authorization serves as an original. By signing below, I am stating I received a copy of Riverstone Chiropractic Privacy Policy.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is a minor, parent/ legal guardian must sign)



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## Health Questionnaire

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

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List any trauma, including but not limited to motor vehicle accidents, sports injuries and broken bones:

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List any surgeries or hospitalizations you have had, complete with the month and year for each:

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List anything you are allergic to: \_\_\_\_\_

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): \_\_\_\_\_

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Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

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Do you wear?  Heel lifts  Arch supports  Prescription Orthotics

For women: Are you pregnant or nursing?  Yes  No If pregnant, How many weeks? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

## History of Treatment

Primary care physician: \_\_\_\_\_ Location: \_\_\_\_\_

Date last seen: \_\_\_\_\_ May we update them on your condition? \_\_\_ Yes \_\_\_ No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: \_\_\_\_\_

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**For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.**

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>
Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Low back pain	<input type="radio"/>	<input type="radio"/>
Angina / Chest pressure	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Mid back pain	<input type="radio"/>	<input type="radio"/>
Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	Neck pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Painful Urination	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Prostate Problems	<input type="radio"/>	<input type="radio"/>
Bladder Condition	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Shoulder pain	<input type="radio"/>	<input type="radio"/>
Birth Control Pills	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Stroke / Aneurysm	<input type="radio"/>	<input type="radio"/>
Chest Pains	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Systematic Lupus	<input type="radio"/>	<input type="radio"/>
Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome	<input type="radio"/>	<input type="radio"/>
Concussion	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Tumor	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>
Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Upper back pain	<input type="radio"/>	<input type="radio"/>
Dizziness / Light-headed	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Wrist pain	<input type="radio"/>	<input type="radio"/>

**Additional comments you would like the doctor to know:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient's signature:** \_\_\_\_\_ **Doctor's signature:** \_\_\_\_\_