RIVERSTONE
CHIROPRACTIC

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 :_____ Gender pronouns:_____

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: _____

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 **$85** 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:

_____

_____

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

_____

_____

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

_____

_____

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): _____

_____

Do you exercise? ☐ Yes ☐ No Hours per week _____What activity(s)? _____

_____

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

Additional comments you would like the doctor to know: _____

_____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____

This **HIPAA** notice is effective as of January 1, 2017. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have reviewed and received a copy of this notice.

_____	_____	_____
Name (printed)	Signature	Date

If you are **a minor**, or if you are being represented by another party:

_____	_____	_____
Personal representative (printed)	Personal representative signature	Date