JASON R. KAUFMAN, D.C.
Scottsdale Neurology
9755 N 90th St. #A200
Scottsdale, AZ 85258

Name:_____Date of Birth:_____

Address:_____ City:_____ State:_____Zip_____

Phone: _____ OK to call or text? **Yes / No**

Email:_____ OK to email info? **Yes / No**

Sex: M / F Marital Status _____

Referred By: _____ Primary Care Doctor: _____

May leave personal information on your voicemail? **Yes / No**

Do you give our office permission to discuss your medical information with family members? Yes No

Name: _____Phone:_____

Name: _____Phone:_____

Emergency Contact: _____Phone:_____

Cancellation Policy: If you fail to cancel within 12 hours or "No Show" scheduled appointments, you will be charged a $75.00 fee.

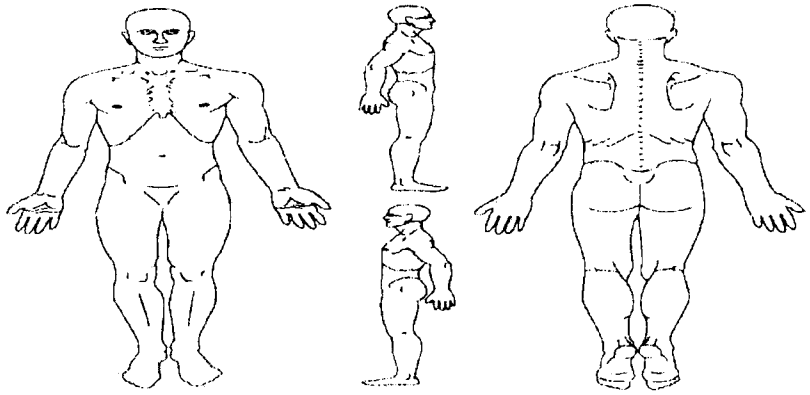
Financial: Services provided by Jason R. Kaufman, D.C. will not be billed to your insurance. However, billing information may be requested. If your insurance plan has chiropractic coverage, you may submit your claims and be reimbursed accordingly. Your signature below acknowledges you understand this.

_____

Signature

HISTORY

Indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10 worst

What improves your symptoms?_____

When/How did your symptoms begin?_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull	Numbness	Other:
Burning	Tingling	Throbbing	

Please List History of Illnesses, Surgeries, Injuries, Medications, Related Family History, etc:

_____
_____
_____
_____
_____
_____
_____
_____

Drink Alcohol? Y / N If yes, how often?_____

Smoke? Y / N If yes, how often? _____

Exercise? Y / N If yes, please explain._____

Signature:_____ Date_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

My work is very safe but consent to treat as a chiropractor is required.

I acknowledge that during the course of my care, I or the person named below for whom I am legally responsible, may receive chiropractic adjustments and other procedures including various modes of physiotherapy and diagnostic x-rays.

I understand that as in the practice of medicine, in the practice of other clinical therapies, there are some risks to treatment. If I receive chiropractic treatment, the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fracture, dislocations, stroke, sprains/strains, burns and aggravation of disc injuries.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him/her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known is in my best interest.

I have no further questions at this time for the doctor I have read, or have had read to me, the above consent. By signing below, I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (PLEASE PRINT) _____

Signature of Patient (or guardian)_____

Today's Date _____