ACCIDENTAL INJURY FORM

NAME ______________________ DATE ______________

Date of Accident ____________ Time: _____am _____pm Location of Accident ______________

AUTO INJURY

Were You: ( ) Driver ( )Passenger ( )Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( )No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the accident, were traffic citations issued to you? ( ) Yes ( ) No

ON-THE-JOB INJURY

How did the injury occur?______________________________

Did you report the injury to your foreman or employer? ( ) Yes ( ) No

Employer:______________________ Address ______________________

OTHER

Describe the circumstances of the accident (Be Specific)______________________

____

* *

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
( ) Neck Pain	( ) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
( ) Neck Stiff	( ) Pins & Needles in Arms	( ) Ears Ringing	( ) Hands Cold
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face Flushed	( ) Stomach Upset
( ) Back Pain	( ) Numbness in Fingers	( ) Buzzing in Ears	( ) Constipation
( ) Nervousness	( ) Numbness in Toes	( ) Loss of Balance	( ) Cold Sweats
( ) Tension	( ) Shortness of Breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of Smell	( ) Other
( ) Chest Pain	( ) Depression	( ) Loss of Taste	

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If yes,____________ through ____________

INSURANCE INFORMATION

Your Insurance Company ______________________ Address ______________________

Other Party(s) Name(s) ______________________ Address ______________________

Other Party(s) Ins. Co. ______________________ Address ______________________

Have you been contacted by an insurance adjustor regarding this claim? ( ) Yes ( ) No

If yes, name of adjustor ______________________ Company______________________

Do you have an attorney that has advised you in this case? ( ) Yes ( ) No

If yes, attorney's name ______________________ Address ______________________

Signature ______________________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____

Employer: _____

Claim/Group # _____

SS#/ID# _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

CRAIG A. DITZLER D.C.
3202 GOVERNOR DR. #200
SAN DIEGO, CA 92122-2940
(858) 452-2202

or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o CRAIG A. DITZLER D.C.
3202 GOVERNOR DR. #200
SAN DIEGO, CA 92122-2940
(858) 452-2202

the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at CRAIG A. DITZLER D.C.
3202 GOVERNOR DR. #200
SAN DIEGO, CA 92122-2940
(858) 452-2202
this _____ day of _____ 20____.

X _____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

FAMILY HEALTH HISTORY

To help determine if your health problem is hereditary in nature, please review the diseases and conditions listed below, and check off (✔) those that are health problems of a family member (simply leave blank those problems that do not apply). Please circle those relatives who live within the same proximity as you, as some hereditary conditions are affected by similar climate.

Patient: _____

HEALTH PROBLEM	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(S) Age ( ) Age ( )		SISTER(S) Age ( ) Age ( )		CHILDREN Age ( )	Age ( )	Age ( )
Arm Pain - Numbness										
Arthritis										
Asthma, Allergy, Hay Fever										
Back Pain										
Bursitis, Tendinitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Hand Pain - Numbness										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Leg Pain - Numbness										
Liver Trouble										
Low Blood Pressure										
Migraine										
Neck Pain										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerves										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Stomach Trouble										
Whiplash										
Other										

If any of your family members are deceased, please list their age at death and cause: _____

_____

_____

_____

Patient Name_____
Date_____

Check each of the activities which you have difficulty performing and/or can perform only with pain.

Housework

_____ Doing laundry
_____ Making beds
_____ Vacuuming/sweeping
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Other_____

Yardwork

_____ Mowing lawn
_____ Raking leaves
_____ Gardening

Personal Grooming

_____ Combing hair
_____ Shaving
_____ In/Out bathtub
_____ Brushing teeth
_____ Other_____

Travel

_____ Driving
_____ Riding
_____ Getting in/out of car

Minutes per day:

_____ Auto/Truck
_____ Train/Bus
_____ Airplane

General

_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Bending
_____ Climbing stairs
_____ Chewing
_____ Sitting in recliner
_____ Sports_____

_____ Using keyboards
_____ Kneeling
_____ Exercising
_____ Sexual intercourse
_____ Lifting children
_____ Sleeping/lying down
_____ Using telephone
_____ Reading

Other activities that cause difficulty and/or pain:_____

TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

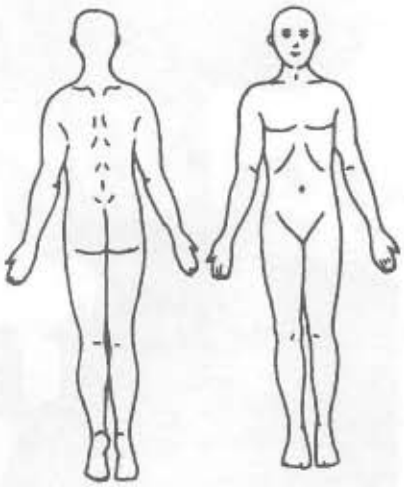
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

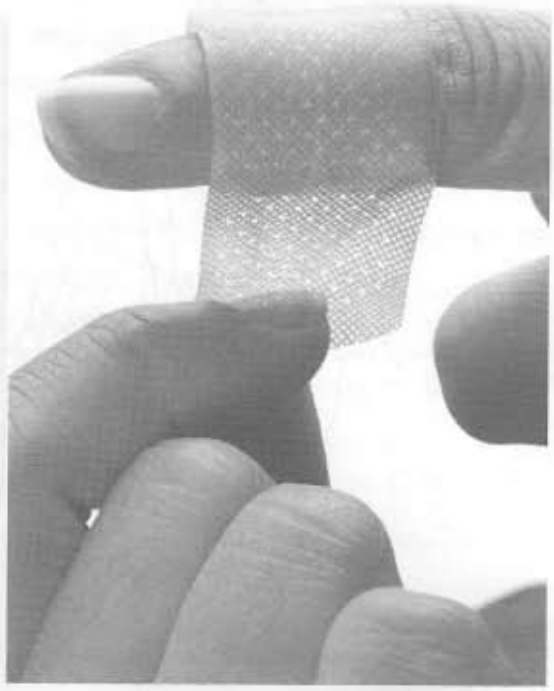
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

Date _____ Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ *Date* _____

Consent to Treat a Minor _____ *Date* _____

Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

DITZLER FAMILY CHIROPRACTIC

PRIVACY CONFIDENTIALITY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment Reminder

It is our policy to call your home or office in the event that an appointment is missed. If you are not at home we leave a message on your answering machine or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us the number you prefer.

Facility Set Up

While our examination and treatment rooms are private, this office utilizes an open reception area. Staff and doctor will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete of inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is not a cost for the first copy. Any copy thereafter will be $25.00.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement, you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.
- You have a right to a copy of the notice upon request.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to Dr. Craig Ditzler by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave., S.W.
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

_____
Patient Name (print)

X _____ _____
Patient's Signature Date

Substance Survey

Patient Name_____ Date_____

Please list current prescriptions, the dosage, and the diagnosis:

Rx:_____ Dx:_____
Rx:_____ Dx:_____
Rx:_____ Dx:_____
Rx:_____ Dx:_____

Please list any over-the-counter medications currently taking, the dosage and frequency:

Medication	Symptom	Occasion, often, daily

Please list any vitamins, supplements, herbs or homeopathic remedies:

Supplement	Amount taken daily	Duration of use

Please list daily intake of the following:

_____ Coffee
_____ Tea
_____ Soft drinks
_____ Candy
_____ Cigarettes/cigars
_____ Alcohol
_____ Antacids
_____ Other

List other tobacco/drugs in use:

_____
_____
_____
_____

List desserts and snacks for the past two weeks: _____

_____

SYMPTOM SURVEY FORM

NAME _____ DOCTOR _____ DATE _____

Phone # ( ) _____

Birthdate: ___/___/___ Sex: M___ F___

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3

(1) for MILD symptoms
(2) for MODERATE symptoms
(3) for SEVERE symptoms
Leave the box BLANK if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up—fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep—hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression—"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

over →

GROUP 6

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ☐ Mucus colitis or "irritable bowel"
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending" type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies—tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion—muscular and nervous
- 172 ☐ Respiratory disorders

FEMALE ONLY

- 173 ☐ Very easily fatigued
- 174 ☐ Premenstrual tension
- 175 ☐ Painful menses
- 176 ☐ Depressed feelings before menstruation
- 177 ☐ Menstruation excessive and prolonged
- 178 ☐ Painful breasts
- 179 ☐ Menstruate too frequently
- 180 ☐ Vaginal discharge
- 181 ☐ Hysterectomy/ovaries removed
- 182 ☐ Menopausal hot flashes
- 183 ☐ Menses scanty or missed
- 184 ☐ Acne, worse at menses
- 185 ☐ Depression of long standing

MALE ONLY

- 186 ☐ Prostate trouble
- 187 ☐ Urination difficult or dribbling
- 188 ☐ Night urination frequent
- 189 ☐ Depression
- 190 ☐ Pain on inside of legs or heels
- 191 ☐ Feeling of incomplete bowel evacuation
- 192 ☐ Lack of energy
- 193 ☐ Migrating aches and pains
- 194 ☐ Tire too easily
- 195 ☐ Avoids activity
- 196 ☐ Leg nervousness at night
- 197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

NAME
ADDRESS
CITY, STATE, ZIP
PHONE #

Print Name(s) of Doctor Treating This Patient

CRAIG A. DITZLER D.C.
3202 Governor Dr. #200
San Diego, CA 92122-2940
(858) 452-2202

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
X Signature of Patient	Date
Signature of Patient's Representative	Date
Witness to Patient's Signature	Date
Translated by	Date

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