

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	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	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 _____

Personal Grooming

- _____ Combing hair
- _____ Shaving
- _____ In/Out bathtub
- _____ Brushing teeth
- _____ Other _____

Yardwork

- _____ Mowing lawn
- _____ Raking leaves
- _____ Gardening

Travel

- _____ Driving
- _____ Riding
- _____ Getting in/out of car

Minutes per day:

- _____ Auto/Truck
- _____ Train/Bus
- _____ Airplane

General

- | | |
|---------------------------|---------------------------|
| _____ Walking | _____ Using keyboards |
| _____ Standing | _____ Kneeling |
| _____ Running | _____ Exercising |
| _____ Sitting | _____ Sexual intercourse |
| _____ Bending | _____ Lifting children |
| _____ Climbing stairs | _____ Sleeping/lying down |
| _____ Chewing | _____ Using telephone |
| _____ Sitting in recliner | _____ Reading |
| _____ Sports _____ | |

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.

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> 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

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

FEMALES ONLY:

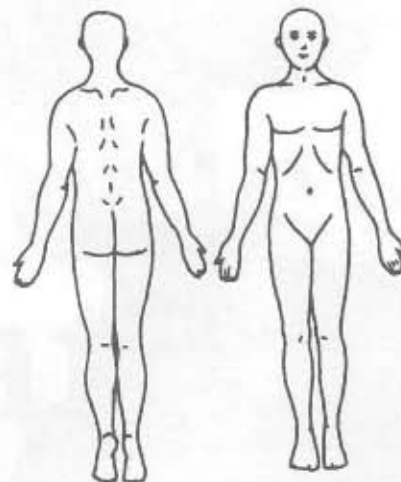
When was your last period? _____

Are you pregnant?

- Yes No Not Sure

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

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

C-V-R CODE

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

GENERAL CODE

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

EENT CODE

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

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

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

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

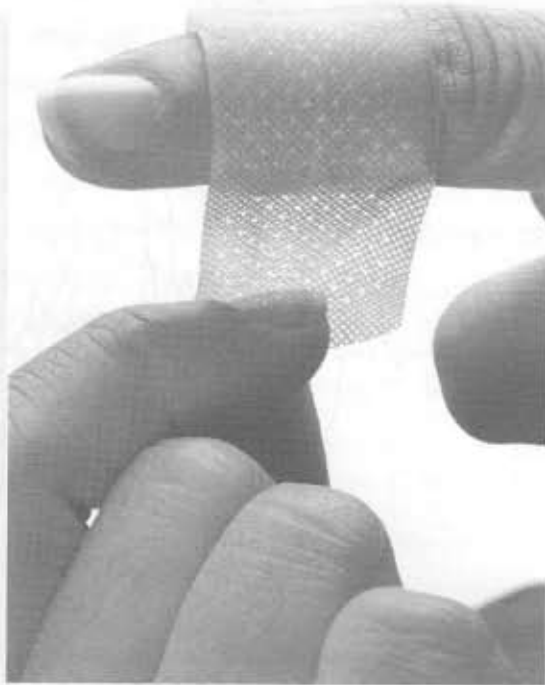
Corrective Care

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 or 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 # () _____

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

Birthdate: ___/___/___ Sex: M ___ F ___

- (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, Homer'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