



**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

Insurance coverage #1 :

Insurance company \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Billing address \_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_

Cardholder's name \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

Insurance coverage # 2:

Insurance company \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Billing address \_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_

Cardholder's name \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

Notify in emergency \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_

Previous physician \_\_\_\_\_

I hereby agree to pay for the services to be rendered to the above-mentioned patient and, if litigation is necessary to enforce payment, to pay a reasonable attorney or collection fee.

Date \_\_\_\_\_ Relationship, if any, to the patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
signature

**New Patient Questionnaire/Personal Injury**

Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to Pay Physician and Financial Agreement**

I hereby authorize the doctor in charge of my case to furnish my insurance company with information concerning my hospital and medical or surgical treatment. A photocopy of this authorization will be considered as valid as the original.

I hereby authorize and instruct my insurance company to pay by check made out and mailed directly to:

**David A. Ditsworth, M.D.**  
**Neurological Surgery**  
**1125 S. Beverly Drive, Suite 603**  
**Los Angeles, CA 90035**

\* \* \* \*

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, including major medical benefits, as payment toward the total charges for services rendered.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

If any legal action or proceeding be brought to enforce this agreement, the prevailing party shall recover in addition to all relief, reasonable costs, including attorney's fees, whether or not the action proceeds to judgment.

\_\_\_\_\_  
date signed

\_\_\_\_\_  
signature of insured

\_\_\_\_\_  
print name

**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

**Authorization to Pay Physician and Financial Agreement**

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**Neurological Surgery**  
**1125 S. Beverly Drive, Suite 603**  
**Los Angeles, CA 90035**

\* \* \* \*

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This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

If any legal action or proceeding be brought to enforce this agreement, the prevailing party shall recover in addition to all relief, reasonable costs, including attorney's fees, whether or not the action proceeds to judgment.

\_\_\_\_\_  
date signed

\_\_\_\_\_  
signature of insured

\_\_\_\_\_  
print name

## New Patient Questionnaire/Personal Injury

Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

### Accident Questions

1. Type of accident:  car versus car  other \_\_\_\_\_

2. Patient was:  driver  passenger  other \_\_\_\_\_

3. Please describe the accident in detail : \_\_\_\_\_

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4. Patient's car was :  at a stop  moving  slowing down  starting  
 other \_\_\_\_\_

5. Patient's car was struck from:  behind  head-on  sideswiped  
 other \_\_\_\_\_

6. Patient's car was hit on:  R L passenger door  R L rear fender  
 R L front fender  R L side of car  
 other \_\_\_\_\_

7. Vehicular damage:  slight  moderate  severe  "totalled"

8. Patient was:  
 unprepared with head turned to RIGHT?/ LEFT? / STRAIGHT?  
 leaning on the armrest  
 braced for the impact  
 held onto steering wheel forcefully  
 other \_\_\_\_\_

9. Patient felt:  
 forceful jolt and jarring  
 thrust to and fro  
 thrown sideways  
 pitched forward and backwards  
 thrown around abruptly  
 head and neck going through sudden to and fro motion  
 other \_\_\_\_\_

**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

10. Patient struck her/his:

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> anterior chest        | <input type="checkbox"/> top of head  |
| <input type="checkbox"/> forehead R L          | <input type="checkbox"/> back of head |
| <input type="checkbox"/> face (including nose) | <input type="checkbox"/> R L thigh    |
| <input type="checkbox"/> R L shoulder          | <input type="checkbox"/> R L arm      |
| <input type="checkbox"/> R L elbow             | <input type="checkbox"/> R L forearm  |
| <input type="checkbox"/> R L hip               | <input type="checkbox"/> R L knee     |
| <input type="checkbox"/> R L ankle             | <input type="checkbox"/> R L foot     |
| <input type="checkbox"/> other _____           |                                       |

11. Part of car patient struck:

- |  |                                    |                                     |
|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> windshield    | <input type="checkbox"/> dashboard | <input type="checkbox"/> door glass |
| <input type="checkbox"/> armrest       | <input type="checkbox"/> door      | <input type="checkbox"/> headrest   |
| <input type="checkbox"/> seat in front | <input type="checkbox"/> uncertain |                                     |
| <input type="checkbox"/> other _____   |                                    |                                     |

12. Following impact:

- patient lost consciousness
- fainted
- blacked out
- has poor recollection of what happened

13. Patient had pain:

- immediately after accident
- hours after accident
- days after accident
- other \_\_\_\_\_

14. Immediately after the accident, patient felt:

- |                                  |                                  |                                   |                                  |                                      |
|----------------------------------|----------------------------------|-----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> nervous | <input type="checkbox"/> stunned | <input type="checkbox"/> confused | <input type="checkbox"/> dizzy   | <input type="checkbox"/> nauseated   |
| <input type="checkbox"/> vomited | <input type="checkbox"/> panicky | <input type="checkbox"/> dazed    | <input type="checkbox"/> shocked | <input type="checkbox"/> lightheaded |
| <input type="checkbox"/> jittery | <input type="checkbox"/> scared  | <input type="checkbox"/> other    | _____                            |                                      |

15. After the accident, the patient went:

- home
- hospital emergency room
- work
- other \_\_\_\_\_

16. Was patient able to physically get up?:  yes  no

17. If no to #16, who helped patient get up:

- police
- paramedics
- bystander
- other \_\_\_\_\_

**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

18. Has patient had any other accidents or symptoms? Please indicate dates, type of accident, and name of attorney if different from the one representing you presently.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Did you fully recover from any prior accidents?                      ( ) yes                      ( ) no

20. Did patient have seat belton at the time of the accident?                      ( ) yes                      ( ) no

21. Did you have any medical symptoms from prior accidents?                      ( ) yes                      ( ) no  
If so, please list symptoms, and whether they are still present. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. Have you had any prior problem with neck or back?                      ( ) yes                      ( ) no  
If so, please list symptoms \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

23. What was the duration of your symptoms? \_\_\_\_\_

24. Have you had any prior treatments to neck, back, arms, or legs?                      ( ) yes                      ( ) no  
If so, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medical Complaints**

1. What was your chief complaint when you visited your doctor? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe your pain. (i.e. sharp, burning, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

3. Does the pain go down your ( ) arm ( ) leg  
On the ( ) left ( ) right  
Down the ( ) back ( ) front

4. Does anything make the pain worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What do you think caused the problem? \_\_\_\_\_

6. When you wake up in the morning, is your pain: ( ) better ( ) worse

7. Do you have numbness? \_\_\_\_\_ Where? \_\_\_\_\_

Do you have weakness? \_\_\_\_\_ Where? \_\_\_\_\_

8. Have you had any bowel or bladder changes? \_\_\_\_\_

9. Have you ever had spine surgery? \_\_\_\_\_

10. Do you have any other medical conditions? \_\_\_\_\_  
\_\_\_\_\_

11. Describe your general health. \_\_\_\_\_

12. Have you seen a chiropractor for your symptoms? ( ) yes ( ) no

If yes, please provide name of chiropractor and/or location of facility. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Were any of your symptoms present before your accident? Please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medical Complaints**

**Back Pain**

1. I have pain in my: ( ) low back ( ) mid back ( ) upper back

2. My pain began: ( ) gradually ( ) suddenly

3. I have pain: ( ) sometimes ( ) constantly

4. My pain goes into: ( ) right leg ( ) left leg ( ) both legs

5. I have tingling and/or numbness in: ( ) right leg ( ) left leg ( ) both legs

## New Patient Questionnaire/Personal Injury

Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

6. My pain is worse when I :

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| sit             | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| bend            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| walk            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| lift            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| push            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| pull            | <input type="checkbox"/> yes | <input type="checkbox"/> no |

7. My pain is worse with sexual activity:  yes  no

8. My pain wakes me up in the middle of the night:  yes  no

9. Changes in the weather affect my pain  yes  no

### Neck Pain

1. My pain began:  gradually  suddenly

2. I have pain:  sometimes  constantly

3. My pain goes into:  right arm  left arm  both arms

4. I have tingling and/or numbness in my:  right arm  left arm  both arms

5. My pain is worse when I :

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| bend forward    | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| lift            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| push            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| pull            | <input type="checkbox"/> yes | <input type="checkbox"/> no |

6. My neck pain wakes me up in the middle of the night:  yes  no

7. Changes in the weather affect my pain:  yes  no

8. I have neck headaches:  yes  no

9. If I do get headaches, they occur:  sometimes  constantly

### Knee Pain

1. How long have you had pain in the knee(s)?: \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

2. How long have you had your present pain?: \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

3. My knee pain began:  gradually  suddenly

4. I have pain:  sometimes  constantly

5. My knee pain is worse when I:

- |              |                              |                             |
|--------------|------------------------------|-----------------------------|
| squat        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| kneel        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| climb stairs | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| run          | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| sit          | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| walk         | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| jump         | <input type="checkbox"/> yes | <input type="checkbox"/> no |

## New Patient Questionnaire/Personal Injury

Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

### 6. My knee(s):

- |                |         |        |
|----------------|---------|--------|
| swells         | ( ) yes | ( ) no |
| catches        | ( ) yes | ( ) no |
| locks          | ( ) yes | ( ) no |
| gives away     | ( ) yes | ( ) no |
| feels unstable | ( ) yes | ( ) no |
| pops           | ( ) yes | ( ) no |
| clicks         | ( ) yes | ( ) no |
| grates         | ( ) yes | ( ) no |

### Urological History

1. Any history of urological problems: ( ) yes ( ) no

2. Any difficulty with urination: ( ) yes ( ) no

	<u>Daytime</u>	<u>Nighttime</u>
3. Frequency:	_____	_____
4. Burning sensations:	_____	_____

5. Incontinence: ( ) yes ( ) no

6. Do you have a sense of urgency?: ( ) yes ( ) no

7. Do you have incontinency under stress?: ( ) yes ( ) no

8. Do you have incontinency with cough or sneeze?: ( ) yes ( ) no

9. Is the incontinency continuous?: ( ) yes ( ) no

10. Is the incontinency occasional?: ( ) yes ( ) no

11. Is there a feeling of not emptying the bladder?: ( ) yes ( ) no

12. My force of urination is: ( ) strong ( ) weak

13. Any difficulty with sexual function? Please describe \_\_\_\_\_

14. How long have you had this problem?: \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

**New Patient Questionnaire/Personal Injury**

**Name** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date** \_\_\_\_\_

15. Has the problem worsened?:     yes         no

16. Problem began:     gradually     suddenly

\_\_\_\_\_

patient signature

\_\_\_\_\_

date

**David A. Ditsworth, M.D.**  
**Neurological Surgery**  
**1125 South Beverly Drive, Suite 603**  
**Los Angeles, CA 90035**  
**(310) 551-0690**

TO: Attorney \_\_\_\_\_  
\_\_\_\_\_  
-----  
\_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

**RE: Medical Reports and Doctor's Lien**

For \_\_\_\_\_ Date Injured \_\_\_\_\_

I do hereby authorize the above Doctor to furnish you, my attorney, with a full report of his examination, diagnosis, prognosis, etc., of myself concerning the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said Doctor such sums as may be due and owed to him for medical service rendered me both by reason of the accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor. I hereby further give a lien on my case to said Doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Doctor for all medical bills submitted by him for service rendered and that this agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. Patient and Attorney both agree to provide the Doctor with copies of the settlement check and disbursement information prior to any discussion of reduction or changes in physician fee. We agree to pay the full amount charged regardless of what is paid by Medicare or private insurance. No disbursements of liens/settlement proceeds shall be made to any party until said Doctor's bills have been paid. This lien is irrevocable.

If any dispute arises between the parties under this lien agreement, said dispute shall be subject to binding arbitration under the rules of the American Arbitration Association; said binding arbitration to be venued in Los Angeles County, California. The prevailing party shall be entitled to attorneys' fees and costs.

Dated \_\_\_\_\_ Patient's Signature \_\_\_\_\_

The undersigned, being attorney of record for the above patient, does hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor named above.

Dated \_\_\_\_\_ Attorney's Signature \_\_\_\_\_

Mr. Attorney: Please sign, date, and return one copy to Doctor's office at once. Keep one copy for your records.

**DOCTOR'S LIEN**

**David A. Ditsworth, M.D.**  
**Neurological Surgery**  
**1125 South Beverly Drive, Suite #603**  
**Los Angeles, CA 90035**  
**(310) 551-0690**

TO: Attorney \_\_\_\_\_

-----  
\_\_\_\_\_  
Phone:(    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

**RE: Medical Reports and Doctor's Lien**

For \_\_\_\_\_ Date Injured \_\_\_\_\_

I do hereby authorize the above Doctor to furnish you, my attorney, with a full report of his examination, diagnosis, prognosis, etc., of myself in regards to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said Doctor such sums as may be due and owed to him for medical service rendered me both by reason of the accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor. I hereby further give a lien on my case to said Doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Doctor for all medical bills submitted by him for service rendered and that this agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. Patient and Attorney both agree to provide the Doctor with copies of the settlement check and disbursement information prior to any discussion of reduction or changes in physician fee. We agree to pay the full amount charged regardless of what is paid by Medicare or private insurance. No disbursements of liens/settlement proceeds shall be made to any party until said Doctor's bills have been paid. This lien is irrevocable.

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Dated \_\_\_\_\_ Patient's Signature \_\_\_\_\_

The undersigned, being attorney of record for the above patient, does hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor named above.

Dated \_\_\_\_\_ Attorney's Signature \_\_\_\_\_

Mr. Attorney: Please sign, date, and return one copy to Doctor's office at once. Keep one copy for your records.

**DOCTOR'S LIEN**

## Permission for Billing

I, \_\_\_\_\_ give permission for Dr. David A. Ditsworth, to use his billing service to bill for the services of a surgical assistant using the billing designation of his choice. Payments are to be made to the billing entity utilized by Dr. Ditsworth.

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**Signature**

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**Date**

**David A. Ditsworth, M.D.**  
**Neurological Surgery**  
**1125 S. Beverly Drive, Suite 603**  
**Los Angeles, CA 90035**  
\* \* \* \*  
**(310) 551-0690**

**OTHER PHYSICIANS YOU ARE SEEING**

Today's date \_\_\_\_\_

1. Physician's name \_\_\_\_\_

Specialty

Address \_\_\_\_\_

number

street

ste.#

city

state

zip code

Phone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_ E-mail address \_\_\_\_\_

-----  
2. Physician's name \_\_\_\_\_

Specialty

Address \_\_\_\_\_

number

street

ste.#

city

state

zip code

Phone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_ E-mail address \_\_\_\_\_

-----  
3. Physician's name \_\_\_\_\_

Specialty

Address \_\_\_\_\_

number

street

ste.#

city

state

zip code

Phone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_ E-mail address \_\_\_\_\_

**New Patient Questionnaire/Personal Injury**

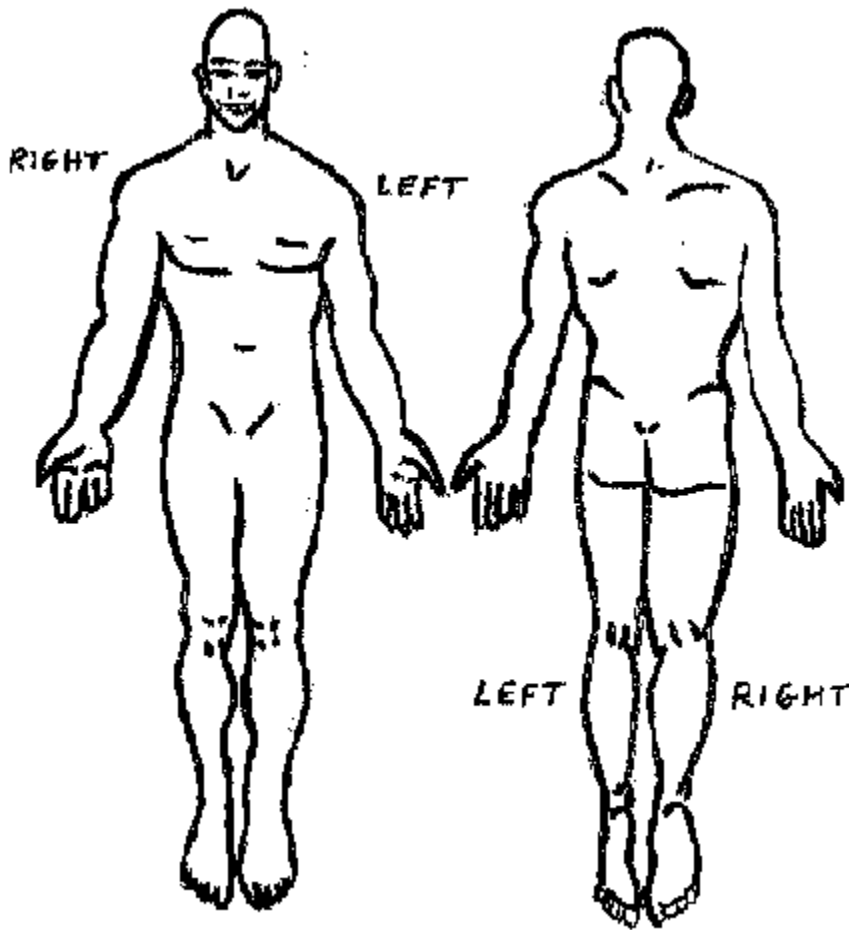
Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

**Medical Complaints**

Please indicate the areas in which you are experiencing **pain** on the models below.

[ ] none



**PAIN**

**New Patient Questionnaire/Personal Injury**

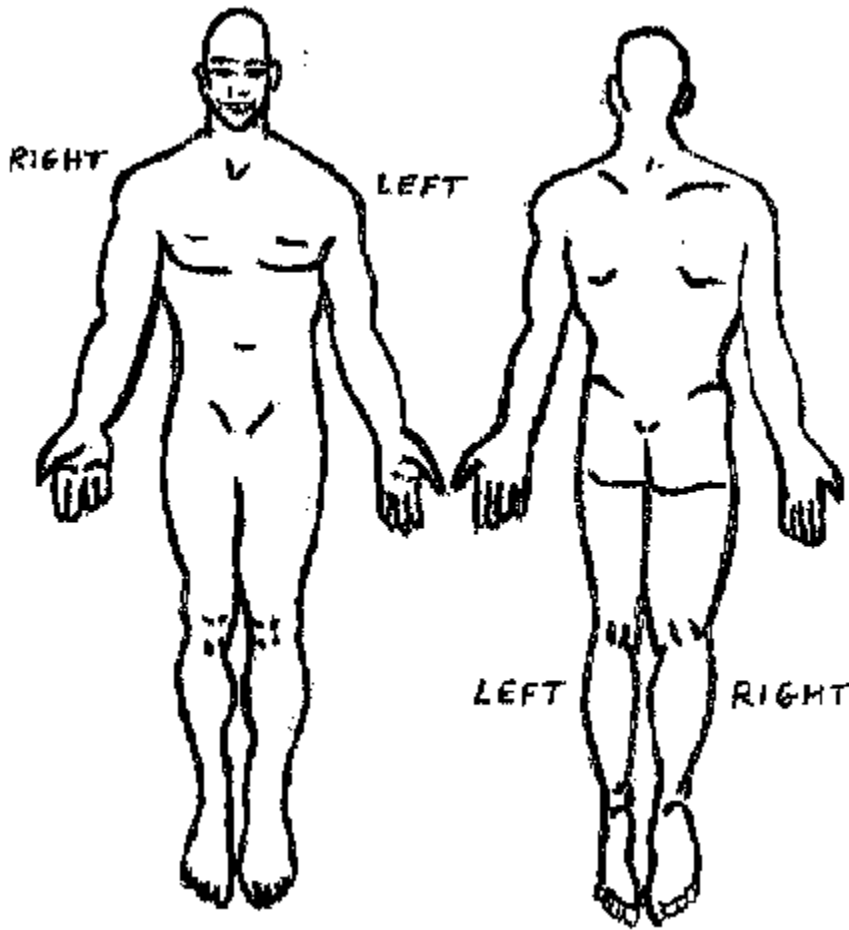
Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

**Medical Complaints**

Please indicate the areas in which you are experiencing weakness on the models below.

[ ] none



**WEAKNESS**

**New Patient Questionnaire/Personal Injury**

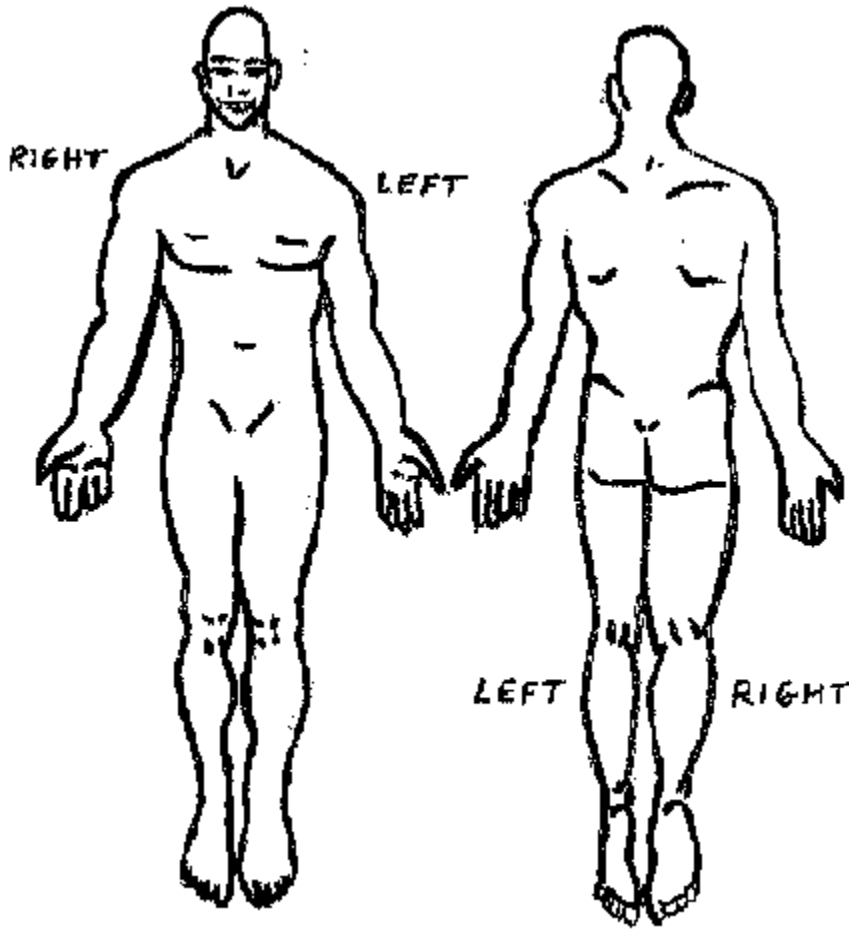
Name \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

**Medical Complaints**

Please indicate the areas in which you are experiencing **numbness** on the models below.

[ ] none



**NUMBNESS**

**David A. Ditsworth, M.D.**  
Neurological Surgery  
1125 S. Beverly Drive, Suite 603  
Los Angeles, CA 90035  
\* \* \* \*  
(310) 551-0690

**AUTHORIZATION FOR RELEASE OF RECORDS**

I, \_\_\_\_\_,  
Patient's name

**Authorize the release of my medical records to:**

**DAVID A. DITSWORTH, M.D.**  
**NEUROLOGICAL SURGERY**  
**1125 S. BEVERLY DRIVE #603**  
**LOS ANGELES, CA 90035-1182**

**Records requested from:**

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**Date(s) of treatment:**

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\_\_\_\_\_  
**signature of patient**

\_\_\_\_\_  
**date signed**

\_\_\_\_\_  
**print name**

\_\_\_\_\_  
**date of birth**