

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

**Patient Information/ Workers Comp.**

**Please print clearly and give this to the receptionist. Thank you!!!**

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

Date of injury \_\_\_\_\_

Mr./ Mrs./ Ms. \_\_\_\_\_

first middle last

Home address \_\_\_\_\_

number street apt. #

city state zip code

Date of birth \_\_\_/ \_\_\_/ \_\_\_ Sex F \_\_\_ M \_\_\_ Marital status \_\_\_\_\_

Home phone( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Drug allergies : \_\_\_\_\_

Type of case: W/Comp. \_\_\_\_\_ Personal Injury \_\_\_\_\_ Private Ins. \_\_\_\_\_ Medicare \_\_\_\_\_

Employer: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_

number street suite

city state zip code

Attorney: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_

number street suite

city state zip code

**New Patient/ Workers Comp. Questionnaire**

**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/ Workers Comp. Questionnaire**

**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/ Workers Comp. Questionnaire**

**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:

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\* \* \* \*

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/ Workers Comp. Questionnaire**

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

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

**Medical Complaints**

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

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

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

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

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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? \_\_\_\_\_

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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. \_\_\_\_\_

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## New Patient/ Workers Comp. Questionnaire

Name \_\_\_\_\_

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

### 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
6. My pain is worse when I :
  - cough or sneeze ( ) yes ( ) no
  - sit ( ) yes ( ) no
  - bend ( ) yes ( ) no
  - walk ( ) yes ( ) no
  - lift ( ) yes ( ) no
  - push ( ) yes ( ) no
  - pull ( ) yes ( ) 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 ( ) yes ( ) no
  - bend forward ( ) yes ( ) no
  - lift ( ) yes ( ) no
  - push ( ) yes ( ) no
  - pull ( ) yes ( ) 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

## New Patient/ Workers Comp. Questionnaire

Name \_\_\_\_\_

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

### 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           ( ) yes           ( ) no  
    kneel           ( ) yes           ( ) no  
    climb stairs   ( ) yes           ( ) no  
    run             ( ) yes           ( ) no  
    sit             ( ) yes           ( ) no  
    walk           ( ) yes           ( ) no  
    jump           ( ) yes           ( ) no
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
3. Frequency:                                Daytime                                Nighttime  
  \_\_\_\_\_                                \_\_\_\_\_
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

**New Patient/ Workers Comp. Questionnaire**

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

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

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

15. Has the problem worsened?: ( ) yes ( ) no

16. Problem began: ( ) gradually ( ) suddenly

\_\_\_\_\_  
patient signature

\_\_\_\_\_  
date

**New Patient/ Workers Comp. Questionnaire**

Name \_\_\_\_\_

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

**Health and Evaluation Questionnaire**

**Workers' Compensation**

Name of patient: \_\_\_\_\_ Date of accident: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

WCAB case # \_\_\_\_\_

**Job Description**

Describe your complete work duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you lost any time from work since the day of the accident? \_\_\_\_\_

If yes, what was your last day of work? \_\_\_\_\_

Have you returned to work? \_\_\_\_\_

If yes, when did you return to work? \_\_\_\_\_

Are you doing all of your regular duties? \_\_\_\_\_

If no, explain what you can and cannot do \_\_\_\_\_  
\_\_\_\_\_

How long have you worked for your employer? \_\_\_\_\_

Are you part-time or full-time? \_\_\_\_\_

Have you notified your employer about your injury? \_\_\_\_\_

Did your employer send you for treatment of your injury? \_\_\_\_\_

If yes, where were you sent? \_\_\_\_\_

Were you hospitalized? \_\_\_\_\_ How long? \_\_\_\_\_

## New Patient/ Workers Comp. Questionnaire

Name \_\_\_\_\_

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

Check the appropriate box for each of the following items to describe the extent of the activity performed

	Number of hours				
	<u>0</u>	<u>1-2</u>	<u>3-4</u>	<u>5-6</u>	<u>7+</u>
1. Sitting	[ ]	[ ]	[ ]	[ ]	[ ]
2. Standing	[ ]	[ ]	[ ]	[ ]	[ ]
3. Walking	[ ]	[ ]	[ ]	[ ]	[ ]
4. Bending over	[ ]	[ ]	[ ]	[ ]	[ ]
5. Crawling	[ ]	[ ]	[ ]	[ ]	[ ]
6. Climbing	[ ]	[ ]	[ ]	[ ]	[ ]
7. Reaching overhead	[ ]	[ ]	[ ]	[ ]	[ ]
8. Crouching	[ ]	[ ]	[ ]	[ ]	[ ]
9. Kneeling	[ ]	[ ]	[ ]	[ ]	[ ]
10. Balancing	[ ]	[ ]	[ ]	[ ]	[ ]
11. Pushing or pulling	[ ]	[ ]	[ ]	[ ]	[ ]
12. Lifting or carrying	[ ]	[ ]	[ ]	[ ]	[ ]
A. 10 lbs. or less	[ ]	[ ]	[ ]	[ ]	[ ]
B. 11 to 25 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
C. 26 to 50 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
D. 51 to 75 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
E. 76 to 100 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
F. Over 100 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
13. Repetitive use of foot control					
A. Right only	[ ]	[ ]	[ ]	[ ]	[ ]
B. Left only	[ ]	[ ]	[ ]	[ ]	[ ]
C. Both	[ ]	[ ]	[ ]	[ ]	[ ]
14. Repetitive use of hands					
A. Right only	[ ]	[ ]	[ ]	[ ]	[ ]
B. Left only	[ ]	[ ]	[ ]	[ ]	[ ]
C. Both	[ ]	[ ]	[ ]	[ ]	[ ]
15. Grasping					
A. Simple/light					
(1) Right only	[ ]	[ ]	[ ]	[ ]	[ ]
(2) Left only	[ ]	[ ]	[ ]	[ ]	[ ]
(3) Both	[ ]	[ ]	[ ]	[ ]	[ ]
B. Firm/strong					
(1) Right only	[ ]	[ ]	[ ]	[ ]	[ ]
(2) Left only	[ ]	[ ]	[ ]	[ ]	[ ]
(3) Both	[ ]	[ ]	[ ]	[ ]	[ ]

**New Patient/ Workers Comp. Questionnaire**

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

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

- |  | Number of hours |            |            |            |           |
|--|-----------------|------------|------------|------------|-----------|
|  | <u>0</u>        | <u>1-2</u> | <u>3-4</u> | <u>5-6</u> | <u>7+</u> |
| 16. Fine dexterity   |                 |            |            |            |           |
| A. Right only  | [ ]             | [ ]        | [ ]        | [ ]        | [ ]       |
| B. Left only   | [ ]             | [ ]        | [ ]        | [ ]        | [ ]       |
| C. Both  | [ ]             | [ ]        | [ ]        | [ ]        | [ ]       |
| 17. Driving cars, trucks, forklifts, or other equipment?   |                 |            |            | yes [ ]    | no [ ]    |
| description: _____   |                 |            |            |            |           |
| 18. Otherwise being around equipment and machinery?        |                 |            |            | yes [ ]    | no [ ]    |
| description: _____   |                 |            |            |            |           |
| 19. Walking on uneven ground?                              |                 |            |            | yes [ ]    | no [ ]    |
| description: _____   |                 |            |            |            |           |
| 20. Exposure to dust, gas or fumes?                        |                 |            |            | yes [ ]    | no [ ]    |
| description: _____   |                 |            |            |            |           |
| 21. Exposure to marked changes in temperature or humidity? |                 |            |            | yes [ ]    | no [ ]    |
| description: _____   |                 |            |            |            |           |

22. Comments: (use reverse side if necessary) \_\_\_\_\_

If yes to 17-21 above, indicate number of hours duty performed daily, and date duty begun

\_\_\_\_\_

**History of Injury**

Give a detailed description of how your injury occurred. \_\_\_\_\_

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

Did you black out, faint, or experience a loss of consciousness? \_\_\_\_\_

Did you have a headache? \_\_\_\_\_

Did you have any pain at the time of injury? \_\_\_\_\_

If yes, please circle:

Pain in:	Neck	Upper back	Lower back	Buttock
Upper extremity:	[ ] Right	[ ] Left		
Lower extremity:	[ ] Right	[ ] Left		

Other: \_\_\_\_\_

**New Patient/ Workers Comp. Questionnaire**

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

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

**Current treatment**

Have you seen any other physician or medical facility for treatment or evaluation of your injury?

\_\_\_\_\_ If so, where? \_\_\_\_\_

If so, how long were you treated? \_\_\_\_\_ Were any tests or x-rays done? \_\_\_\_\_

If yes, by whom? \_\_\_\_\_

What tests or x-rays were done? \_\_\_\_\_

Please list all doctors, hospitalizations, diagnostic testing, physical therapy, consultations, etc. concerning this injury? \_\_\_\_\_

\_\_\_\_\_

**Present Complaints**

What types of activities aggravate the pain of your injury? \_\_\_\_\_

\_\_\_\_\_ What can't you do that you were able to do before your injury? \_\_\_\_\_

Which of the following movements increase pain?

Stooping \_\_\_\_\_ Pushing \_\_\_\_\_ Sitting \_\_\_\_\_ Bending \_\_\_\_\_

Standing \_\_\_\_\_ Pulling \_\_\_\_\_ Walking \_\_\_\_\_ Climbing \_\_\_\_\_

Riding in car \_\_\_\_\_ Stairs \_\_\_\_\_

Other \_\_\_\_\_

Does anything that give you relief from the pain? \_\_\_\_\_

Does the weather affect your pain? \_\_\_\_\_

Do you feel that your condition is worsening \_\_\_\_\_, improving, \_\_\_\_\_, the same \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Which ones? \_\_\_\_\_

Have you ever taken medication for your injury? \_\_\_\_\_ Which ones? \_\_\_\_\_

**Neck Pain**

Pain began: gradually [ ] suddenly [ ] Pain is: constant [ ] intermittent [ ]

Pain radiates to: right arm [ ] left arm [ ] both [ ]

Tingling or numbness in: right arm [ ] left arm [ ] both [ ]

Pain is worse with: coughing bending forward lifting pushing pulling turning head

Does the pain disturb your sleep? \_\_\_\_\_ Is your neck stiff? \_\_\_\_\_

Do you have associated headaches? \_\_\_\_\_ Are they constant? \_\_\_\_\_ Intermittent? \_\_\_\_\_

## New Patient/ Workers Comp. Questionnaire

Name \_\_\_\_\_

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

### Back Pain

Pain is located in the: low back\_\_\_\_, mid back \_\_\_\_\_, upper back \_\_\_\_\_.

Pain began: gradually\_\_\_\_, suddenly \_\_\_\_\_. Pain is: constant \_\_\_\_\_, intermittent \_\_\_\_\_.

Pain radiates to: right leg [ ] left leg [ ] both [ ]

Tingling or numbness in: right leg [ ] left leg [ ] both [ ]

Pain is worse with: coughing bending forward lifting pushing pulling turning head

Knee Pain right \_\_\_\_ left \_\_\_\_ both \_\_\_\_

Pain began: gradually\_\_\_\_, suddenly \_\_\_\_\_. Pain is: constant \_\_\_\_\_, intermittent \_\_\_\_\_.

Pain is worse with: squatting kneeling climbingstairs running sitting walking  
jumping descending stairs

The knee: swells catches locks gives way pops locks grates feels unstable

Other complaints: (Please list all current medical complaints, i.e., nervousness, dizziness, nausea, etc., as well as psychological problems including sleeping problems or depression)

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### Past Medical History

Have you ever filed any other workers' compensation cases? \_\_\_\_\_ If so, where and what part of the body did you injure? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ If so, for what reason? \_\_\_\_\_

Prior to your injury, have you ever had:

allergies	[ ]	chickenpox	[ ]	heart attack	[ ]	liver disease	[ ]
anemia	[ ]	diabetes	[ ]	migraine	[ ]	measles	[ ]
arthritis	[ ]	emphysema	[ ]	hepatitis	[ ]	mumps	[ ]
asthma	[ ]	epilepsy	[ ]	jaundice	[ ]	phlebitis	[ ]
cancer	[ ]	glaucoma	[ ]	kidney disease	[ ]	stomach ulcer	[ ]
colitis	[ ]	goiter	[ ]	leukemia	[ ]	high blood pressure	[ ]
gout	[ ]	hay fever	[ ]	stroke	[ ]		

Are you allergic to any medication or food? \_\_\_\_\_ If so, which? \_\_\_\_\_

Please list all prior accidents, illnesses, surgeries, hospitalizations (other than this accident), allergies, or food intolerances \_\_\_\_\_

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**New Patient/ Workers Comp. Questionnaire**

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

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

**Family History**

Is your mother alive? \_\_\_\_\_ Is your father alive? \_\_\_\_\_  
How many brothers and sisters do you have? \_\_\_\_\_ Are they living? \_\_\_\_\_  
Do any of them have health problems? \_\_\_\_\_ If so, what? \_\_\_\_\_  
\_\_\_\_\_

**Social History**

What is your marital status? \_\_\_\_\_  
How much coffee do you drink per day? \_\_\_\_\_  
How much alcohol do you drink per day? \_\_\_\_\_  
How many cigarettes do you smoke per day? \_\_\_\_\_  
What grade did you complete in school? \_\_\_\_\_ Any other training? \_\_\_\_\_  
Do you have mental or psychological problems? \_\_\_\_\_  
Are you depressed? \_\_\_\_\_ anxious? \_\_\_\_\_ angry? \_\_\_\_\_  
Do you have trouble sleeping? \_\_\_\_\_  
Do you have recurring recollections of the accident? \_\_\_\_\_  
Who do you blame for the injury? \_\_\_\_\_  
Are you angry with anyone for your injury? \_\_\_\_\_  
Are you being treated fairly? \_\_\_\_\_

## 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 \_\_\_\_\_

3 number street ste.#

city state zip code

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

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

Specialty \_\_\_\_\_

Address \_\_\_\_\_

number street ste.#

city state zip code

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

## New Patient Questionnaire

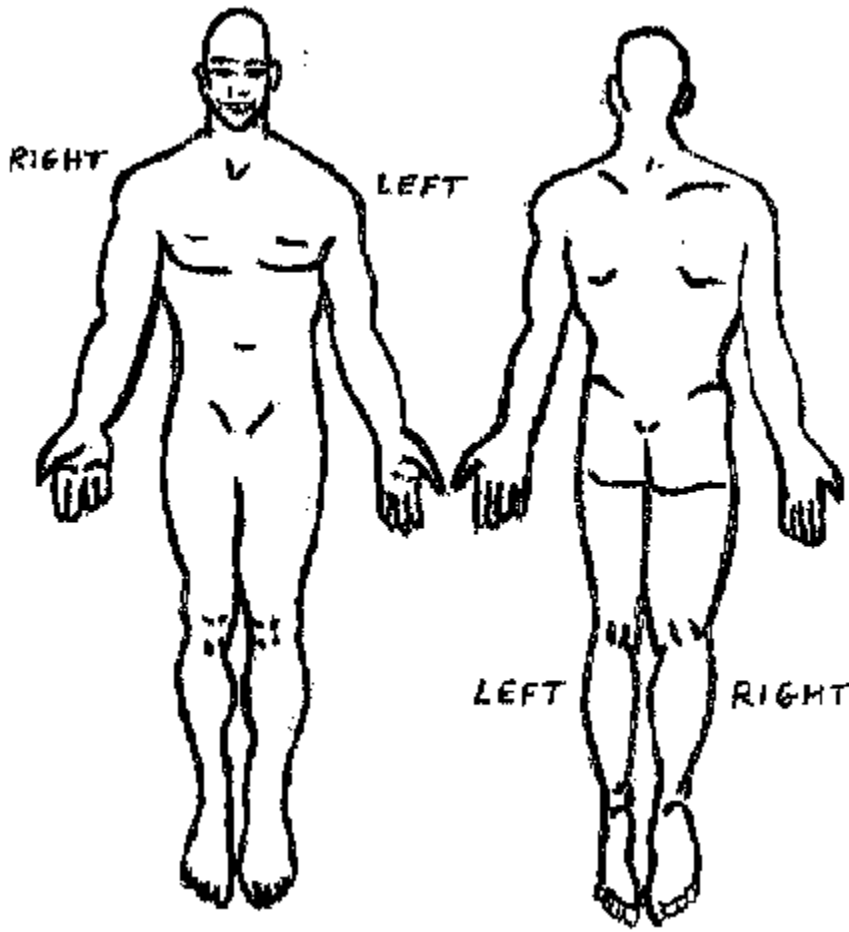
Name \_\_\_\_\_

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

### Medical Complaints

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

[ ] none



PAIN

New Patient Questionnaire

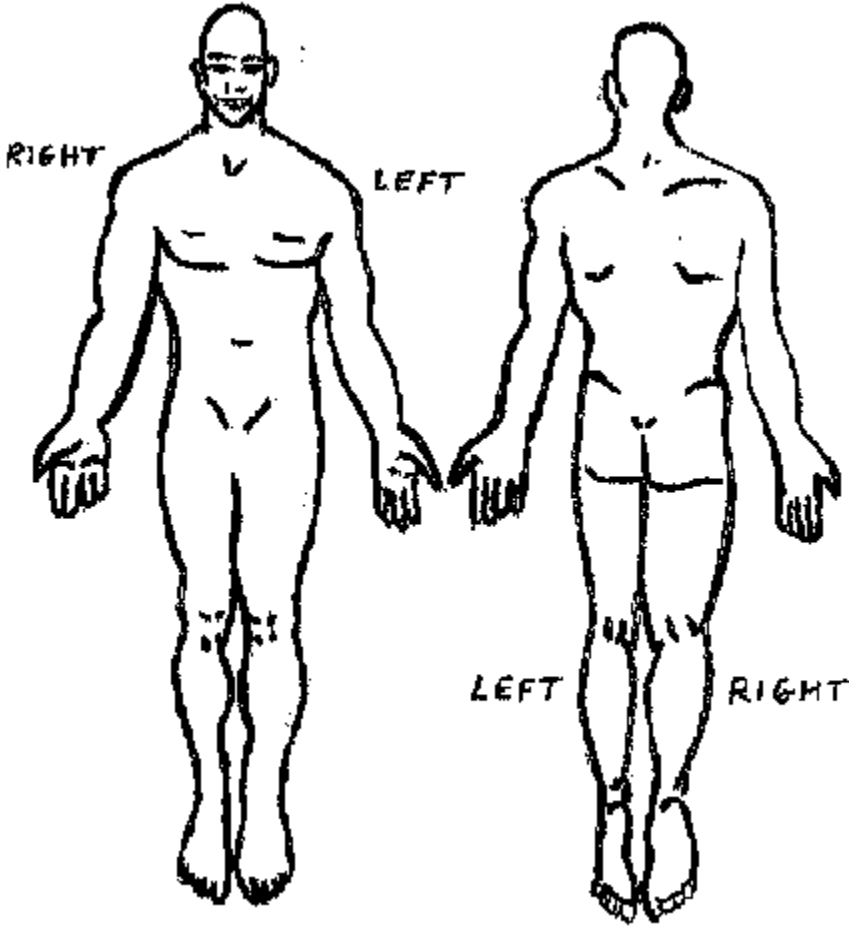
Name \_\_\_\_\_

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

Medical Complaints

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

[ ] none



WEAKNESS

## New Patient Questionnaire

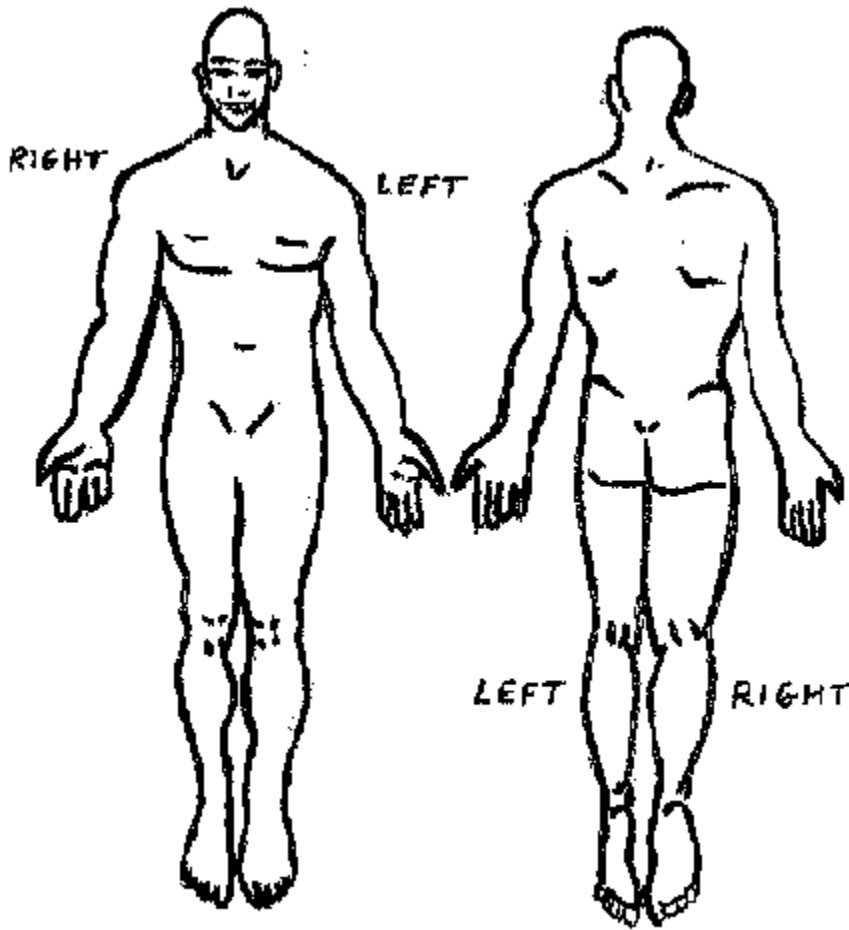
Name \_\_\_\_\_

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.**  
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**1125 S. Beverly Drive, Suite 603**  
**Los Angeles, CA 90035**  
\* \* \* \*  
**(310) 551-0690**

**AUTHORIZATION FOR RELEASE OF RECORDS**

**I,** \_\_\_\_\_,  
Patient; s nam

**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**

