ROB BONTA
Attorney General of California
KAREN R. DENVIR
Supervising Deputy Attorney General
KATELYN E. DOCHERTY
Deputy Attorney General
State Bar No. 322028
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6277
Facsimile: (916) 327-8643
E-mail: Katelyn.Docherty@doj.ca.gov
Attorneys for Complainant

BEFORE THE
BOARD OF CHIROPRACTIC EXAMINERS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:** **DALE LEROY JACOBSON** **1153 Cement Hill Rd.** **Nevada City, CA 95959** **Chiropractic License No. DC 12716** Respondent.	Case No. AC-2025-2053 **ACCUSATION**

PARTIES

1. Kristin Walker (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Chiropractic Examiners, Department of Consumer Affairs.

2. On or about January 1, 1979, Board of Chiropractic Examiners issued Chiropractic License Number DC 12716 to Dale Leroy Jacobson (Respondent). The Chiropractic License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2025, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board of Chiropractic Examiners ("Board"), Department of Consumer Affairs, under the authority of the following sections of the Chiropractic Act (Act).[1]

4. Section 10 of the Act states, in pertinent part, that the Board may suspend or revoke a license to practice chiropractic or may place the license on probation for violations of the rules and regulations adopted by the Board or for any cause specified in the Chiropractic Initiative Act.

5. California Code of Regulations, title 16, section 372 states:

> The suspension, expiration, or forfeiture by operation of law of a license issued by the board, or its suspension, or forfeiture by order of the board or by order of a court of law, or its surrender without the written consent of the board shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

STATUTORY PROVISIONS

6. Section 10 of the Act states, in relevant part:

> . . . .
>
> (b) The board may refuse to grant, or may suspend or revoke, a license to practice chiropractic in this state, or may place the licensee upon probation or issue a reprimand to him, for violation of the rules and regulations adopted by the board in accordance with this act, or for any cause specified in this act.
>
> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 316, subdivision (c), states in relevant part:

> …
>
> (c) The commission of any act of sexual abuse, sexual misconduct, or sexual relations by a licensee with a patient, client, customer or employee is unprofessional

[1] The Chiropractic Act, an initiative measure approved by the electors on November 7, 1922, while not included in the Business and Professions Code by the legislature, is set out in West's Annotated California Codes as sections 1000-1 to 1000-19, and is included in Deering's California Codes as Appendix I, for convenient reference.

conduct and cause for disciplinary action. This conduct is substantially related to the qualifications, functions, or duties of a chiropractic license.

This section shall not apply to sexual contact between a licensed chiropractor and his or her spouse or person in an equivalent domestic relationship when that chiropractor provides professional treatment.

8. California Code of Regulations, title 16, section 316.5, states:

(a) For the purposes of the denial, suspension or revocation of a license pursuant to Section 141 of the Business and Professions Code, Division 1.5 (commencing with Section 475) of the Business and Professions Code, or a violation of Section 10(b) of the Chiropractic Initiative Act of California, a crime, professional misconduct, or act shall be considered substantially related to the qualifications, functions or duties of a licensee, if, to a substantial degree, it evidences present or potential unfitness of a person holding a license to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare.

(b) In making the substantial relationship determination required under subdivision (a) for a crime, the Board shall consider all of the following criteria:

(1) The nature and gravity of the offense.

(2) The number of years elapsed since the date of the offense.

(3) The nature and duties of a chiropractor.

(c) For purposes of subdivision (a), a substantially related crime, professional misconduct, or act shall include, but is not limited to, the following:

(1) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of the Chiropractic Initiative Act of California, these regulations and/or other state or federal laws governing the practice of chiropractic.

. . .

9. California Code of Regulations, title 16, section 317, states in relevant part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct which has been brought to its attention, or whose license has been procured by fraud or misrepresentation or issued by mistake.

Unprofessional conduct includes, but is not limited to, the following:

(a) Gross negligence;

. . .

(e) Any conduct which has endangered or is likely to endanger the health, welfare, or safety of the public;

. . .

(k) The commission of any act involving moral turpitude, dishonesty, or corruption, whether the act is committed in the course of the individual's activities as a license holder, or otherwise;

(m) Violating or attempting to violate, directly or indirectly, or assisting in or abetting in the violation of, or conspiring to violate any provision or term of the Act or the regulations adopted by the board thereunder;

. . .

10. California Code of Regulations, title 16, section 318, states in relevant part:

(a) Chiropractic Patient Records. Each licensed chiropractor is required to maintain all active and inactive chiropractic patient records for five years from the date of the doctor's last treatment of the patient unless state or federal laws require a longer period of retention. Active chiropractic records are all chiropractic records of patients treated within the last 12 months. Chiropractic patient records shall be classified as inactive when there has elapsed a period of more than 12 months since the date of the last patient treatment.

All chiropractic patient records shall be available to any representative of the Board upon presentation of patient's written consent or a valid legal order. Active chiropractic patient records shall be immediately available to any representative of the Board at the chiropractic office where the patient has been or is being treated. Inactive chiropractic patient records shall be available upon ten days notice to any representative of the Board. The location of said inactive records shall be reported immediately upon request.

Active and inactive chiropractic patient records must include all of the following:

(1) Patient's full name, date of birth, and social security number (if available);

(2) Patient gender, height and weight. An estimated height and weight is acceptable where the physical condition of the patient prevents actual measurement;

(3) Patient history, complaint, diagnosis/analysis, and treatment must be signed by the primary treating doctor. Thereafter, any treatment rendered by any other doctor must be signed or initialed by said doctor;

(4) Signature of patient;

(5) Date of each and every patient visit;

(6) All chiropractic X-rays, or evidence of the transfer of said X-rays;

(7) Signed written informed consent as specified in Section 319.1.

…

11. California Code of Regulations, title 16, section 319.1, states:

(a) A licensed doctor of chiropractic shall verbally and in writing inform each

patient of the material risks of proposed care. "Material" shall be defined as a procedure inherently involving known risk of serious bodily harm. The chiropractor shall obtain the patient's written informed consent prior to initiating clinical care. The signed written consent shall become part of the patient's record.

(b) A violation of this section constitutes unprofessional conduct and may subject the licensee to disciplinary action.

COST RECOVERY

12. California Code of Regulations, title 16, section 317.5, subdivision (a), states, in pertinent part:

In any order in resolution of a disciplinary proceeding before the Board of Chiropractic Examiners, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the Chiropractic Initiative Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DEFINITIONS

13. Internal tailbone adjustment is a recognized procedure for the treatment of tailbone pain and dysfunction. This procedure requires the insertion of the chiropractor's finger into the anus and rectum of the patient.

FACTUAL ALLEGATIONS

14. At all times relevant, Respondent's conducted a chiropractic practice under the name "Jacobson Chiropractic[2]," and "Hunt Vitality Chiropractic & Wellness Center[3]," both of which are located in Nevada City, California.

Patient 1:

15. On or around February 27, 2018, Patient 1, presented for care at Jacobson Chiropractic with a chief complaint of acute pain in the tailbone area. During Patient 1's initial visit she declined an x-ray examination due to financial hardship.

16. On or around February 27, 2018, and March 5, 2018, Respondent rendered internal tailbone adjustments to Patient 1.

///

[2] Jacobson Chiropractic closed on or around the end of 2022. Jacobson Chiropractic was owned by Respondent.

[3] Hunt Vitality Chiropractic & Wellness is owned by chiropractor Dr. H.H.. Dr. H.H. is Respondent's daughter.

17. On or around February 27, 2018, Respondent provided Patient 1 with an informed consent document that consisted of generalized statements regarding chiropractic adjustments and physical therapy. The informed consent document did not include any specific language regarding a tailbone diagnosis or any discussion of proposed treatment that gives any indication of the internal nature of the procedure or the material risks associated with an internal tailbone adjustment or mention alternative treatments.

18. On or around March 15, 2018, an x-ray was taken of Patient 1, due to Patient 1 receiving no relief from the prior adjustments. On March 15, 2018, internal tailbone adjustments were suspended on Patient 1.

19. On or around July 24, 2024, a Board investigator met with Respondent regarding his treatment of Patient 1 and his internal tailbone technique. Respondent described his internal tailbone technique involving the patients stomach on an adjusting table that has an adjusting pelvic piece that can be raised or lowered. Respondent further stated that the procedure involves him positioning the pelvic piece high, with the patients' butt in the air and him pulling the patients' pants to their bottom buttock, so the patient has a bare butt. Respondent explained the only time someone else would be present in the room when he performs an internal tailbone adjustment is if it's "a volatile person or a child."[4]

Patient 2:

20. On or around March 4, 2021, Patient 2 sought treatment for a sprained ankle and injuries to her left leg. Due to continuing pain, Patient 2 requested an x-ray. Patient 2 presented at Jacobson Chiropractic at which time x-rays were taken by Respondent. Patient 2 reports that the x-ray procedure was a difficult balancing act where one leg was propped on a chair, and her legs were spread apart while leaning on crutches. In order for Patient 2 to achieve this position Respondent had to crouch down and manipulate Patient 2's body to properly position her leg. Patient 2 reports that while Respondent was positioning her leg Respondent grazed her vagina

[4] It is common practice for providers who perform internal tailbone adjustments to have an assistant or chaperone present during the procedure.

with his hand. Patient 2 reported that after the exam Respondent walked her to the car and she left.

21. Patient 2's medical record for the March 4, 2021, x-ray procedure, does not contain Respondent's signature or initials.

22. Later, on March 4, 2021, Patient 2 sought follow-up treatment from Dr. H.H., Respondent's daughter and another chiropractor at Jacobson Chiropractic.

23. On or around March 10, 2021, Patient 2 sent an email to Jacobson Chiropractic and Dr. H.H. regarding her experience being treated by Respondent.

Patient 3:

24. On or around October 21, 2021, Patient 3 asked Respondent if he would take an x-ray of an old injury. During Patient 3 and Respondent's discussion regarding the x-ray, Respondent made a statement along the lines of "Yes, and if you're brave you can take off your top."

25. Patient 3 reported that on or around October 21, 2021, during the entire x-ray procedure she was never offered a gown and x-rays were taken of her while she was wearing only a regular bra and pants.

26. On or around October 21, 2021, Respondent was notified by M.G., a prior office manager for Jacobson Chiropractic, that Patient 3 was very unhappy after seeing Respondent and would not be returning to the office. Patient 3 informed M.G. that Respondent had been inappropriate with her in the x-ray room and had asked her to remove her shirt without offering her a gown and had made an inappropriate comment.

27. After the incident with Patient 3, the Jacobson Chiropractic practice established a new protocol regarding x-rays and that patients should always be provided with a gown.

28. On or around July 24, 2024, a Board investigator met with Respondent regarding his treatment of Patient 3. Respondent informed the investigator that he remained in the treatment room with Patient 3 while she removed her shirt. Respondent further stated after Patient 3 removed her shirt he positioned her and took the x-rays.

///

///

Interaction with Patients, Employees and Colleagues:

29. Respondent made inappropriate comments during his interactions with numerous individuals during work which include, but were not limited to:

a.) On or around March of 2021, Respondent was talking with M.G. about a mutual acquaintance and said to M.G. "I always thought she was the most beautiful woman at Ananda and I wanted to have sex with her, but then one day I saw her swimming and you would not believe how disgusting her thighs were—all covered in cellulite."

b.) On or around October 2022, Dr. H.H. sent a text message to M.G. stating "Just had a lovely talk with [A.M.] about dad's inappropriate joke."

c.) M.G. reported that she has heard Respondent make fat jokes, sex jokes and blonde jokes.

d.) Respondent made comments to M.G. while she was at the front desk about women he found attractive, and commonly discussed patients who Respondent found to be sexually frustrated. M.G. stated that Respondent on one occasion made a comment about a woman who was in a car accident and had anxiety, stating to M.G. that the woman was just sexually frustrated.

e.) On or around March of 2023, Respondent tried to show M.G. pictures of some African women who have "giant butts." Respondent proceed to make comments about the women in the photographs, including that they store water in their butts "like camels."

f.) On or around June of 2023, M.G. observed Respondent's wife, D.J., entering the building and approaching the front desk, Respondent walked out of his office and loudly and said "One reason I keep [D.J.] around is she has great breasts." M.G. reported that when Respondent made this statement a patient was in the waiting room.

g.) L.W., an prior office manager of Respondent's practice, observed Respondent make unprofessional/inappropriate comments including, but not limited to, the following: On one occasion a friend of L.W. came into the office for treatment and L.W. observed Respondent look the patient up and down and say "you look fun to work on."

h.) Dr. P.R., a chiropractor that used to work for Jacobson Chiropractic heard Respondent make politically incorrect jokes/comments in the waiting room to male and female patients. Dr.

P.R. states that patients reported concerns to him about Respondent's inappropriately political jokes.

30. Respondent made non-clinical physical contact with patients and staff including, but not limited to:

a.) When Respondent hugged M.G. would use his hand to rub her all the way down her back to her rear end.

b.) Respondent hugged patients and employees.

c.) M.G. made the following statement regarding Respondent's interactions with her, "[b]ut something interesting happens with [Respondent]. He gets very close to people. He gets right up in your space and he touches you without asking you first. When he stands next to me, I feel needles in my body. It scares me."

31. Respondent disregarded office polices for the purpose of patient privacy on the following occasions:

a.) After the complaint was received by Patient 3, a new protocol was created regarding x-ray procedures. The protocol required staff to guide the patient into the X-ray room, hand them a gown of the appropriate size, point out the printout located on the wall regarding the x-rays, and explain which items of clothing needed to be removed or could stay on. The patients would then be instructed to close the curtain across the changing area, the staff would then close the door to the changing room as well, and the patient would be informed that once they were finished changing they could sit in the chair near the door and open the door a crack to let Respondent know they were finished changing.

b.) After this policy/protocol was put into place, employees observed Respondent continue to walk into patient rooms without knocking or waiting for the patient to crack the door.

32. Respondent made M.G. feel uncomfortable at work to the point she had to take time off from work to deal with the stress and due to interactions with Respondent.

///

///

///

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

33. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 317, subdivision (a), in that Respondent committed acts constituting gross negligence in his care of Patient 3, as set forth in paragraphs 24-28 above, as follows:

i. Respondent failed to maintain Patient 3's privacy when preforming an x-ray procedure on Patient 3 on or around October 21, 2021.

SECOND CAUSE FOR DISCIPLINE

(Patient Records)

34. Respondent is subject to disciplinary action under 16 CCR section 318, subdivision (a), in that he failed to sign patient records for Patient 2 and Patient 3, as follows:

i. On or around March 4, 2021, Respondent failed to sign or initial Patient 2's medical record.

///

ii. On or around October 21, 2021, Respondent failed to sign or initial Patient 3's medical record.

Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 13 through 31, inclusive, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Informed Consent)

35. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 319.1, because he failed to obtain proper written informed consent from Patient 1, as described above.

FOURTH CAUSE FOR DISCIPLINE

(Sexual Misconduct)

36. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 316, for sexual misconduct or relations with employees and patients while at work, as set forth in paragraphs 14 through 32 above.

FIFTH CAUSE FOR DISCIPLINE

(Conduct Likely to Endanger Health, Welfare, or Safety of the Public)

37. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 317, subdivision (e), because he engaged in conduct that has endangered, or is likely to endanger, public health, welfare, or safety, as set forth in paragraphs 14 through 32 above.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

38. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 317, in that he committed unprofessional conduct as set forth in paragraphs 14 through 32.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Chiropractic Examiners issue a decision:

1. Revoking or suspending Chiropractic Number DC 12716, issued to Dale Leroy Jacobson;

2. Ordering Dale Leroy Jacobson to pay the Board of Chiropractic Examiners the reasonable costs of the investigation and enforcement of this case, pursuant to Title 16, California Code of Regulations, section 317.5 and if placed on probation, the costs of probation monitoring; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 07/09/2025

Signature on File
KRISTIN WALKER
Executive Officer
Board of Chiropractic Examiners
Department of Consumer Affairs
State of California
Complainant

SA2025301557
38953687.docx