223 Route 10 East
Succasunna, NJ 07876

Ralph Lindel, DC
TID#: 45-5189767

PATIENT HISTORY

Last _____ **First** _____ **Middle Initial** _____

Date of Birth _____ **Age** _____ **Social Security Number** _____

Address _____ **City** _____ **ST** _____ **Zip** _____

Phone (H) _____ **(W)** _____ **(C)** _____

Email _____ **Emergency Contact** _____ **Phone** _____

Your Occupation _____ **Employer** _____

Spouse's Name _____ **Spouse DOB** _____ **Spouse SSN:** _____

Insurance _____ **Policy Holder Name** _____ **DOB** _____ **ID#** _____

Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb **Does the Pain Radiate into your:** ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no **How often do you experience these symptoms?** ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? _____

Do you take birth control? ☐yes ☐no **Have you ever taken birth control in the past?** ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

_____

PATIENT SIGNATURE _____ **DATE** _____

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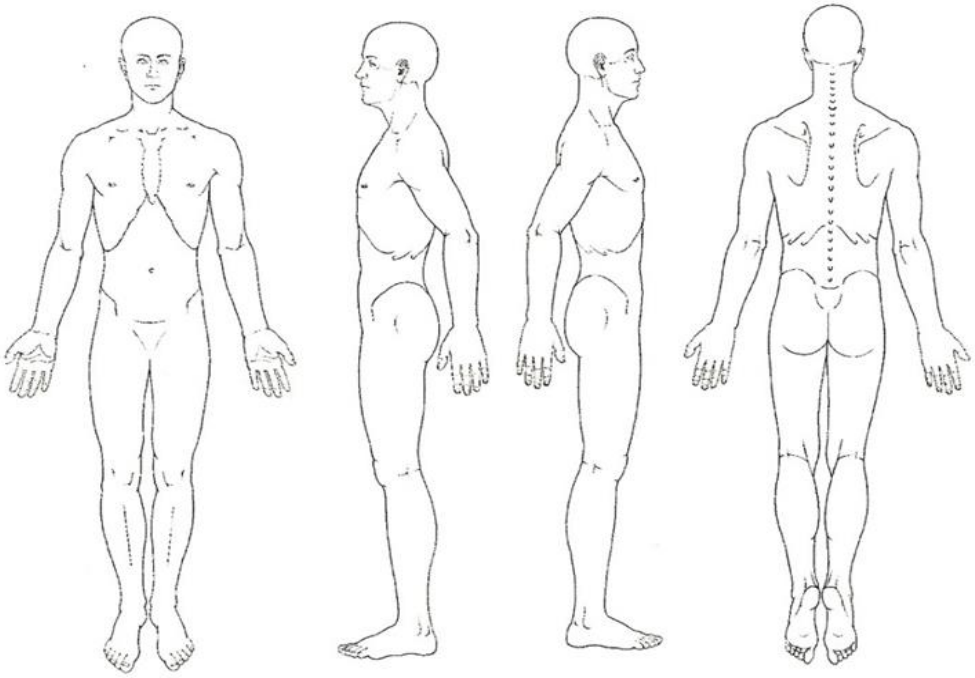
PATIENT HISTORY

Please mark off the areas of your complaint on the diagram above with the following indicators:

X = pain
O = numbness
Z = tingling
B = burning
C = cramping



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE _____ **DATE** _____

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NECK PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours)

Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Recreation
- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

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LOW BACK PAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights, at the most.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than ten minute without increasing pain.
- ☐ I avoid standing, because it increases the pain straight away.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Succasunna Chiropractic and Spine Rehab
Dr. Ralph Lindel

2020 PATIENT INSURANCE/HIPAA FORM

Name: _____

Primary Medical Doctor: _____

Insurance Co: _____ ID# _____

Policyholder Name: _____ Date of Birth: _____

Relationship to patient: _____

If we are submitting insurance forms on your behalf, please provide us with a new copy of your insurance card as well as photo ID such as, driver's license, student ID or work ID.

Your insurance policy is a contract between you and your insurance carrier. Please contact your insurance company with any questions regarding your benefits. You are responsible to pay any deductibles, copayments or co-insurance required at the time services are rendered.

HIPAA-Health Information Portability Accountability Act

I authorize Succasunna Chiropractic and Spine Rehab and, Dr. Ralph Lindel, and/or any other covering provider and/or staff member to act on my behalf in regards to claims processing or payment activities as it relates to services rendered in our office. I also authorize the use of my name as it relates to Recalls, Newsletters, Mailings and/or Patient Referral Board. I also authorize any messages relating to the above to be left on voicemail or email address provided below.

Phone # to leave messages: _____ email address: _____

Patient's Signature : _____ Date: _____

AUTHORIZATION TO TREAT AND EXAMINE

I hereby authorize Dr. Lindel at Succasunna Chiropractic and Spine Rehab to examine and treat me (or my child) as he determines appropriate through the use of chiropractic manipulation of the spine, contiguous structure and adjunctive therapy. The doctors will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis

Patient's Name (print) _____

_____ Date: _____
Patient's Signature /Parent or Guardian

RECORDS RELEASE

To: Succasunna Chiropractic and Spine Rehab
223 Route 10 East
Succasunna, NJ 07876

I hereby authorize Dr. Lindel at Succasunna Chiropractic and Spine Rehab to obtain x rays, medical records and/or other medical information pertinent to any diagnosis and treatment relating to myself.

Patient's Name (print) _____

Patient's Signature/Parent or Guardian _____ Date _____

ASSIGNMENT OF BENEFITS TO OUR OFFICE

I hereby request (insurance company name) _____ to make Direct Payment to Dr. Lindel at Succasunna Chiropractic and Spine Rehab at 223 Route 10 East, Succasunna, NJ 07876.

I authorize the reimbursement from my insurance company to Dr. Lindel and/or covering doctor based on any benefits due me under a contract I have with my medical insurance, personal injury and/or workman's compensation.

I am herein noticed that an insurance company based on its own policies and guidelines may make determinations of medical necessity different from the doctors at Succasunna Chiropractic and Spine Rehab. I acknowledge that I have been noticed that the insurance company may not fully reimburse for my chiropractic care regardless of the doctors participation in these plans. I agree to be personally responsible for payment of any services rendered to me or my child by Dr. Lindel at Succasunna Chiropractic and Spine Rehab that are not reimbursed by my insurance company.

I authorize Dr. Lindel to release any information pertinent to my care at Succasunna Chiropractic and Spine Rehab to any insurance company, utilization company or attorney that may request records.

Patient's Name (print) _____

Patient's Signature _____ Date _____

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Informed Consent for Chiropractic Care

I understand that as a patient of Dr. Ralph Lindel, I am eligible to receive a range of chiropractic services in accordance with recognized and acceptable chiropractic procedures.

The type and extent of services that I will receive will be determind following an initial assessment and thorough discussion with me.

The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information pertaining to my health history is confidential and no information will be released without my consent.

I understand that while chiropractic procedures and modalities may provide significant benefits, it may also pose risks and may have unwanted side effects, I understand that I may discuss any concerns regarding the risk versus benefit of treatment at any time with Ralph Lindel, D.C.

I understand that no guarantee or assurance has been made as to the results that may be obtained.

If I have any questions regarding this consent form or about the services offered by Ralph Lindel, D.C, I may discuss them with my chiropractic physician.

I have read and understand the above.

I consent to participate in the evaluation and treatment recommended to me. I understand that I may stop treatment at any time.

Print: _____

Signature: _____ Date_____