

223 Route 10 East
Succasunna, NJ 07876

Ralph Lindel, DC
TID #: 45-5189767

PATIENT HISTORY

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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:

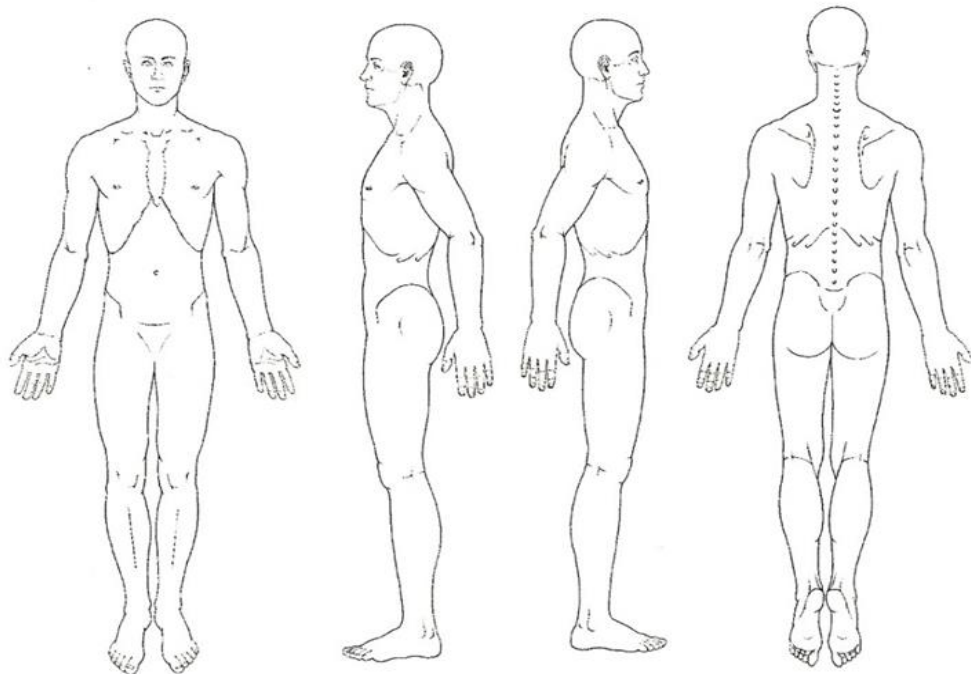
PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

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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:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> 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 <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment.	Concentration <input type="checkbox"/> I can concentrate fully when I want to with no difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all.
Personal Care (Washing, Dressing, etc.) <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally, but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help, but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self care. <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.	Work <input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can only do my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I cannot do any work at all.
Lifting <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all.	Driving <input type="checkbox"/> I can drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> I cannot drive my car at all.
Reading <input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck. <input type="checkbox"/> I cannot read at all.	Sleeping <input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="checkbox"/> My sleep is completely disturbed (5-7 hours)
Headaches <input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time.	Recreation <input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck. <input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck. <input type="checkbox"/> 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 <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much.	Standing <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain while standing, but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ten minute without increasing pain. <input type="checkbox"/> I avoid standing, because it increases the pain straight away.
Personal Care <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="checkbox"/> Washing and dressing increases the pain, but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain, I am unable to do any washing or dressing without help.	Sleeping <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed, but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one than one quarter. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one-half. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than three-quarters. <input type="checkbox"/> Pain prevents me from sleeping at all.
Lifting <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights, at the most.	Social Life <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal, but increases the degree of my pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain.
Walking <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me from walking more than one mile. <input type="checkbox"/> Pain prevents me from walking more than 1/2 mile. <input type="checkbox"/> Pain prevents me from walking more than 1/4 mile. <input type="checkbox"/> I can only walk while using a cane or on crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.	Traveling <input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down.
Sitting <input type="checkbox"/> I can sit in any chair as long as I like without pain. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> Pain prevents me from sitting at all.	Changing Degree of Pain <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates, but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better, but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.

Succasunna Chiropractic and Spine Rehab
Dr. Ralph Lindel

2023 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 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 _____