



**SARATOGA SPINE
NEW PATIENT PACKET**

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Saratoga Office
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INITIAL PATIENT VISIT:

Name: _____ DOB: _____
Address: _____
Age: _____ Sex: _____ Weight: _____ Height: _____
Phone: Home: _____ Work: _____ Mobile: _____
Social Security Number: _____
Email address _____
Local Pharmacy name _____ Address _____
Mail Order Pharmacy _____
Employer _____ Occupation _____
Who referred you to Saratoga Spine? _____

Referring Physician Name _____ Referring Physician Telephone # _____

Referring Physician Address _____ City _____ State _____ Zip Code _____

Who is your Primary Care Physician? _____

Please describe your main problem/complaint: _____

CURRENT MEDICAL CONDITION:

Do you have: ___ Only Back Pain ___ Back And Leg Pain ___ Only Leg Pain
 ___ Only Neck Pain ___ Only Shoulder/Arm Pain
 ___ Neck, Shoulder and Arm Pain ___ Other _____

Which is worse: ___ Back Pain ___ Leg Pain ___ Neck Pain ___ Shoulder/Arm Pain

I have had back/neck pain: ___ Less than 1 month ___ 1-3 Months ___ 3-6 Months ___ 6 Months- 1 Year
 ___ 1-3 Years ___ 3-5 Years ___ Greater than 5 Years

My pain came on: ___ Gradually, over time ___ Quickly

Saratoga Spine

Patient name _____

My pain was brought on by: No specific incident Following an accident or incident at work
 Following an accident or incident **NOT** at work Motor vehicle accident?

_____ Date of accident/injury

Describe the accident/incident: _____

Do you have: Numbness: Where _____

Tingling: Where _____

Weakness: Where _____

What time of the day is your pain worse Morning Late in the day The middle of the night

My Pain pattern is: A single attack of pain Attacks of pain with pain free intervals
 Continuous Pain Continuous pain with attacks of severe pain

I experience pain: The entire day A fair amount of the day (2-7 hours)
 Most of the day (16-20 Hours) A small amount of the day (1 hour or less)
 A good part of the day (8-15 Hours) Less than once a day

How long does the pain attack last: Seconds Minutes Hours Constant

For how long can you walk: <15 minutes 15-30 Minutes 30-60 Minutes NO Restrictions

How long can you stand: < 15 minutes 15-30 Minutes 30-60 Minutes NO Restrictions

Do you need assistive device (walker/crutches etc.) _____ How long using assistive device?

Do you need help getting dressed Personal hygiene? Y/N Are you able to self transport? Y/N

What position/activity make the pain worse or better?

Standing Sitting Walking Stairs Lying Down Bending Lifting Coughing Bowel Mov't General Activity

Better: _____
Worse: _____

Pain Rating Scale: How would you rate your pain today: (**check One Number**)

0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__
None Moderate Moderate Severe Worst Possible Pain

Name, Date, and Location of office you have sought help for your pain: (Fill out all that apply)

Family Doctor: _____

Orthopedist: _____

Spine Surgeon: _____

Physical Therapist: _____

Chiropractor: _____

Pain Management: _____

Physiatrist: _____

Neurologist: _____

Psychiatrist/Psychologist: _____

Have any of the above treatments decreased your pain: NO YES, describe below

Which medications do you take for your pain: _____

My pain now seems to be: Getting better Staying the same Getting worse

Have you noticed any change in your bowel or bladder habits? NO YES, describe:

Saratoga Spine

Patient name _____

Have you seen a spine surgeon for this issue? ____ NO ____ YES

What was recommended? _____

Have you Previous Spine Surgery? ____ NO ____ YES

When: ____ / ____ / ____

Doctor: _____

TYPE OF SPINE SURGERY:

If you had previous spine surgery, did the surgery make the pain better: ____ YES ____ NO

Have or are you planning to apply for Disability or Worker's Compensation: ____ YES ____ NO

Is there a lawsuit or litigation pending in relationship to your pain? ____ YES ____ NO

Date of Injury: _____

REVIEW OF SYSTEMS:

Primary Reason for Today's Visit:

Do you presently have any problems with the following areas? If YES, give explanation and date

Fever ____ YES ____ NO Weakness of Upper or Lower extremities ____ YES ____ NO

Chills ____ YES ____ NO Gait imbalance ____ YES ____ NO

Weight loss ____ YES ____ NO Dropping objects ____ YES ____ NO

H/O Falls ____ YES ____ NO Bowel or Bladder Incontinence ____ YES ____ NO

Eyes(eye pain, vision loss) ____ YES ____ NO

Ears, Nose, Mouth, Throat: ____ YES ____ NO

Cardiovascular, (heart, blood vessels) ____ YES ____ NO

Respiratory (lungs/breathing) ____ YES ____ NO

Gastrointestinal (stomach/intestines) ____ YES ____ NO

Genitourinary (genitals/kidney/bladder) ____ YES ____ NO

Musculoskeletal (muscles/joints) ____ YES ____ NO

Integument (skin/breast) ____ YES ____ NO

Neurological ____ YES ____ NO

Psychiatric (depression, anxiety, bipolar, substance abuse) ____ YES ____ NO

Endocrine (hormones, glands) ____ YES ____ NO

Hematologic/Immunologic (blood) ____ YES ____ NO

Do you have blood clotting problems? ____ YES ____ NO

Excessive bleeding? ____ YES ____ NO

Blood loss during surgery? ____ YES ____ NO

Seasonal Allergies (hay fever) ____ YES ____ NO

Diabetes ____ YES ____ NO if yes, Last A1c level? _____ Date _____

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PAST MEDICAL HISTORY:

Check below if you have had any of the following:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV

Other _____

PAST SURGERIES: (Procedure and date): _____

FAMILY HISTORY (Muscle or nerve problems, Diabetes, or Bleeding Disorders): _____

CURRENT MEDICATIONS and DOSAGE: (Dates started meds and include non-prescription)

****ALLERGIES TO MEDICINE/SUBSTANCES/LATEX:** (Include reaction)

WORK STATUS:

Employer Name and Address _____

Occupation _____ Duties _____

Are you currently? Working Full Time Working Part time
 Unemployed Retired
 Disabled, Temp Disabled, Perm
 Housewife

Other

If you are currently NOT working: How long have you been off work due to your back/neck pain?

PAIN DIAGRAM:

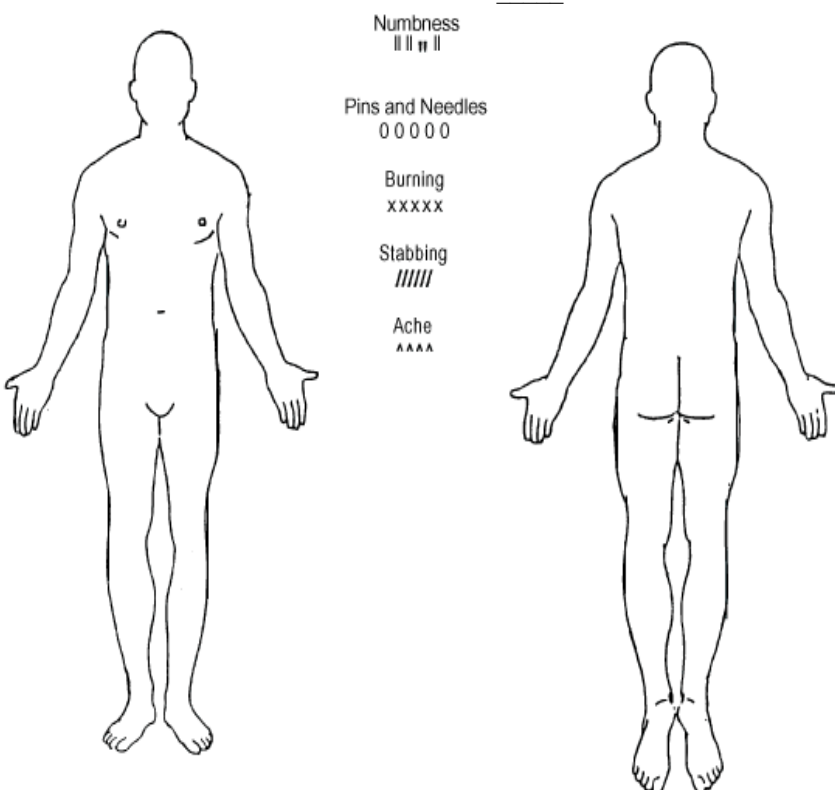
If you have the ability to download, draw, and scan to email, please use the following diagrams to show us where you are experiencing pain and numbness. If you do not, please describe : _____

Check any/all of following that describe pain.

DULL___ BURNING___ COLD___

TIGHT___ THROBBING___ SHOOTING___

ELECTRIC TINGLING___



Saratoga Spine

Patient name _____

SOCIAL HISTORY:

Marital Status: Single Married Divorced Separated Widowed

Highest Education Level Completed:

Grade school High School College, Technical Graduate, Professional

Do you currently use Tobacco? Yes No Started Age/Total years Stopped

Have you ever used tobacco products? Yes No If yes, what tobacco products? _____

Indicate quantity per day: Cigarettes Cigars Chewing Tobacco

Do you currently consume Alcohol? Yes No If yes, how much? _____ Amount Per day

Do you have any history of recreational drug use? Current use Yes No What drug(s) _____

Past use Yes No What drug(s) _____

Patients with known Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS/ KYPHOSIS

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis / Kyphosis: Parent Brother/Sister

Cousin None

Other

Previous non-operative treatment: None Observation Only

Exercise Brace Other _____

First operative event: ___/___/___

Second operative event: ___/___/___

Current concerns: None Feel imbalance

New or increased back pain Painful rod

Unhappy with my appearance

If you have back pain, then where: Upper Back Mid Back Lower Back

Do you feel that your curves have increased or decreased over time: Yes No

Do you feel you have lost height in the last few years: Yes No

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PATIENT NAME _____

INSURANCE

Insurance policy holder? _____

Relationship to patient: (self, wife, etc.) _____

Policy holder's employer _____

Birth date: _____ SS# _____

Health Insurance company : _____

ID# _____ Group # _____

Is patient covered by secondary insurance? Y/N (If yes, Please Complete the Following)

Insurance company name: _____

ID#: _____ Group # _____

***WORKER'S COMPENSATION or NO FAULT INFORMATION ***

This information is Mandatory if you are filing a claim thru Workers Comp or No Fault insurance

Is patient covered by No-Fault insurance? Y/N _____

Is patient covered by Workers Compensation? Y/N _____

Onset date of Injury or accident _____

WC or NF Insurance company name: _____ Policy # _____

WC Case ID# _____ Group # _____

Case worker's name and phone/fax #: _____

Employer Name: _____

Employer Address: _____ City _____ State _____ Zip _____

Job Title: _____

Job Activity (ie; sit, stand etc) _____

Saratoga Spine

Patient Name _____

I certify that I have insurance with the above company and assign Saratoga Spine all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature on all insurance submissions.

The offices of Saratoga Spine may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits and the benefits payable to related services.

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to Dr. John Herzog for their services. I authorize any holder of medical or other information about me to be released to Medicare or Medicaid services and their agents any information needed to determine these benefits related to services.

Signature of Beneficiary, Guardian or Personal Representative

Print Name of Beneficiary, Guardian or Personal Representative

Date

Relationship to Beneficiary

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM SARATOGA SPINE IF I OR MY MINOR CHILD, EVER HAVE A CHANGE IN ANY OF THE ABOVE INFORMATION

Signature of Patient, Parent or Guardian

Date

Saratoga Spine

Patient Name _____

HIPPA PRIVACY STATEMENT

This notice describes how health information about you, if you decided to become a patient of this practice, may be used, disclosed and how you can get access to your health information. This is required by the Privacy Regulations used as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Commitment to your privacy:

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the integrity of your health information. We realized these laws are complicated, but we must provide you with the following information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or of another individual of the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the US Military forces and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

Rights regarding your health information:

You can request that our practice communication with you about your health in a particular manner. We will accommodate reasonable requests.

1. You can request a restriction in our use or disclosure of your health information for treatment and payment of health care operations.
2. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician's name to 7 Murray Street, Glens Falls, NY 12801. We will respond within ten (10) business days.
3. You may ask to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by our practice. To request and amendment, your request must be made in writing and submitted to this office. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice.
5. Right to file a complaint if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosure that are not identified by this notice or permitted by applicable law. This practice shares an electronic medical record database. We do cover each other and your medical records will be accessed when necessary.

Additional person(s) authorized to speak with regarding appointment messages and/or medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature _____ Date _____

Saratoga Spine

Patient Name _____

Financial Responsibility

You must present a valid insurance card and photo ID such as a valid Driver's license at each visit. It is your responsibility to report any insurance changes to the office as soon as possible. Any information that is inaccurate or received after the date of service may not be billable to the insurance carrier and may become the responsibility of the account guarantor.

All co-payments and past due balances are due at time of check-in. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

If your insurance pays you directly for services rendered by us, you agree to forward the payment to us immediately.

There is a \$25 service charge for all returned checks.

There is a \$25.00 fee for all visit cancelled with less than 24-hour notice.

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If you have any questions regarding this notice or our health information privacy policies, please contact our office at (518) 743-1010.

Acknowledgment that I have received that above policy:

Name _____

Signature _____ Date _____

SARATOGA SPINE

PAIN MEDICATION AND CONTROLLED SUBSTANCE POLICY

Pain medication will be prescribed when necessary, in the immediate post-operative period only. Narcotics are usually prescribed for no longer than 6-8 weeks for a non-deformity surgery such as Laminectomy, Discectomy or Cervical Fusion. Narcotics will usually be prescribed for no longer than 12 weeks for a lumbar spinal fusion.

Most research has shown worse outcomes for patients who are on chronic narcotics. However, some pain specialists still routinely prescribe these medicines for prolonged periods of time. This requires specialized expertise and close follow up by a pain management specialist.

All Prescription refill requests must be made by the patient only and will be processed during normal business hours. We require at least 48 hours notice. Please plan ahead.

Controlled substance medications may not be renewed if stolen or lost until the prescription has expired.

All prescriptions will be electronically transmitted to your pharmacy. When requesting a medication refill, please state the pharmacy you would like the prescription electronically sent to along with your name, date of birth, medication name requested. Your request will be reviewed by our providers and you will get a return phone call notifying you of the status of your request.

I agree to the following and understand that I may be discharged from Saratoga Spine if I break any of these conditions:

I will not attempt to get pain medication from any person or healthcare provider not authorized my Saratoga Spine provider.

I will not use medication in a way that is not prescribed.

I will not exhibit deceitful behavior nor provide false information

I will not make calls after hours to obtain medication.

I will not sell or give my medications to any other person.

I will sign and follow the "Patient Understanding for Opioid Treatment Form"

I will sign and follow the "Patient Informed Consent for Opioid Treatment form"

I am aware that I may be subjected to random testing including but not limited to: urine screening and random pill counts.

I _____, Acknowledge that I have read the all the pages and agree to comply with Saratoga Spine's Pain Medication and Controlled Substance Policy. I understand that failure to follow these policies may result in my being discharged from Saratoga Spine and I could risk prosecution as directed by state and federal agencies.

Patient or Guardian Signature _____ Date: _____

Oswestry Low Back Pain Scale

Name _____ Signature _____ Date _____

Please rate the severity of your pain by circling a number below:

No pain 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___ Unbearable pain

Please read: This questionnaire has been designed to give the doctor information on how your back pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain walking.
1. I have some pain walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

NECK DISABILITY INDEX

Name _____ Signature _____ Date _____

Please rate the severity of your pain by circling a number below:

<i>No pain</i> 0 <u> </u> 1 <u> </u> 2 <u> </u> 3 <u> </u> 4 <u> </u> 5 <u> </u> 6 <u> </u> 7 <u> </u> 8 <u> </u> 9 <u> </u> 10 <u> </u> <i>Unbearable pain</i>
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Please read: This questionnaire has been designed to give the doctor information on how your neck pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity

0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g. on the table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headache

0. I have no headache at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches most of the time.

Section 6 – Concentration

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8 – Driving

0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 - Recreation

0. I am able to engage in all recreational activities with no pain in my neck.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of my neck pain.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.