



Armin Afsar-Keshmiri, M.D., M.S.

Board Certified In Orthopaedic Surgery

Fellowship Trained Spine Surgeon

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 _____

How did you find us? ☐ Referring MD ☐ Friend/Family Member ☐ Website ☐ Facebook ☐ Commercial
☐ Other (describe) _____

Referring Physician Name _____ Referring Physician Telephone # _____

Who is your Primary Care Physician? _____

CURRENT MEDICAL CONDITION:

Please describe your main problem/complaint:

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

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

Date of MVA/Injury: _____

Describe the accident/incident: _____

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

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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

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

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: **(Circle One Number)**

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

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

Family Doctor: _____

Orthopaedist: _____

Spine Surgeon: _____

Physical Therapist: _____

Chiropractor: _____

Pain Management: _____

Physiatrist: _____

Neurologist: _____

Psychiatrist/Psychologist: _____

Have any of the above treatments decreased your pain: _____ NO

_____ YES, describe: _____

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: _____

Has any other Surgeon recommend surgery? _____ NO _____ YES, who: _____

Have you had previous Spine Surgery?

_____ NO _____ YES → When: ____/____/____ Doctor: _____

Type of 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, Date of Injury _____ NO

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

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Saratoga Spine

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

CHILLS _____ YES _____ NO

WEIGHT LOSS _____ YES _____ NO

EYES _____ YES _____ NO

EARS, NOSE, MOUTH, THROAT

_____ YES _____ NO

CARDIOVASCULAR, (heart, blood vessels)

_____ YES _____ NO

RESPIRTORY (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, etc)

_____ YES _____ NO

ENDOCRINE (hormones, glands)

_____ YES _____ NO

HEMATOLOGIC/IMMUNOLOGIC (blood)

_____ YES _____ NO

CLOT NORMALLY AFTER CUTS? _____ YES _____ NO

EXCESSIVE BLEEDING? _____ YES _____ NO

BLOOD LOSS DURING SURGERY? _____ YES _____ NO

SEASONAL ALLERGIES (hay fever, etc) _____ YES _____ NO

PAST MEDICAL HISTORY:

Check below if you have had any of the following:

_____ Heart Disease

_____ High Blood Pressure

_____ Diabetes

_____ Asthma

_____ Kidney Disease

_____ Tuberculosis

_____ Migraine Headaches

_____ Hepatitis

_____ Epilepsy

_____ Emotional Disorder

_____ Cancer

_____ HIV

Other _____

PAST SURGERIES: (Procedure and date): _____

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

MEDICINE/SUBSTANCE/LATEX ALLERGIES: (Include reaction)

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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

Indicate quantity per day: Cigarettes___ Cigars___ Chewing Tobacco___

Do you currently consume Alcohol? ___Yes ___No

Indicate quantity per day: Beer___ Wine___ Distilled Spirits___

WORK STATUS:

Employer Name and Address _____

Occupation _____

Are you currently?

___ Working Full Time

___ Working Part time

___ Unemployed

___ Retired

___ Disabled, Temp

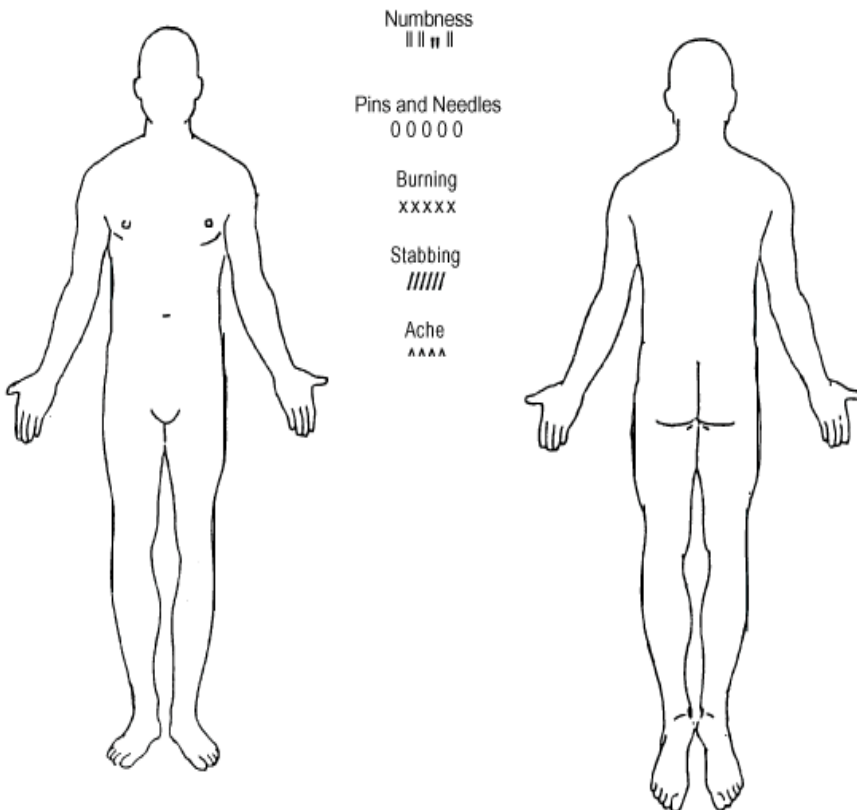
___ Disabled, Perm

___ Housewife

___ Other _____

If you are currently NOT working:

How long have you been off work due to your back/neck pain? _____



PAIN DIAGRAM:

Please use the following diagrams to show us where you are experiencing pain and numbness:

Please circle all of the following adjectives which describe your pain:

DULL

BURNING

COLD

SHOOTING

TIGHT

THROBBING

ELECTRIC TINGLING

OTHER _____

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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

INSURANCE

Name of person responsible for this account _____

Relationship to patient: _____

Birthdate: _____ SS#: _____

Primary Insurance company name: _____

ID# _____ Group #: _____

Secondary Insurance company name: _____

ID#: _____ Group #: _____

Is patient covered by No-Fault insurance? _____ (If yes, Please Complete the Following)

Is patient covered by Workers Compensation? _____ (If yes, Please Complete the Following)

Insurance company name: _____ WC or NF Case # _____

ID#/Case # : _____

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

_____ Emplo
yer _____ Phone # _____

Occupation: _____

I certify that I have insurance with the above company (ies) and assign Dr. John C. Herzog and/or Dr. Armin Afsar-Keshmiri 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 Drs. John C. Herzog and Armin Afsar-Keshmiri 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 Drs. John Herzog and Armin Afsar-Keshmiri 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 AREAS.

Signature of Patient, Parent or Guardian _____ Date _____

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 an 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: _____ Name: _____
Signature _____ Date _____

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.

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_____

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
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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	1	2	3	4	5	6	7	8	9	10	<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.