



Dr. John C. Herzog  
www.saratogaspine.com

Director of Spine Surgery at Saratoga Hospital  
Board Certified In Orthopaedic Surgery, Fellowship Trained Spine Surgeon

Hetal T. Amin, DO, Radka Dooley, MD,  
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Saratoga Office  
31 Myrtle Street  
T:518.587 SPINE(7746)

Glens Falls Office  
7 Murray Street  
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**INITIAL PATIENT VISIT**

**DATE:**     /     /

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  Website  Facebook  
 Commercial  Other (describe) \_\_\_\_\_

Referring Physician Name \_\_\_\_\_ Referring Physician Telephone # \_\_\_\_\_

Referring Physician Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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 \_\_\_\_\_

Percent of pain each region     \_\_\_% Back Pain     \_\_\_% Leg Pain     \_\_\_% Neck Pain     \_\_\_% Shoulder/Arm Pain

I have had back/neck pain for \_\_\_\_\_ DAYS MONTHS YEARS (circle one)

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**HISTORY OF PRESENT ILLNESS**

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 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:  Minutes  Hours  Unlimited

How long can you stand:  Minutes  Hours  Unlimited

How long can you sit:  Minutes  Hours  Unlimited

You are able to:  Dress yourself  Bathe yourself  Feed yourself

How long can you drive:  Minutes  Hours  Unlimited

Do you use any assistive devices (crutches, cane, etc.)? \_\_\_\_\_

What position/activity makes the pain worse or better?

	<u>Standing</u>	<u>Sitting</u>	<u>Walking</u>	<u>Stairs</u>	<u>Lying Down</u>	<u>Bending</u>	<u>Lifting</u>	<u>Coughing</u>	<u>Bowel Mov't</u>	<u>General Activity</u>
Better:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Worse:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

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

Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weakness of Upper or Lower extremities	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chills	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gait imbalance	<input type="checkbox"/> YES <input type="checkbox"/> NO
Weight loss	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dropping objects	<input type="checkbox"/> YES <input type="checkbox"/> NO
H/O Falls	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bowel or Bladder Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Clumsiness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Worsening Hand Writing	<input type="checkbox"/> YES <input type="checkbox"/> NO

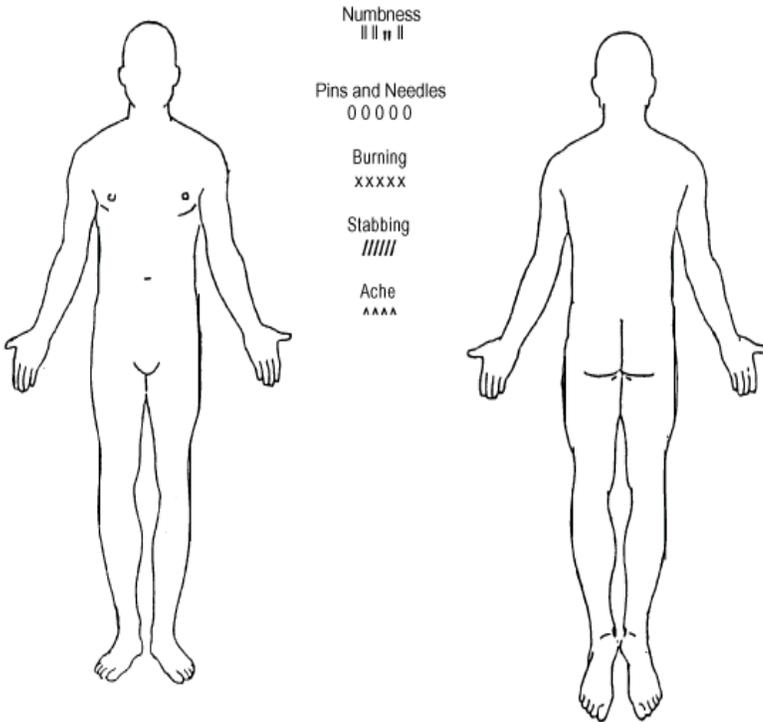
Describe \_\_\_\_\_

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**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



### **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    ELECTRIC        TINGLING  
TIGHT         THROBBING

**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 below

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

Which medications do you take for your pain:

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

**Has any other Surgeon recommend surgery?**  NO  YES

**Surgeon's name:** \_\_\_\_\_

**PAST SPINE SURGERY:**

Have you had previous Spine Surgery?

NO  YES → When: \_\_\_/\_\_\_/\_\_\_ Doctor: \_\_\_\_\_

\_\_\_\_\_

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

**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** (Scoliosis, Kyphosis, Muscle or Nerve Problems, Diabetes, Bleeding Disorders, Problems with Anesthesia):

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICINE/SUBSTANCE/LATEX ALLERGIES:** (Include reaction)

\_\_\_\_\_



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**INSURANCE**

PATIENT NAME \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Birth date: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance company name: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

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

Insurance company name: \_\_\_\_\_

ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by No-Fault insurance? (circle) Y/N (If yes, Please Complete the Following)

Is patient covered by Workers Compensation? (circle) Y/N (If yes, Please Complete the Following)

Insurance company name: \_\_\_\_\_ WC Case # \_\_\_\_\_

ID# \_\_\_\_\_ Case # \_\_\_\_\_

Case worker's name and phone/fax #: \_\_\_\_\_

Name and phone number of employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

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**INSURANCE (2)**

I certify that I have insurance with the above company and assign Dr. John C. Herzog all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize use of my signature on all insurance submissions.

The offices of Dr. John C. Herzog 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.

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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 RESPONSIBILTY TO INFORM SARATOGA SPINE IF I OR MY MINOR CHILD, EVER HAVE A CHANGE IN ANY OF THE ABOVE INFORMATION**

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**Signature of Patient, Parent or Guardian**

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**Date**

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## 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 \_\_\_\_\_

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**Financial Responsibility**

I understand that the above named Dr(s) may or may not be a participating provider with my insurance company and that I am financially responsible for all charges whether or not paid by my insurance company. I give my permission to bill my insurance carriers with the understanding that I am financially responsible for all charges whether or not paid by my insurance carrier. Above named Dr(s) may use my healthcare information in any way for the purpose of obtaining payment for services rendered. I authorize the use of my signature on all insurance submissions.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at (518) 587-7746.

Acknowledgment that I have received that above policy:

Name \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **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 by 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: \_\_\_\_\_

Revised 7/28/17

Low Back Pain Scale

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 1/2 mile without increasing pain.
- 4. I cannot walk more than 1/4 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 1/2 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 1/2 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 1/2 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.

TOTAL \_\_\_\_\_

Print Name

Signature

Neck Pain Scale

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 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.
- 5. I cannot do any work at all.
- 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.

TOTAL \_\_\_\_\_

Print name

Signature

Date