Inspired Spine

1601 Hwy 13 East, Burnsville, MN 55337
(727) MY-SPINE
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PATIENT REGISTRATION

Chart Number: _______________________

Patient Name____ Date of Birth ____________________

Mailing Address ____

City ____ State ________ Zip Code ______________

Marital Status (Circle One) S M W D Sex (Cirlce One) M F Email____

Home Phone ____________________________ Cell Phone ____________________________ Work Phone ___________________

Social Security Number ________ - _____ - __________ Ethnic Group (circle one) Non- Hispanic/Hispanic Race ___________

Spouse Name (Parent/Guardian, if minor) ____________________________________ Spouse Phone _______________________

Emergency Contact, NOT living with you____ ___________________

Relationship____ Phone# ____

Primary Care MD_____________________________________ Clinic Name____

Referring MD____ Clinic Name ____

We will need to obtain copies of your insurance card(s) and a photo ID

Primary Medical Insurance____

ID: ____ Group # ____

Policyholder____________________________________ Date of Birth (for policyholder)_______________________________

Secondary Medical Insurance ____

ID: ____ Group # ____

Policyholder____ Date of Birth (for policyholder)_____________________________

Is condition auto, liability, or Work Comp related? Y or N Date of Injury: ____

****Please see the back to supply the injury claim information****

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Worker's Compensation Claim Information

All fields required in order to properly file a claim to your insurance

Your health insurance will need to be obtained as well

Insurance Company Name____

Address____

City _______________________________________ State________ Zip Code _______________

Claim # ____ Body Part Injured ____________________

Claim Adjuster Name ____

Phone# ___________________________________ Fax#_______________________________________

QRC Name ____

Phone# ____________________________________ Fax# ______________________________________

Automobile/Liability Claim Information

All fields required in order to properly file a claim to your insurance

Your health insurance information will need to be obtained as well

Insurance Company Name____

Address____

City ____ State____________ Zip Code ______________

Claim#____ Body Part Injured__________________________

State in which accident occurred____________________

Claim Adjuster Name____

Phone#_______________________________________ Fax#____________________________________

What is your main symptom and how long have you had this symptoms? _________________________

____

Height: Blood pressure: Weight: Heart rate:

Recent weight gain/loss? Dominant hand (Circle One) Right Left

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Review of Symptoms

HEENT	Neurologic	Endrocrine	GI	Skin	Musculoskeltal	Hematology/ Lymphatic	Genitourinary	Respiratory
Headaches Chills Fever Blurred Vision	Tremors Dizzy Spells Numbness Tingling	Excessive Thirst Fatigued Too Hot Too Cold	Nausea Vomiting Abdominal Pain Heartburn	Rashes Boils Itching	Joint Pain Neck Pain Back Pain	Swollen Glands Blood Clotting Problems Prolonged wound oozing	Urine Retention Painful Urination Urinary frequency	Wheezing Frequent Coughing Shortness of Breath

PAST MEDICAL HISTORY (Please check any of the following medical problems you have or have had)

General	Lung	Psychological	Neurological	Blood	GI	Cardiovascular	GU	Other
Cancer: ____________ Arthritis Lupus Thyroid problem Diabetes Osteoporosis Fibromyalgia Carpal Tunnel	Asthma Pneumonia Emphysema Tuberculosis	Anxiety Bipolar Disorder Depression Schizophrenia	Stroke Brain tumor Headaches Back injury Neck injury Head injury Seizure Epilepsy Parkinson Disease Multiple Sclerosis	Anemia Blood Clots Previous Transfusion Bleeding Problems	Hepatitis GERD Heartburn Liver disease Colitis Ulcers	Heart Attack Hypertension High Cholesterol Atrial Fibrillation Pacemaker Carotid Disease Coronary Artery Disease	Kidney Problem Kidney Stones Urinary Tract Infection Bladder Problem Prostate Problem	

Pertinent Imaging Studies

Date	Facility Name	What	Have Report?	Have Report?
		MRI		
		CT		
		Discogram		
		Xrays/Flexion and Extension		

Previous Treatments for this problem

Past Surgical History

Have you had previous surgery for this problem? (Circle One) Yes No If Yes, how long ago?

When	Where	Surgeon	What surgery	Help?

Conservative Therapy

Check	Modality	Where	Dates/how long	Result
	Physical Therapy			
	Chiropractic therapy			
	Injections			
	Other			

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Social History

Children (Living) Yes No If Yes, how many

Do you current smoke? Yes No If Yes, how long and how many packs daily?

If you quit smoking, when did you quit?

Do you currently consume Alcohol? Yes No Socially

How much do you drink daily?

Family History

	Alive	Dead	Age	Medical Problems /cause of death
Father				
Mother				
Other				
Symptoms				

Please rate your symptoms from 1 (very mild) to 10 (very severe)

Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Numbness	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Weakness	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Describe your Main Symptoms	**Constant**	**Intermittent**								
Duration of the symptoms										
Bladder/bowel incontinent	**None**	**Once**	**Continuous**	**Since:**	**On/Off**					
How far can you walk?	**Walking not limited**	**___Blocks**	**Unable to walk**							
Other symptoms										

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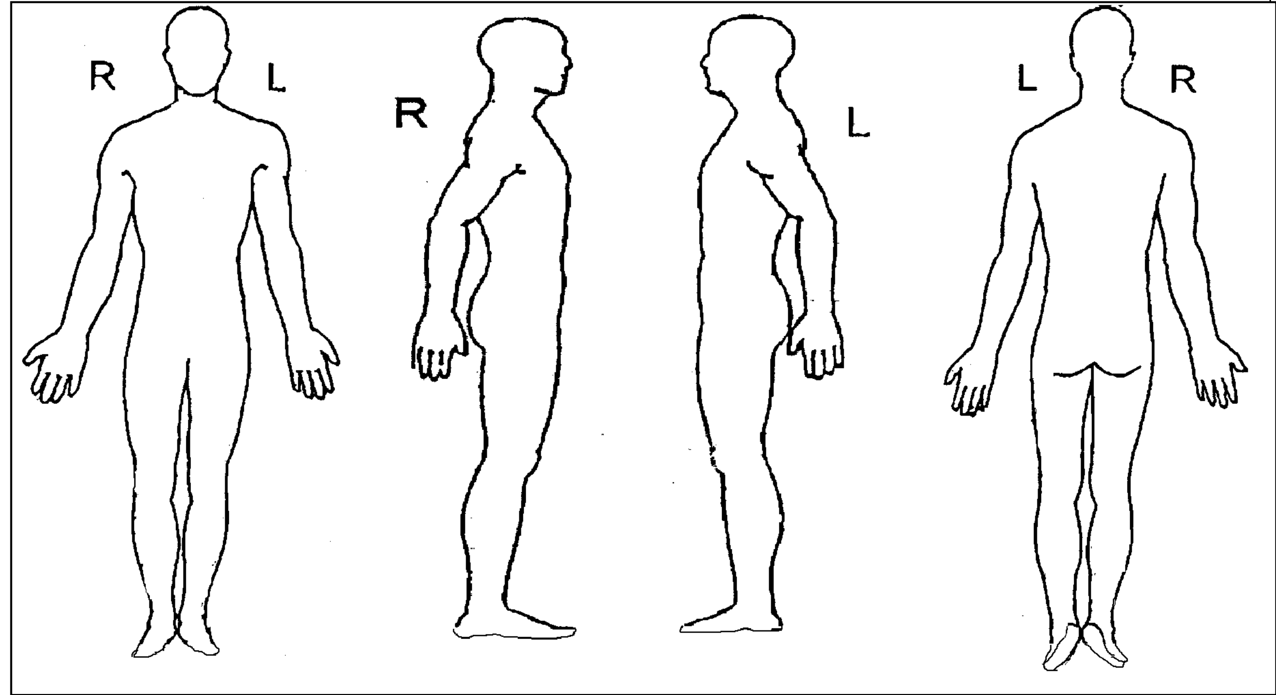
Circle what best describe your symptoms and draw on the drawing of the body the locations of your symptoms as below coding shows.
ACHE >>>>>   NUMBNESS -------   TINGLING 000000   BURNING XXXXXXX STABBING ////////



FOR OFFICE USE:

	Motor	Refl	Path	Priopriception/others
RUE	D___ B____ T___ G___ L___	B____ T____ BR___	Hoffman	
LUE	D___ B____ T___ G___ L___	B____ T____ BR___	Hoffman	
RLE	Q___ H___ G___ TA___ EHL__	Ptl____ Ach_____	Babinski- SLR	
LLE	Q___ H___ G___ TA___ EHL__	Ptl____ Ach_____	Babinski- SLR	
CN	II III/IV/VI V VII VIII IX-X XI XII			
MS	AAOx3 GSC15 Speech Dementia			
Coor	FNF Balance Romberg			

Patients Signature:

Doctors Signature:

Making minimally invasive spinal care easy on you

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MEDICATION LIST

Patient Name:__________________ _________________________________ DOB: ____________________

Phone# _____________________________________

Pharmacy Name: __________________________________ City:____________________________________

Pharmacy # _______________________________________

Date	Medication	Dose	Frequency

Allergies: