# Patient Summary Form

PSF-750 (Rev:2/18/2009)

**Instructions**
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

## Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

## Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

## Provider Completes This Section:

**Date you want *THIS* submission to begin:**

**Patient Type**

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

**Cause of Current Episode**

(1) Traumatic (4) Post-surgical →
(2) Unspecified (5) Work related
(3) Repetitive (6) Motor vehicle

**Date of Surgery**

**Type of Surgery**

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other _____

**Diagnosis (ICD code)**
*Please ensure all digits are entered accurately*

1° ___.___
2° ___.___
3° ___.___
4° ___.___

**Nature of Condition**

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

**DC ONLY**
**Anticipated CMT Level**

○ 98940 ○ 98942
○ 98941 ○ 98943

**Current Functional Measure Score**

Neck Index | DASH | (other)
Back Index | LEFS

## Patient Completes This Section:

(Please fill in selections completely)

**Symptoms began on:**

**1. Briefly describe your symptoms:**

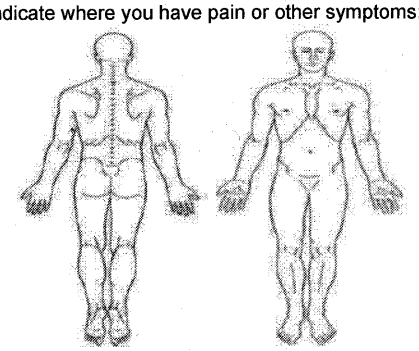
**2. How did your symptoms start?**

**3. Average pain intensity:**

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Indicate where you have pain or other symptoms:



**4. How often do you experience your symptoms?**

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

**5. How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

**6. How is your condition changing, since care began at *this* facility?**

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

**7. In general, would you say your overall health right now is...**

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

**Patient Signature:** X _____ **Date:** _____