

# 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			<input type="radio"/> Female <input type="radio"/> 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

Dr Robert Weissfeld					2. Federal tax ID(TIN) of entity in box #1								
Robert Weissfeld DC					1 MD/DO	<input checked="" type="checkbox"/> DC	3 PT	4 OT	5 Both PT and OT	6 Home Care	7 ATC	8 MT	9 Other
4. Alternate name (if any) of entity in box #1				5. NPI of entity in box #1				6. Phone number					
2055 S. Oneida St #300				Denver				CO		80224			

### Provider Completes This Section:

<b>Date you want THIS submission to begin:</b> [ ][ ][ ]	<b>Cause of Current Episode</b> (1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical (5) Work related (6) Motor vehicle	<b>Date of Surgery</b> [ ][ ][ ]	<b>Type of Surgery</b> (1) ACL Reconstruction (2) Rotator Cuff/Labral Repair (3) Tendon Repair (4) Spinal Fusion (5) Joint Replacement (6) Other	<b>Diagnosis (ICD code)</b> Please ensure all digits are entered accurately 1° [ ][ ][ ] . [ ][ ] 2° [ ][ ][ ] . [ ][ ] 3° [ ][ ][ ] . [ ][ ] 4° [ ][ ][ ] . [ ][ ]
<b>Patient Type</b> (1) New to your office (2) Est'd, new injury (3) Est'd, new episode (4) Est'd, continuing care	<b>DC ONLY Anticipated CMT Level</b> (1) 98940 (2) 98942 (3) 98941 (4) 98943	<b>Current Functional Measure Score</b> Neck Index [ ][ ] DASH [ ][ ][ ] (other) [ ][ ] Back Index [ ][ ] LEFS [ ][ ]		

### Patient Completes This Section:

Symptoms began on: [ ][ ][ ]

1. Briefly describe your symptoms: \_\_\_\_\_

2. How did your symptoms start? \_\_\_\_\_

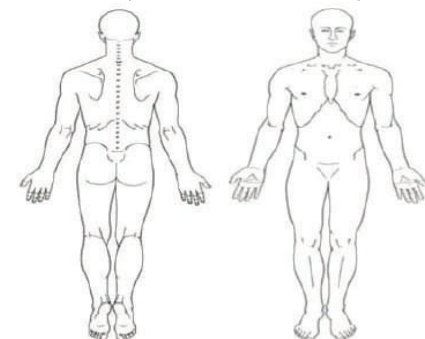
3. Average pain intensity:  
Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain  
Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

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

Indicate where you have pain or other symptoms:  


Patient Signature: X Date: \_\_\_\_\_