

# 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

<input type="checkbox"/> Female		<input type="checkbox"/> Male	
Patient name Last		Patient date of birth	
Patient address		City	
Patient insurance ID#		Health plan	
Referring physician (if applicable)		Date referral issued (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	
3. Name and credentials of the individual performing the service(s)		6. Phone number	
4. Alternate name (if any) of entity in box #1		5. NPI of entity in box #1	
7. Address of the billing provider or facility indicated in box #1		8. City	

### Provider Completes This Section:

<p><b>Date you want THIS submission to begin:</b></p> <input type="text"/>	<p><b>Cause of Current Episode</b></p> <p> <input type="radio"/> 1 Traumatic    <input type="radio"/> 4 Post-surgical  <input type="radio"/> 2 Unspecified    <input type="radio"/> 5 Work related  <input type="radio"/> 3 Repetitive    <input type="radio"/> 6 Motor vehicle         </p>	<p><b>Date of Surgery</b></p> <input type="text"/>	<p><b>Diagnosis (ICD code)</b> Please ensure all digits are entered accurately</p> <p>1° <input type="text"/></p> <p>2° <input type="text"/></p> <p>3° <input type="text"/></p> <p>4° <input type="text"/></p>
<p><b>Patient Type</b></p> <p> <input type="radio"/> 1 New to your office  <input type="radio"/> 2 Est'd, new injury  <input type="radio"/> 3 Est'd, new episode  <input type="radio"/> 4 Est'd, continuing care         </p>	<p><b>Type of Surgery</b></p> <p> <input type="radio"/> 1 ACL Reconstruction  <input type="radio"/> 2 Rotator Cuff/Labral Repair  <input type="radio"/> 3 Tendon Repair  <input type="radio"/> 4 Spinal Fusion  <input type="radio"/> 5 Joint Replacement  <input type="radio"/> 6 Other         </p>	<p><b>DC ONLY</b></p> <p><b>Anticipated CMT Level</b></p> <p> <input type="radio"/> 98940    <input type="radio"/> 98942  <input type="radio"/> 98941    <input type="radio"/> 98943         </p>	
<p><b>Nature of Condition</b></p> <p> <input type="radio"/> 1 Initial onset (within last 3 months)  <input type="radio"/> 2 Recurrent (multiple episodes of &lt; 3 months)  <input type="radio"/> 3 Chronic (continuous duration &gt; 3 months)         </p>	<p><b>Current Functional Measure Score</b></p> <p>Neck Index <input type="text"/> DASH <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/></p>		

### Patient Completes This Section:

Symptoms began on:

(Please fill in selections completely)

Indicate where you have pain or other symptoms:

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

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

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **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 very severe.
- ⑤ The pain is very severe and does not vary much.

## **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 sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## **Sitting**

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit 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.

## **Standing**

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while 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 pain immediately.

## **Walking**

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't 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.

## **Personal Care**

- ⓪ I do 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 increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases 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.

## **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 from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## **Traveling**

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## **Social Life**

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect 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.

## **Changing degree of pain**

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score