

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

Female
 Male

Patient name: Last [] First [] MI [] 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

Back & Neck Wellness Center

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

Bonnie J. Langrehr
 MD/DO
 DC
 PT
 OT
 Both PT and OT
 Home Care
 ATC
 MT
 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: **608-222-4244**

4222 Milwaukee St, Ste. 83
MADISON
WI
53558

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
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 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: [] [] [] []

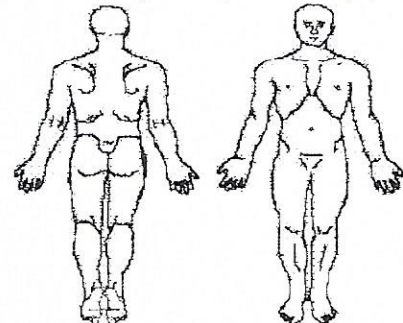
Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

[] [] []

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: _____



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The STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My pain has spread at some time in the past 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 In addition to my main pain, I have had pain elsewhere in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 In the last 2 weeks, I have only walked short distances because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's really not safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my pain is terrible and that it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general in the last 2 weeks, I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all

0

Slightly

0

Moderately

0

Very much

1

Extremely

1