WARWICK BRAIN & SPINE THERAPY
Dr. Calvin Hargis, Board Certified Chiropractic Orthopedist

40 MAPLE AVENUE, ROUTE 94
WARWICK, NY 10990
845-986-5500

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

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

1 MD/DO 2 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

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:

1. Briefly describe your symptoms:

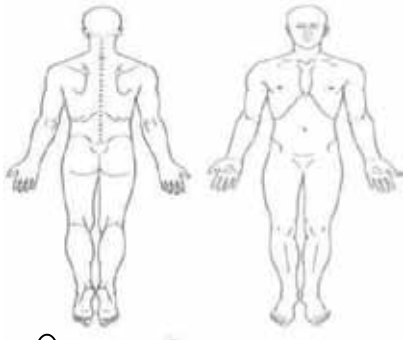
2. How did your symptoms start?

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:** _____