Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

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): ASKELAND CHIROPRACTIC

2. Federal tax ID(TIN) of entity in box #1: 25-1908617

3. Name and credentials of the individual performing the service(s): DR. ERIK J. ASKELAND

1 MD/DO | 2 DC (marked) | 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: 1770536633

6. Phone number: 919-841-0081

7. Address of the billing provider or facility indicated in box #1: 7511 MOURNING DOVE RD., STE. 104

8. City: RALEIGH

9. State: NC

10. Zip code: 27615

Provider Completes This Section:

Date you want *THIS* submission to begin: ______

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 codes)
Please ensure all digits are entered accurately

1° ______
2° ______
3° ______
4° ______

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

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 FOM)

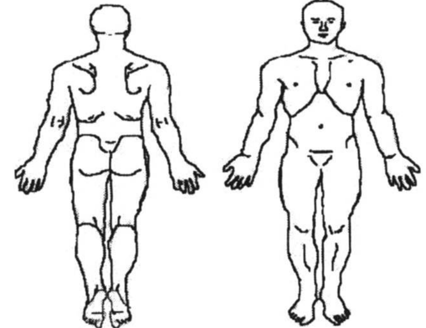
Back Index ____ LEFS ____

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:** ______

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Telephone: (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: ______________________________ Date: ____________

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

		No 0	**Yes** 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

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

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): ________________ **Sub Score (Q5-9):**____________

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Funded by Arthritis Research UK