Patient Summary Form (PSF – 750)

Today's Date: ___________

Patient Name: ____________________________ **DOB**: _________________

Describe your symptoms: ____

____

How did your symptoms start: ____

What is your Average Pain Intensity? Please circle below

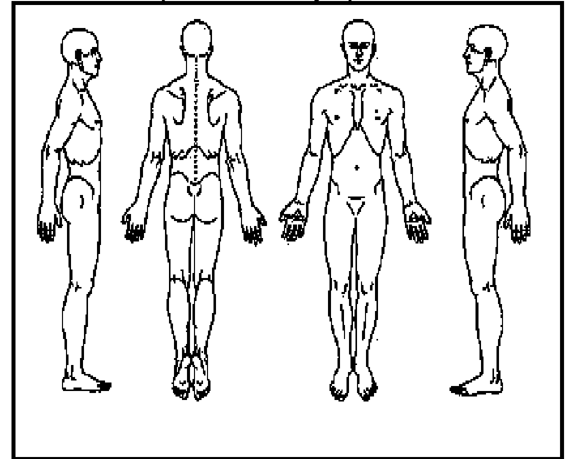
Last 24 hours: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Past Week: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How often do you experience your symptoms?

- ❑ Constantly (76-100 % of the time)
- ❑ Frequently (51-75% of the time)
- ❑ Occasionally (26-50% of the time)
- ❑ Intermittently (0-25% of the time)

Please indicate below where you have pain or other symptoms.



How much have your symptoms interfered with your usual daily activities?

- ❑ Not at all
- ❑ A little bit
- ❑ Moderately
- ❑ Quite a bit
- ❑ Extremely

How has your condition changed since care began at *this facility*?

- ❑ N/A – this is my first visit
- ❑ Much worse
- ❑ Worse
- ❑ A little worse
- ❑ No change
- ❑ A little better
- ❑ Better
- ❑ Much better

In general would you say your health right now is…..

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor

Signature: __________________________________

This Box is for Doctor's Use Only

Patient Type: New E'd New Injury
E'd New Episode E'd Continuing

Cause: Traumatic Unspecified
Repetitive Post-Surgical (see below)
Work Related MVA

Nature of Condition:
Initial Onset (within last 3 months)
Recurrent (multiple episodes of < 3 mos)
Chronic (multiple episodes of > 3 mos)

If post surgical above, what procedure was performed?
____

Anticipated CMT Level:
98940 98941 98942 98943

Date for Submission to begin: ________________

Other Notes:
____

Dr.'s Signature: ______________________________