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.

Complete this section

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: (715) 832-2223

7. Address of the billing provider or facility indicated in box #1: 503 E. Clairemont Avenue

8. City: Eau Claire

9. State: WI

10. Zip code: 54701

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 codes)
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 FOM)

Back Index | LEFS

Complete this section

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms:

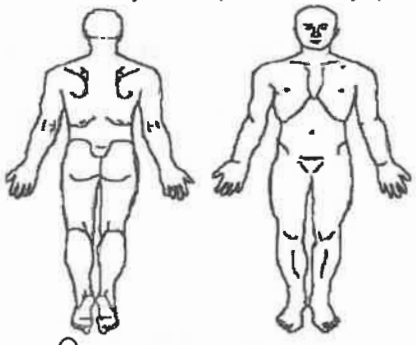
2. How did your symptoms start?

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:** _____

OPTUM®
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):**_____

Funded by Arthritis Research UK

Neck Pain Disability Index Questionnaire

Score:_____

Name:_____ Date:_____

This questionnaire is designed to enable your chiropractor to understand how much your neck pain has affected your ability to manage your everyday life. Please answer each section by marking in each section **ONE BOX** that best describes your condition today. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your condition as you are feeling today.**

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self–care.
- ☐ I do not get dress, I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (e.g. on a table).
- ☐ Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot list or carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all because of pain in my neck.

Section 5 –Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 –Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 –Driving
- ☐ I can drive without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all because of neck pain.

Section 9 –Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less that 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1–2 hours sleepless).
- ☐ My sleep is moderately disturbed (2–3 hours sleepless).
- ☐ My sleep is greatly disturbed (3–5 hours sleepless).
- ☐ My sleep is completely disturbed (5–7 hours sleepless).

Section 10 –Recreation
- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of neck pain.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any of my recreational activities at all.

The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409–415

Quadruple Numerical Rating Scale

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: Please answer the following questions in regard to your **NECKPAIN**

1. What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

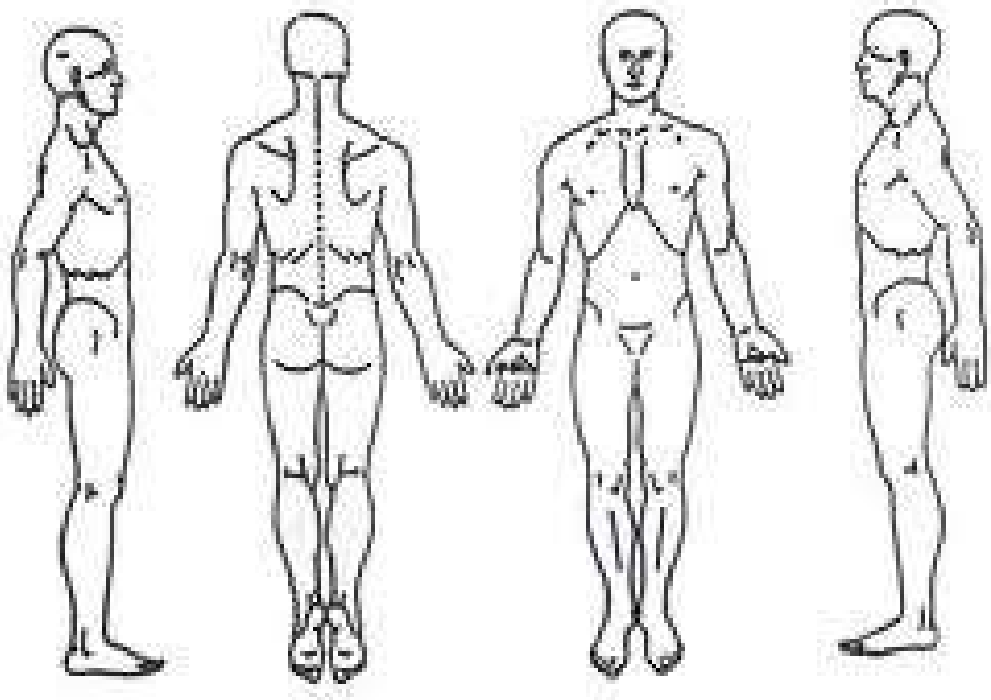
No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

INSTRUCTIONS: Please mark the diagram below to indicate where you are experiencing pain/symptoms



Oswestry Low Back Pain Questionnaire

Score:_____

Name:_____ Date:_____

This questionnaire is designed to enable your chiropractor to understand how much your low back pain has affected your ability to manage your everyday life. Please answer each section by marking in each section **ONE BOX** that best describes your condition today. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your condition as you are feeling today.**

Section 1 – Pain Intensity

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is severe.
☐ The pain is severe and does not vary much.

Section 2 – Personal Care

☐ I do not have to change my way of washing or dressing to avoid pain.
☐ I do not change my way of washing or dressing even though it causes me pain.
☐ I sometimes change my way of washing or dressing because it increases pain.
☐ I find it necessary to change my way of washing or dressing because it increases pain.
☐ Because of the pain I am unable to do some washing and dressing without help.
☐ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (skip if you have not attempted lifting since the onset of your low back pain)

☐ I can lift heavy weights without extra low back pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me lifting heavy weights off the floor.
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (e.g. on a table).
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift light weights at the most due to low back pain.

Section 4 – Walking

☐ I have no pain walking.
☐ I have some pain on walking, but I can still walk my required to normal distances.
☐ I cannot walk more than 1 mile without increasing pain.
☐ I cannot walk more than ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain
☐ I cannot walk at all without increasing pain.

Section 5 –Sitting

☐ Sitting does not cause me any pain.
☐ I can sit as long as I need provided I have my choice of sitting surfaces.
☐ Pain prevents me from sitting more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 –Standing

☐ I can stand as long as I want without pain.
☐ I have some pain with standing. It does not increase with time.
☐ I cannot stand for longer than 1 hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 mins without increasing pain.
☐ I avoid standing because it increases the pain immediately.

Section 7 –Sleeping

☐ I have no pain while in bed.
☐ I have pain in bed, but it does not prevent me from sleeping.
☐ Because of pain I sleep only ¾ of normal time.
☐ Because of pain I sleep only ½ of normal time.
☐ Because of pain I sleep only ¼ of normal time.
☐ Pain prevents me from sleeping at all.

Section 8 –Social Life

☐ My social life is normal and gives me no pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain prevents me from participating in more energetic activities (e.g. sports, dancing).
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I hardly have any social life because of pain.

Section 9 –Traveling

☐ I get no pain while traveling.
☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
☐ I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling that requires me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

Section 10 –Employment/Homemaking

☐ My normal job/homemaking duties do not cause pain.
☐ My normal job/home duties cause me extra pain, but I can still perform all that's required of me.
☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from even light duties.
☐ Pain prevents me from performing any job/household chore.

Reference: The Oswestry Disability Index. Spine 25:2940–2953.2000.

Quadruple Numerical Rating Scale

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: Please answer the following questions in regard to your **BACKPAIN**

1. What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

INSTRUCTIONS: Please mark the diagram below to indicate where you are experiencing pain/symptoms