Patient Summary Forn Patient Information	1 :2/18/2009)	male	timeline and f	ete this form within the specified ax to the specified fax number on Plan Summary or plan infor-
Detient name	Ma O Ma			may vary by plan.
Patient name Last First	MI -	Patient da	te of birth	
Patient address	City		State	Zip code
				•
atient insurance ID# Health plan		Group number		
Referring physician (if applicable)	Date referral issued (if applica	ble)	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 II	O(TIN) of entity in box #1	
, , , , , , , , , , , , , , , , , , , ,			nd OT 6 Home Care 7 ATC	8 MT 9 Other
3. Name and credentials of the individual performing the se		F1 4 01 3 Bouil 1 a	nd of s nome care 7 Are	[8] III. [9] Ottler —
	1.03(0)			
4. Alternate name (if any) of entity in box #1	5. NPI of entity	in box #1		6. Phone number
	3 3. 3.m.y	-		
7. Address of the billing provider or facility indicated in box	#1	8. City		te 10. Zip code
Provider Completes This Section:			Die	agnosis (ICD code)
Date you want <i>THIS</i>		Date of Su		lease ensure all digits are
	se of Current Episode		1°	entered accurately
(1) Trau	matic (4) Post-surgical -	Type of Surge	: I	
2 Unsp	ecified 5 Work related	ACL Reconstruction	ction 2°	
Patient Type (3) Repe	etitive 6 Motor vehicle	2 Rotator Cuff/La	: -	
New to your office		3 Tendon Repair	3°	
2 Est'd, new injury		4) Spinal Fusion		<u> </u>
(3) Est'd, new episode		5 Joint Replacem	ent 4°	
(4) Est'd, continuing care		(6) Other		
Nature of Condition	DC ONLY		Current Functional Mea	asure Score
1) Initial onset (within last 3 months)	Anticipated CMT Level			
2) Recurrent (multiple episodes of < 3 months)	98940 () 98942	Neck Inc	dex DASH	(other)
3 Chronic (continuous duration > 3 months)	98941 98943	Back Inc	dex LEFS	
	ptoms began on:		Indicate where you have	e pain or other symptom
(Please fill in selections completely)			F-7	()
1. Briefly describe your symptoms:			60	
2. How did your symptoms start?			<i>J?</i> }~\\\\	111:411
			W 1	Tew Was 4
3. Average pain intensity:			HH	
Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9	(10) worst pain		CON
	3)(4)(5)(6)(7)(8)(9) (10) worst pain) **()) ((
4. How often do you experience your sy (1) Constantly (76%-100% of the time) (2) Freq		Occasionally (26% 50%	of the time) (4) Intermittently	(00) 050) of the time)
0	O		\circ	(0%-25% of the time)
5. How much have your symptoms inte		\sim	g both work outside the home an	d housework)
0 0	. •	(5) Extremely		
6. How is your condition changing, sin 0 N/A — This is the initial visit 1 M	ce care began at <i>this</i> facility uch worse 2 Worse 3 A little		ge (5) A little better (6) Be	tter (7) Much better
7. In general, would you say your overa	all health right now is	(5) Poor		
0 0	\bigcup	\cup	D-4	
Patient Signature: X			Date:	