**Medical Chronology/Summary**

*Confidential and privileged information*

**Usage guideline/Instructions**

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

***Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes"*** in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

**General Instructions:**

- *The medical summary focuses on **Motor vehicle collision** on **MM/DD/YYYY,** the injuries and clinical condition of **XXXX** as a result of accident, treatments rendered for the complaints and progress of the condition.*

- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*

**Injury Report:**

| DESCRIPTION | DETAILS |
|---|---|
| **Prior injury details** | *No prior injury records available.* |
| **Date of injury** | MM/DD/YYYY |
| **Description of injury** | 25-year-old female presents s/p MVC who was the driver and reports being parked and T-boned on driver side by a truck on residential street. She reports being a fully seatbelt- restrained (seatbelt and shoulder harness) driver. Her vehicle was struck on the left rear by another vehicle. She did not see the collision coming. |
| **Injuries - Diagnoses** | • Right Shoulder pain<br>• Low back pain<br>• Closed head injury<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Sciatica, unspecified site<br>• Circadian rhythm sleep disorder, unspecified type<br>• Chronic pain syndrome<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter<br>• Impingement syndrome of left shoulder<br>• Impingement syndrome of right shoulder<br>• Left shoulder pain<br>• Radiculopathy, cervical region<br>• Radiculopathy, lumbar region<br>• Cervical disc disorder w radiculopathy, unspecified cervical region<br>• Intervertebral disc disorders w radiculopathy, lumbar region<br>• Intervertebral disc disorders w radiculopathy, lumbosacral region<br>• Brachial neuritis and/or radiculitis due to displacement Of Cervical intervertebral disc (disorder) |
| **Treatments rendered** | • Pain medications<br>• Chiropractic treatment - **04/23/YYYY-06/06/YYYY, 01/02/YYYY-02/01/YYYY**<br>• L4−5 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy- **06/04/YYYY, 06/26/YYYY**<br>• C5-6 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy- **06/12/YYYY, 07/10/YYYY** |

| | |
|---|---|
| | • Sub acromial injection to left shoulder- **06/11/YYYY**<br>• Sub acromial injection to right shoulder- **07/11/YYYY** |
| **Condition of the patient as per the last available record** | As of 02/01/YYYY, Patient undergoing chiropractic treatment stated that she was feeling sore and tight on the right side of her neck and right shoulder. She had right shoulder pain, neck pain, mid-back pain, and lower back pain. |

## Patient History

**Past Medical History:** History of low back pain. **(***Pdf ref: 1)*

**Surgical History:** History of tonsillectomy**, (***Pdf ref: 2)*

**Family History:** No significant history

**Social History**: Occasional use of alcohol, (*Pdf ref: 3*, reports the use of caffeine. (*Pdf ref: 4)*

**Allergy:** No known drug allergies

## Detailed Summary

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| ***Summary of post motor vehicle collision<br>Date of collision: 04/16/YYYY*** | | | |
| 04/16/YYYY | Hospital/ Provider | **Police Report:**<br><br>**Total number of units:**2<br><br>**Total number of persons:** 3<br><br>**Crash date:** 04/16/YYYY<br><br>**Crash time:** 00:05 hours<br><br>**Identification and location:**<br>**County:** Bexar<br><br>**City:** San Antonio<br><br>**Road on which crash occurred**<br>**Roadway part:** 1<br>**Street name:** Prue<br><br>**Intersecting Road:**<br>**At intersection:** No<br>**Roadway part:** 1<br>**Street name:** Terra Rye | 5-6 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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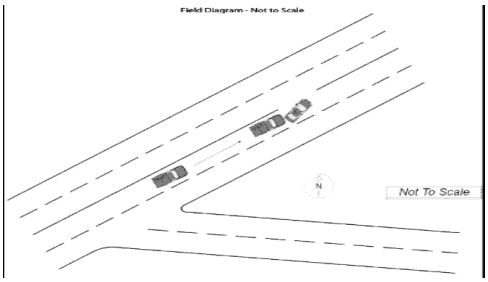
| | | **Vehicle number #1:**<br>**LP state**: Texas<br>**LP number**: CHT6090<br>**VIN**: 3B7HC13Y41M281817<br>**Vehicle year**: 2001<br>**Color**: Brown<br>**Make:** Dodge<br>**Model**: RAM 50<br>**Body type**: PK<br>**Person name:** Brett Kilgore<br><br>**Vehicle number #2:**<br>**LP state**: Texas<br>**LP number**: 12102P9<br>**VIN**: SHHFK7H49JU208500<br>**Vehicle year**: 2018<br>**Color**: Grey<br>**Make:** Honda<br>**Model**: Civic<br>**Body type**: P2<br>**Person name:** Selena Berlanga, Faith Gonzalez<br><br>**Narrative**:<br>Unit 1 was traveling NB on the 6300 Block of Prue Rd before Terra Rye RD. Unit 2 was turn right from Terra Rye Rd to get on to Prue Rd. Unit 2 merged over the to the turnaround lane area, preparing to turn around to go South on Prue RD when Unit 1 collided with Unit 2. EMS was called to the scene to check on the occupants of Unit 2. No injuries were present, and no signs of DWI from either driver. Both cars were towed from the scene. Crash report written<br><br>  | |
| 04/16/YYYY | Hospital/ Provider | **Triage record:**<br><br>**Chief Complaint:** Patient complains of headache, back pain and left shoulder pain. Patient was involved in a MVA 1 hour 30min ago. Patient was hit driver door side. Patient was the driver. Patient reports other vehicle was about 50mph when they hit her car. Patient was at a stopped position.<br><br>**ED Triage Assessment Pain Score:** 9 | 7-15 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **ESI Level:** ESI 4<br><br>**Diagnoses**:<br>Back pain<br>Headache | |
| 04/16/YYYY | Hospital/ Provider | **Emergency room visit:**<br><br>**Associated diagnoses:** Shoulder pain, low back pain, closed head injury, mvc (motor vehicle collision)<br><br>**Arrival mode:** Private vehicle, walking**.**<br><br>**Chief Complaint:** Patient c/o of headache, back pain and left shoulder pain. Patient was involved in a MVA 1 hour 30min ago. Patient was hit driver door side. Patient was the driver. Patient reports other vehicle was about 50mph when they hit her car. Patient was at a stopped position**.**<br><br>**History of present illness:**<br>The patient presents following motor vehicle collision. The onset was 2 hours ago. The Collision was driver side impact and 50 mph. The patient was the driver. There were safety mechanisms including seat belt. Location: left, forehead, back shoulder. Type of injury: direct blow. The degree of pain is severe. The degree of bleeding is none. Risk factors consist of none. Therapy today: see nurse's notes. Associated symptoms: back pain, Headache, left shoulder pain and denies nausea. Additional history: none. 25 year old female presents to ED s/p MVC 2 hours ago. Patient was driver and reports being parked and T-boned on driver side by a truck on residential street. Patient says she does not remember much, but has HA, left shoulder and back pain. Denies n/v<br><br>**Review of systems:**<br>**Musculoskeletal symptoms**: Back pain, left shoulder pain.<br><br>**Neurologic symptoms**: Headache<br><br>**Vital signs:**<br>**Temperature** F: 98.0 deg F<br>**Heart Rate**: 82 bpm<br>**Respiratory Rate**: 18 breaths/min<br>**Blood Pressure**: 143/82 mmHg<br>**SpO2/Pulse Oximetry**: 98 %<br>**Pain score**:9<br><br>**Physical examination:**<br>**Musculoskeletal**: Left trapezius tenderness, Paraspinal lumbar tenderness.<br><br>**Medical Decision Making**<br>**Trauma team:** Trauma criteria met. | 16-23 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Differential Diagnosis**: Motor vehicle collision, head injury, contusion, concussion not cervical spine injury, not solid organ injury.<br><br>**Rationale**: Main concern for patient is headache and left shoulder pain. Pain began about 20min after the accident. Concussion is possible and concussion precautions given. Likely back/shoulder and trapezius strain. Patient counseled on need for f/u and re-x-ray in 5 days if no improvement in case of occult fracture<br><br>**Course**: Improving.<br>**Pain status**: Decreased.<br>**Assessment**: Exam improved, patient ambulates well.<br><br>**Decision to Discharge**: Discharge Patient<br><br>**Impression and Plan**<br>**Diagnosis:**<br>• Shoulder pain<br>• Low back pain<br>• Closed head injury<br>• MVC (motor vehicle collision<br><br>**Plan**<br>**Condition**: Stable.<br>**Disposition**: Medically cleared, Discharged: Time 04/16/YYYY 03:46:00, to home.<br><br>**Reviewer's comment: The diagnostic reports are elaborated in detail below**<br><br>**Prescriptions**: Launch prescriptions<br>**Pharmacy**:<br>Ultram 50 mg oral tablet<br>Ibuprofen 600 mg oral tablet | |
| 04/16/YYYY | Hospital/ Provider | **CT head without contrast:**<br><br>**History**: MVA trauma**.**<br><br>**Comparison:** No comparison exams**.**<br><br>**Findings:** No evidence of acute intracranial hemorrhage. Normal gray-white differentiation, ventricles and CSF spaces. There is no acute fracture. No fluid in the sinuses or mastoids.<br><br>**Impression:** No evidence of acute intracranial hemorrhage or fracture**.** | 24-25 |
| 04/16/YYYY | Hospital/ Provider | **X-Ray of left shoulder:**<br><br>**Comparison:** No prior**.** | 26-28, 29-32 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | **Findings:** Normal alignment of glenohumeral and AC joints. No acute fractures.<br><br>**Impression:** No acute bony abnormality of the left shoulder**.** | |
| 04/16/YYYY | Hospital/ Provider | **Discharge Summary:**<br><br>**ED Disposition:** Discharge<br><br>**ED Mode of Discharge:** Ambulatory<br><br>**Mode of Transportation:** Private vehicle<br><br>**ED Discharged:** Home<br><br>**ED Condition:** Good, Stable, Improved<br><br>**Accompanied By, Discharge:** Sibling<br><br>**ED Suture Removal:** No<br><br>**Discharge Comments:** Patient is alert awake no s/s of distress at this time**.** Patient ambulates with no assistance. Patient verbalized discharge instructions and rx instruction. Patient verbalized side effects of medication | 33-36 |
| 04/23/YYYY | Hospital/ Provider | **Initial chiropractic visit:**<br><br>The above-captioned patient was seen today for the purpose of initial consultation, examination and evaluation of injuries sustained in an automobile collision that occurred on 04/16/YYYY.<br><br>**Details of collision and patient history:**<br>Patient provided the following information regarding the particulars of the incident.<br>The weather was clear, and the visibility on the road was good. Ms. Berlanga reports being a fully seatbelt- restrained (seatbelt and shoulder harness) driver. Her vehicle was struck on the left rear by another vehicle. She did not see the collision coming. She was completely unprepared for the impact with her head facing straight forward. The patient struck the center console, the side door, and the steering wheel. She reports that her vehicle was totaled in the collision. Immediately following the collision, Ms. Berlanga experienced headaches, neck pain, and low back pain, and states that she lost consciousness at some point during or shortly after the incident. She reports being dazed. The patient's head was injured. Following the collision she was taken to St. Luke's Baptist Hospital by her brother. The following tests were done at the hospital: X-Rays and CT-Scan. The patient reports an increase in symptoms. Ms. Berlanga reports losing time from work as a result of this collision. She reports not being able to perform normal work activities at this time because of pain. Since the collision the patient has had problems with standing, leaning, walking, squatting, climbing, kneeling, bending, twisting, | 37-47 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | carrying, lifting, pushing, pulling, reaching, sitting, performing sports, exercising, restful sleeping, and loss of concentration. The patient has difficulty going to sleep as a result of the collision. She wakes up in the middle of the night because of pain. The patient reports having no prior sleep problems.<br><br>**Symptoms**<br>The patient reports the following complaints.<br><br>**Right sacroiliac joint pain:**<br>This symptom came on gradually. It is progressively getting worse. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 10. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right, straining, standing, lifting, sitting, cold, and lying down. Brought on by resting. Relieved by coughing, sneezing, heat, and medications.<br><br>**Low Back Pain**<br>This symptom came on gradually. It is progressively getting worse. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 10. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right, straining, standing, lifting, sitting, cold, resting, and lying down. Relieved by coughing, sneezing, heat, and medications. Numbness down right leg to toes.<br><br>**Neck Pain:**<br>This symptom came on gradually. It is progressively getting worse. The intensity of this complaint is moderate- severe. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 10. Patient describes the feeling associated with this complaint as aching, shooting, throbbing, numbing, and tingling. Located on the right side. It is relieved in the morning and is aggravated in the afternoon. Aggravated by straining, standing, lifting, sitting, and cold. Brought on by bending forward, bending back, bending to the left, bending to the right, twisting left, and twisting right. Relieved by coughing, sneezing, heat, resting, lying down, and medications. Headaches and numbness down right arm to hand.<br><br>**Lower Mid-back Pain** | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | This symptom came on gradually. It is progressively getting worse. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 10. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right, straining, standing, lifting, sitting, cold, resting, and lying down. Relieved by coughing, sneezing, heat, and medications.<br><br>**Left Shoulder Pain:**<br>This symptom came on immediately. It has not changed since it started. The intensity of this complaint is moderate-severe. This complaint is frequent, or occurs 50% to 80% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 8. Patient describes the feeling associated with this complaint as aching, throbbing, and tingling. Located on the left side. It is aggravated in the morning and in the afternoon. Aggravated by straining and lifting. Relieved by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right, coughing, sneezing, standing, sitting, heat, cold, resting, lying down, and medications.<br><br>**Headache:**<br>This symptom came on immediately. It is progressively getting worse. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 10. Patient describes the feeling associated with this complaint as sharp, aching, shooting, throbbing, and tingling. Located on the left side. It is aggravated in the morning and in the afternoon. Aggravated by straining, standing, lifting, heat, and cold. Brought on by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right, coughing, and sneezing. Relieved by sitting, resting, lying down, and medications.<br><br>**Physical Examination**<br>The patient's vital signs are:<br><br>**Skin/Breast:** Ecchymosis of the left eye, lower right ribs and right thigh lateral aspect.<br><br>**Musculoskeletal examination**<br>**Cervical spine**<br>There was tenderness to digital palpation and muscle tension on the right side of the cervical spine. There was muscle hypertonicity present on both sides of the cervical spine. There was muscle spasm present on both sides of the cervical spine. Digital palpation for trigger points was positive in the | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | cervical area. Multiple active trigger points are stimulated with moderate digital pressure to the cervical muscles and are associated with consistent referred pain. Trigger points are located on Para cervical bilateral and trapezius bilateral. Fixations are noted at the following levels: C4, C5, C6, and C7.<br><br>**Thoracic Spine:** There was tenderness to digital palpation and muscle tension on the right side of the thoracic spine. There was muscle hypertonicity present on both sides of the thoracic spine. There was muscle spasm present on both sides of the thoracic spine. Digital palpation for trigger points was positive in the thoracic area. Multiple active trigger points are stimulated with moderate digital pressure to the thoracic muscles and are associated with consistent referred pain. Trigger points are located on Para thoracic bilateral. Fixations are noted at the following levels: T3, T4, T5, T6, T9, and T10.<br><br>**Lumbar Spine**<br>There was tenderness to digital palpation and muscle tension on both sides of the lumbar spine. There was muscle hypertonicity present on both sides of the lumbar spine. There was muscle spasm present on both sides of the lumbar spine. Digital palpation for trigger points was positive in the lumbar area. Multiple active trigger points are stimulated with moderate digital pressure to the lumbar muscles and are associated with consistent referred pain. Trigger points are located on Para lumbar bilateral. Fixations are noted at the following levels: L2, L3, L4, and L5.<br><br>**Head**<br>There was tenderness to digital palpation and muscle tension on the left side of the head. Tenderness along lateral aspect of left eye and head.<br><br>**Shoulders**<br>There was tenderness to digital palpation and muscle tension on the left shoulder. Digital palpation for trigger points was positive in the shoulders. Multiple active trigger points are stimulated with moderate digital pressure to the shoulder muscles and are associated with consistent referred pain. Trigger points are located on left trapezius, left deltoid, and left levator scapulae.<br><br>**Range of motion**<br>**Cervical Spine:** Ranges of motion were reduced in all ranges with pain. Cervical Flexion is 35/50. Cervical Extension is 30/60. Cervical Lateral Right is 40/45. Cervical Lateral Left is 30/45. Cervical Rotation Right is 70/80. Cervical Rotation Left is 65/80. Patient states pain on extension, flexion, lateral bending bilaterally, and rotation bilaterally.<br><br>**Lumbar Spine:** Ranges of motion were moderately reduced with pain. Lumbar Flexion is 30/60. Lumbar Extension is 15/25. Lumbar Lateral Right is 25/25. Lumbar Lateral Left is 20/25. Lumbar Rotation Right is 30/45. Lumbar Rotation Left is 30/45. Patient states pain on flexion, extension, | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | lateral bending bilaterally, and rotation bilaterally.<br><br>**Shoulders:** Ranges of motion were severely restricted in all ranges with pain for the left shoulder. Left shoulder flexion is 110/180. Left shoulder abduction is 80/180. Left shoulder internal rotation is 70/90. Left shoulder external rotation is 60/90. Patient states pain on flexion on the left, internal rotation on the left, external rotation on the left, and abduction on the left.<br><br>**Orthopedic signs**<br>**Cervical tests**<br>**Maximal Cervical Compression Test:** Maximum Cervical Rotary Compression with the patient passively rotating, laterally bending and extending the head, while the Doctor waits and watches for the patient's response, was positive on both sides. A positive result of spinal pain or radicular pain on the opposite side of rotation may suggest muscular strain in the cervical spine.<br><br>**Shoulder Depression Maneuver:** Positive on both sides. Flexion of the head away from affected area while compressing patient's shoulder to point of pain. A positive sign may indicate adhesions of the nerve roots of dural sheath.<br><br>**Soto Hall Test:** The Soto Hall test was positive for pain at the cervico thoracic region level. A positive test of localized non-radiating pain in the cervico dorsal spine during passive flexion may suggest likely ligamentous sprain in the posterior spinal segments or possible vertebral fracture.<br><br>**lumbar tests:**<br>**Bechterew's Sitting Test:** Bechterew's Test (seated straight-leg rising) was positive on the right. A positive sign of low back pain during seated leg extension may suggest lumbosacral injury.<br><br>**Kemp's Test:** Kemp's test was positive on both sides. A positive result of localized non-radiating low back pain as the patient extends and rotates the trunk may suggest vertebral facet or periscapular inflammation.<br><br>**Neck disability index**:<br>**Total score**:36<br>Therefore, her current level of disability is 72%. Disability levels between 69 and 100% mean that the patient is completely disabled.<br><br>**Revised Oswestry Assessment**<br>**Total points**: 24<br>Therefore, her current level of disability is 48%. Disability levels between 41 and 60% qualify as severe, meaning that while the pain is the main problem, activities of daily living are also affected. The patient requires a detailed investigation.<br><br>**Diagnosis:** | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | • Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br><br>**Treatment**<br>Treatment today consisted of the following procedures and therapies:<br>• E/M New Patient, level 3<br>• Hot/cold packs applied to the neck, mid back, and low back for 1 unit.<br>• Electric muscle stimulation was applied to the Para cervical bilateral, trapezius bilateral, Para thoracic bilateral, and Para lumbar bilateral for 1 unit.<br>• Ultrasound applied to the neck for one unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V.<br>• Electrodes.<br><br>**Final Comments:** Patient exhibits injuries which are associated to the subjective complaints and the trauma she received. The injuries have caused altered biomechanics, ligamentous damage, muscular damage, muscle spasms, decreased range of motion, paresthesia and possible disc herniation. If she does not respond to conservative treatment as expected, she will be referred out for an MRI study of the left shoulder, spine to rule out significant rotator cuff tears, disc disease, and/or herniation facet arthropathy and spinal stenosis. Due to the nature of the patient's injuries, a follow-up consultation with a medical doctor is recommended for further evaluation and possible medication. If any further questions should arise concerning the disposition of this case, please contact my office. | |
| 04/30/YYYY | Hospital/ Provider | **LOP History and Physical:** *(Illegible notes)*<br><br>**Date of injury:** 04/16/YYYY<br><br>**General cause of injury:** Motor vehicle accident<br><br>**HPI:** if due to MVA: patient was driver, was struck on driver side- T bone<br><br>**Locations of pain noticed immediately:**<br>Neck- left<br>Left shoulder<br>Other location: left face | 48-50 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Location of pain manifested later**:<br>Head<br><br>**Evaluation or treatment done before**: ER/ urgent care, chiropractor<br><br>**Review of systems:**<br>**Neurologic:** RUE/RLE ___/ weakness with sharp shooting____<br><br>**Physical exam:**<br>**Musculoskeletal:** 5/5 in RUE/RLE, LUE/LLE<br><br>**Assessment:** Neck sprain/strain, thoracic sprain / strain, lumbar sprain/ strain<br><br>**Plan:** Begin or continue physical therapy<br><br>**Imaging**: Done<br><br>Follow up results with some restrictions and precautions<br><br>Return for follow up as needed to review results | |
| 04/30/YYYY | Hospital/ Provider | **MRI of lumbar spine:**<br><br>**History:** Patient complains of severe lower back pain**.**<br><br>**Findings:**<br>Alignment of the lumbar spine is anatomic. Sacralisation of L5 is seen. Narrowing with diminished signal of the L4-5 disc is noted. The lumbar vertebrae are intact as are the posterior elements. The conus medullaris as well as cauda equina reveal no intra or extradural mass. The L1-2, L2-3 and L3-4 levels are normal. At L4-5 a focal 3.0 mm subligamentous disc herniation is seen with a radial tear in the outer annulus flattening the thecal sac with impingement upon the L5 nerve root sleeves bilaterally. Mild bilateral foraminal narrowing is noted. The L5-S1 level is unremarkable.<br><br>**Impression:**<br>• Alignment of the lumbar spine is anatomic. Sacralisation of L5 is noted with a transitional vertebra.<br>• At the L4-5 level a focal 3.0 mm subligamentous disc herniation is seen with a radial tear in the outer annulus flattening the thecal sac with impingement upon the L5 nerve root sleeves bilaterally. Mild bilateral foraminal encroachment is seen. | 51-65 |
| 04/30/YYYY | Hospital/ Provider | **MRI of cervical spine:**<br><br>**History:** Patient complains of severe neck pain**.**<br><br>**Findings:** | 66-81 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | Alignment of the cervical spine is anatomic. No subluxation or retrolisthesis is seen. No disc space narrowing or disc desiccation is noted. The cervical vertebrae are intact as are the posterior elements.<br>The cervical cord reveals cord no cord contusion or syrinx.<br>The C2-3, C3-4 and C4-5 levels are normal.<br>At C5-6 a 3.0 mm subligamentous disc herniation flattens the thecal sac without foraminal narrowing.<br>At C6-7 a diffuse disc bulge flattens the thecal sac with mild narrowing of the left neuroforamen.<br>The C7-T1 level is unremarkable.<br><br>**Impression:**<br>• Alignment of the cervical spine is anatomic.<br>• At C5-6 a 3.0 mm subligamentous disc herniation is seen flattening the thecal sac without foraminal narrowing.<br>• At C6-7 an annular disc bulge flattens the thecal sac with mild narrowing of the left neuroforamen. | |
| 04/30/YYYY | Hospital/ Provider | **MRI of left shoulder:**<br><br>**History:** Patient complains of severe shoulder pain**.**<br><br>**Findings:**<br>The oblique coronal T1 W sequence reveals that the size and configuration of both the supraspinatus and infraspinatus tendons are normal without retraction of the musculo tendinous junction or muscle atrophy. On the heavily T2W coronal and sagittal images, no partial or full thickness rotator cuff tear is seen.<br>The acromio clavicular joint reveals mild joint space narrowing with mild articular hypertrophy. A Type II acromion is noted with mild impingement upon the rotator cuff.<br>The glenohumeral joint reveals no joint space narrowing or effusion. A tear to the anterior inferior rim of the glenoid labarum is seen. The subscapularis tendon is intact. No tear of the biceps labral complex is noted.<br><br>**Impression:**<br>• Anterior glenohumeral joint instability is seen with a tear involving the anterior inferior rim of the glenoid labrum. No occult fracture is seen.<br>• Mild impingement upon the subacromial space and rotator cuff is noted.<br>• No glenohumeral joint instability is seen. The biceps labral complex is intact. | 82-100 |
| 05/02/YYYY | Hospital/ Provider | **Progress Notes:** *(Illegible notes)*<br><br>**Chief complaint:** Follow up / pain/ medication refills, MRI results. Left hand, shoulder, neck or back pain. Stable ____. Here for results and work release | 101 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Review of system:**<br>• Fever/chills<br>• Chest paining<br>• Sob (Shortness of breath)<br>• Weakness<br><br>**Assessment**:<br>• Cervical and lumbar herniated nerve pulposus<br>• Left glenohumeral joint instability with tenderness<br>• Left subacromial impingement ___<br><br>**Plan**:<br>Dr. ___referral<br>May return to work as tolerated | |
| 05/17/YYYY | Hospital/ Provider | **Office visit:**<br><br>**Nursing Note:** 25 year old female referred by Dr. Eric Salinas, DC, due to lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper back/shoulders. Patient states that on 4/16/18 she was at a turn around when she was t-boned on the back of the left passenger door and since then has been in severe pain. Pain scale is at a 10/10 today<br><br>**Chief Complaint(s):** Cervical spine pain radiating to upper back /shoulders , lower back pain radiating down right Lower extremity<br><br>**History of present illness:**<br>**Cervical spine pain radiating to upper back /shoulders.**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to upper extremity bilateral shoulders<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** Always there**.**<br>**Exacerbated:** with standing**.**<br>**Current and Associated Symptoms:** No fevers; No ch1Us, No blood m stool; No decrease in appetite; No shortness of breath; No chest pain; No headaches, No nausea; No vomiting; No diarrhea.<br><br>**Lower back pain radiating down right lower extremity:**<br><br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to lower extremity right leg and toes<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** at rest; when standing; with exertion, constant<br>**Relieved:** PT**.**<br><br>**Review of systems:**<br>**Musculoskeletal: Neck** | 102-109 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | Complains of limitation of activity, limitation of movement, pain with cause, stiffness, tenderness, Right leg pain<br>**Neurological**: Complains of numbness, tingling<br>**Psychiatric**: Mood: complain of insomnia<br><br>**Physical exam:**<br>**Musculoskeletal**: Straight leg raise: Right – positive 40 degrees<br>**Gait and station**: Antalgic gait<br>**Back: Lumbar spine**: Tenderness in the midline, Strength and tone: normal<br><br>**Problems**:<br>• Low back pain<br>• Opioid dependence, uncomplicated<br>• Sciatica, unspecified site<br>• Circadian rhythm sleep disorder, unspecified type<br>• Chronic pain syndrome<br><br>**Plan**:<br>A/P 25 year old female with lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper back/ shoulder<br><br>MRI scan of the Cervical and Lumbar Spine discuss with patient This allowed us to evaluate this patient's current anatomy as well as the source of her persistent pain.<br><br>This patient is having radicular type pain unresponsive to conventional non-invasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. At this point I would like to proceed with this minimally invasive treatment in order to reduce patient's level of pain. This is the simplest and least invasive procedure for discogenic and radicular derived pain. It is based on the corticosteroid injections are targeted towards thee nerve roots in order to counter the inflammation and relive the pain. The level has been selected after careful; evaluation of the patients diagnostic studies as well as detailed physical examination. The goal of the treatment is to minimize the effects of the patients injury, prevent further disease, maintain or enhance the patients functional level, allow patient to perform appropriates rehabilitation, decrease the amount of medication patient is on and promote safe return to normal activities as soon as possible<br><br>Return to clinic next available for fluoroscopy guided TF CESI (transforaminal cervical epidural steroid injection) bilateral C5-6 X2 and TF LESI (transforaminal lumbar epidural steroid injection) bilateral L4-5 x2. Procedure risks and expectations were discussed understanding and is willing to proceed with the plan<br><br>Continue chiropractic therapy to help alleviates her pain level, patient will go 2-3 times per week | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | Medications reviewed. No side effects<br>• Start Biofreeze q.i.d as needed<br>• Start Tizanidine 4mg<br>• Start Medrol dose pak #1<br><br>Follow up 1 month post injection series | |
| 04/24/YYYY - 05/30/YYYY | Hospital/ Provider | **Summary of interim chiropractic visits:**<br><br>**Date of visits:** *04/24/YYYY, 04/25/YYYY, 04/26/YYYY, 04/27/YYYY, 04/30/YYYY, 05/01/YYYY, 05/02/YYYY, 05/03/YYYY, 05/07/YYYY, 05/15/YYYY, 05/16/YYYY, 05/18/YYYY, 05/21/YYYY, 05/24/YYYY, 05/30/YYYY*<br><br>**04/24/YYYY:** "I am feeling more neck and back pain today, I woke up stiff and hurting this morning, I didn't sleep much last night, I am taking Ibuprofen for pain, I am feeling numbness and tingling down my right leg to my toes, shoulder hurts to lift or move it, headaches are the same, I have a hard time sitting too long, I get more headaches with being on light duty and looking at monitors, never had that before."<br><br>**04/25/YYYY:** "I am feeling neck to lower back and my left shoulder, my lower back hurts me a lot on the right side and my neck on the right side, my shoulder hurts to lift my arm above my shoulder, headaches all day, I am not sleeping good, I feel pain and tingling down my right leg to my toes and my right arm feels heavy, I can't sleep in one position too long."<br><br>**04/26/YYYY:** "I am not sleeping good, I am feeling a lot of neck and back pain today, I am still getting headaches throughout the day, my left shoulder is hurting me, I can lift my arm a little more, I can't lay on left side, I feel most of my neck and back pain on the right side, I feel numbness down right leg to my toes, when I sit or stand too much I feel pain into the back of my right leg to knee."<br><br>**04/27/YYYY: "**I didn't sleep much last night, I feel tired, my neck and back are hurting me, I still have headaches, my shoulder hurts me the same pain, I feel numbness down my right leg to foot, if I sit too long I get pain into my right thigh, taking Ibuprofen for pain."<br><br>**04/30/YYYY: "**I saw Dr. Rojas assistant today she gave me Robaxin and Gabapentin for pain and had MRI today, I was ok for first 15 minutes, then I started to get spasms into my lower back, it was horrible, I had hard time getting off the table, I was able to sleep longer this weekend, I am able to move my head more, my neck and back still hurting me, my shoulder pain is little less, I feel it more when i lift my arm, my right arm feels heavy, like its numb to my hand.<br><br>**05/01/YYYY:** "I took medications for pain and they put me to sleep for a while, I am still feeling the neck and back pain, if I put pressure on my right | 110-166 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | leg I get sharp pain into my back, neck and shoulder are hurting me, slight headaches, my right arm feels heavy at times, if I stand or sit too long I feel pain down my right leg."<br><br>**05/02/YYYY:** "I am feeling neck and back pain, more on the right side of my neck and back, if I sit too long I get pain into my right thigh, I get it more with sitting too long, I am still taking medications for pain, headaches come and go, my sleep is good with medicines, left shoulder is sore, hurts to lift it too high.<br><br>**05/03/YYYY:** "I am feeling a lot of lower back pain since last night, I drove for about an hour and then sat down for dinner, my back started hurting me a lot more, I had sharp pains towards the evening yesterday, I was off yesterday and didn't do much, I had to lay down after dinner, taking Ibuprofen for pain, I wasn't able to sleep much last night, shoulder and neck hurts, my neck feels stiff today, slight headaches."<br><br>**05/07/YYYY:** "I am feeling neck and back pain, my left shoulder is the same, I am not able to do my normal things, I am missing out on playing softball with my team now, headaches come and go, I didn't sleep good this weekend."<br><br>**05/15/YYYY:** I am feeling more pain into my lower back and I feel like a muscle on my right side is going to pull when I move certain ways, I am taking Ibuprofen for pain, my neck feels stiff and hurts to move my head, I sleep on my back most of the time sometimes I go to my stomach. I had to go to funeral yesterday and wear my uniform, the utility belt hurts my back and the standing and sitting hurt my back more.<br><br>**05/16/YYYY**: "My lower neck and upper back is hurting me, feels tight, middle to lower back hurting me, I feel pain down right leg to my toes, my right arm feels heavy, left shoulder hurts to lift my arm, I didn't sleep good last night, I get a few hours straight, taking Ibuprofen."<br><br>**05/18/YYYY:** "I am taking Ibuprofen and Tylenol for pain, I was able to sleep longer, but I still feel tired, the neck and back pain gets worse at the end of the day, I am feeling neck, middle to lower back pain, I feel heaviness down my right arm to hand, my right thigh I get sharp pain into the side of my thigh, I get numbness down my right leg to foot."<br><br>**05/21/YYYY:** "I am feeling pain on the right side of my neck and right side of my lower back, I felt pain all weekend, I get sharp pain down my right thigh to knee, left shoulder is doing better, I can move it more, not much pain this morning, sleep is off and on, taking Ibuprofen for pain."<br><br>**05/24/YYYY: "**I was so exhausted yesterday I went to sleep at 10 am and slept for about 10 hours, I am feeling lower back pain on the right side, not as strong, I still get pain into my right thigh, I had bad calf spasms last night, I am able to lift my arms, but it hurts when I go all the way, or reach out, I | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | am able to lay on left side now, I am not able to go to the gym and I want to get back to working out, if I sit down too much I get sharper back pains."<br><br>**05/30/YYYY:** "I feel tightness and pain on the right side of my neck, my left shoulder is hurting me but not much and I am able to move my arm more, I had some tingling down my arm to hand today, and I am getting tingling down my right leg to foot, my right buttock hurts me, feels like a bad cramp, my sleep is not good, I have to sleep on my back."<br><br>**Subjective**<br>The patient complained of the following symptoms today:<br>• Right sacroiliac joint pain.<br>• Low back pain.<br>• Neck pain.<br>• Lower mid-back pain.<br>• Left shoulder pain.<br>• Headache.<br><br>**Objective**<br>**Examination today revealed the following positive findings:**<br>• Spinal fixation(s) noted at C4, C5, C6, C7, T3, T4, T5, T6, T9, T10, L2, L3, L4, and L5.<br>• Tenderness upon palpation of the paracervical bilateral, trapezius bilateral, parathoracic bilateral, and paralumbar bilateral.<br>• Tenderness upon palpation of the left trapezius, left deltoid, and left levator scapulae.<br><br>**Diagnosis:**<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter.<br><br>**Assessment**<br>• Goals are consistent with the last examination.<br>• No adverse reaction to treatment. | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Plan**<br>Treatment today consisted of the following procedures and therapies**:**<br>• Spinal adjustment 3-4 regions at the level(s) of restrictions using activator.<br>• Hot/cold packs applied to the neck, mid back, and low back for 1 unit.<br>• Electric muscle stimulation (97014) was applied to the paracervical bilateral, trapezius bilateral, parathoracic bilateral, and paralumbar bilateral for 1 unit.<br>• Ultrasound applied to the neck for one unit.<br>• Mechanical traction (97012) was applied to the cervical, thoracic, and lumbar spine for 1 unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V<br><br>** Reviewer's Comments: Only the initial and final visits have been elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.** | |
| 06/04/YYYY | Hospital/ Provider | **Procedure Report:**<br><br>**Procedure performed:** L4−5 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy<br><br>**Surgeon:** Kanishka Monis, MD<br><br>**Anesthesia:** Local anesthesia<br><br>**Preoperative and Postoperative Diagnosis:**<br>• Low back pain.<br>• Lumbar radiculopathy.<br>• Herniated nucleus pulposus of the lumbar spine.<br><br>**Procedure performed:**<br>• Lumbar epidural steroid injection with local anesthetics, DepoMedrol.<br>• Fluoroscopy.<br>• Radiological examination and interpretation of lumbar epidurogram**.**<br><br>**Procedure in detail:** Fluoroscopy was used as an independent procedure in this case.<br><br>Radiologic examination and interpretation of lumbar epidurogram: On examination of the lumbar spine in AP, lateral and oblique views I was able to identify the needle tip within the epidural space with contrast medium spreading cephalad and caudad from the needle tip. An informed consent was obtained. The patient was placed prone on the fluoroscopic table. The low back was prepped and draped in the usual sterile fashion. Then 2% lidocaine was infiltrated intradermally at L4−5; an 18 gauge needle was used | 167-168 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | to nick the skin, and an 18 gauge Tuohy needle was inserted through the skin nick and advanced slowly into the epidural space using the loss−of−resistance to saline technique. After negative aspiration, 0.5 cc of Omnipaque 240 was injected demonstrating epidural spread without intrathecal or intravascular uptake. After negative aspiration, 3 cc of PFNS with 40 mg of DepoMedrol was injected slowly and incrementally. The needle was withdrawn after flushing. A Band− Aid was applied. There were no complications. | |
| 06/06/YYYY | Hospital/ Provider | **Final chiropractic visit:**<br><br>The above-captioned patient was seen today for the purpose of final consultation, examination and evaluation.<br><br>**History of present illness**<br>I had a shot to my lower back on Monday; I was having more pain with the whole thing.<br><br>**Symptoms**<br>The patient reports the following complaints.<br><br>**Right sacroiliac joint pain:**<br>The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 8. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, straining, and standing, lifting, and sitting. Relieved by heat, resting, and medications.<br><br>**Low Back Pain**<br>The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as8. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, twisting left, twisting right, straining, and standing, lifting, and sitting. Relieved by heat, resting, lying down, and medications.<br><br>**Neck Pain:** The intensity of this complaint is moderate-severe. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 5. Patient describes the feeling associated with this complaint as aching, shooting, throbbing, numbing, and tingling. Located on the right side. It is relieved in the morning and is aggravated in the afternoon. Aggravated by lifting. Brought on by bending forward, bending back, twisting left, and twisting right. Relieved by heat, resting, lying down, and medications. Headaches. | 169-178 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Lower Mid-back Pain:** The intensity of this complaint is moderate-severe. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 8. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, twisting left, twisting right, straining, and standing, lifting, and sitting. Relieved by heat, resting, lying down, and medications.<br><br>**Left Shoulder Pain:** It is progressively getting better.<br><br>**Right shoulder pain:** It is progressively getting better.<br><br>**Musculoskeletal examination**<br>**Cervical spine**<br>There was tenderness to digital palpation and muscle tension on the right side of the cervical spine. There was muscle hypertonicity present on right sides of the cervical spine. There was muscle spasm present on right side of the cervical spine. Digital palpation for trigger points was positive in the cervical area. Multiple active trigger points are stimulated with moderate digital pressure to the cervical muscles and are associated with consistent referred pain. Trigger points are located on Para cervical right and trapezius bilateral. Fixations are noted at the following levels: C4, C5, and C6<br><br>**Thoracic Spine:** There was tenderness to digital palpation and muscle tension on the right side of the thoracic spine. There was muscle hypertonicity present on right sides of the thoracic spine. There was muscle spasm present on right sides of the thoracic spine. Digital palpation for trigger points was positive in the thoracic area. Multiple active trigger points are stimulated with moderate digital pressure to the thoracic muscles and are associated with consistent referred pain. Trigger points are located on Para thoracic bilateral. Fixations are noted at the following levels: T3, T4, T5, T6, T9, and T10.<br><br>**Lumbar Spine**<br>There was tenderness to digital palpation and muscle tension on right sides of the lumbar spine. There was muscle hypertonicity present on right sides of the lumbar spine. There was muscle spasm present on right sides of the lumbar spine. Digital palpation for trigger points was positive in the lumbar area. Multiple active trigger points are stimulated with moderate digital pressure to the lumbar muscles and are associated with consistent referred pain. Trigger points are located on Para lumbar bilateral. Fixations are noted at the following levels: L2, L3, and L4<br><br>**Head:** Palpatory evaluation of the head was found to be well within normal physiological limits. There was no tenderness or edema noted. | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Shoulders**<br>There was tenderness to digital palpation and muscle tension on the left shoulder. Digital palpation for trigger points was positive in the shoulders. Multiple active trigger points are stimulated with moderate digital pressure to the shoulder muscles and are associated with consistent referred pain. Trigger points are located on left trapezius, and left levator scapulae.<br><br>**Range of motion**<br>**Cervical Spine:** Ranges of motion were reduced in all ranges with pain. Cervical Flexion is 50/50. Cervical Extension is 40/60. Cervical Lateral Right is 45/45. Cervical Lateral Left is 45/45. Cervical Rotation Right is 80/80. Cervical Rotation Left is 65/80. Patient states pain on flexion, lateral bending left, and rotation bilaterally<br><br>**Lumbar Spine:** Ranges of motion were moderately reduced with pain. Lumbar Flexion is 40/60. Lumbar Extension is 20/25. Lumbar Lateral Right is 25/25. Lumbar Lateral Left is 25/25. Lumbar Rotation Right is 40/45. Lumbar Rotation Left is 40/45. Patient states pain on flexion, and extension<br><br>**Shoulders:** Ranges of motion were severely restricted in all ranges with pain for the right shoulder and within normal limits without pain for the left shoulder. Right shoulder flexion is 140/180. Left shoulder flexion is 180/180. Right shoulder abduction is 140/180. Left shoulder abduction is 180/180. Right shoulder internal, rotation is 70/90. Left shoulder internal rotation is 90/90.<br><br>**Orthopedic signs**<br>**Cervical tests**<br>**Maximal Cervical Compression Test:** Maximum Cervical Rotary Compression with the patient passively rotating, laterally bending and extending the head, while the Doctor waits and watches for the patient's response, was positive on both sides. A positive result of spinal pain or radicular pain on the opposite side of rotation may suggest muscular strain in the cervical spine.<br><br>**Shoulder Depression Maneuver:** Negative on both sides. Flexion of the head away from affected area while compressing patient's shoulder to point of pain. A positive sign may indicate adhesions of the nerve roots of dural sheath.<br><br>**Soto Hall Test:** The Soto Hall test was positive for pain at the cervico thoracic region level. A positive test of localized non-radiating pain in the cervico dorsal spine during passive flexion may suggest likely ligamentous sprain in the posterior spinal segments or possible vertebral fracture.<br><br>**lumbar tests:**<br>**Bechterew's Sitting Test:** Bechterew's Test (seated straight-leg rising) was positive on the right sides. A positive sign of low back pain during seated leg extension may suggest lumbosacral injury. | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Kemp's Test:** Kemp's test was positive on both sides. A positive result of localized non-radiating low back pain as the patient extends and rotates the trunk may suggest vertebral facet or periscapular inflammation.<br><br>**Shoulder tests**<br>**Shoulder Apprehension Test**: Negative on the left shoulder. Positive sign is shoulder pain with a look of apprehension, possibly indicating a shoulder dislocation<br><br>**Apley's Scratch Test**: Decreased range of motion or asymmetry on the right shoulder, possibly indicating adhesive capsulitis. The patient abducts and internally/externally rotates the arm.<br><br>**Neck disability index**:<br>**Total score**:19<br>Therefore, her current level of disability is 42%. Disability levels between 29 and 48% are considered moderate.<br><br>**Revised Oswestry Assessment**<br>**Total points**: 24<br>Therefore, her current level of disability is 48%. Disability levels between 41 and 60% qualify as severe, meaning that while the pain is the main problem, activities of daily living are also affected. The patient requires detailed investigation<br><br>**Diagnosis:**<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter.<br><br>**Treatment**<br>Treatment today consisted of the following procedures and therapies:<br>• E/M New Patient, level 2<br>• Hot/cold packs applied to the neck, mid back, and low back for 1 unit. | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | • Electric muscle stimulation was applied to the Para cervical bilateral, trapezius bilateral, Para thoracic bilateral, and Para lumbar bilateral for 1 unit.<br>• Ultrasound applied to the neck for one unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V.<br><br>• Patient to follow-up with pain management.<br>• Patient pending an orthopedic consultation.<br>• Patient to continue home exercises.<br>• Patient to follow-up if symptoms increase.<br><br>**Final Comments**<br>Patient response to treatment has been progressive and fair for this type of injury and condition, but with residuals. It can be expected that she will require further therapy on an as needed basis. At some future time, further diagnostic testing, pain management and orthopedic evaluation may be required. She was released from care on 06/06/YYYY. If any further questions should arise concerning the disposition of this case, please contact my office. | |
| 06/11/YYYY | Hospital/ Provider | **Office visit:**<br><br>**Chief Complaint:** New patient bilateral shoulder pain, pain 8/10 ROM left 2/4 right 2/4<br><br>**Assessment/Plan**<br>• Impingement syndrome of left shoulder<br>• Injury of superior glenoid labrum of left shoulder joint<br>• Impingement syndrome of right shoulder<br>• Left shoulder pain<br><br>**History present illness**<br>New patient 25-year-old female involved in a motor vehicle accident 4/16/YYYY. Patient was seat belted driver stopped when her vehicle was hit in the right rear fender spinning the car ran. Patient sustained injury to both shoulders at that time. Patient is right-hand dominant.<br>1. Right shoulder 8/10 pain, night pain, pain pushing, pulling, lifting, and overhead work. There is no pain rating down the arm. There is pain radiating to the neck, and scapula. Patient has had physical therapy, has not had any injections, and without history of prior injury.<br>2. Left shoulder pain 7/10 include night pain, pain pushing, pulling, lifting, and overhead work. The pain radiating down the arm has no pain to the neck, and no pain to the scapula. Patient has had physical therapy, has not had injections, and without history of prior injury or surgery.<br><br>**Diagnostic imaging**<br>**MRI of the left shoulder**<br>Premier medical imaging, April 30, 2018<br>**Impression** | 179-182 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | Anterior joint instability is tear involving the anterior inferior rim of the glenoid labrum. No occult fracture is seen<br>Mild impingement in subacromial space rotator cuff is noted<br>No lateral joint instability is biceps labral complex is intact<br><br>**Physical exam**<br>1 Examination left shoulder, 3/4 range of motion, positive supraspinatus deltoid pain with internal/external rotation of the left upper extremity, neurovascular intact gross exam. There are no skin lesions or deformities. There is no evidence of instability. Patient has acromial tenderness, scapular tenderness, and trapezial tenderness.<br>2 Examination right shoulder range of motion 3/4, + supraspinatus positive deltoid pain with internal/external rotation. The right upper extremity is neurovascular intact on gross exam. There is no evidence of instability, the fingers acromial tenderness, scapular tenderness, and trapezial tenderness.<br><br>**Impression:**<br>1 Left shoulder impingement syndrome<br>2 Left shoulder labral injury<br>3 Right shoulder impingement syndrome<br><br>**Plan**<br>• MRI of the right shoulder<br>• Naprosyn 500 mg p.o. twice daily #60<br>• physical therapy left shoulder for impingement syndrome 3 times a week for 4 weeks<br>• Follow-up after the MRI<br>• Subacromial steroid injection today<br><br>**Procedure**<br>Patient was given a left shoulder subacromial injection, patient tolerated procedure well. | |
| 06/12/YYYY | Hospital/ Provider | **Procedure Report:**<br><br>**Procedure performed:** C5-6 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy<br><br>**Medical necessity:** Treatment and diagnosis of the intractable cervical spine pain with radiation to the upper extremity associated with the diagnosis of the above which has been confirmed by the radiological/ physical findings. Necessity to perform using fluoroscopy guidance for accurate placement of needles in the corresponding neuro foramina, and to decrease complications.<br><br>**Surgeon:** Kanishka Monis, MD<br><br>**Anesthesia:** Local anesthesia<br><br>**Preoperative and Postoperative Diagnosis:** | 183-184 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | • Cervical pain.<br>• Cervical radiculopathy.<br>• Herniated nucleus pulposus of the cervical spine.<br><br>**Procedure performed:**<br>• Cervical epidural steroid injection with local anesthetics, DepoMedrol.<br>• Fluoroscopy.<br>• Radiological examination and interpretation of cervical epidurogram**.**<br><br>**Procedure in detail:** Fluoroscopy was used as an independent procedure in this case.<br><br>**Radiologic examination and interpretation of cervical epidurogram**: On examination of the cervical spine in AP, lateral and oblique views I was able to identify the needle tip within the epidural space with contrast medium spreading cephalad and caudad from the needle tip.<br><br>**Note**: An informed consent was obtained. The patient was taken to the procedure room, and was placed in the prone position. Standard ASA monitors were applied (pulse Ox, EKG and NIBP). The neck was prepped and draped in the usual sterile fashion. Then 2% lidocaine was infiltrated intradermally and deeper overlying the C5−6 space as identified by fluoroscopy. Skin nick was made using an 18g needle then an 18 G Tuohy needle was inserted through the skin nick and advanced slowly under fluoroscopic guidance until the tip of the needle touched the lamina. The needle was redirected and entered the epidural space with LOR to PF saline technique. After negative aspiration, a 1cc of Omnipaque 240 was injected under life fluoro. Appropriate spread of contrast material within the epidural space in the usual distribution was observed. There was no intrathecal spread nor vascular uptake noted. After negative aspiration, 2ml of PF Normal Saline and DepoMedrol 40mg was injected. The needle was withdrawn. Band Aids were applied. There were no complications. The patient was taken to the recovery room awake, alert, and in stable condition. | |
| 06/25/YYYY | Hospital/ Provider | **MRI of left shoulder:**<br><br>**History:** Patient complains of severe right shoulder pain.<br><br>**Findings:**<br>The oblique coronal T1 W sequence reveals that the size and configuration of both the supraspinatus and infraspinatus tendons are normal without retraction of the musculo tendinous junction or muscle atrophy. On the heavily T2W images, no partial or full thickness tear of either the supraspinatus or infraspinatus tendons is seen.<br><br>The acromio clavicular joint reveals joint space narrowing with articular hypertrophy. Coronal images reveal a Type III acromion with impingement | 185-196 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | upon the rotator cuff.<br><br>The glenohumeral joint reveals no significant joint effusion or occult fracture. The glenoid labrum is intact as is the subscapularis tendon. No tear of the biceps-labral complex is noted.<br><br>**Impression:**<br>• No partial or full thickness rotator cuff tear is seen.<br>• Impingement upon the subacromial space and rotator cuff is noted.<br>• No glenohumeral joint instability or occult fracture is present. | |
| 06/26/YYYY | Hospital/ Provider | **Procedure Report:**<br><br>**Procedure performed:** L4−5 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy<br><br>**Surgeon:** Kanishka Monis, MD<br><br>**Anesthesia:** Local anesthesia<br><br>**Preoperative and Postoperative Diagnosis:**<br>• Low back pain.<br>• Lumbar radiculopathy.<br>• Herniated nucleus pulposus of the lumbar spine.<br><br>**Procedure performed:**<br>• Lumbar epidural steroid injection with local anesthetics, DepoMedrol.<br>• Fluoroscopy.<br>• Radiological examination and interpretation of lumbar epidurogram.<br><br>**Procedure in detail:** Fluoroscopy was used as an independent procedure in this case.<br><br>**Radiologic examination and interpretation of lumbar epidurogram**: On examination of the lumbar spine in AP, lateral and oblique views I was able to identify the needle tip within the epidural space with contrast medium spreading cephalad and caudad from the needle tip. An informed consent was obtained. The patient was placed prone on the fluoroscopic table. The low back was prepped and draped in the usual sterile fashion. Then 2% lidocaine was infiltrated intradermally at L4−5; an 18 gauge needle was used to nick the skin, and an 18 gauge Tuohy needle was inserted through the skin nick and advanced slowly into the epidural space using the loss−of−resistance to saline technique. After negative aspiration, 0.5 cc of Omnipaque 240 was injected demonstrating epidural spread without intrathecal or intravascular uptake. After negative aspiration, 3 cc of PFNS with 40 mg of DepoMedrol was injected slowly and incrementally. The needle was withdrawn after flushing. A Band− Aid was applied. There were no complications. | 197-198 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| 07/10/YYYY | Hospital/ Provider | **Procedure Report:**<br><br>**Procedure performed:** C5-6 Interlaminar Epidural Steroid Injection; Epidurography; Fluoroscopy<br><br>**Medical necessity:** Treatment and diagnosis of the intractable cervical spine pain with radiation to the upper extremity associated with the diagnosis of the above which has been confirmed by the radiological/ physical findings. Necessity to perform using fluoroscopy guidance for accurate placement of needles in the corresponding neuro foramina, and to decrease complications.<br><br>**Surgeon:** Kanishka Monis, MD<br><br>**Anesthesia:** Local anesthesia<br><br>**Preoperative and Postoperative Diagnosis:**<br>• Cervical pain.<br>• Cervical radiculopathy.<br>• Herniated nucleus pulposus of the cervical spine.<br><br>**Procedure performed:**<br>• Cervical epidural steroid injection with local anesthetics, DepoMedrol.<br>• Fluoroscopy.<br>• Radiological examination and interpretation of cervical epidurogram**.**<br><br>**Procedure in detail:** Fluoroscopy was used as an independent procedure in this case.<br><br>**Radiologic examination and interpretation of cervical epidurogram**: On examination of the cervical spine in AP, lateral and oblique views I was able to identify the needle tip within the epidural space with contrast medium spreading cephalad and caudad from the needle tip.<br><br>**Note**: An informed consent was obtained. The patient was taken to the procedure room, and was placed in the prone position. Standard ASA monitors were applied (pulse Ox, EKG and NIBP). The neck was prepped and draped in the usual sterile fashion. Then 2% lidocaine was infiltrated intradermally and deeper overlying the C5−6 space as identified by fluoroscopy. Skin nick was made using an 18g needle then an 18 G Tuohy needle was inserted through the skin nick and advanced slowly under fluoroscopic guidance until the tip of the needle touched the lamina. The needle was redirected and entered the epidural space<br>With LOR to PF saline technique. After negative aspiration, a 1cc of Omnipaque 240 was injected under life fluoro. Appropriate spread of contrast material within the epidural space in the usual distribution was observed. There was no intrathecal spread nor vascular uptake noted. After | 199-200 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | negative aspiration, 2ml of<br>PF Normal Saline and DepoMedrol 40mg was injected. The needle was withdrawn. Band Aids were applied. There were no complications. The patient was taken to the recovery room awake, alert, and in stable condition. | |
| 07/11/YYYY | Hospital/ Provider | **Follow-up visit:**<br><br>**Chief Complaint:** Follow-up MRI right shoulder, bilateral shoulder injury, pain left shoulder 5/10 ROM 4/4, pain right shoulder 8/10 ROM 4/4<br><br>**Assessment/Plan**<br>• Right shoulder pain<br>• Left shoulder pain<br>• Impingement syndrome of right shoulder<br>• Impingement syndrome, shoulder, left<br><br>**Diagnosis**<br>• Left shoulder impingement syndrome<br>• Right shoulder impingement syndrome<br><br>**Diagnostic imaging**<br>**MRI of the right shoulder**<br>Premier medical imaging, June 25, 2018<br><br>**Impression**<br>1 No partial or full-thickness rotator cuff tears are seen<br>2 Impingement in subacromial space and rotator cuff is noted<br>3 No glenohumeral joint instability or occult fractures are present<br><br>Current condition<br>1 left shoulder pain 5/10 occasional, range of motion 4/4<br>2 right shoulder pain 8/10 occasional range of motion 4/4<br><br>**Impression**<br>1 Patient with bilateral shoulder impingement syndrome. Left shoulder has had an injection which has improved condition; however, patient has not had physical therapy, and has not had an injection of the right shoulder.<br><br>**Plan**<br>• Right shoulder subacromial steroid injection today<br>• Physical therapy bilateral shoulders for impingement syndrome 3 times a week for 6 weeks<br>• Naprosyn 500 mg p.o. twice daily #60<br>• Follow-up 6 weeks' time<br><br>**Procedure patient**<br>Patient was given a subacromial steroid injection right shoulder tolerated procedure well. | 201-202 |
| 07/11/YYYY | Hospital/ | **Referral Report:** | 203 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | Provider | **Diagnosis:** Bilateral shoulder<br><br>**Treatment:** Frequency: 3, duration: 6<br><br>Physical therapy, evaluate and treat | |
| 08/09/YYYY | Hospital/ Provider | **Follow up visit:**<br><br>**Nursing Note:** 25 year old female returns for post injection follow-up for C5−6 Interlaminar ESI X 2 reports 40% relief of pain, and L4−5 Interlaminar Epidural Steroid Injection X 2 reports 30% relief of pain. Patient states she still has pain. Pain level today is 8/10 today<br><br>**Chief Complaint(s):** Cervical spine pain radiating to upper back /shoulders , lower back pain radiating down right Lower extremity<br><br>**History of present illness:**<br><br>**Cervical spine pain radiating to upper back /shoulders.**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to upper extremity bilateral shoulders<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** Always there**.**<br>**Exacerbated:** with standing**.**<br>**Current and Associated Symptoms:** No fevers; No ch1Us, No blood m stool; No decrease in appetite; No shortness of breath; No chest pain; No headaches, No nausea; No vomiting; No diarrhea.<br><br>**Lower back pain radiating down right lower extremity:**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to lower extremity right leg and toes<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** at rest; when standing; with exertion, constant<br>**Relieved:** PT**.**<br><br>**Review of systems:**<br>**Musculoskeletal:**<br>**Neck-** Complains of pain, stiffness<br>**Back pain**-Complains of limitation of activity, limitation of movement, pain with cause, stiffness, tenderness, Right leg pain<br>**Neurological**: Complains of numbness, tingling<br>**Psychiatric**: Mood: complain of insomnia<br><br>**Physical exam:**<br>**Musculoskeletal**: Straight leg raise: Right – positive 40 degrees<br>**Gait and station**: Antalgic gait<br>**Back: Lumbar spine**: Tenderness in the midline, Strength and tone: normal | 204-207 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | **Pain scale:**8/10<br><br>**Problems**:<br>• Low back pain<br>• Circadian rhythm sleep disorder, unspecified type<br>• Radiculopathy, cervical region<br>• Radiculopathy, lumbar region<br><br>**Plan**:<br>A/P 25 year old female with lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper back/ shoulder<br><br>MRI scan of the Cervical and Lumbar Spine discuss with patient This allowed us to evaluate this patient's current anatomy as well as the source of her persistent pain.<br><br>This patient is having radicular type pain unresponsive to conventional non-invasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. At this point I would like to proceed with this minimally invasive treatment in order to reduce patient's level of pain. This is the simplest and least invasive procedure for discogenic and radicular derived pain. It is based on the corticosteroid injections are targeted towards thee nerve roots in order to counter the inflammation and relive the pain. The level has been selected after careful; evaluation of the patients diagnostic studies as well as detailed physical examination. The goal of the treatment is to minimize the effects of the patients injury, prevent further disease, maintain or enhance the patients functional level, allow patient to perform appropriates rehabilitation, decrease the amount of medication patient is on and promote safe return to normal activities as soon as possible<br><br>S/P C5-6 Interlaminar ESI X 2 reports 40% relief of pain, and L4-5 Interlaminar Epidural Steroid Injection X 2 reports 30% relief of pain.<br><br>Continue chiropractic therapy to help alleviates her pain level, patient will go 2-3 times per week<br><br>Medications reviewed. No side effects<br>• Continue Biofreeze q.i.d as needed<br>• Discontinue Tizanidine 4mg<br>• Start Baclofen 10 mg TID #90 for muscle spasm<br>• Patient scheduled with Dr. Earle 08/23/YYYY @ 10:30<br>• RTC 1 month re−evaluation<br><br>Follow up 1 month post injection series | |
| 08/22/YYYY | Hospital/ Provider | **Office visit: (***Incomplete record***)**<br><br>**Diagnosis**<br>• Cervical disc disorder with radiculopathy, unspecified cervical | 208-209 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | region<br>• Intervertebral disc disorders with radiculopathy, lumbar region<br>• Intervertebral disc disorders with radiculopathy, lumbosacral region<br><br>**Plan**<br>**Office Procedures**<br>**MRI review: cervical spine:**<br>My review of the MRI scan of the non-weight bearing cervical spine without contrast performed at premier medical imaging on April 30 2018 reveals contained disc herniation rated as stage I-II with annular herniation, protrusion, and spinal stenosis at C3-4 and C4-5 Contained disc herniation rated as stage II with annular herniation, protrusion, and spinal stenosis at C6-7. Non-contained disc herniation rated as stage III with annular herniation, nuclear extrusion, and spinal stenosis at C5-6<br><br>**MRI review: lumbar:**<br>My review of the MRI scan of the non-weight bearing lumbar spine without contrast performed at premier medical imaging on April 20 2018 reveals contained disc herniation rated as stage I-II with annular herniation, protrusion, and spinal stenosis at L3-4. non-contained disc herniation rated as stage III with annular herniation, nuclear extrusion, and spinal stenosis at L4-5<br><br>**Procedures**<br>MRI Lumbar Spine W/o Dye<br>MRI Neck Spine W/o Dye<br><br>**Problem List**<br>Brachial neuritis and/or radiculitis due to displacement of cervical intervertebral disc (disorder) | |
| 09/06/YYYY | Hospital/ Provider | **Follow up visit:**<br><br>**Nursing Note:** 26 year old female here for refill on medications. Patient's states that she had to reschedule appointment Dr. Earl will not be seeing him until 9/17/18. Pain level today is 9/10<br><br>**Chief Complaint(s):** Cervical spine pain radiating to upper back /shoulders , lower back pain radiating down right lower extremity<br><br>**History of present illness:**<br><br>**Cervical spine pain radiating to upper back /shoulders.**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to upper extremity bilateral shoulders<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** Always there**.**<br>**Exacerbated:** with standing**.** | 210-213 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Lower back pain radiating down right lower extremity:**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to lower extremity right leg and toes<br>**Severity:** severe 10 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** at rest; when standing; with exertion, constant<br>**Relieved:** PT.<br><br>**Review of systems:**<br>**Musculoskeletal:**<br>**Neck**- Complains of pain, stiffness<br>**Back pain**-Complains of limitation of activity, limitation of movement, pain with cause, stiffness, tenderness, Right leg pain<br>**Neurological**: Complains of numbness, tingling<br>**Psychiatric**: Mood: complain of insomnia<br><br>**Physical exam:**<br>**Musculoskeletal**: Straight leg raise: Right – positive 40 degrees<br>**Gait and station**: Antalgic gait<br>**Back: Lumbar spine**: Tenderness in the midline, Strength and tone: normal<br>**Pain scale:**9/10<br><br>**Problems**:<br>• Low back pain<br>• Circadian rhythm sleep disorder, unspecified type<br>• Radiculopathy, cervical region<br>• Radiculopathy, lumbar region<br><br>**Referrals**<br>**Referral to Physical Therapy**<br>ICD Code: Radiculopathy, cervical region , Low back pain<br>Notes: 4 times a week for 6 weeks<br>Evaluate and Treat<br><br>**Plan**:<br>A/P 26 year old female with lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper back/ shoulder<br><br>MRI scan of the Cervical and Lumbar Spine discuss with patient This allowed us to evaluate this patient's current anatomy as well as the source of her persistent pain.<br><br>This patient is having radicular type pain unresponsive to conventional non-invasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. At this point I would like to proceed with this minimally invasive treatment in order to reduce patient’s level of pain. This is the simplest and least invasive procedure for discogenic and | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
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| | | radicular derived pain. It is based on the corticosteroid injections are targeted towards thee nerve roots in order to counter the inflammation and relive the pain. The level has been selected after careful; evaluation of the patients diagnostic studies as well as detailed physical examination. The goal of the treatment is to minimize the effects of the patients injury, prevent further disease, maintain or enhance the patients functional level, allow patient to perform appropriates rehabilitation, decrease the amount of medication patient is on and promote safe return to normal activities as soon as possible<br><br>Continue chiropractic therapy to help alleviates her pain level, patient will go 2-3 times per week<br><br>S/P C5-6 Interlaminar ESI X 2 reports 40% relief of pain, and L4-5 Interlaminar Epidural Steroid Injection X 2 reports 30% relief of pain. Medications reviewed. No side effects<br>• Continue Biofreeze q.i.d as needed<br>• Discontinue Tizanidine 4mg<br>• Refill Baclofen 10 mg TID #90 for muscle spasm<br>• RTC 1 month re−evaluation<br><br>Follow up 1 month post injection series | |
| 09/13/YYYY | Hospital/ Provider | **Follow-up visit:**<br><br>**Subjective**<br><br>**Chief Complaint:** Neck pain and low back pain<br><br>**History of Present Illness:** Neck pain and low back pain<br><br>**Location**<br>**Reported:** Right sided lower back, radiation to lower extremity, right sided neck, radiation to upper extremity<br><br>**Quality**<br>**Reported:** shooting<br><br>**Severity**<br>**Reported:** 8 of 10 pain level today. Affecting daily activities. Affecting sleep patterns<br><br>**Duration**<br>**Reported:** 3-12 months<br><br>**Timing**<br>**Reported:** constant<br><br>**Context**<br>**Reported:** Tried over-the-counter medications to treat cervical & lumbar | 214-221, 222-229 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | symptoms. Currently taking prescription medication to treat cervical & lumbar symptoms.<br>**Denied:** History of depression. History of back surgery<br><br>**Modifying Factors**<br>**Reported:** Aggravated by certain movements**.**<br><br>**Associated Signs and Symptoms**<br>**Reported:** Muscle weakness. Upper extremity pain, lower extremity pain, difficulty walking, headaches, upper extremity paresthesias, lower extremity paresthesias<br><br>**History**: Selena is in today with her husband Robert at the referral of her PCP Dr. Samaniego and pain management physician Dr. Monis for evaluation of neck pain, headaches, and right arm pain associated with numbness, tingling, and weakness that awakes her from sleeping as well as lower back pain and right leg pain associated with numbness, tingling, and weakness with no previous history of the same after injury sustained in a motor vehicle accident on April 16, 2018. In the accident, she was a driver of vehicle, was wearing her seatbelt, denies loss of consciousness, the impact was to the driver side of the car, and her airbags d\d not deploy. She is right-hand dominant and denies any bowel or bladder symptoms. She has had MRI scans performed of both cervical spine and lumbar spine after the accident of April 16, 2018, which by report reveals discal pathology. She has no previous history of these types of symptoms by verbal confirmation today and available medical records were reviewed. She has failed conservative treatment over the last five (5) months to include exercise program, medications, therapy, pain management, and injection therapy without resolution of symptoms. She presents here for surgical consultation and treatment recommendations after failure of conservative treatment. Pre surgical provocation discography of both cervical spine and lumbar spine was discussed. She understands that this is a permanent injury and cannot heal on its own.<br><br>**Review of Systems**<br>**Musculoskeletal - reported:** Back Problems, Weakness, Restricted Motion,<br><br>**Physical Exam**<br>**Musculoskeletal**<br>**Cervical Spine**<br>• Paresthesias at C5, C6, C7 on the right side.<br>• Compression test is positive<br>• Lhemitte's Test is negative<br>• Shoulder Abduction Test is positive on the right<br>• Negative for Phalen's<br>• Negative for Tinels<br>• Negative for Hoffman's.<br>• The biceps, triceps, brachioradialis reflexes are negative | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | • Range of Motion is decreased<br>• Negative for Spurling's Test<br>• Trigger point LSO, Trigger point mid trapezius on the right<br>• Muscle Spasms**:** Patient is not experiencing muscle spasms<br><br>**Lumbar Spine**<br>• Range of motion is decreased with extensor lag.<br>• Fortin finger test is negative Spring test is positive at L5-S1<br>• Sciatic notch tenderness is positive on the right<br>• Flip test is positive on the right<br>• Lasegue's Test is positive on the right side<br>• Patient is positive for ankle jerk, posterior tibial jerk on the right<br>• Paresthesias on the right at S1, L5<br>• Braggard's test is positive on the right<br><br>**Assessment**<br>**Diagnosis**<br>Cervical Disc Disorder W Radiculopathy, Unspecified Cervical Region<br>Intervertebral Disc Disorders W Radiculopathy, Lumbar Region<br>Intervertebral Disc Disorders W Radiculopathy, Lumbosacral Region<br><br>**Plan:**<br>**Flexion-extension x-rays: cervical spine:**<br>Flexion-extension x-rays of cervical spine reveal functional spinal unit collapse measuring 2.5mm at C3-4. Functional spinal unit collapse measuring 2mm at C4-5. Functional spinal unit collapse measuring 2mm at C5-6. Functional spinal unit collapse measuring 2mm at C6-7. C3-4, C4-5, C5-6 and C6-7 demonstrate foraminal stenosis as well as clinical instability<br><br>**Flexion-extension x-rays: lumbar spine:**<br>Flexion-extension x-rays of the lumbar spine reveal<br>Functional spinal unit collapse measuring 12mm at L2-3.<br>Functional spinal unit collapse measuring 10 mm at L3-4.<br>Functional spinal unit collapse measuring 5mm at L4-5. Functional spinal unit collapse measuring 0 mm at L5-S1. L4-5 and L5-S1demonstrate foraminal stenosis as well as meet the clinical instability criteria of the American academy of orthopedic surgeons instructional course lectures clinical instability checklist associated with cauda equina damage, ODG #2, #3, and #5 associated with lumbar spine fusion selection of patients, and the 2005 congress of neurological surgeons recommendations for arthrodesis associated with discal pathology should this treatment regime be entertained<br><br>**X-ray of pelvis:**<br>X-ray of pelvis are within normal limits<br><br>**Follow-Up**<br>Follow-Up ( As Needed) with Stephen Earle, | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Care Plan**: Continue with pain management<br><br>**Surgical Options, Cervical**<br>Discussed surgical treatment options versus nonsurgical treatment options. Patient does qualify for surgical candidacy for cervical spine. Discussed provocation discography and post discographic CT scan as indicated by MRI scans. Also discussed non-surgical treatment options to include pain management, medication management, physical therapy, exercise program, and epidural steroid injections.<br><br>**Surgical Options, Lumbar**<br>Discussed surgical treatment options versus nonsurgical treatment options. Patient does qualify for surgical candidacy for lumbar spine. Discussed provocation discography and post discographic CT scan as indicated by MRI scans. Also discussed non-surgical treatment options to include pain management, medication management, physical therapy, exercise program, and epidural steroid injections.<br><br>Patient was instructed to call with if the pain increased.<br>Patient is to contact chronic pain management doctor with update of care plan.<br>Patient was instructed to contact PCP for update of care plan.<br><br>**Problem List:**<br>Brachial neuritis and/or radiculitis due to displacement of cervical intervertebral disc (disorder)<br><br>**Reviewers comment: The above mentioned original reports of X-ray reports of pelvis, cervical and lumbar spine are unavailable for review** | |
| 09/13/YYYY | Hospital/ Provider | **Surgical Evaluation note:**<br><br>Enclosed is a copy of my initial office consultation dated September 13, 2018, with review of records and MRI scans concerning injuries sustained in a motor vehicle accident by patient on April 16, 2018. Her diagnosis is one of traumatic internal disc disruption syndrome with discogenic pain, stenosis, and instability of the cervical spine C3-C4, C4-C5, C5-C6, and C6-C7 as well as traumatic internal disc disruption syndrome with discogenic pain, stenosis, and instability of the lumbar spine L3-L4 and L4-L5. Patient states she had no previous history of the same and there are no old medical records to indicate otherwise. She has failed conservative treatment over the last nearly five (5) months. She remains a surgical candidate for both her cervical spine and lumbar spine in relationship to injuries sustained in the motor vehicle accident on April 16, 2018.<br><br>If she chose to proceed with cervical spine surgical intervention, the procedure would be 2 stages. Stage I is pre-surgical provocation discography and post discographic CT scan at C3-C4, C4-C5, C5-C6, C6-C7 and a control at the cost in the San Antonio area at this point in time of approximately $15,000. Follow-up surgical procedure would include anterior | 230-233 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | cervical decompression, discectomy, and instrumented arthrodesis at the demonstrated pain generators at the cost of an additional $125,000 to include, but not limited to, surgeon's fees, assistant surgeon's fees, anaesthesia fees, hospitalization fees but not including lost wages for an average of 2 weeks.<br><br>If she chose to proceed with lumbar spine surgical intervention, the procedure would also be a minimum of 2 stages. Stage I is pre-surgical provocation discography and post discographic CT scan at L3-L4, L4-L5, and a control at the cost of an additional $15,000. Follow-up surgical procedure would include decompressive lumbar laminectomy, discectomy, and instrumented arthrodesis at the demonstrated pain generators at the cost of an additional $175,000 to include, but not limited to, surgeon's fee, assistant surgeon's fees, anaesthesia fees, physical therapy for 6-12 weeks, hospitalization fee but not including lost wages for an average of 6-12 weeks. Should the procedure be performed at two (2) interspaces or more, I would recommend a temporary implantable bone growth stimulator which requires removal at 24 weeks postop by manufacturer's recommendations. This would add an additional fee of $40,000 to the overall medical care for this type of outpatient surgery.<br><br>I believe it is more likely than not and within all reasonable medical probability that she will undergo surgical intervention of both her cervical spine and lumbar spine at some time in the future in relationship to the injuries sustained in a motor vehicle accident on April 16, 2018. | |
| 10/01/YYYY | Hospital/ Provider | **Future Medical expenses assessment:**<br><br>The following is the recommended procedure and the cost related to the accident. The procedure we have discussed is a right shoulder open rotator cuff exam or repair and open decompression. The procedure is reasonable, medically necessary and related to the patient's accident.<br><br>The following charges are the estimated charges related to the date of accident.<br>Surgeon: $ 16,500.00<br>Surgical Assistant: $ 2800.00<br>Anesthesiologist: $. 4500.00<br>Hospitalization: $ 36,500.00<br><br>The following estimated charges are subject to change post procedure<br><br>Patient will be in a sling for 2 weeks and out of work for 2 weeks.<br>This patient will require physical therapy after surgery for 6 weeks with an extra estimated cost of $11,500.00. Please allow $1500.00 for medication and DME. | 234 |
| 10/04/YYYY | Hospital/ Provider | **Follow up visit:**<br><br>**Nursing Note:** Patient is here to follow up with lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper | 235-238 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | back/shoulders. She did go see Dr. Earle for further evaluation. On a pain scale level 0/10 she rates her pain 8/10<br><br>**Chief Complaint(s):** Cervical spine pain radiating to upper back /shoulders , lower back pain radiating down right Lower extremity<br><br>**History of present illness:**<br><br>**Cervical spine pain radiating to upper back /shoulders.**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to upper extremity bilateral shoulders<br>**Severity:** severe 8 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** Always there**.**<br>**Exacerbated:** with standing**.**<br><br>**Lower back pain radiating down right lower extremity:**<br>**Pain:** constant, sharp, stabbing; throbbing.<br>**Location of pain:** Radiating to lower extremity right leg and toes<br>**Severity:** severe 8 (scale 10 = severe).<br>**Onset:** 04/16/YYYY<br>**Pain occurs:** at rest; when standing; with exertion, constant<br>**Relieved:** PT**.**<br><br>**Review of systems:**<br>**Musculoskeletal:**<br>**Neck-** Complains of pain, stiffness<br>**Back pain**-Complains of limitation of activity, limitation of movement, pain with cause, stiffness, tenderness, Right leg pain<br>**Neurological**: Complains of numbness, tingling<br>**Psychiatric**: Mood: complain of insomnia<br><br>**Physical exam:**<br>**Musculoskeletal**: Straight leg raise: Right – positive 40 degrees<br>**Gait and station**: Antalgic gait<br>**Back: Lumbar spine**: Tenderness in the midline, Strength and tome: normal<br>**Pain scale:**8/10<br><br>**Problems**:<br>• Low back pain<br>• Circadian rhythm sleep disorder, unspecified type<br>• Radiculopathy, cervical region<br>• Radiculopathy, lumbar region<br><br>**Plan**:<br>A/P 26 year old female with lower back pain that radiates down right leg to toes and cervical spine pain that radiates to upper back/ shoulder | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | MRI scan of the Cervical and Lumbar Spine discuss with patient This allowed us to evaluate this patient's current anatomy as well as the source of her persistent pain.<br><br>This patient is having radicular type pain unresponsive to conventional non-invasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. At this point I would like to proceed with this minimally invasive treatment in order to reduce patient's level of pain. This is the simplest and least invasive procedure for discogenic and radicular derived pain. It is based on the corticosteroid injections are targeted towards thee nerve roots in order to counter the inflammation and relive the pain. The level has been selected after careful; evaluation of the patients diagnostic studies as well as detailed physical examination. The goal of the treatment is to minimize the effects of the patients injury, prevent further disease, maintain or enhance the patients functional level, allow patient to perform appropriates rehabilitation, decrease the amount of medication patient is on and promote safe return to normal activities as soon as possible<br><br>Suggested patient seek chiropractic therapy to help alleviates her pain level, patient will go 2-3 times per week<br><br>Dr. Earle recommends surgery in future when patient is ready because of young age.<br>S/P C5-6 Interlaminar ESI X 2 reports 40% relief of pain, and L4-5 Interlaminar Epidural Steroid Injection X 2 reports 30% relief of pain.<br>Medications reviewed. No side effects<br>• Continue Biofreeze q.i.d as needed<br>• Continue Baclofen 10 mg TID #90 for muscle spasm<br><br>Follow up 1 month post injection series | |
| 01/02/YYYY | Hospital/ Provider | **Initial chiropractic visit:**<br><br>The above-captioned patient was seen today for the purpose of follow-up consultation, examination and evaluation.<br><br>**History of present illness**<br>I was having more right shoulder pain after I was done here, Dr. Clemence sent me out for right shoulder MRI and I have some tears in there, he wants me to have therapy on it before surgery.<br><br>**Symptoms**<br>The patient reports the following complaints.<br><br>**Right sacroiliac joint pain:**<br>The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 7. It is aggravated in | 239-247 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | the morning and in the afternoon. Aggravated by bending forward, bending back, straining, and standing, lifting, and sitting. Relieved by heat, resting, and medications.<br><br>**Low Back Pain**<br>The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 7. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, twisting left, twisting right, straining, and standing, lifting, and sitting. Relieved by heat, resting, lying down, and medications.<br><br>**Neck Pain:** The intensity of this complaint is moderate-severe. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 8. Patient describes the feeling associated with this complaint as aching, shooting, throbbing, numbing, and tingling. Located on the right side. It is relieved in the morning and is aggravated in the afternoon. Aggravated by lifting. Brought on by bending forward, bending back, twisting left, and twisting right. Relieved by heat, resting, lying down, and medications. Headaches.<br><br>**Lower Mid-back Pain:** The intensity of this complaint is moderate-severe. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 7. Patient describes the feeling associated with this complaint as sharp, aching, shooting, spasmodic, throbbing, numbing, and tingling. Located on the right side. It is aggravated in the morning and in the afternoon. Aggravated by bending forward, bending back, twisting left, twisting right, straining, and standing, lifting, and sitting. Relieved by heat, resting, lying down, and medications.<br><br>**Left Shoulder Pain:** It is progressively getting better. Patient describes the feeling associated with this complaint as aching and throbbing**.**<br><br>**Right shoulder pain:** It is progressively getting worse. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time. On a scale from 0 to 10, with 10 being the highest possible level of pain, patient graded the pain as 9. Aggravated by bending forward, bending back, and lifting**.**<br><br>**Musculoskeletal examination**<br>**Cervical spine**<br>There was tenderness to digital palpation and muscle tension on the right side of the cervical spine. There was muscle hypertonicity present on right | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | sides of the cervical spine. There was muscle spasm present on right side of the cervical spine. Digital palpation for trigger points was positive in the cervical area. Multiple active trigger points are stimulated with moderate digital pressure to the cervical muscles and are associated with consistent referred pain. Trigger points are located on Para cervical right and trapezius bilateral. Fixations are noted at the following levels: C4, C5, and C6<br><br>**Thoracic Spine:** There was tenderness to digital palpation and muscle tension on the right side of the thoracic spine. There was muscle hypertonicity present on right sides of the thoracic spine. There was muscle spasm present on right sides of the thoracic spine. Digital palpation for trigger points was positive in the thoracic area. Multiple active trigger points are stimulated with moderate digital pressure to the thoracic muscles and are associated with consistent referred pain. Trigger points are located on Para thoracic bilateral. Fixations are noted at the following levels: T3, T4, T5, T6, T9, and T10.<br><br>**Lumbar Spine**<br>There was tenderness to digital palpation and muscle tension on right side of the lumbar spine. There was muscle hypertonicity present on right sides of the lumbar spine. There was muscle spasm present on right sides of the lumbar spine. Digital palpation for trigger points was positive in the lumbar area. Multiple active trigger points are stimulated with moderate digital pressure to the lumbar muscles and are associated with consistent referred pain. Trigger points are located on Para lumbar bilateral. Fixations are noted at the following levels: L2, L3, and L4<br><br>**Shoulders**<br>There was tenderness to digital palpation and muscle tension on the left shoulder. Digital palpation for trigger points was positive in the shoulders. Multiple active trigger points are stimulated with moderate digital pressure to the shoulder muscles and are associated with consistent referred pain. Trigger points are located on left trapezius<br><br>**Shoulders**<br>There was tenderness to digital palpation and muscle tension on the right shoulder. Digital palpation for trigger points was positive in the shoulders. Multiple active trigger points are stimulated with moderate digital pressure to the shoulder muscles and are associated with consistent referred pain. Trigger points are located on right trapezius, right deltoid, and right levator scapulae.<br><br>**Range of motion**<br>**Cervical Spine:** Ranges of motion were reduced in all ranges with pain. Cervical Flexion is 50/50. Cervical Extension is 40/60. Cervical Lateral Right is 45/45. Cervical Lateral Left is 45/45. Cervical Rotation Right is 80/80. Cervical Rotation Left is 65/80. Patient states pain on flexion, lateral bending bilaterally | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | **Lumbar Spine:** Ranges of motion were moderately reduced with pain. Lumbar Flexion is 40/60. Lumbar Extension is 20/25. Lumbar Lateral Right is 25/25. Lumbar Lateral Left is 25/25. Lumbar Rotation Right is 40/45. Lumbar Rotation Left is 40/45. Patient states pain on flexion, and extension<br><br>**Shoulders:** Ranges of motion were severely restricted in all ranges with pain for the right shoulder and within normal limits without pain for the left shoulder. Right shoulder flexion is 140/180. Left shoulder flexion is 180/180. Right shoulder abduction is 140/180. Left shoulder abduction is 180/180. Right shoulder internal, rotation is 70/90. Left shoulder internal rotation is 90/90. Right shoulder external rotation is 70/90. Left shoulder external rotation is 90/90. Patient states pain on flexion on the right, internal rotation on the right, external rotation on the right, and abduction on the right<br><br>**Orthopedic signs**<br>**Cervical tests**<br>**Maximal Cervical Compression Test:** Maximum Cervical Rotary Compression with the patient passively rotating, laterally bending and extending the head, while the Doctor waits and watches for the patient's response, was positive on both sides. A positive result of spinal pain or radicular pain on the opposite side of rotation may suggest muscular strain in the cervical spine.<br><br>**Shoulder Depression Maneuver:** Positive on right sides. Flexion of the head away from affected area while compressing patient's shoulder to point of pain. A positive sign may indicate adhesions of the nerve roots of dural sheath.<br><br>**Soto Hall Test:** The Soto Hall test was positive for pain at the cervico thoracic region level. A positive test of localized non-radiating pain in the cervico dorsal spine during passive flexion may suggest likely ligamentous sprain in the posterior spinal segments or possible vertebral fracture.<br><br>**lumbar tests:**<br>**Bechterew's Sitting Test:** Bechterew's Test (seated straight-leg rising) was negative on the both sides. A positive sign of low back pain during seated leg extension may suggest lumbosacral injury.<br><br>**Kemp's Test:** Kemp's test was positive on both sides. A positive result of localized non-radiating low back pain as the patient extends and rotates the trunk may suggest vertebral facet or periscapular inflammation.<br><br>**Shoulder tests**<br>**Shoulder Apprehension Test**: Positive sign is shoulder pain with a look of apprehension, possibly indicating a right shoulder dislocation. Negative on the left shoulder.<br><br>**Apley's Scratch Test**: Decreased range of motion or asymmetry on the right shoulder, possibly indicating adhesive capsulitis. Negative on the left | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | shoulder. The patient abducts and internally/externally rotates the arm.<br><br>**Neck disability index**:<br>**Total score**:15<br>Therefore, her current level of disability is 30%. Disability levels between 29 and 48% are considered moderate.<br><br>**Revised Oswestry Assessment**<br>**Total points**: 16<br>Therefore, her current level of disability is 32%. Disability levels between 21 and 40% qualify as moderate, meaning that the patient experiences pain and difficulty with sitting, lifting, and standing. Travel and social life are more difficult and the patient may be disabled from work. Personal care, sexual activity, and sleeping are not grossly affected, and the patient can usually be managed by conservative means.<br><br>**Diagnosis:**<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter.<br>• Pain in right shoulder<br><br>**Treatment**<br>Treatment today consisted of the following procedures and therapies:<br>• E/M New Patient, level 2<br>• Hot/cold packs applied to the neck, mid back, and low back for 1 unit.<br>• Electric muscle stimulation was applied to the Para cervical bilateral, trapezius bilateral, Para thoracic bilateral, and Para lumbar bilateral for 1 unit.<br>• Ultrasound applied to the neck for one unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V.<br><br>Patient is scheduled for 3 visits per week for 4 weeks at which time a re-evaluation will be performed to monitor treatment effectiveness and modify | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | treatment plan as necessary.<br>The patient has been recommended to continue taking her medication as directed. | |
| 01/10/YYYY - 01/30/YYYY | Hospital/ Provider | **Summary of interim chiropractic visits:**<br><br>**Date of visits:** *01/10/YYYY, 01/11/YYYY, 01/23/YYYY, 01/25/YYYY, 01/30/YYYY*<br><br>**01/10/YYYY:** Sharp pain going down right front leg. Consistent pain in right shoulder, lower back and neck. Right arm falls asleep and tingles and numb**.** Right shoulder, neck, low back- 9<br><br>**01/11/YYYY:** "I am feeling a lot of pain into my right shoulder, I feel it when I lift it even with my shoulder or more, my neck and back are still sore and hurt, I haven't been sleeping good, I can't lay on right side, I take Benadryl to help with sleep, I have to keep moving positions because of my pains."<br><br>**01/23/YYYY:** "I am feeling pain into my right shoulder and neck on the right side, my lower back is hurting me today, more on the right, the cold weather has me feeling more pains, I feel like I have been working out, and I haven't done anything, I am feeling my shoulder pop when I move it certain ways, I am able to move my arm more now, my neck is popping too, sleep is ok, longer but not normal."<br><br>**01/25/YYYY:** "I am still having a lot of shoulder pain, hurts me to move or use it still, if I sit on my couch the pain is less, if I look down my neck and shoulder hurt more, lifting or using it hurts me. All directions make it hurt, mid to lower back are the same, my shoulder pops a lot when I move, even getting dressed it pops."<br><br>**01/30/YYYY:** Patient stated: "I am feeling right shoulder pain and right side of my neck pain, more when I move them, the pain doesn't go down my arm it stays in the back of my shoulder, my middle back is sore, lower back is sore, I just feel neck and shoulder pain the most, I get more pain if I hold the phone up with my right arm, I can't lay on right side."<br><br>**Subjective**<br>The patient complained of the following symptoms:<br>• Right shoulder pain.<br>• Low back pain.<br>• Neck pain.<br>• Lower mid-back pain.<br>• Left shoulder pain.<br><br>**Objective**<br>**Examination today revealed the following positive findings:**<br>• Spinal fixation(s) noted at C4, C5, C6, T3, T4, T5, T6, T9, T10, L2, | 248-258, 259-264 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | L3 and L4.<br>• Tenderness upon palpation of the paracervical bilateral, trapezius bilateral, parathoracic bilateral, and paralumbar bilateral.<br>• Tenderness upon palpation of the left trapezius.<br>• Tenderness upon palpation of the right trapezius, right deltoid, and right levator scapulae.<br><br>**Diagnosis**<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter.<br>• Pain in right shoulder.<br><br>**Assessment:**<br>There is no change in the treatment goals since the last examination.<br>No adverse reaction to treatment.<br><br>**Plan:** Treatment today consisted of the following procedures and therapies<br>• E/M Established Patient, level 1 (99211).<br>• Hot/cold packs applied to the right shoulder for 1 unit.<br>• Electric muscle stimulation (97014) was applied to the right shoulder for 1 unit.<br>• Ultrasound applied to the right shoulder for one unit.<br>• Therapeutic Exercises (97110) right shoulder for one unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V.<br><br>** Reviewer's Comments: Only the initial and final visits have been elaborated. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.** | |
| 02/01/YYYY | Hospital/ Provider | **Final chiropractic evaluation:**<br><br>Patient stated: I am feeling sore and tight on the right side of my neck and my right shoulder hurts to the front this morning, I can't sleep on my stomach anymore, so I am going side to side and on my back, I am doing some light exercises, more on my legs, my lower back hurts when I sit or | 265-266 |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | bend too much."<br><br>**Subjective**<br>The patient complained of the following symptoms:<br>• Right shoulder pain.<br>• Low back pain.<br>• Neck pain.<br>• Lower mid-back pain.<br><br>**Objective**<br>**Examination today revealed the following positive findings:**<br>• Spinal fixation(s) noted at C4, C5, C6, T3, T4, T5, T6, T9, T10, L2, L3 and L4.<br>• Tenderness upon palpation of the paracervical bilateral, trapezius bilateral, parathoracic bilateral, and paralumbar bilateral.<br>• Tenderness upon palpation of the left trapezius.<br>• Tenderness upon palpation of the right trapezius, right deltoid, and right levator scapulae.<br><br>**Diagnosis**<br>• Concussion with loss of consciousness of 30 minutes or less, initial encounter.<br>• Post-traumatic headache, unspecified, not intractable.<br>• Nerve root and plexus compressions in diseases classified elsewhere.<br>• Sprain of ligaments of cervical spine, initial encounter.<br>• Sprain of ligaments of thoracic spine, initial encounter.<br>• Sprain of ligaments of lumbar spine, initial encounter.<br>• Unspecified sprain of left shoulder joint, initial encounter.<br>• Contusion of left eyelid and periocular area, initial encounter.<br>• Contracture of muscle, multiple sites.<br>• Driver injured in collision with other motor vehicles in traffic collision, initial encounter.<br>• Other cervical disc displacement, unspecified cervical region.<br>• Other intervertebral disc displacement, lumbar region.<br>• Superior glenoid labrum lesion of left shoulder, initial encounter.<br>• Pain in right shoulder**.**<br><br>**Assessment:**<br>Treatment goals remain the same.<br>No adverse reaction to treatment.<br><br>**Plan:**<br><br>Treatment today consisted of the following procedures and therapies<br>• Spinal adjustment 1-2 regions (98940) at the level(s) of restrictions using Specific light Diversified at thoracic and lumbar<br>• Hot/cold packs applied to the right shoulder for 1 unit. | |

| DATE | FACILITY/ PROVIDER | MEDICAL EVENTS | PDF REF |
|---|---|---|---|
| | | • Electric muscle stimulation (97014) was applied to the right shoulder for 1 unit.<br>• Ultrasound applied to the right shoulder for one unit.<br>• Therapeutic Exercises (97110) right shoulder for one unit.<br>• Therapy was performed by Lizette G, Steifanie M and/or Maria V.<br><br>Patient is to return on 02/04/YYYY. | |

***Other records:***

***Cover pages:*** *Pdf ref: 267-287*

***Affidavit:*** *Pdf ref: 288-447*

***Other patient records:*** *Pdf ref: 448-479*

***Others:*** *Pdf ref: 480-566*

***Medical bills:*** *Pdf ref: 567-596*

***Prescription records:*** *Pdf ref: 597-602*

***Patient's Information:*** *Pdf ref: 603-691*

***Referral Report:*** *Pdf ref: 692-697*

***Legal Documents:*** *Pdf ref: 698-702*

***Orders:*** *Pdf ref: 703-720*

***Consent:*** *Pdf ref: 721-726*

***Photos/Photocopy:*** *Pdf ref: 727-750*

**Reviewer's Comments: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.**