Medical Synopsis

MVA – 03/11/YYYY

Ms. Angelina XXXX was involved in an MVA on March 11, YYYY. She is healthy and reported no medical problems. She denied any problems with her heart, lungs, kidney, bowel, or bladder. She denied diabetes or seizure disorder. She does not smoke and does not drink alcoholic beverages. Her family history was negative and non-contributory. She had no known drug allergies. She takes no medications on a regular basis. Ms. XXXX is married and lives with her husband and daughter in Reno. She is currently employed as a nanny. She denies tobacco or excessive alcohol use. Ms. XXXX stated she has missed two weeks of work as she is unable to perform all of the duties required of her, such as lifting children and driving.

Mechanism of injury:

Ms. XXXX was the restrained driver when she was turning out of a parking lot another vehicle T-boned her to the passenger side at approximately 30 mph. Her airbags did deploy. She denies any LOC but states she did hit her head and felt dazed. Other than her headache she also reported some neck pain.

Events following the accident:

On March 11, YYYY, Ms. Angelina XXXX was evaluated by XXXX, Paramedic and XXXX, Paramedic of REMSA for MVA complaints. EMS arrived at the dispatched location to find a 23-year-old female standing upright outside the vehicle pulled off to the side of a street intersection. She was A&Ox4 and ambulatory. She complained of neck pain and a headache and stated, "it hurts when I turn my head." She also complained of a headache. EMS noted no obvious deformity, discoloration or hemorrhaging to the rest of the body. CMS was intact. She denied any radiating pain or tingling sensations. She was at a stop light when her light turned green. As she approached the intersection, her vehicle was hit by another vehicle that was going approximately 30-35 mph. She was restrained. Side airbags were deployed. Moderate damage noted to the vehicle's right side (mainly front end of passenger side). She refused ambulance transport and stated that someone was going to take her to the hospital. She did not complain of chest pain, SOB, head pain, blurred vision, abdominal pain, nausea, vomiting, or any other traumatic injuries or illnesses. She refused the need for her vitals to be taken. She was advised of possible risks of refusing transport such as worsening conditions of the neck pain and any unforeseen internal injuries that could lead to the possibility of death. She understood and was advised to call 911 in the future if necessary. AMA signature was obtained and EMS left the scene without incident.

On March 11, YYYY, Ms. XXXX was evaluated by XXXX, Paramedic and XXXX, Paramedic of REMSA for MVA complaints. EMS arrived at the dispatched location to find a 23-year-old female sitting upright outside on the sidewalk on the side of a street intersection. She was A&Ox4 and ambulatory. She complained of neck pain, which was rated as 7/10 on the pain scale. She stated that "it hurts when I turn my head." She also complained of a headache. She denied hitting her head or losing consciousness. EMS noted no obvious deformity, discoloration or hemorrhaging to the rest of her body. She had tenderness to the midline neck area upon palpation. CMS was intact. She was at a stop light when

her light turned green. As she approached the intersection, her vehicle was hit by another vehicle that was going approximately 30-35 mph. She was restrained. Side airbags were deployed. Moderate damage noted to the vehicle's right side (mainly front end of passenger side). She was placed on a C-collar and was walk-assisted to the ambulance. She had requested to be transported to Renown Regional Medical Center for further evaluation and care. Upon transport, her vital signs and condition were monitored. She was given Ibuprofen and Acetaminophen PO for her pain. She did not complain of chest pain, SOB, blurred vision, dizziness, abdominal pain, nausea, vomiting, or any other traumatic injuries or illnesses. Upon arrival at the hospital (Renown Regional Medical Center), her report was given and care was transferred to ED RN without incident.

On March 11, YYYY, Ms. XXXX was evaluated by XXXX, M.D., XXXX, R.N and Claire LaPresle, R.N. at XXXX for T-5000 MVA and neck pain. She was taken by ambulance with complaints of neck pain and headache after she was the restrained driver of a vehicle that was struck on the driver side by a vehicle traveling approx. 30 mph. She has positive airbag deployment. She was given Tylenol and Ibuprofen 600 mg by EMS. She presented to the emergency department complaining of neck pain and headache after a motor vehicle collision. She was the restrained driver when she was turning out of a parking lot another vehicle T-boned her to the passenger side at approximately 30 mph. Her airbags did deploy. She denies any LOC but states she did hit her head and felt dazed. Other than her headache she also reported some neck pain. Her review of systems was positive for headache and neck pain. Exam revealed slight abrasion over the right scalp. Cervical collar was in place. She had midline tenderness at approximately C5 without deformity or step-off. Her diagnosis included strain of neck muscle - initial encounter and Motor vehicle accident - initial encounter. She was treated with Ketorolac. She was recommended CT of head and CT of cervical spine to evaluate her symptoms as she would not be low risk by Canadian CT criteria. Upon re-evaluation, she had no new complaints. Her pain was improved, cervical-collar removed. She had full range of motion without significant pain in her neck and planned for discharge. She was prescribed Naprosyn 500 mg. She was referred to a primary physician for blood pressure management, diabetic screening, and for all other preventative health concerns. She was advised to follow-up at Northern Nevada Hopes. She was advised to return to work on Monday (March 16, YYYY). She was discharged home in stable condition.

On March 11, YYYY, XXXX, M.D., obtained Ms. XXXX's CT of head without contrast at Renown Health for moderate-severe head trauma, neck pain, and headache. The study revealed no acute intracranial findings.

On March 11, YYYY, XXXX, M.D., obtained Ms. XXXX's CT of cervical spine without contrast, with reconstructions at Renown Health for cervical spine injury and neck pain. The study revealed no acute fracture or dislocation seen in the CT scan of the cervical spine.

On March 12, YYYY, Ms. XXXX was evaluated by XXXX, M.D., XXXX, R.N, and XXXX, R.N at Renown Health for mid back pain and left arm pain. She presented to the Emergency Department for back, neck and arm pain secondary to an MVA that occurred yesterday. She was seen at the ER yesterday and was diagnosed with a neck strain. CT of head and C–spine was reported to be negative. She was T-boned while restrained at 30 mph. She stated that she hit her head and was dazed but she had no LOC. She endorsed returning to the ED because the pain has radiated down her neck into her spine, as

well as left arm pain that she did not have yesterday. Her review of systems was positive for back pain, neck pain, and arm pain. Examination of the neck revealed paraspinal tenderness to palpation. Examination of the back revealed bilateral paraspinal rhomboidal interspersed tenderness to palpation. She had tenderness to palpation over left bicep. Her diagnosis included acute bilateral thoracic back pain and left arm pain. She was seen and examined at bedside. She was treated with Acetaminophen 1000 mg. She was explained that the pain radiating down her spine is typical of trauma sustained after an MVA and that she should rest the affected area while avoiding tasks that could stress the upper back. She agrees with the plan of care. She was prescribed Flexeril 5 mg. She was advised to take Tylenol and Ibuprofen. She was advised to follow-up at Renown Regional Medical Center, Emergency Dept. She was discharged home in stable condition.

On March 25, YYYY, Ms. XXXX was evaluated by XXXX, DC at XXXX Chiropractic for MVA that she sustained on March 11, YYYY. She stated that she was the driver of an Acura traveling through the intersection between McCarran Boulevard and Sierra Highlands Drive in XXXX when she was struck on the passenger side by a Toyota Tacoma who failed to yield at the light. At the time of the accident, the roads were dry. She was looking straight ahead, and she was wearing her safety belt. She was totally surprised by the impact and did not have a chance to brace herself. Ms. XXXX was transported by ambulance from the scene of the crash to Renown Regional Medical Center Emergency Room. She was treated at the ER and she was diagnosed with whiplash and muscle strains. CT imaging of the head and neck showed no evidence of fracture or dislocation. She was prescribed an anti-inflammatory medication and instructed to rest. She returned to the Emergency Room the next day for increased pain and was prescribed Cyclobenzaprine. Home treatments included heat, rest, massage, and she was prescribed medications. She had chief complaints of headaches, neck pain, upper back pain, and low back pain. She described her headaches as intermittent. She has noticed a bump on her head since the accident. She describes her neck pain as constant and guarded, with the left side worse than the right. Her upper back pain was worse when her neck pain was bad. She located her upper back pain near the spine. She reported low back pain with movements. She stated that since the collision she had been experiencing mental and emotional problems. Cervical spine exam revealed both shoulders approximately level with no abnormal curvature of the spine present. Ms. XXXX was careful and apprehensive, turning her head to both the right and left. She had restriction in right and left lateral flexion, right rotation, and left rotation, with pain at the end-ranges of all planes. She had tenderness and hypertonicity upon palpation of the upper trapezius, rhomboids, and levator scapulae musculature bilaterally, and SCM musculature on the left. Cervical Maximum Foraminal Compression test was positive for dysfunction in the cervical spine. The spinous processes of C4-7 were tender to palpation. Motion palpation revealed fixation of C2-4 with both right and left lateral bending. Thoracic Spine revealed spinous processes tenderness to palpation at T2-10. Lumbar spine exam showed the right and left ilium to be approximately level. Lumbar range of motion revealed pain at the end ranges of flexion, right lateral flexion, and left lateral flexion. Lumbar extension increased the pain in her upper back. Palpation of the low back revealed muscle tenderness and hypertonicity of the lumbar paraspinal musculature bilaterally. The L5 spinous process was tender to palpation. Ms. XXXX completed a questionnaire regarding mental and emotional symptoms she has experienced since the collision. Symptoms included wanting to be alone, sleepiness, nausea, mood swings, agitation including anger and irritability, personality changes, reduced confidence, and feeling "woozy." Her diagnosis included cervical sprain/strain; loss of cervical range of motion; articular dysfunction at C2-4; acute traumatic cervicogenic headaches; thoracic sprain/strain; articular dysfunction

at T2-10; lumbar sprain/strain; articular dysfunction at L4-5; myofascitis of the cervical and upper thoracic spinal areas and post-concussion syndrome. It was opined as "It is my opinion from a reasonable degree of medical certainty that all of Ms. XXXX's complaints and symptoms described above and my objective findings are directly related to March 11, YYYY. injury. This opinion is based upon the patient's history, her current complaints, the above physical examination, and the mechanics of the crash. Ms. XXXX stated she was feeling fine immediately prior to this accident." Today, she received adjustment and was applied to physiotherapy in the form of vibratory massage, heat, intersegmental traction, and low level laser therapy. She tolerated this well. Ms. XXXX was recommended chiropractic spinal manipulation to her cervical, thoracic, and lumbar spine along with physiotherapy in the form of intersegmental traction, heat/diathermy, deep tissue massage, and low level laser therapy for three times per week for four weeks. She was advised that a re-evaluation will then be performed to determine the need for any additional care. Ms. XXXX was provided a cervical pillow to help with pain control and assist in the healing process depending upon response to initial treatment. She was advised that if her emotional post-concussion syndrome problems persist, she would be recommended a psychological evaluation.

On May 18, YYYY, Ms. XXXX was evaluated by XXXX, M.D., at RCS - Reno Carson Spine for neck pain with left greater than right periscapular pain. She was involved in an MVA on March 11, YYYY. She stated that was crossing from Walmart to Kohl's across Mae Anne on a green light when a car ran a red light and hit her in the right front portion of her car. She was driving an Acura and the other person was in a small pickup truck. She said that he was traveling at least 40 miles an hour. Her car was totaled, and she believed he was as well. She told me the driver got out and said, "was it red on my side?" She was working as a nanny at the time and had a child with her who was fortunately not injured. Ms. XXXX was taken by ambulance to the hospital (Renown), she said her neck started hurting approximately 15 minutes after the accident. She had pain in her neck that was left greater than right. She felt her neck was stuck and leaning towards the left side. She could not straighten it out. This was also evident in the CT scan of the cervical spine that was performed at Renown. At Renown they told her she did not have a concussion. She was given an anti-inflammatory. She was discharged home on the same day, however her pain worsened overnight and the next day she went back to the emergency room. At that time, she was having pain that moved downward into the trapezius musculature and along the periscapular borders, left greater than right. She noted that her head continued to lean towards the left and felt stuck there. She also complained of continued pain up under the skull. She was also dizzy for a time following the accident. Over the past year, she has had continued pain. She stated that there have been times when she has been less and times when it has been worse. She sought treatment with a chiropractor, Dr. Rovetti. He eventually referred her to Dr. Goode, a physiatrist at Tahoe Fracture, because he could not get control of her symptoms. This was a couple of months after the injury. She received her first set of trigger point injections which did not work. He then did facet injections which helped with her pain for about 5 months. However, her pain returned. Dr. Goode had recommended possibly doing ablations. She had been symptomatic for the entire time since the injury. She did have a period of time when she was not treated and it was simply due to her life. She is in nursing school, going to work, she is a mother and wife. She was so busy with work, school and taking care of her child that she could not make it for treatment. She reported working 12 hour shifts. Once she switched back to day shifts she was able to make time and continue treatment. Since that time, she has been treated regularly, but her symptoms have remained. She complained of her neck twitching at night and spasming and wanting to tilt to the left side. She also

complained of pain in the left trapezius and also along the periscapular border in roughly a C5-6 referred discogenic pain pattern. The pain was worse on the left than the right. She said sometimes the right side is better but the left is always there. Upon exam, she had a restricted range of motion cervical spine. She does not turn her head very far to the right. Palpation of the cervical spine revealed tenderness over the left paraspinous muscles and over the trapezius. She has also had tenderness left greater than right in the periscapular border about the area of the referred pattern for a C5-6 disc injury. Range of motion of the cervical spine was limited to the right side with rotation only going to 30°. To the left she could go 70°. When she looked to the right, she had a pulling sensation with tightness and burning on the left. She was able to extend her neck only about 10°. She was able to bring her chin to 3 finger breadths from her chest. Overall, her range of motion was restricted significantly for a 24-year-old. Her Spurling's maneuver produced periscapular pain and trapezial pain bilaterally and it was worse when going to the left. It was difficult to perform Lhermitte's maneuver and Jackson's maneuver due to limited range of motion. Her diagnosis included status post motor vehicle accident March 11, YYYY, with impact significant enough to total both cars, restrained driver; left-sided greater than right neck pain, with left greater than right periscapular pain suggestive of a cervical disc injury following the accident and no prior history of neck problems. She has been symptomatic now for over a year. She explained that she had an injury that was more significant than a simple sprain/strain type injury. She also explained that most sprain/strain injuries resolve in 6-8 weeks. There was a subset that will go 3-6 months before getting better. She explained her that once somebody has symptoms greater than 9 months to a year it becomes more likely than not that there is a significant injury to cervical disc given her pain pattern and distribution of pain. It was well established that the cervical discs refer pain to the medial scapular borders such that she has. Her pain distribution was suggestive of a C5-6 discogenic injury. She had undergone trigger point injections that have not helped and underwent facet injections that helped her symptoms. She likely had significant injuries to the facet joint capsules that would account for her continued axial neck pain. She had pain along the periscapular borders and was likely referred from the disc itself. It was discussed that an MRI scan of the cervical spine is warranted at this time. She had been symptomatic for over a year. Recommended to assess for any possible instability and a full set of X-rays should be obtained including AP, lateral, flexion and extension. She was advised that another round of facet injections would be appropriate and consideration for facet ablations could be made at that time. She was explained that if her periscapular pain continues after doing this, it is highly suggestive of a cervical disc injury. MRI scan and X-rays would determine if there is any evidence already of a cervical disc injury. She was advised to follow-up for review of images to make further plans.

Reviewer's Comments:

- *Consultation report by Dr. Goode is unavailable for review.*
- *Procedure report for trigger point injections and facet injections by Dr. Goode is unavailable for review.*

From April 01, YYYY, to August 20, YYYY, Ms. XXXX received chiropractic treatment from XXXX, DC at Northwest Reno Chiropractic for MVA that she sustained on March 11, YYYY. Her assessment included resolved lumbar sprain/strains; mostly resolved cervicothoracic sprain/strain; mostly resolved cervicogenic headaches; continued left upper cervical articular dysfunction; continued post-concussion anxiety and continued myofascial pain of the left cervicothoracic spinal area. On April 01, YYYY, she was with a cervical pillow that she stated helps and she continues to use. On April 27,

YYYY, Ms. XXXX's condition was not progressing as quickly as it should, so she was referred to her physiatrist, XXXX, M.D., for physical medicine/pain management. He treated Ms. XXXX with trigger point, steroid joint, and nerve block injections. Ms. XXXX stated that all of these helped to some degree. On June 17, YYYY, Ms. XXXX reported that she still has to be careful when she sleeps and does homework. She got a lot of pain in her neck. She wants to hold off on medial branch because she has been making progress with treatment here with messages. Her treatment frequency was reduced to 1x/week and was advised to continue with massages. On October 28, YYYY, Ms. XXXX she has been unable to come in regularly for the past 2 months due to work and school (works MWF – same day office is open with Dr. Randall here). She continues to have neck pain, back pain, and headaches. She was advised to resume treatment 1x/1-2 weeks and reevaluate in 4-6 weeks. She stated that job will change next week and she will be more able to come in for regular treatments. On February 12, YYYY, she stated she gets occasional neck "spasms" described as shooting pain in the left side of her neck. She stated she is unsure what causes this as it happened yesterday while she was simply lying in bed. She stated this pain only lasts a few seconds and has improved since her last injection, which was a medial branch block. She also reported "clicking" when she moves her neck - specifically when she turns her head to the left. Her mid and low back pain has seemingly resolved. She reported occasional headaches lately which she attributes to tension. Her only residual post-concussion symptom is occasional anxiety while driving - especially when she drives near the area of the crash. Throughout treatment, she made slow but steady progress both subjectively and objectively. There were some small gaps in treatment in the latter half of YYYY. This is attributed to difficulties and restrictions surrounding the COVID pandemic. It was opined as "It is my opinion that even though Ms. XXXX has continued complaints, she has reached a plateau in her condition. I don't believe any additional scheduled chiropractic care will necessarily improve her overall status to any significant degree." On August 06, YYYY, she complained of worse headaches and neck pain, mid back pain and low back pain and improved post-concussion symptoms. Her diagnosis included articular dysfunction, myofascial pain in cervical spine post cervical sprain/strain, cervicalgia and cervicogenic headaches. On August 20, YYYY, her soreness was improving. She was advised to continue the treatment.

On January 08, YYYY, Bradley Clark, M.D., obtained Ms. XXXX's X-ray of the cervical spine at Reno Diagnostics Centers for neck pain that radiates to the left shoulder. The study revealed straightening of the cervical spine without listhesis with maintained intervertebral disc spaces.

On January 08, YYYY, Bradley Clark, M.D., obtained Ms. XXXX's MRI of Cervical Spine without contrast at Reno Diagnostics Centers for left sided chronic neck pain. The study revealed mild straightening of the cervical spine which may be positional.

On November 03, YYYY, Vijay Sekhon, M.D., obtained Ms. XXXX's X-ray of chest at Reno Diagnostics Centers for cough. The study has no acute cardiopulmonary process.

MVA – 12/26/YYYY

On December 26, YYYY, Ms. XXXX was evaluated by XXXX, M.D., and Alexa P Rubenau, R.N. at Renown Health for MVA complaints and neck pain. She was BIB by private vehicle (24 weeks gravid) involved in rear-end collision with another vehicle. She reported being at a complete stop when

she was rear-ended at about 45 MPH. She had a head strike. She had midline cervical neck pain, collar placed in triage. She reported consistent prenatal care throughout pregnancy thus far. She was the restrained driver of a vehicle that was rear-ended approximately 30 mph. She was able to self-extricate. She presented to the emergency department with neck pain in the high cervical region. There was no radicular component. She does not have any paresthesia nor functional loss of her extremities. She stated that she has some fullness in her abdomen but is currently 24 weeks pregnant. She has had good prenatal care without complications. She has not had any irregular vaginal bleeding or discharge. She did not have any loss of consciousness and she was restrained. She does not have a headache. Examination of the cervical spine revealed some midline discomfort in the upper cervical region without step-offs. She had some diffuse paraspinal muscle discomfort in the cervical region. Her diagnosis included strain of neck muscle - initial encounter, motor vehicle collision - initial encounter and 24 week IUP. She was advised to contact Dr. XXXX the obstetrician that is on-call for Dr. XXXX. Dr. XXXX was contacted and he recommended to transfer her up to labor and delivery for further monitoring. She continued to be hemodynamically stable with no other evidence of injury. She was discharged in stable condition with instructions to go directly to labor and delivery.

On December 26, YYYY, XXXX, M.D., obtained Ms. XXXX's CT of cervical spine without contrast, with reconstructions at Renown Health for trauma. The study revealed no cervical spine fracture.

On December 27, YYYY, Ms. XXXX was evaluated by XXXX, DC at Northwest Reno Chiropractic for MVA that she sustained on December 26, YYYY. She was the driver of a Dodge Journey stopped at the intersection of Stead Boulevard and Cascade Street in Reno when the driver of another vehicle rear-ended Ms. Maya's car at approximately 40-miles-per-hour. At the time of the accident, the roads were dry, Ms. XXXX was looking straight ahead, and she was wearing her safety belt. She was totally surprised by the impact and did not have a chance to brace herself. She did not lose consciousness in this accident nor was an ambulance used. Soon after the crash, Ms. XXXX was taken to the Renown Regional Medical Center Emergency Room. A CT scan was performed. She complained of neck pain, mid back pain, and low back pain. She described her neck pain as a sharp pain on the right side. She was unable to look over either of her shoulders. She described her mid back pain as sharp and achy. She describes her low back pain as a soreness. Cervical range of motion was restricted in all cervical motions with pain at the end-ranges. She had tenderness and hypertonicity upon palpation of the left suboccipital, bilateral cervical paraspinals, bilateral upper trapezius, left rhomboid, bilateral levator scapulae, and the left SCM musculature. The cervical paraspinal musculature was relatively non-tender. Motion palpation revealed fixation of C2-5 with left lateral bending. Thoracic spine exam revealed spinous processes of Tl-10 were tender to palpation. Lumbar range of motion revealed restriction in right lateral bending with pain at the end-ranges of both extension and left lateral bending. Palpation of the low back revealed muscle tenderness and hypertonicity of the lumbar paraspinal musculature bilaterally. The spinous processes of L4-5 were tender to palpation. Her diagnosis included cervical sprain/strain; loss of cervical range of motion; articular dysfunction at C2-5; thoracic sprain/strain; articular dysfunction at T1-10; myofascitis of the cervical and upper thoracic spinal areas; lumbar sprain/strain; articular dysfunction at L4-5 and myofascial pain of the lumbar paraspinal musculature. She was recommended with chiropractic spinal manipulation to her cervical, thoracic, and lumbar spine along with physiotherapy in the form of traction, heat, and deep tissue massage. Initial treatment will be three times per week for four weeks. She was advised that a re-evaluation would then be performed to determine the need for any

additional care. She was provided with a cervical pillow to help with pain control and assist in the healing process. Today she was provided adjustment and was applied to physiotherapy in the form of traction and heat. She tolerated this well. It was opined as "It is my opinion from a reasonable degree of medical certainty that all of Ms. Maya's complaints and symptoms described above, and my objective findings are directly related to the December 26, YY injury. This opinion is based upon the patient's history, her current complaints, the above physical examination, and the mechanics of the crash. Ms. XXXX stated she was feeling fine immediately prior to this accident." She was recommended for regular-duty work as tolerated.

On January 02, YYYY, Ms. XXXX was evaluated by XXXX, M.D. Her pain level was rated as 9. She was involved in a motor vehicle accident December 26, YYYY. She states that she was stopped at a stop sign and rear-ended. She experienced significant left-sided neck pain that radiated into the left trapezius area and shoulder as well she had significant daily left-sided headaches. She is pregnant at 25 weeks. Exam revealed decreased range of motion of the cervical spine. She had significant pain to palpation over the left-sided cervical facet joints which caused pain and headaches on the left side. She had multiple trigger points throughout the left trapezius muscle. Her diagnosis included status post motor vehicle accident on December 26, YYYY, and cervical facet joint pain. It was suspected that most of her pain was in the left-sided cervical facet joint origin. Unfortunately, she was 25 weeks pregnant and cannot proceed forward with interventional techniques that require fluoroscopy. She was recommended to proceed with left-sided third occipital nerve, C3, C4, C5 medial branch blocks after the delivery. In the interim, she was advised to continue with chiropractic care (Dr. XXXX), massage therapy and stretching techniques. It was opined as "To a high degree of medical certainty, the above complaints and findings are related to the accident of December 26, YYYY." She was advised to follow-up closer to her delivery date (March 05, YYYY).

On March 19, YYYY, Ms. XXXX was evaluated by XXXX, M.D. She was involved in a motor vehicle accident December 26, YYYY. She stated that she was stopped at a stop sign and rear-ended. She experienced significant left-sided neck pain that radiated into the left trapezius area and shoulder as well. She had significant, daily left-sided headaches. She is now 36 weeks pregnant and plans on being induced April 14. She has not made any significant improvement with chiropractic care and continues to have left-sided headaches, neck pain, trapezius pain. She had been holding off on diagnostic medial branch blocks until she delivered. Exam revealed decreased range of motion of the cervical spine. She had significant pain to palpation over the left-sided cervical facet joints which caused pain and headaches on the left side. Multiple trigger points throughout the left trapezius muscle was noted. Her diagnosis included status post motor vehicle accident on December 26, YYYY, and cervical facet joint pain. She is 36 weeks pregnant with a planned induction date of April 14. She was recommended for the left third occipital nerve, C3, C4, C5 medial branch blocks to be performed after her delivery date. She was advised to continue with chiropractic care and follow-up after medial branch blocks. It was opined as "To a high degree of medical certainty, the above complaints and findings are related to the accident of December 26, YYYY." She was advised to return to the office as needed.

From December 29, YYYY, to March 25, YYYY, Ms. XXXX received chiropractic treatment from XXXX, DC at Northwest Reno Chiropractic for MVA that she sustained on December 26, YYYY. Her diagnosis included cervical sprain/strain; loss of cervical range of motion; articular dysfunction at

C2-5; thoracic sprain/strain; articular dysfunction at T1-10; myofascitis of the cervical and upper thoracic spinal areas; lumbar sprain/strain; articular dysfunction at L4-5 and myofascial pain of the lumbar paraspinal musculature. On February 07, YYYY, she reported that her neck pain, mid back pain, and low back pain were the same. She stated that some days are better than always, felt super tight in the upper left neck. Her diagnosis included partially resolved CTL sprain/strain and continued myofascial pain. Her prognosis was fair. She was advised to reduce frequency to 2x/week. She was recommended to begin massage and trigger point therapy. On March 25, YYYY, she had increased neck pain without treatment. She reported continued CT pain post-MVA. She was recommended to continue therapy.

On May 10, YYYY, Ms. XXXX was evaluated by XXXX, M.D., for left TON C3, 4, 5 MBB. Her pre-procedure and post-procedure diagnosis included cervical facet joint pain. She received the left Third Occipital nerve, C3, C4, C5 medial branch nerve block, under fluoroscopy. She tolerated the procedure well, without complications. She was observed for approximately 20 minutes and discharged home in satisfactory condition and given the appropriate discharge instructions. She was advised to return to the office as needed.

On May 21, YYYY, Ms. XXXX was evaluated by XXXX, M.D. She was involved in a motor vehicle accident on March 11, YYYY, as well as December 26, YYYY. She continued to complain of significant left-sided headaches and neck pain. She was complaining of these types of symptoms after the accident on March 11, YYYY. Her treatment was delayed secondary to a pregnancy, and then unfortunately she had a second accident. She is status post a left third occipital nerve, C3, C4, C5 medial branch block on May 10, YYYY. She reported approximately 80% reduction of her pain lasting for 5-6 hours. She did have significant ataxia during this time frame. Her pain level was rated as 4. Exam revealed decreased range of motion of the cervical spine. She had significant pain to palpation over the left-sided cervical facet joints which caused pain and headaches on the left side. Multiple trigger points throughout the left trapezius muscle. Her diagnosis included cervical facet joint pain and status post motor vehicle accident on March 11, YYYY, and December 26, YYYY. She was recommended to proceed forward with radiofrequency ablation at the above-mentioned levels (left third occipital nerve, C3, C4, C5 radiofrequency ablation, lien patient). She was also given a brochure to review. She was very anxious about this procedure. It was opined as "To a high degree of medical certainty, the above complaints and findings are 90% related to the accident of March 11, YYYY, and 10% related to the December 26, YYYY, accident." She was advised to follow-up in 6 weeks.

On August 06, YYYY, Ms. XXXX was evaluated by XXXX, M.D. She was involved in a motor vehicle accident on March 11, YYYY, as well as December 26, YYYY. She continued to complain of significant left-sided headaches and neck pain. She was complaining of these types of symptoms after the accident on March 11, YYYY. Her treatment was delayed secondary to a pregnancy, and then unfortunately she had a second accident. She is status post a left third occipital nerve, C3, C4, C5 medial branch block on May 10, YYYY. She reported approximately 80% reduction of her pain lasting for 5-6 hours. She wanted to proceed forward with the radiofrequency ablation, however this was delayed secondary to breast-feeding. Her pain level was rated as 4. Exam revealed decreased range of motion of the cervical spine. She had significant pain to palpation over the left-sided cervical facet joints which causes pain and headaches on the left side. Multiple trigger points throughout the left trapezius muscle were noted. Her diagnosis included cervical facet joint pain and status post motor vehicle accident on

March 11, YYYY, and December 26, YYYY. She wishes to proceed forward with left third occipital nerve, C3, C4, C5 radiofrequency ablation and she is done breastfeeding. She was advised to follow-up in 4-6 weeks. It was opined as "To a high degree of medical certainty, the above complaints and findings are 90% related to the accident of March 11, YYYY, and 10% related to the December 26, YYYY, accident." She was advised to return to the office as needed.

On December 27, YYYY, Ms. XXXX was evaluated by XXXX, M.D., for left TON C3, 4, 5 MBB. Her pain level was rated as 6. Her diagnosis included pain of cervical facet joint pain. Her pre-procedure and post-procedure diagnosis included cervical spondylosis and cervical facet joint pain. She received Left Third Occipital nerve, C3, C4, C5 medial branch nerve block, under fluoroscopy. She tolerated the procedure well, without complications. She was observed for approximately 20 minutes and discharged home in satisfactory condition. She was given the appropriate discharge instructions. She was advised to return to the office as needed.

On April 25, YYYY, Ms. XXXX was evaluated by XXXX, M.D., for left TON C3, 4, 5 RFA. Her diagnosis included pain of cervical facet joint pain. Her pre-procedure and post-procedure diagnosis included cervical spondylosis and cervical facet joint pain. She received radiofrequency ablation of the left third occipital nerve, C3, C4, C5 medial branch nerves, under fluoroscopy. She tolerated the procedure well, without complications. She was observed for approximately 20 minutes and was discharged home in satisfactory condition. She was given the appropriate discharge instructions. She was advised to return to the office as needed.

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