Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/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 Accident** 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.*
- *Unrelated visits for prior medical conditions have been captured briefly.*
- *Medical records pertinent to the musculoskeletal condition for prior medical conditions have been captured in detail.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	Right ankle sprain Bilateral shoulder pain Low back pain – Received PT on 09/27/YYYY Left chest pain status post fall Lateral epicondylitis of both elbows.
Date of injury	05/10/YYYY **Reviewer's Comments: The date of injury was obtained from the office visit dated 06/01/YYYY*
Description of injury	The patient was a restrained driver of a vehicle that was involved in a motor vehicle collision. She was stopped and someone behind her didn't realize there was a stop sign.
Injuries/ Diagnoses	• Whiplash injury • Vertebrogenic low back pain • Lumbar spondylosis • Myalgia • Inflammation of sacroiliac joint • Shoulder pain • Cervicalgia • Mid back pain • Cervical radiculopathy • Left arm and hand pain with numbness • Left elbow joint pain • Left hand pain • Lateral epicondylitis of left humerus • Carpal tunnel syndrome of left wrist • Cervical disc herniation • Lumbar disc herniation • Bulging of cervical intervertebral disc • Bulging of lumbar intervertebral disc • Pain in the thoracic spine • Muscle spasm of back • Left wrist pain
Treatments rendered	• NSAID • Tylenol PRN • Atypical chest pain exacerbated by MVC • Meloxicam 15 mg • Cyclobenzaprine • Fexmid 7.5 mg • Lidozen gel • LSO brace • TENS unit • Wrist brace **Therapy:** **06/20/YYYY-08/15/YYYY:** Underwent multiple physical therapy

	sessions at University Orthopedics Inc **08/23/YYYY-11/01/YYYY:** Underwent multiple physical therapy sessions at Highbar Health **04/11/YYYY-04/29/YYYY:** Underwent multiple chiropractic therapy sessions at St. Pete Injury & Wellness, LLC
Condition of the patient as per the last available record	**As of 04/29/YYYY:** Patient had a chiropractic therapy session with Dr. Michael Ward at St. Pete Injury & Wellness, LLC for the diagnosis and management of cervicalgia, low back pain, pain in left shoulder, pain in thoracic spine and muscle spasm of back. She presented with neck pain, cervicothoracic junction pain, upper back pain, thoracolumbar junction pain, lower back pain, and shoulder pain. she estimated her pain level as 7-8/10. On exam, she exhibited tenderness on palpation of the cervical, thoracic, lumbar, sacrum areas and associated musculature. She also exhibited restricted range of motion in cervical, thoracic, lumbar, and sacrum spine, and left shoulder. She received CMT, manual therapy, mechanical traction therapy, hot/cold packs at the level of the neck and low back, and electrical muscle stimulation. She reported an improvement in function and reduction of pain.

Patient History

Past Medical History: Allergic rhinitis, anxiety, arthritis, breast implants, chronic rhinitis, dry eye syndrome, dyspepsia, tummy tuck, eczematous dermatitis, borderline A1C, gestational diabetes, colonic adenoma, thyroid problems, left carpal tunnel ***(PDF Ref:** 384)*

Surgical History: No surgical history documented ***(PDF Ref:** 385)*

Family History: Non-contributory ***(PDF Ref:** 385)*

Social History: She is originally from China. She does not work. No tobacco. No alcohol. ***(PDF Ref:** 386)*

Allergy: No known allergies ***(PDF Ref:** 387)*

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Summary of prior injury record	
10/10/YYYY	Hospital/ Provider	**Colonoscopy Procedure Report:** **Referring physician:** XXXX, M.D. **Indications:** Colon cancer screening inadequate bowel prep on last procedure Personal history of adenomatous polyp(s) 5 years ago or longer **Administered Medications:** Fentanyl 100 mcg IV Versed 3 mg IV **Nurse(s):** Arvetta Boykins, RN **Findings:** Protruding lesions. A single sessile 10 mm non-bleeding polyp of benign appearance was found in the ascending colon. A single-piece polypectomy was performed using a cold snare in the ascending polyp. The polyp was completely removed. **Samples:** **Jar# A:** Polypectomy in the ascending polyp **Findings:** Polyp **Test(s) requested:** Histology **Comments:** Jar #1 **Limitations/Complications:** None. **Impressions:** Polyp (10 mm) in the ascending colon. (Polypectomy). **Recommendations:** • Follow up biopsy results • Repeat colonoscopy interval pending pathology results ***Related records:*** *Pre-procedure assessment, post-procedure assessment, intra-procedure nursing notes, post-procedure nursing notes, consent, orders, electronic vital sign monitor strip, pathology report* *(PDF Ref: 3-12)*	1-2
10/19/YYYY	Hospital/ Provider	**Office Visit:** **Chief complaint:** I am doing well **History of present illness:** This is a 56-year-old patient of mine here for follow-up of several medical issues including allergic rhinitis, borderline A1C, recent large serrated colonic adenoma.	13-15

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		She reports she has been doing well overall she has a local PCP that she also follows with who got lab work on her. Her A1C was 5.8, her TSH was 0.91. She also saw dermatology for some perianal pain and itching. She is prescribed a topical steroid cream which has helped. She continues to report occasional burning pain at night under her sternum. She denies ever having chest pain with exercise or with golfing. On review of her health records that show that she has reported this as far back as 2010. She has not tried any antacids. She also had a colonoscopy 10 days ago which showed a 1 cm serrated adenoma. It was recommended that she follow-up with another surveillance colonoscopy in 3 years. She also brings in her recent mammogram report which showed a BI-RADS 1. Her family is doing well. Her 2 sons are also doing well with their work. One is in New York City and one is in Huntsville Alabama. She is leaving for Florida next week with her husband for 6 months. Her left knee for which she had a steroid shot 8 years ago is doing okay. She thinks she might need another shot when she returns from her Trip to Florida. **Assessment and plan:** 56-year-old patient of mine here for follow-up of several medical issues including allergic rhinitis, borderline A1C, recent large serrated colonic adenoma. **Allergic rhinitis:** Recommended to restart loratadine and fluticasone nasal spray. We will also prescribe ketotifen eyedrops **Borderline A1C:** A1C 5.8 at her local PCP. Discussed that this just puts her at higher risk overall long-term development of diabetes however given her normal weight and high activity level low concern for this. Continue to track. **Serrated colonic adenoma:** Repeat colonoscopy in 3 years. **Burning substernal discomfort:** Long-standing. Occurs only at night when laying flat. Happens infrequently. Never has any exertional symptoms. Likely mild acid reflux. Recommended trial of Tums. **Health Maintenance:** • Colonoscopy as above, mammogram BI-RADS 1, Pap smear was done • this year and patient reports it was normal but she had a positive HPV. Will obtain records and determine next best step. • Flu vaccine today, Tdap at next visit • Return to clinic 1 year or sooner if needed	
07/24/YYYY	Hospital/ Provider	**Office Visit:** **Diagnosis:** Right ankle sprain. **History:** Patient returns to see me. Her ankle is improving. She has less pain, and feels more stable. She is started to have some pain over the medial aspect of the ankle in addition to the lateral ankle symptoms. She has tried golfing which she can do tolerably. She also notes some persistent stiffness in her ankle. She is not	16

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		scheduled to start PT until next month. **Examination:** Well-appearing, no distress, alert, oriented #3, normal affect. Has good understanding of her medical complaints. Breathing comfortably. Skin temperature and color is normal. **Right ankle exam:** **Inspection:** Normal alignment, no bruising or swelling **Palpation:** ATFL: Tender, CFL: Nontender, PTFL: Nontender, lateral malleolus: Nontender, medial malleolus: Nontender, tib/fib: Nontender, fifth metatarsal: Nontender, navicular: Nontender, midfoot: Nontender, peroneal tendons: Nontender, anterior tibialis: Tender **ROM:** Dorsi/plantar flexion: slight restriction in plantar flexion compared to the contralateral side **Strength:** Dorsi/plantar flexion: 5/5, inversion/eversion: 5/5 **Special tests:** Anterior drawer the ankle: Negative, talar tilt: Normal **Assessment:** *37-year-old (Must be "57-year-old")* female here for follow-up evaluation of a right ankle sprain. She is improving as expected. I encouraged her to continue with range of motion and icing, and using the brace as needed. I would expect this to continue to improve, although still would like her to do physical therapy to work on retraining her balance and proprioception. She will follow-up as needed if symptoms persist despite her course of PT. **Shared decision making:** We discussed the pathophysiology, natural history, and treatment options for the above.	
09/09/YYYY	Hospital/ Provider	**Office Visit:** **Reason for visit:** Bilateral shoulder pain **History of present illness:** Patient is a 57 year old right-hand-dominant female who has had several weeks of bilateral shoulder pain. It hurts golfing and lifting. She also has lower back pain and some left elbow pain. She does not take any NSAIDs. She has continued to remain active, despite the pain. She denies any numbness or tingling. **Review of systems:** A 13 point review of systems was done with the patient today via the intake form. Slight ankle swelling. All other systems negative. **Physical examination:** **Vitals:** BP: 104/74. Heart Rate: 67. **General:** Alert and oriented. No apparent distress. **Musculoskeletal:** Forward elevation is 170 degrees bilaterally. External rotation is 60 degrees bilaterally. Internal rotation is to the lower thoracic spine bilaterally. Internal and external rotation strength as well as resisted supraspinatus testing is 5/5 bilaterally. No pain over the bilateral AC joints or proximal biceps. No pain over the lateral shoulders. Mild impingement signs bilaterally.	17-18

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Images: X-rays of the bilateral shoulders were obtained to BID Needham today and were independently evaluate by me. Glenohumeral joint space is maintained bilaterally. Acromiohumeral distance is maintained. The AC joint is normal bilaterally. No soft tissue abnormalities. No fracture or dislocation. **Assessment and Plan:** Bilateral shoulder pain. She has symptoms of impingement. We discussed various treatment options including postural mechanics, periscapular and rotator cuff strengthening, NSAIDs, alternating ice and heat and activity modification. I have given her prescription for physical therapy. If her symptoms do not improve, she could consider cortisone injections. She will follow-up if her pain persists.	
09/20/YYYY	Hospital/ Provider	**CT of Chest without Contrast:** *Incomplete record* **Ordering provider:** XXXX, M.D. **Indication:** 57 year old woman with lung nodule; Eval Lung nodule seem incidentally in shoulder X-ray **Reviewer's Comments: Record incomplete, impression not available.*	19
09/27/YYYY	Hospital/ Provider	**Physical Therapy Record – Initial Evaluation:** **Primary Care MD:** XXXX. **Medical DX/ICD Diagnosis:** Low back pain **Referring MD:** XXXX. **Current Condition/Subjective Complaint:** 57 YO female plays golf every day and doesn't stretch. Doesn't do any stretching/strengthening. A year ago July, had back pain. Pt want to use muscles properly- wants exercise to help back issues. Pt has pain all the time and when she sits down she gets pain. When she stands too long, she gets pain- better moving around. Pt plays 7 days/week both here and Florida. Goes to Florida end of October until May. Does not have any weakness in the legs. Doesn't hurt with golfing, just other times. **Social/Occupational History** **Patient lives (with):** Spouse only. **Setting:** House. **Environment/Assistive Devices:** Stairs, railing. **Functional Status:** Difficulty with work/leisure. **Cardiovascular/Pulmonary Review of Systems:** Not grossly impaired. **Integumentary** **Integumentary disruption:** Not grossly impaired. **Continuity of skin color:** Not grossly impaired. **Pliability:** Not grossly impaired. **Temperature:** Not grossly impaired. **Communication/Affect/Cognition/Learning Style** **Communication, age appropriate:** Not grossly impaired. **Orientation:** Not grossly impaired. **Emotional/behavioral responses:** Not grossly impaired.	20-23

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Learning Barriers: None. **Preferred Learning Method:** Pictures, demonstration. **Musculoskeletal** **Neuromuscular** **History of falls/imbalance:** No. **Spine Tests and Measures** **Pain** **Pain at rest:** 7/10. **Pain with activity:** 3/10. **Location:** Thoracolumbar spine region. **Quality:** Achy. **Aggravating factors:** After golf. **Easing factors:** Golfing. **Tenderness with palpation:** Nothing significant- minimal along the thoraco lumbar paraspinals. **Range of Motion and Flexibility** **Lumbar spine:** WNL. **Hamstrings (70 degrees normal):** Left: + Right: + **Slump test:** Left: - Right: - **SLR or Lesegue test:** Left: - Right: - **Patrick/FABER:** Left: + Right: + **Muscle Performance/Motor Function/Sensation** **Myotomes:** **L2/3 Iliopsoas:** Left: 5 Right: 5 **L3/4 Quadriceps:** Left: 5 Right: 5 **L4/5 Tibialis anterior:** Left: 5 Right: 5 **L5/S1 Extensor hallucis longus:** Left: 5 Right: 5 **S1/2 Gastrocnemius/soleus:** Left: 5 Right: 5 **S2/3 Hamstrings:** Left: 5 Right: 5 **Scale:** 5=Normal 4=Good 3=Fair 2=Poor l=Trace 0=No contraction **Reflexes:** **L3/4 Quadriceps:** Left: 2 Right: 2 **S1/2 Gastrocnemius/soleus:** Left: 2 Right: 2 **Scale:** 3=Hyperactive 2=Normal 1=Hypoactive 0=Absent	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Trunk Strength: **Abdominals:** Left: 4 Right: 4 **Gluteus maximus:** Left: 4 Right: 4 **Scale:** 5=Normal 4=Good 3=Fair 2=Poor 1=Trace 0=No contraction **Impairments:** Impaired muscle performance, impairment in work, community or leisure integration. **Physical Therapy Diagnosis** Impaired posture. Impaired muscle performance. Impaired joint mobility, motor function, muscle performance, ROM and reflex integrity associated with spinal disorders. **Evaluation/Prognosis:** 57 YO female who has signs and symptoms of low back strain/postural weakness. Pt should do fine on a short course of PT focusing on instruction of self-stretching with golfing/during the day and strengthening exercises. Due to pt's good health, prognosis is good. Pt needs PT to address goals. Pt current and goal mobility status is CI, per clinical judgement. **Goals/Outcomes:** Goals (4-6 visits) Patient is able to participate in leisure and recreational activities. Patient is able to self-manage symptoms. Patient demonstrates an understanding of how to make changes in posture, body mechanics and ergonomics. Risk of secondary impairments is reduced. **Intervention/Treatment Plan:** **Frequency/Duration:** 4-6 total visits over 4-6 weeks. **Direct Interventions:** Therapeutic exercise. Posture/lifting/carrying activities **Patient Education:** **Home exercise program:** Done. **Communication:** Patient/family. **Treatment plan and rationale explained, and the patient agrees to participate:** Yes. **Today's treatment:** Cat/camel, prayer, prayer side to side, prone on elbows, standing hamstring/quad and calf stretch, standing back extension. **Reviewer's Comments: Further physical therapy records and physical therapy discharge summary are not available for review.*	
10/02/YYYY	Hospital/ Provider	**FDG Tumor Imaging (PET-CT):** *Incomplete record* **Ordering provider:** XXXX, M.D.	24

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Reason: Lung mass, non-smoker; Evaluate lung mass and also liver lesion not fully clarified on non-contrast CT lung **History:** 57-year-old woman with the pulmonary lesion. **Reviewer's Comments: Record incomplete, impression not available.*	
10/22/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** Nice to see you again I am so relieved **History of present illness:** This is my 57-year-old female here for her annual exam. Past medical history includes anxiety, colonic adenoma, thyroid nodule. **Assessment/Plan:** 57-year-old female here for her annual exam and follow-up of chronic medical conditions. **Pulmonary nodule:** Unclear cause, no FOG avidity, has CT scan scheduled in 6 months no recommendation was 3 as she will be traveling in Florida. **Thyroid nodule:** Followed in endocrinology. **HPV positivity on pap:** Followed by outside OB/GYN status post colpo. **Health Maintenance:** Flu shot today Up-to-date on colonoscopy, mammogram Return to clinic 1 year or sooner if needed.	25-26
07/04/YYYY	Hospital/ Provider	**CT of Chest without Contrast:** *Incomplete record* **Ordering provider:** XXXX, M.D. **Indication:** 57-year-old woman with LUL lung nodule/evaluate known LUL lung nodule **Reviewer's Comments: Record incomplete, impression not available.*	27
07/04/YYYY	Hospital/ Provider	**MRI of Abdomen with and without Contrast:** *Incomplete record* **Ordering provider:** XXXX, M.D. **Indication:** 57-year-old woman with incidentally found liver lesion/evaluate known liver lesion **Reviewer's Comments: Record incomplete, impression not available.*	28
09/01/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I have a few things to talk about **History of present illness:** 58 YO F here for follow up. PMH thyroid nodule, colonic adenoma, lung nodule, anxiety. Fell while running - slipped on a wet floor. Went to UC and had X-ray, no fracture, told she has a bone bruise. Worried this is her heart. **Physical examination:** **Chest:** No ecchymosis in area of fall, mild tenderness along L lateral chest wall **Assessment/plan:** 58 YO F here for follow up. **Lung nodule:** Follow up CT to ensure stability **Thyroid nodule:** Per endo, continue conservative measures	29-30

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		L chest pain: S/P fall, imaging normal and EKG normal at UC, advised PRN Tylenol. **Chest burning:** Intermittent, may be related to anxiety, rec'ed to trial Tums to see if helps **Colonic adenoma:** Colo due next year **Positive HPV:** Followed in GYN **Health Maintenance:** Shingrix today Mammo report to be send Pap and colo as above RTC 06/YYYY	
05/11/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I'm OK **History of present illness:** 59 YO F here for follow up of chronic conditions. **Assessment/plan:** 59 female YO F here for f/u. **GERD:** Persistent, reasonable to check for stool antigen of H. pylori given h/o. **Lung nodule:** Will f/u CT from today. **Thyroid nodule:** Followed by outside endo who though RFA might be reasonable. Have emailed Dr. Sacks at thyroid center for assistance, awaiting updated thyroid u/s. **Serrate adenoma:** Due for repeat this year, ordered **Health Maintenance:** Vaccinations: UTD Age appropriate cancer screenings: Pap: Followed at 1 Brookline place, will obtain records Mammogram: UTD Lipids: Check today A1C: Check today Return to clinic 09/YYYY for annual	31-33
05/11/YYYY	Hospital/ Provider	**Follow-up Visit:** Follow up visit for this 59 year-old last seen in YYYY by Dr. Vemula with a history of: • Normal exam today. None new or changing • White spots on extremities • Brown lesions on the right breast and right thigh • History of perianal pruritus for which she uses tacrolimus • Denies use of baby wipes **My impression is:** **Few BAN:** ABCDs reviewed. Discussed broad-spectrum SPF 30+ sunscreen and symptoms and signs of skin cancer **IGH:** Reassurance **Few SKs:** Reassurance **History of perianal pruritus, without active eruption today:**	34

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Trial Pramoxine lotion • Printed RF for tacrolimus if needed **Pruritus of scar:** Trial Pramoxine as above I asked the patient to follow up inly in CHO.	
05/11/YYYY	Hospital/ Provider	**CT of Chest without Contrast:** *Incomplete record* **Ordering provider:** XXXX, M.D. **Indication:** 57-year-old woman with LUL lung nodule/evaluate known LUL lung nodule **Addendum:** Given the irregular/somewhat spiculated appearance of the medial margin of the left upper lobe lesion (6;49), continued attention on follow up is recommended with chest CT in 12 months. **Reviewer's Comments: Record incomplete, impression not available.*	35
05/11/YYYY	Hospital/ Provider	**Labs:** **High:** Total cholesterol: 225, triglycerides: 171, cholesterol ratio: 3.8, calculated cholesterol LDL: 131	36-37
10/13/YYYY	Hospital/ Provider	**Colonoscopy Procedure Report:** **Referring physician:** XXXX, M.D. **Indications:** Personal history of adenomatous polyp(s) 3 years ago or longer **Administered Medications:** As per Anesthesia Record **Nurse(s):** Kay-Lourde Gelin, RN **Anesthesia Provider:** Patricia O'Connor, CRNA **Findings:** **Mucosa:** Normal mucosa was noted in the whole colon. **Protruding lesions:** A single sessile 5 mm non-bleeding polyp of benign appearance was found in the sigmoid colon. A single-piece polypectomy was performed using a cold snare in the sigmoid polyp. The polyp was completely removed. **Samples:** **Jar# A:** Polypectomy in the sigmoid polyp Findings: Polyp Test(s) requested: Histology **Impression:** • Polyp (5 mm) in the sigmoid colon. (Polypectomy). • Normal mucosa in the whole colon. **Recommendations:** • Colonoscopy in 5 years pending pathology • We will contact you with your polypectomy results by mail or phone within the next 2-3 weeks. Please call our office if you do not hear by then	38-39

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Related records: *Pre-procedure assessment, post-procedure assessment, intra-procedure nursing notes, post-procedure nursing notes, consent, orders, electronic vital sign monitor strip, pathology report* *(PDF Ref: 40-53)*	
10/20/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I'm OK **History of present illness:** 59 YO F here for annual. PMH anxiety, goiter, colonic adenoma, lung nodule. No acute concerns today, doing well. Traveling to Florida next week for the winter. **Assessment/plan:** 59 YO F here for annual. **Lung nodules:** CT for 05/YYYY ordered she will call to schedule. **Colonic Adenoma:** Seen YYYY, repeat in 2026. **Goiter:** Refer to endocrine here for next steps, like will need resection, TSH normal 5/YYYY. **Health Maintenance:** Pap done in YYYY, normal, repeat in 5 years 1 Brookline place Mammo UTD Flu shot today Return to clinic 1 year or sooner PRN	54-55
05/02/YYYY	Hospital/ Provider	**Follow-up Visit:** **Diagnosis:** Bilateral lateral epicondylitis **History:** Patient returns to see me. She is here to follow-up for a new problem. Over the last few weeks she has been having progressive pain in the bilateral elbows. The left is worse than the right. Symptoms localized to the lateral elbow with motion involving her wrist and hand. **Examination:** Well-appearing, no distress, alert, oriented # 3, normal affect. Has good understanding of her medical complaints. Breathing comfortably. Skin temperature and color is normal. **Bilateral Elbow Exam:** **Inspection:** Normal alignment, no swelling or deformity **Palpation:** Lateral epicondyle: tender **ROM:** Full elbow flexion/extension, pronation/supination **Special tests:** Pain with resisted wrist extension **Imaging:** 3-view X-rays of both shoulders were ordered and personally reviewed. They demonstrate normal alignment without fracture or dislocation. There is extensive enthesopathy bilaterally. **Assessment:** 60 year old female with lateral epicondylitis of both elbows. **Shared decision making:** We discussed the pathophysiology, natural history, and treatment options for the above.	56

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Her symptoms are consistent with lateral epicondylitis. There is extensive enthesophytes over the lateral epicondyle, suggesting this is more chronic. She was given a referral to PT.	
05/02/YYYY	Hospital/ Provider	**X-Ray of Bilateral Elbows:** **Ordering provider:** Everett Hayes, M.D. **Indication:** 60 year old woman with bilateral elbow pain/bilateral elbow pain **Comparison:** None. **Impression:** **Right elbow:** No acute fracture or dislocation seen. Moderate enthesopathy of the lateral epicondyle, mild of the medial. Joint spaces are preserved. No joint elbow joint effusion seen. **Left elbow:** No acute fracture or dislocation seen. Moderate to severe enthesopathy of the lateral epicondyle, minimal of the medial. Minimal degenerative changes. No elbow joint effusion seen.	57
06/21/YYYY	Hospital/ Provider	**CT of Chest without Contrast:** *Incomplete record* **Ordering provider:** XXXX, M.D. **Indication:** 57 year old woman with LUL lung nodule; Eval known LUL Lung nodule **Reviewer's Comments: Record incomplete, impression not available.*	58
10/25/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I'm doing well **History of present illness:** 60 YO F here for annual. PMH hyperglycemia, stable lung nodule, colonic adenoma, stable thyroid nodule. No acute concerns today. **Assessment/plan:** 60 YO F here for annual. PMH hyperglycemia, stable lung nodule, colonic adenoma, stable thyroid nodule. **Thyroid nodule:** Continue with endocrine, TSH normal reportedly **Hyperglycemia/Pre-diabetes:** In setting of h/o gestational OM. A1C last year was 5.9%, repeat today, continue with current active lifestyle, healthy diet. **Colonic adenoma:** Repeat in 2026 **Health Maintenance:** **Vaccinations:** Flu today, COVID booster at local pharmacy **Pap:** UTD last year **Mammogram:** 08/YYYY Lipids: Normal last year Return to clinic 1 year for annual ***Related records:*** *Labs* *(PDF Ref: 62)*	59-61
		Motor Vehicle Collision on MM/DD/YYYY **Reviewer's Comments: The date of injury was obtained from the office visit dated 06/01/YYYY*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/17/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I am OK **History of present illness:** 61 YO F here for follow up. Suffering from bas seasonal allergies including eye itching. She would like to get a second opinion on the removal of her goiter. Her current ENT rec'ed removal which she is very worried about. Was in a car accident 10 days prior, rear ended. She was stopped and someone behind her didn't realize there was a stop sign. Did not seek medical care at the time. Had no pain that day but that evening developed neck, shoulder and back pain, mostly on the left. Hard for her to walk to sit for longer periods of time. She is also feeling pin-prick lasting a few seconds left-sided chest pain. She has had this pain previously. **Review of systems:** Positive per HPI. 10 point review of systems otherwise negative. **Physical examination:** **Vitals:** BP: 111/70, HR: 61, weight: 113 lbs, BMI: 21.0, temperature: 96.7 F **General:** Well appearing female, NAD **Neck:** Para spinal muscle TTP most prominent in cervical and upper thoracic region, FROM though painful with full flexion. **CV:** Regular rate, no MRG appreciated, no carotid bruits **Pulmonary:** Clear bilaterally, no wheeze, crackle, or rhonchi **Abdomen:** NABS, soft, NTND **Extremities:** No edema or skin changes, warm, well perfused **Skin:** No ecchymoses **Psych:** Appropriate mood and affect **Assessment/plan:** 61 YO F here for evaluation after being rear ended. **Whiplash:** Exam and history c/2 with whiplash injury. No concern for fracture given mechanism of injury and she is able to ambulate. Did not hit her head. Review typical time course to recovery of several week to a month. Can trial cyclobenzaprine at night, no EtOH or driving. Otherwise NSAID and Tylenol PRN pain. **Atypical chest pain:** Fleeting pin prick, longstanding, may have been exacerbated by MVC. Treatment as above. Return to clinic 10/YYYY for annual.	63-64
05/21/YYYY	Hospital/ Provider	**Physician Note:** The patient has been known to have a thyroid nodule for about a year There is no known family history of thyroid malignancy or other endocrine neoplasia. There is no history of exposure to low dose ionizing radiation such as was formerly used for thymic enlargement, acne, ringworm, or chronic tonsillitis.	65

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient has no mechanical symptoms from this problem such as pressure or difficulty swallowing. The dominant left nodule largely replaces the left lobe and has been biopsied twice at BIDMC with benign results. There is tracheal deviation to the right The right lobe has some benign appearing sub cm nodules. Lives in Norton Doug is husband She is a software engineer. On general examination the patient appeared to be in good health. The patient can move the neck normally with good extension. The patient and I had a good discussion about the proposed operation which is left thyroidectomy owing to the size of the lesion and progressive growth. Her PCP is at BIDMC and she wishes to be done there. The customary risks associated with thyroid surgery were mentioned even though they are infrequent, namely temporary or permanent voice change, and parathyroid issues if a total thyroidectomy is performed, as well as risks of surgery in general such as bleeding and infection. Additionally, the patient was provided with prepared literature about thyroid surgery. This contains the operative steps in some detail, as well as the general preoperative, and postoperative care instructions, and again mentions the associated risks, and measures taken to reduce complications. The patient was told to read this material carefully, and then send me any additional questions by calling the office or by emailing me directly. Additionally, the patient has access to my web site, bostonthyroidsurgery.com, where additional information is available. Thyroid neoplasm.	
05/22/YYYY	Hospital/ Provider	**Office Visit:** **Chief complaint:** Right foot pain **Primary care provider:** XXXX, M.D. **Vitals:** Weight: 115 lbs, height: 5 feet 11 inches, BMI: 16 **Medications:** • Fluticasone propionate 50 mcg/actuation nasal spray, suspension – Spray 1 to 2 sprays into each nostril 2 times a day • Ibuprofen 800 mg tablet – Take 1 tablet by mouth every 8 hours as needed for pain **Problems:** Callosity on toe – Onset 05/22/YYYY **History of present illness:** Patient is a pleasant 61-year-old female patient who is being evaluated today for right foot discomfort. She has lesion along the inside of her little toe. This has been there for few months. It is bothering her. She had tried to shave it but it keeps coming back. She also has a smaller lesion on the contralateral foot between the 4th and 5th toes. She denies any fevers or chills or any systemic symptoms. **Review of systems:** *All systems reviewed and are negative.*	66-68

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Focused examination of right lower extremity was performed. **Skin:** Intact with no wounds or ulcers **Swelling:** None on exam today **Tenderness:** Over the callosity at the 5th toe **Ankle ROM:** 10 degrees past neutral dorsiflexion, 40 degrees of plantar flexion **Hindfoot ROM:** 15 degree of inversion, 10 degree of aversion **Strength:** 5/5 strength in plantarflexion, dorsiflexion, inversion and aversion **Sensations:** Sensations intact to light touch throughout the SPN, DPN, saphenous, tibial and sural nerves distributions **Vascularity:** 2+ DP and PT pulses and brisk capillary refill **Other:** Callosity along the medial side of the 5th toe **Imaging:** Weight-bearing three views of the right foot were obtained and interpreted with the patient in the office today. No acute fractures or dislocations appreciated. No widening of the Lisfranc interval. Mild hallux valgus deformity. Marginal osteophytes off of the middle phalanx of the 5th toe **Procedure Documentation** **Pepyne Callus Debridement Single Lesion 11055:** The patient has evidence of a hyperkeratotic lesion associated with the right 5th toe. Treatment options were discussed. I recommend beginning with conservative care. Painful, pre-ulcerative hyperkeratotic lesion was reduced using a sterile #15 blade to tolerance. The patient reported that this procedure did improve their pain. We also discussed utilizing off-loading device such as a metatarsal pad or Budin splint. If pain persists despite conservative care, we will consider surgical intervention. **Assessment/ Plan** 61-year-old female patient with right 5th toe callosity. I reviewed the clinical and radiographic findings with the patient. We discussed options of treatment including conservative management with toe spacers, shoe modifications, bedside debridement and surgical intervention. We decided to proceed with bedside debridement and she tolerated the procedure well. She will utilize 2 spacers to minimize recurrence. Follow-up on as-needed basis. **Pain in right foot:** X-ray of right foot **Callosity on toe:** Corns and callosities **Return to office:** XXXX, M.D. for new patient 30 at Mansfield Reservoir 2 on 06/01/YYYY at 1300 hours.	
05/22/YYYY	Hospital/ Provider	**X-Ray of Right Foot:** **Reviewer's Comments: The corresponding radiology reports are not available for review.*	69
06/01/YYYY	Hospital/ Provider	**Office Visit:** **Chief complaint:** Low back **Vitals:** Weight: 115 lbs, height: 5 feet 11 inches, BMI: 16 **Medications:**	70-74

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Cyclobenzaprine 5 mg tablet – Take 1 tablet twice a day by oral route as needed for 30 days • Fluticasone propionate 50 mcg/actuation nasal spray, suspension – Spray 1 to 2 sprays into each nostril 2 times a day • Ibuprofen 800 mg tablet – Take 1 tablet by mouth every 8 hours as needed for pain • Meloxicam 15 mg tablet – Take 1 tablet in the morning with food as needed for pain. **Reviewed problems:** • Callosity on toe – Onset: 05/22/YYYY • Inflammation of sacroiliac joint – Onset: 06/02/YYYY • Lumbar spondylosis – Onset: 06/02/YYYY • Neck pain – Onset: 06/01/YYYY • Low back pain – Onset: 06/01/YYYY • Muscle pain – Onset: 06/01/YYYY **History of present illness:** The patient presents to University Orthopedics for consultation. They are being seen by ortho foot and ankle - Dr. Abousayed for right 5th toe callosity. The patient's chief complaint is of low back pain. **Onset/duration:** 05/10/YYYY. **Precipitating event:** The patient was involved in a motor vehicle accident on 5/10/YYYY. Patient recalls being a restrained driver at a stop light when she was rear-ended. Airbags did not deploy. She denies LOC at time of accident. She was not evaluated afterwards. She reports she sustained multiple injuries including pain in her left lower back, left shoulder, left side of neck, and left arm that started progressively the night of her injury. She reports she was unsuccessful in getting in with her PCP's office for evaluation. The patient denies having a prior history of similar complaints. The pain is along left more than right buttock and does refer into the left lower extremity, intermittently, to the left lateral thigh but usually stops at the knee. Patient reports tingling and warmth in her left leg but denies numbness or weakness. Pain is exacerbated by all activities as improved with heat, ice, and rest and is described as dull, aching, pulling, burning, shooting. Pain level can be up to 9/10. Patient denies any changes in bowel or bladder function Denies anogenital numbness. **Previous diagnostic workup:** X-ray lumbar spine AP, lateral, flexion, extension UOI 06/01/YYYY.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Prior conservative treatment(s): None. **Prior injection treatment(s) or surgery:** None for her low back. **Medications related to their pain (dose/frequency):** Aspirin PRN w/ temporary relief. **Review of systems:** *All systems reviewed and are negative.* **Physical examination:** **Extremities:** Left Upper extremity no edema, erythema, or change in skin color and normal temperature. Right Upper Extremity no edema, erythema, or change in skin color and normal temperature. Left Lower extremity no edema, erythema, or change in skin color and normal temperature. Right Lower Extremity no edema, erythema, or change in skin color and normal temperature. **Neurological System:** Gait and station steady and upright and no antalgic gait. Sensory Lower Extremity Left L2 Normal, L3 Normal, L4 Normal, L5 Normal, and S1 Normal and Right L2 Normal, L3 Normal, L4 Normal, L5 Normal, and S1 Normal. Motor Lower Extremity Left L2 Hip Flexion Abnormal With giveaway weakness, L3 Knee Extension Abnormal With giveaway weakness, L4 Ankle Dorsiflexion Abnormal With giveaway weakness, L5 Extensor Hallucis Abnormal With giveaway weakness, and S1 Plantar Flexion Abnormal With giveaway weakness; Right L2 Hip Flexion Abnormal With giveaway weakness, L3 Knee Extension Abnormal With giveaway weakness, L4 Ankle Dorsiflexion Abnormal With giveaway weakness, L5 Extensor Hallucis Abnormal With giveaway weakness, and S1 Plantar Flexion Abnormal With giveaway weakness; and Left Ankle Evertors Normal 5/5. Reflexes Lower Extremity Left Patellar L4 Normal 2+ and Achilles S1 Normal 2+ and Right Patellar L4 Normal 2+ and Achilles S1 Normal 2+. Straight Leg Raise Seated negative bilaterally. Upper Motor Neuron tests: Clonus negative and Cross adduction negative. **Musculoskeletal System:** Lumbar Spine AROM grossly limited, Noted with ropy muscle spasm in the bilateral lower paraspinal muscles without radiation and with twitch response, and Facet loading positive over bilateral lower facet joints. Sacrum positive tenderness Left and Right and negative Yeoman's bilateral (and produces proximal low back pain) and Fortin's sign bilateral. **Imaging/ Results:** X-ray Lumbar X-ray lumbar spine AP, lateral, flexion, extension UOI 06/01/YYYY: Possible lumbosacral transitional anatomy with pseudo-articulation of right L5 transverse process with sacrum and possible hypoplastic ribs at T12. There appears to be slight upper lumbar lower thoracic scoliotic curvature. Vertebral body heights appear to be fairly well-maintained alignment. There appears to be fusion of L5-S1 disc space consistent with Bertolotti syndrome. There is disc space narrowing at multiple levels with associated endplate spurring. There is diffuse facet Joint arthropathy. There is neuroforaminal narrowing noted at the lower lumbar levels. SI joints appear to be patent bilaterally with degenerative changes. No significant spondylolisthesis and appears stable on flexion-extension views.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Reviewer's Comments: The corresponding direct radiology report is not available for review.* **Assessment/ Plan **Low back pain** Reviewed L-spine X-ray images with the patient. Clinical presentation is consistent with diffuse lumbar facet joint pain, myalgia, and bilateral SI joint tenderness in the setting of an MVA. She does have giveaway weakness diffusely in both legs, although unsure if this is related to pain related weakness vs poor effort vs possible nerve related issues from the lumbar spine though I note the remainder of her lower limb exam is not strongly suggestive of lumbar radiculopathy. We discussed treatment options for low back pain including medications (oral and topical), therapy (including formal PT and HEP) and injections. The patient may benefit from interventional procedures. Imaging is advised to evaluate anatomy, rule out tumor or infection, and to determine the optimal anatomical location for performing the procedure. Due to her diffuse lower limb weakness we will proceed with L spine MRI for further evaluation. Prescription for Meloxicam 15 mg sent to pharmacy to help with pain and inflammation. Reviewed with patient NSAID risks and use, common NSAID adverse effects, to limit use and to take with food. Reviewed with pt that if NSAIDS were needed for more than a few weeks they were advised to take NSAID vacations; pt given scenarios of 1 week on - 1 week off, 2 weeks on, 2 weeks off, or 1 month on - 1 month off. Patient was advised to avoid concurrent use of other NSAIDS (Ibuprofen, Naproxen, etc.) and they verbalized their understanding and agreed. Patient will benefit from a course of physical therapy. Script provided today. Discussed with patient back precautions and the patient was advised regarding cautious bending, lifting, twisting and posture. **Low back pain, unspecified** X-ray of lumbar spine MRI of lumbar spine – Diffuse lumbar facet joint pain, myalgia, and giveaway weakness in bilateral Les in the setting of an MVA Physical therapist referral - Schedule Within: Provider's discretion Note to Provider: Myofascial release, modalities, range of motion, stretching, stabilization exercises, provide Home Exercise Program Evaluate & Treat diffuse lumbar facet joint pain, myalgia, and bilateral SI joint tenderness in Visits per Week: 2-3x/week, 4-6 the setting of a MVA weeks Meloxicam 15 mg tablet - Take 1 tablet in the morning with food as needed for pain. Qty: (30) tablet Refills:0 **Lumbar spondylosis**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient has pain that is determined to be axial and/or significantly exacerbated by extension and rotation. May consider FJI/MBB/RFA procedures as part of a comprehensive pain management program including physical rehabilitation. Other spondylosis, lumbar region **Muscle pain** Prescribed Flexeril for muscle spasms. Reviewed with patient muscle relaxants and their use intended for acute muscle spasms. Patient was instructed to avoid using them daily for prolonged periods. Patient expressed they understood and agreed. Discussed with pt medication precautions, including hypotension, sedation, operating motor vehicles. Myalgia, other site Cyclobenzaprine 5 mg tablet - To be submitted on or around 06/02/YYYY Take 1 tablet(s) twice a day by oral route as needed for 30 days. Qty: (60) tablet Refills: 0 **Inflammation of sacroiliac joint** Positive tenderness in bilateral SIJs though it does not appear that these are primary pain generators at this time - monitor for improvement with PT Sacroiliitis, not elsewhere classified **Motor vehicle accident victim** Patient rear-ended at a stoplight 05/10/YYYY, causing pain in low back, mid back, neck, and shoulder. Absent any countering evidence from prior medical records, it is my professional opinion that the patient's mechanism of injury, subjective complaints and objective findings are consistent and causally-related to the motor vehicle accident in question with a reasonable degree of medical probability. Person injured in unspecified motor-vehicle accident, traffic, initial encounter **Neck pain** Discussed with patient that we would evaluate and address her complaint of left side neck, mid pain, left arm pain and left shoulder pain at a later visit. Patient indicated they understood and agreed. We will obtain XR C spine and T spine when pt returns for this visit Patient indicates her left shoulder pain is being referred from the neck therefore we will start with XR C spine and then may consider XR shoulder depending on her exam findings during her evaluation Cervicalgia **Return to Office** XXXX, M.D. for Established New 15 at Mansfield Reservoir 2 on 06/15/YYYY at 0930 hours XXXX, M.D. for Follow Up 15 at Mansfield Reservoir 2 on 06/29/YYYY at 1300 hours	
06/01/YYYY	Hospital/ Provider	**Orders:** **To:** Shields MRI Brockton **Diagnosis:** Low back pain **Order:** MRI of lumbar spine **Note to imaging facility:** Diffuse lumbar facet joint pain, myalgia, and giveaway	75-76

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		weakness in bilateral LEs in the setting of an MVA. **Weight:** 115 lbs	
06/01/YYYY	Hospital/ Provider	**X-Ray of Lumbar Spine:** **Reviewer's Comments: The corresponding radiology reports are not available for review.*	77
06/02/YYYY	Hospital/ Provider	**MRI of Lumbar Spine without Contrast:** **Exam requested by:** XXXX, M.D. **History:** Diffuse lumbar facet joint pain. Bilateral lower extremity weakness. MVA. **Findings:** **Comparison:** No prior. Vertebral bodies are normal in height. Lumbosacral dextroscoliosis without subluxation. No spondylolysis is present. Conus terminates normally at T12-L1. At L1-L2, there is no significant central canal nor foraminal stenosis. At L2-L3, central disc extrusion without significant central canal stenosis. At L3-L4, right paracentral disc protrusion and bilateral facet hypertrophy without significant central canal stenosis. At L4-L5, right foraminal disc protrusion impinges upon exiting right L4 nerve root. Central disc protrusion without significant central canal stenosis. At L5-S1, bilateral facet hypertrophy without significant central canal stenosis. 8 mm subcapsular mildly T2 hyperintense lesion of the right hepatic lobe posteriorly on series 2 image 107. Lesion does not have the appearance of a simple cyst and may be complicated by hemorrhage or solid. **Conclusion:** • L4-L5 right foraminal disc protrusion impinges upon exiting right L4 nerve root. • Multilevel disc herniations without significant central canal stenosis. • No fracture nor ligamentous injury. • Incompletely characterized right hepatic lobe lesion. Tumor cannot be excluded. Further evaluation with gadolinium-enhanced MR abdomen recommended. Results faxed as wet reading at time of dictation. ***Related records:*** *Others, consent, authorization, cover pages, assessment (PDF Ref: 84-91)*	78-83
06/05/YYYY	Hospital/ Provider	**Orders:** **To:** Shields MRI Brockton **Diagnosis:** Low back pain **Order:** MRI of abdomen with contrast **Note to imaging facility:** Please evaluate for MRI lumbar spine findings of hyperintense lesion of right hepatic lobe. Please perform gadolinium enhanced MR abdomen.	92-93
06/12/YYYY	Hospital/ Provider	**MRI of Abdomen:** **Exam requested by:** XXXX, M.D. **Clinical indication:** Other specified diseases of liver. Follow-up right hepatic lesion seen on lumbar spine MRI.	94-97

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Comparison: MRI lumbar spine 06/02/YYYY **Findings:** **Visualized lower thorax:** Bilateral breast implants are incidentally noted. **Liver:** There is an 8 mm high T2 signal lesion within hepatic segment 6 with peripheral discontinuous arterial enhancement on the early phase sequence and homogeneous retention of contrast similar in intensity to the blood pool on the more delayed phase sequence. This corresponds to the finding on prior MRI and is compatible with a hemangioma. Additionally, there are adjacent high T2 signal lesions with discontinuous peripheral enhancement and progressive filling within segment IVb measuring 2.3 cm and 1.0 cm (series 4 images 12 and 13). These are also compatible with hemangiomas. No additional hepatic lesions are identified. **Gallbladder:** Unremarkable. **Bile ducts:** No biliary ductal dilatation. **Spleen:** Normal. **Pancreas:** No focal pancreatic lesion or main pancreatic ductal dilatation. **Adrenal glands:** Unremarkable. **Kidneys:** No hydronephrosis. No focal renal lesion. **Stomach/upper GI tract:** Stomach and visualized abdominal bowel normal in caliber. **Peritoneum and retroperitoneum:** No free fluid. **Lymph nodes:** No lymphadenopathy. **Vessels:** Abdominal aorta is nonaneurysmal. **Bones:** Unremarkable. **Impression:** Several hepatic hemangiomas, one of which corresponds to the abnormality seen on prior MRI lumbar spine. ***Related records:*** *Others, consent, authorization, cover pages, assessment, others (PDF Ref: 98-115)*	
06/15/YYYY	Hospital/ Provider	**X-Ray of Thoracic Spine and Cervical Spine:** **Reviewer's Comments: The corresponding radiology reports are not available for review.*	116
06/15/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** None recorded **Medications:** • Cyclobenzaprine 5 mg tablet – Take 1 tablet twice a day by oral route as needed for 30 days. • Fluticasone propionate 50 mcg/actuation nasal spray, suspension – Spray 1 to 2 sprays into each nostril 2 times a day • Ketotifen 0.025% (0.035%) eye drops • Meloxicam 15 mg tablet – Take 1 tablet in the morning with food as needed for pain. **History of present illness:**	117-120

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient presents for evaluation of neck and mid back pain. **Onset/duration:** 05/10/YYYY. **Precipitating event:** MVA. She reports no history of neck and back pain prior to the MVA. She locates the pain to primarily on the left side of the neck which radiates into the left arm but not into the hand. There is also pain in the bilateral lower thoracic region. She also reports some weakness in the left hand, noting weaker grip. This weakness was noted about 1 week ago and has been worsening since she noticed it. No numbness and tingling in the left arm or hand, but there has been a persistent dull ache in the left arm. The pain in the lower thoracic region is a constant dull ache and is alleviated by lying down. **Previous diagnostic workup:** X-ray cervical spine AP, lateral, flexion, extension UOI 06/15/YYYY. X-ray thoracic spine two views UOI 06/15/YYYY. **Prior conservative treatment(s):** She has scheduled PT and starts next week. **Prior injection treatment(s) or surgery:** None for the neck or mid back. **Medications related to their pain (Dose/frequency):** She has been prescribed meloxicam and cyclobenzaprine and she takes it as needed. She does not take ibuprofen with meloxicam. She did have MRI abdomen with and without contrast Shields 06/12/YYYY. **Physical examination:** **Extremities:** Left Upper extremity no edema, erythema, or change in skin color and normal temperature. Right Upper Extremity no edema, erythema, or change in skin color and normal temperature. Left Lower extremity no edema, erythema, or change in skin color and normal temperature. Right Lower Extremity no edema, erythema, or change in skin color and normal temperature. **Neurological System:** Gait and station steady and upright and no antalgic gait. Sensory Upper Extremity LT C5 Normal, C6 Normal, C7 Normal, C8 Normal, and T1 Normal and RT C5 Normal, C6 Normal, C7 Normal, C8 Normal, and T1 Normal. Motor Upper Extremity Left C5 Shoulder Abduction Abnormal With giveaway weakness and Elbow Flexion Abnormal With giveaway weakness; Left C6 Wrist Extension Abnormal With giveaway weakness, C7 Elbow Extension Abnormal With giveaway weakness, C8 Extrinsics Abnormal With giveaway weakness, and T1 Intrinsics Abnormal With giveaway weakness; Right C5 Shoulder Abduction Abnormal With giveaway weakness and Elbow Flexion Abnormal With giveaway weakness; and Right C6 Wrist Extension Abnormal With giveaway weakness, C7 Elbow Extension Abnormal With giveaway weakness, C8 Extrinsics Abnormal With giveaway weakness, and T1 Intrinsics Abnormal With giveaway weakness. Reflexes Upper Extremity Left Biceps C5 Normal 2+, Brachioradialis C6 Normal 2+, and Triceps C7 Normal 2+ and Right Biceps C5	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Normal 2+, Brachioradialis C6 Normal 2+, and Triceps C7 Normal 2+. **Musculoskeletal System:** Cervical Spine AROM grossly limited, Noted with ropy muscle spasm in the bilateral upper trapezius muscles without radiation and with twitch response, Facet loading positive over bilateral middle facet joints, and Spurling's Test positive left. Thoracic Spine Noted with ropy muscle spasm in the bilateral paraspinal muscles and with twitch response and Facet loading positive over bilateral facet joints and AROM grossly functional. **Imaging/ Results:** X-ray cervical **X-ray cervical spine AP, lateral, flexion, extension UOI 06/15/YYYY:** Vertebral body heights appear to be fairly well maintained alignment. There is mild multilevel cervical spondylosis with disc space narrowing and endplate spurring posteriorly most prominent at C3-4 followed by C4-5 and C5-6. There appears to be fusion at the posterior facet joints of C3 and C4 on lateral view. No significant spondylolisthesis and fairly stable on flexion and extension views. **Thoracic** **X-ray thoracic spine two views UOI 06/15/YYYY:** Vertebral body heights are well maintained appear to be in alignment with slight hyper kyphotic curvature. There is mild multilevel thoracic spondylosis with disc space narrowing and endplate spurring. No obvious signs of compression fracture and no significant spondylolisthesis noted. **Lumbar** **X-ray lumbar spine AP, lateral, flexion, extension UOI 06/01/YYYY:** Possible lumbosacral transitional anatomy with pseudoarticulation of right L5 transverse process with sacrum and possible hypoplastic ribs at T12. There appears to be slight upper lumbar lower thoracic scoliotic curvature. Vertebral body heights appear to be fairly well-maintained alignment. There appears to be fusion of L5-S1 disc space consistent with Bertolotti syndrome. There is disc space narrowing at multiple levels with associated end plate spurring. There is diffuse facet joint arthropathy. There is neuroforaminal narrowing noted at the lower lumbar levels. SI joints appear to be patent bilaterally with degenerative changes. No significant spondylolisthesis and appears stable on flexion-extension views.. **MRI abdomen** **MRI abdomen with and without contrast Shields 06/12/YYYY:** Several hepatic hemangiomas 1 of which corresponding to abnormality seen on MRI lumbar spine. No additional hepatic lesions are noted. **Lumbar** **MRI L spine Shields 06/02/YYYY:** L2-3 cent DE without significant CCS or NFS. L3-4 Cent-RT PC DP without significant NFS or CCS. L4-5 RT foraminal DP w/ RT NFS and impingement of exiting RT L4 NR. L5-S1 with bilateral FJA w/ associated effusions. Noted with 8 mm subcapsular mildly T2 hyperintense lesion of RT hepatic lobe and cannot exclude tumor. **Reviewer's Comments: The corresponding direct radiology reports are not*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		available for review. **Assessment/Plan** **Neck pain** Reviewed XR of C spine UOI 06/01/YYYY images and report with the patient Clinical presentation is consistent with left cervical radiculopathy, bilateral mid cervical spondylosis and facet joint arthropathy, and diffuse thoracic back pain which may be related to myalgia and facet joint pain. Overall pain level is at a 9/10 and patient was very tender on exam. There is giveaway weakness on both upper limbs, so I was unable to evaluate if there was any specific neurological deficit. Because of this, I will order an MRI of the cervical spine and thoracic spine. Symptoms are consistent with whiplash secondary to MVA, so I will also order PT to address this as well as treatment for the low back. The patient may benefit from interventional procedures. Imaging is advised to evaluate anatomy, rule out tumor or infection, and to determine the optimal anatomical location for performing the procedure. In the interim, I advised that she start taking meloxicam 15 mg daily with food for the next two weeks to help reduce inflammation before she starts on PT in earnest. I explained that if she starts PT without addressing the inflammation, it will be difficult for her to complete PT exercises regularly and with adequate focus on form. Patient voiced understanding and is agreeable to this. Cervicalgia X-ray if cervical spine Physical therapist referral - Schedule Within: provider's discretion Note to Provider: Myofascial release, modalities, range of motion, stretching, stabilization exercises, provide Home Exercise Program Evaluate & Treat: Left cervical radio, bilateral mid cervical and diffuse thoracic facet joint arthropathy, MVA Visits per Week: 2-3x/week, 4-6 weeks MR, cervical spine - Note to Imaging Facility: Left cervical radiculopathy, bilateral mid cervical spondylosis and facet joint pain MR, thoracic spine - Note to Imaging Facility: diffuse thoracic back pain which may be related to myalgia and facet joint pain **Low back pain** Reviewed with pt that MRI abdomen with and without contrast Shields 06/12/YYYY notes Several hepatic hemangiomas, 1 of which corresponding to abnormality seen on MRI lumbar spine and no additional hepatic lesions are noted. She was advised to follow up with PCP regarding if next steps for evaluation of hepatic findings are needed and she verbalized her understanding. She will plan to return for review of images of MRI lumbar spine, this was previously reviewed with pt via phone and she is in PT now for her low back. Low back pain, unspecified Meloxicam 15 mg tablet- Take 1 tablet in the morning with food as needed for pain. Qty: (30) tablet Refills: 0	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Muscle pain Refilled Flexeril for muscle spasms as she is tolerating this medication well and without side effects. Reviewed with patient muscle relaxants and their use intended for acute muscle spasms. Patient was instructed to avoid using them daily for prolonged periods. Patient expressed they understood and agreed. Discussed with pt medication precautions, including hypotension, sedation, operating motor vehicles. Myalgia, other site X-ray of thoracic spine Cyclobenzaprine 5 mg tablet - To be submitted on or around 06/20/YYYY Take 1 tablet(s) twice a day by oral route as needed for 30 days. Qty: (60) tablet Refills: 0 **Lumbar spondylosis** Patient has pain that is determined to be axial and/or significantly exacerbated by extension and rotation. May consider FJI/MBB/RFA procedures as part of a comprehensive pain management program including physical rehabilitation. Other spondylosis, lumbar region **Motor vehicle accident victim** Person injured in unspecified motor-vehicle accident, traffic, sequels **Return to Office** XXXX, M.D. at Mansfield Reservoir 2 on or around 06/29/YYYY XXXX, M.D. for Follow Up 15 at Mansfield Reservoir 2 on 06/29/YYYY at 1300 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 06/29/YYYY at 1530 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/03/YYYY at 1600 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 07/06/YYYY at 1700 hours	
06/20/YYYY	Hospital/ Provider	**Physical Therapy Record – Initial Evaluation:** **Treatment diagnosis:** • Vertebrogenic low back pain • Cervicalgia **Reason for referral:** On 05/10/YYYY pt was involved in MVA: she was restrained driver red light rearended airbags did not deploy. no treatment at scene. Through night pain began to increase in LB and neck/ shoulder. She was initially seen by PCP who prescribed medication, no improvement she made an appt with UO - Dr. XXXX who ordered imaging and upon review refer to PT for treatment. She reports pain cervical L>R shoulder and refer down arm to elbow. LBP across LB with sensation "warm" when standing. numbness left lateral thigh. She reports Slower to complete ADLS, not performing H/H chores due to pain. **Pain worse:** Sitting unable to sit still to find comfortable, standing > 2' begin, walking more than a few minutes. Cervical ROM - all motions, reaching OH L > R, gripping Pain lessens with lying down, using medication as needed, Aspercreme rub **Recreation:** Golf, tennis,	121-123

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<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
Neck pain increases cervical rotation, reaching OH over L hand, grip
Pain Cervical - 9/10-> 10/10
Lumbar 10/10 pain

Medical History
Fall History: Patient has not been injured by a fall in the past year. Patient has not had two or more falls in the past year. Patient is not at risk for falls.

Clinical Findings
Low Back
Palpation - Posterior upper quadrant (soft tissue mobility): Cervical segmental myofascia soft tissue restrictions, upper thoracic segmental myofascia restrictions, scalene soft tissue/myofascial restrictions, levator scapula soft tissue/myofascial restrictions. upper trapezius soft tissue/myofascial restrictions, latissimus dorsi soft tissue/myofascial restrictions
Palpation - Quadratus lumborum (provocation reproduces symptoms): Positive
Palpation - Lower trunk region (provocation reproduces symptoms): Lumbar paraspinals, lumbar multifidi

Head And Neck
Onset mechanism - Whiplash-type injury: Yes
Ligament integrity tests (upper cervical spine): Negative
Strength tests (neck): Not tested at this time due to acuity

Measures:
The following measures were identified for the patient’s low back condition:
<table>
<tr><th>Measure</th><th>Current (06/20/YYYY)</th><th>Target</th></tr>
<tr><td>Flexibility/muscle length (hamstring/straight leg raise)
Hamstring flexibility assessed using the straight leg raising test</td><td>Mild hamstring/straight leg raise flexibility deficits: 55 degrees to 70 degrees</td><td>Normal hamstring/straight leg raise flexibility: > 70 degree</td></tr>
<tr><td>Nerve mobility (sciatic/symptom response)
Symptom level with sciatic nerve/straight leg raise test</td><td>Normal: Pain free lower limb/nerve mobility</td><td>Normal: Pain free lower limb/nerve mobility</td></tr>
<tr><td>Modified Oswestry back index (ODI)
Score of the modified Oswestry low back disability index (ODI)</td><td>31
31/45</td><td>No activity limitation: ODI score of less than 5 percent</td></tr>
<tr><td>Walking medium distances (symptoms)</td><td>Severe problem: Only able to walk < 100</td><td>No problem: Able to walk > 1000 yards</td></tr>
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF

Walking medium distances without symptoms	yards without symptoms	without symptoms
Sitting (symptoms) Ability to sit without symptoms	Shift immediately upon sitting	No problem: Sitting not limited by symptoms
Standing (capacity) Ability to stand	2’	No difficulty: Standing capability is unlimited
Standing (symptoms) Ability to stand without symptoms	2’	No problem: Standing not limited by symptoms

Additional Evaluative Findings
Neurological status examination reveals normal sensation, reflexes B UE and B LE
Shoulder ROM flexion R 60/150 L 40/160, abduction R 40/140 L 40/140
Cervical ROM: Flexion 30 pain limited, extension 10 pain sharp in nature, SB R 10 L 12 pain limited B, ROT 25% pain limited B to L>R
Lumbar ROM flexion 30 pain, extension 10 sharp pain SB, 10 B pain
LE MMT hip flexion 3 pain limited knee extension 3 / pain limit, ankle DF 3 pain limit
Shoulder MMT deferred due to pain/limited shoulder mobility

Assessment
Patient is a 61 y/o female who has been referred to skilled PT with neck and LBP after being involved in MVA. Objective assessment identifies limited cervical and lumbar ROM (pain limited) decreased shoulder mobility, decreased strength (pain limited), myofascial restrictions and with pain. Overall assessment pain limited. Pt currently with decreased tolerance for performing ADLs and daily activities due to impairments and will benefit from skilled treatment to improve functional capacity.

Plan
STM cervical/ lumbar
Self-stretch shoulder rom
Cervical mobility
Chin tucks supine
LTR
SKC
Pullies
Knee fallout
H/L march

Plan of Care: Low back and Head and neck
Functional Goals:

- Pt will be independent with established HEP to maintain gains achieved with skilled treatment.
- Low back pain will improve to be able to forward bend using correct body mechanics to 12 inches above the floor six or more times per day to perform household tasks; Time frame: 4 weeks.

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Arm radiating pain will improve while reaching overhead repeatedly to grasp/lift items from a cabinet or shelf for 2 hours daily to return to independent cooking/preparing meals; Time frame: 4 weeks. • Neck range of motion and pain will improve to fully view traffic and obstacles required for safe driving for 1 hour daily: Time frame: 8 weeks. • LBP and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for daily household activities; Time frame: 8 weeks. **Intervention Strategy** **Low Back** Therapeutic Activities education, instruction and performance cues to incorporate pain free lumbar spine mobility, motor control and optimal trunk. pelvic girdle and hip alignment while performing dynamic functional activities designed to restore movement tolerance and maximize safe, efficient and competent activity performance. Therapeutic Exercise incorporating verbal, manual and proprioceptive performance cues and instruction for flexibility, strength and endurance exercises for the muscles of the low back; range of motion and stretching exercises for this region's joints: and mobility exercises for the tissues adjacent to the dura and spinal nerve roots to achieve or maximize safe, efficient and pain-free function. Neuromuscular Reeducation techniques incorporating verbal, manual and proprioceptive performance cues and instruction to reeducate movement and improve posture, proprioception, coordination, kinesthesia and balance to achieve efficient, pain free, coordinated and integrated thorax, low back and pelvic girdle movements during sustained functional movement patterns and activities. Manual Therapy soft tissue mobilization, joint mobilization and manual stretching procedures to improve the joint and soft tissue mobility required for pain free, active, passive and accessory movements of the lumbar spine and pelvis and normal low back function. **Head and Neck** Therapeutic Activities education, instruction and performance cues to maintain optimal head, neck and shoulder girdle alignment while performing dynamic functional activities to restore movement tolerance and maximize safe and efficient sustained activity performance. Therapeutic Exercise incorporating verbal, manual and proprioceptive performance cues and instruction to restore optimal head, neck and shoulder girdle alignment by improving the strength, endurance and motor control of weak neck muscles and improving the flexibility of tight neck and shoulder girdle muscles to improve the ability of the patient to sustain pain free, neutral cervical positions while performing functional activities. Neuromuscular Reeducation techniques incorporating verbal, manual and	

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		proprioceptive performance cues and instruction to reeducate movement patterns, improve coordination, normalize cervicothoracic posture and integrate endurance, motor control and flexibility gains with the ability to safely and efficiently perform sustained functional movement patterns and activities with reduced or eliminated symptoms. Manual Therapy soft tissue mobilization, joint mobilization and manual stretching procedures to improve the mobility of the upper thoracic vertebral segments and the flexibility of the neck and shoulder girdle muscles to restore head, neck, shoulder girdle and thorax alignment. **Recommendations** Patient will be seen for therapy as described at the following frequency and duration: 2 visits per week for 8 weeks. The patient was actively involved in the development of the Therapy Plan of Care and understands it and is in agreement with it. **Treatment Provided Today** **The following interventions were performed for the patient's low back condition:** **PT evaluation low complexity:** 25 min **Therapeutic Exercise:** 5 min **The following interventions were performed for the patient's head and neck condition:** **PT Evaluation Low Complexity:** 20 min **Therapeutic Exercise:** 5 min **Provider Interactions With Patient During Visit** Education on the current condition, prognosis and expected functional outcomes based on evaluative findings. Education on movements and activities to avoid to limit the exacerbation of the patient's current condition. Educated the patient on the need for consistency in treatment to achieve the mutually established goals. Verbal cueing on proper performance of the prescribed exercises.	
06/26/YYYY	Hospital/ Provider	**MRI of Cervical Spine without contrast:** **Ordering doctor:** XXXX, M.D. **Reason for Exam:** Pain **Clinical history:** Patient complains of neck pain since MVA on 05/10/YYYY **Findings:** No prior studies available for comparison. There is mild straightening of the usual cervical lordosis. There is normal signal noted within the cervical cord. The cervicomedullary junction is intact. There are normal vertebral body heights. No bone marrow edema is seen.	124-125

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		C1 is intact upon C2. At the C2-C3 level, no disc herniation is seen At the C3-C4 level, there is a minimal broad-based disc protrusion minimally indenting the thecal sac. The neural foramen are patent. At the C4-C5 level, there is a mild broad-based disc protrusion mildly indenting the thecal sac. The neural foramen are patent. At the C5-C6 level, there is a left paracentral/lateral intraforaminal disc extrusion/uncinate the complex which mildly narrows the left lateral recess and moderate to severely narrows the left neural foramen. A right paracentral disc protrusion/uncinate vertebral hypertrophy complex mildly narrows the right lateral recess and mildly narrows the right neural foramen. At the C6-C7 level, no disc herniation is seen. Mild facet degenerative changes are noted. No significant foraminal narrowing seen. At the C7-T1 level, no disc herniation is seen. **Impression:** • Straightening of the usual cervical lordosis. • **C5-C6:** Moderate left paracentral/left lateral foraminal disc extrusion/uncinate vertebral hypertrophy complex mildly narrows left lateral recess and moderate to severely narrows left neural foramen and a right paracentral disc protrusion/uncinate vertebral hypertrophy complex mildly narrows the right lateral recess and mildly narrows the right neural foramen. • Other mild cervical spondylosis present as described above.	
06/26/YYYY	Hospital/ Provider	**MRI of Thoracic Spine without Contrast:** **Ordering doctor:** XXXX, M.D. **Reason for Exam:** Pain **Clinical history:** Patient complains of back pain since MVA on 05/10/YYYY **Findings:** No prior studies available for comparison. There is normal signal noted within the thoracic cord. There are normal vertebral body heights. No bone marrow edema is seen. At the T1-T2 level, a small central disc protrusion minimally indents of thecal sac. At the T2-T3 level, a small central disc protrusion mildly indents of thecal sac. At the T9-T10 level, there are mild facet hypertrophic degenerative changes. At the T11 -T12 level, there are mild facet hypertrophic degenerative changes.	126-127

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		There is a question of a possible large 3.5 cm nodule in the left lobe of the thyroid (images 2-6 of series, 4). **Impression:** • There is very small central disc protrusions at T1-T2 and T2-T3. • Mild facet hypertrophic degenerative changes are seen at T9-T10 and T11-T12. • No other disc herniation is noted. • Question of a large nodule in the left lobe of the thyroid gland. Correlate with thyroid workup.	
06/29/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** None recorded **Vitals:** Weight: 115 lbs, height: 5 feet 11 inches, BMI: 16, pain scale: 8 **Medications:** • Cyclobenzaprine 5 mg tablet - Take 1 tablet(s) twice a day by oral route as needed for 30 days. • Fluticasone propionate 50 mcg/actuation nasal spray, Suspension - Spray 1 to 2 sprays into each nostril 2 times a day • Ketotifen 0.025 % (0.035 %) eye drops • Meloxicam 15 mg tablet - Take 1 tablet in the morning with food as needed for pain. • Triamcinolone acetonide 0.1 % dental paste - Apply to affected area 4 times daily **History of present illness:** Patient presents for review of findings of images of MRI lumbar spine Shields, but instead asked that we review images of MRI cervical spine and thoracic spine. She is aware that reports for these studies have not been obtained by my office. She expressed frustration at this, but we advised patient we do not have control over this. she has started PT with some relief. Patient otherwise denies significant changes in their condition. **Physical examination:** *Remains same as on 06/15/YYYY* **Imaging/ Results:** *Reviewed.* **Assessment/ Plan** **Neck pain** Discussed MRI cervical spine images with pt that do show some degenerative changes with C5-6 DH w/ LRS and mod-severe LT NFS and MRI thoracic spine which shows only mild deg changes in the facet joints and small DPs at T1-2 and T2-3. However, no significant central canal narrowing appreciated. Advised pt that we would obtain radiology reports for both studies and I did correlate these reports with my interpretation prior to locking this note. Strongly encouraged pt to continue ongoing PT which was recently started. Patient	128-131

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		does not want to proceed with injections or medications at this time, therefore we will have pt continue therapy and follow up in 4 weeks to re-assess. She was advised that she can contact office if pain worsens. We also discussed that her neck, mid and low back pain are likely the results of her MVA, as she did not have these symptoms before. She was advised that if radiology reports emergent findings, my office will contact her. She declines telehealth visit to review radiology report findings. Cervicalgia **Low back pain** Recommend to continue ongoing therapy for low back pain. Low back pain, unspecified **Muscle pain** Continue Flexeril for muscle spasms as she is tolerating this medication well and without side effects. Myalgia, other site **Lumbar spondylosis** Previously noted with lumbar facet joint pain on exam. Other spondylosis, lumbar region **Motor vehicle accident victim** Person injured in unspecified motor-vehicle accident, traffic, sequela **Return to Office** Joey Teixeira, PTA for Follow Up 30 at Easton PT on 07/06/YYYY at 1700 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/10/YYYY at 1640 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/13/YYYY at 1550 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/17/YYYY at 1600 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/19/YYYY at 1530 hours XXXX, MD for Follow Up 15 at Mansfield Reservoir 2 on 07/20/YYYY at 0930 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/24/YYYY at 1630 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/27/YYYY at 1530 hours Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/31/YYYY at 1630 hours	
07/20/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** None recorded **Vitals:** Weight: 115 lbs, BMI: 16, pain scale: 7 **History of present illness:** Patient presents today for further evaluation for neck pain. She reports that her neck pain has slightly improved, but she is still not where she would like to be pain-wise. She has been undergoing PT since May YYYY. She would like to review images of prior MRI cervical spine. **Physical examination:** *Remains same as of 06/15/YYYY* **Imaging results:** *Reviewed.*	132-135

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/ Plan **Neck pain** Discussed MRI cervical spine images and report with pt that do show some degenerative changes with C5-6 LT PC DE w/ LRS and mod-severe LT NFS. I again discussed with pt MRI thoracic spine finding of incompletely visualized nodule in the left lobe of the thyroid and I strongly recommended she follow up with her PCP for further evaluation via possible US thyroid. She reports she is in process of following up with PCP regarding this finding. Strongly encouraged pt to continue ongoing PT which was recently started as she notes some mild improvement. Patient at this time does not want to proceed with injections or medications, therefore we will have pt continue therapy. She was advised that she can contact office if pain worsens. We also discussed that her neck, mid and low back pain are likely the result suggests her MVA, as she did not have these symptoms before. Cervicalgia **Cervical radiculopathy:** We discussed that her left cervical radiculopathy symptoms are likely due to C5-6 DH seen on MRI cervical spine which may be secondary to her MVA. We reviewed natural course of recovery with disc herniations and treatment options. Discussed with patient about the option for cervical CESI procedures for cervical radiculopathy as part of a comprehensive pain management program including physical rehabilitation. Patient does express some reluctance to proceed with injections at this time. We discussed other options for treatment to include simply continuing with PT with the addition of cervical traction. I also recommended against visiting a chiropractor at this time, as chiropractic adjustments may potentially aggravate her symptoms. Radiculopathy, cervical region Physical therapist referral - Schedule Within: provider's discretion Note to Provider: Provide cervical traction, Myofascial release, modalities, range of motion, stretching, stabilization exercises, cervical traction, provide Home Exercise Program. Evaluate & Treat: Cervical radiculopathy, cervical spondylosis, myalgia, MVA Visits per Week: 2-3x/week, 4-6 weeks **Muscle pain** Continue Flexeril for muscle spasms as she is tolerating this medication well and without side effects. Myalgia, other site **Motor vehicle accident victim** Person injured in unspecified motor-vehicle accident, traffic, sequela **Return to Office** Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/24/YYYY at 1630 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 07/26/YYYY at 1700 hours	

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Simon XXXX, MD for New Patient 15 at Mansfield Reservoir 2 on 07/31/YYYY at 1415 hours
Rebecca Smith, PT for Follow Up 30 at Easton PT on 07/31/YYYY at 1630 hours
Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/03/YYYY at 1700 hours
Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/07/YYYY at 1700 hours
XXXX, MD for Follow Up 15 at Mansfield Reservoir 2 on 08/17/YYYY at 1330 hours
To see XXXX, MD at Mansfield Reservoir 2 on or around 08/20/YYYY</td><td></td></tr>
<tr><td>07/24/YYYY</td><td>Hospital/ Provider</td><td>Physical Therapy Record – Re-evaluation:
Treating diagnosis:
Vertebrogenic low back pain
Cervicalgia

Reason for referral:
Pt reports she continues to have pain through spine. Pain varies depending on her positions and activities. She reports sitting > 30' mostly neck - mid back. She reports pain going down L arm to forearm and hand. She reports she has only been standing/walking for -30' hasn't tried to go further. When driving she continues to rely on mirrors vs turning her head. She states she still has limitations with OH activities with pain. She is able to perform light chores, but can't heavier chores- vacuuming/ washing floor/lifting and carrying. She states she feels "weak". She was seen by Dr. XXXX last week who recommended continued PT and new script for continued treatment was written. She is also is being referred to Dr. Comelissen for elbow/ hand pain.

Cervical pain- 7/10
Back - 7-8/10

Measures
The following measures were identified for the patient's Low Back condition:
<table>
<tr><th>Measure</th><th>Current (07/24/YYYY)</th><th>Target</th></tr>
<tr><td>Flexibility/muscle length (hamstring/straight leg raise)
Hamstring flexibility assessed using the straight leg raising test</td><td>Normal hamstring/straight leg raise flexibility: > 70 degree</td><td>Normal hamstring/straight leg raise flexibility: > 70 degree</td></tr>
<tr><td>Modified Oswestry back index (ODI)
Score of the modified Oswestry low back disability index (ODI)</td><td>27
27/50, 54%</td><td>No activity limitation: ODI score of less than 5 percent</td></tr>
<tr><td>Walking medium distances (symptoms)
Walking medium distances without</td><td>Mild problem: Able to walk (501 to 1000) yards without symptoms</td><td>No problem: Able to walk > 1000 yards without symptoms</td></tr>
</table></td><td>136-138</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF

symptoms		
Sitting (symptoms) Ability to sit without symptoms	30’	No problem: Sitting not limited by symptoms
Standing (capacity) Ability to stand	30’	No difficulty: Standing capability is unlimited
Standing (symptoms) Ability to stand without symptoms	30’	No problem: Standing not limited by symptoms
Segmental mobility (upper thoracic) Available mobility with segmental motion testing	Mild segmental mobility deficit	Normal segmental mobility
Segmental mobility (mid thoracic) Available mobility with segmental motion testing	Mild segmental mobility deficit	Normal segmental mobility

Additional Evaluative Findings
Shoulder AROM flexion B 150 pain limit end range, abduction R 150 L 130 pain limit B
Shoulder PROM WNL all motions with pain end range
Cervical ROM: Flexion 45 pain with OP, extension 40 pain sharp in nature, SB R 32 L 35 pain limited B, rotation 75% pain limited
Lumbar ROM flexion 45 pain- tightness end range, extension 20 sharp pain SB 30 B pain
LE MMT hip flexion 3+ pain limited knee extension 3+ pain limit, ankle DF 3 pain limit
Shoulder MMT flexion R 3+ L 3+ abduction R 3+ L 3+, ER B 3+ , L wrist 3+
Overall pain limits her tolerance for resistance with MMT

Assessment
Patient is making slow gains with treatment overall limited by high pain intensity. She demonstrates increasing cervical/ B shoulder/ and lumbar mobility as well as increasing strength but overall pain limits with assessment. She continues to demonstrate decreased trunk control for maintaining posture with sitting and standing / walking leading to symptoms progressive with her daily tasks. She will benefit from skilled treatment to increase functional capacity and achieve goals for treatment.

Plan
Cervical: UBE warm up add PREs shoulder flexion/abduction resisted 2-3#, serratus wall slides with/ without band . prone chin tuck with head off table/ with added scap depression , wrist PREs 2# flexion/extension, pee stretch 1/2 FR
Lumbar. Seated on ball pelvic rocking with TA control , straight arm pulldown (shoulder extension) standing with TA control gm band , lying on 1/2 FR TA

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		control with march **Plan of Care:** Low back and Head and neck **Intervention Strategy** **Low Back** PT Evaluation Low Complexity, PT Re-evaluation, Therapeutic Activities, Therapeutic Exercise, Neuromuscular Reeducation, Manual Therapy **Head and Neck** PT Evaluation Low Complexity, Therapeutic Activities, Therapeutic Exercise, Neuromuscular Reeducation, Manual Therapy **Recommendations:** Patient will be seen for therapy as described at the following frequency and duration: 2 visits per week for 4 weeks. The patient was actively involved in the development of the Therapy Plan of Care and understands it and is in agreement with it. **Treatment Provided Today** Therapeutic exercise Patient education **Provider Interactions With Patient During Visit** Education on the current condition, prognosis and expected functional outcomes based on evaluative findings. Assessed understanding and comprehension of the condition and the relation of therapy intervention strategies to functional goal attainment. Verbal and manual cueing for appropriate alignment, muscle strategies and movement patterns.	
07/31/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** Left hand pain, left elbow pain **Vitals:** Weight: 115 lbs, BMI: 16 **Problems:** Thyroid nodule - Onset: 07/05/YYYY Callosity on toe - Onset: 05/22/YYYY Inflammation of sacroiliac joint - Onset: 06/02/YYYY Lumbar spondylosis - Onset: 06/02/YYYY Neck pain - Onset: 06/01/YYYY Cervical radiculopathy - Onset: 07/21/YYYY Low back pain - Onset: 06/01/YYYY Muscle pain - Onset: 06/01/YYYY Lateral epicondylitis of left humerus - Onset: 07/31/YYYY Carpal tunnel syndrome of left wrist - Onset: 07/31/YYYY **History of present illness:** Patient is here for evaluation of discomfort in her left arm. She has been treated for left neck and shoulder girdle discomfort following a motor vehicle accident in	139-141

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		March. She says that she has not improved with therapy. She describes discomfort over the lateral side of the left elbow. She also describes intermittent numbness and tingling in the hand and fingers. This bothers her at night. She tells me there is a legal case that she has launched as a result of this motor vehicle accident **Physical examination:** In the left elbow, there is tenderness over the lateral epicondyle. Pain in this region is exacerbated by resisted wrist extension. The skin is intact. The patient is neurologically intact throughout. There is full range of motion of the elbow and the elbow is stable. There is no tenderness over the medial epicondyle or the olecranon. The forearm is soft and nontender and resisted long finger extension does not exacerbate the pain. Examination of the left hand and wrist reveals no clinical deformity. The skin is intact throughout. There is full range of motion of the wrist and all digits. The fingers are well-perfused. There is a positive compression test at the carpal tunnel reproducing symptoms in the fingertips and median nerve distribution. Tinel's testing is also positive. There is no obvious thenar atrophy. There is full range of motion of the elbow. The forearm is soft and nontender. I cannot elicit any carpal instability. **Assessment/ Plan** AP, lateral views of the left elbow are reviewed. I do not see any fractures or dislocations. Bony alignment is normal AP, lateral, and oblique views of the left hand revealed no fractures or dislocations. Bony alignment is normal. No bony abnormalities are noted. **Assessment:** Left arm and hand pain with numbness following motor vehicle accident We discussed treatment options. For the hand we are going to obtain some nerve conduction studies to evaluate her for possible carpal tunnel syndrome. We also are going to start her working with physical therapy for the lateral epicondylitis. She is in agreement with this plan. I will see her back after her nerve studies have been done. **Pain of left elbow joint** X-ray of left elbow **Pain of left hand** X-ray of left hand **Lateral epicondylitis of left humerus** Lateral epicondylitis, left elbow Occupational therapist referral - Schedule Within: Provider's discretion **Carpal tunnel syndrome of left wrist** Carpal tunnel syndrome, left upper limb	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nerve conduction study/EMG, upper extremity **Return to Office** Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/03/YYYY at 1700 hours Mostafa Abousayed, MD for Follow Up 15 at Easton on 08/07/YYYY at 1615 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/07/YYYY at 1700 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/10/YYYY at 1700 hours Zachary Bohart, MD for EMG 30 at Easton on 08/15/YYYY at 1330 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/15/YYYY at 1530 hours XXXX, MD for Follow Up 15 at Mansfield Reservoir 2 on 08/17/YYYY at 1330 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/17/YYYY at 1730 hours To see XXXX, MD at Mansfield Reservoir 2 on or around 08/20/YYYY Rebecca Smith, PT for Therapy Re-evaluation at Easton PT on 08/23/YYYY at 1630 hours Simon XXXX, MD for Follow Up 15 at Mansfield Reservoir 2 on 08/29/YYYY at 1430 hours	
07/31/YYYY	Hospital/ Provider	**X-Ray of Left Elbow and Left Hand** **Reviewer's Comments: The corresponding radiology reports are not available for review.*	142
06/29/YYYY-08/15/YYYY	Hospital/ Provider	**Summary of interim Physical Therapy visits for low back pain and cervicalgia:** **Diagnosis**: • Vertebrogenic low back pain • Cervicalgia **Treatment dates**: 06/29/YYYY, 07/03/YYYY, 07/06/YYYY, 07/10/YYYY, 07/13/YYYY, 07/17/YYYY, 07/20/YYYY, 07/31/YYYY, 08/03/YYYY, 08/07/YYYY, 08/10/YYYY, 08/15/YYYY **Treatment provided:** Therapeutic exercises Manual therapy Patient education Home exercise program **As of 08/15/YYYY:** **Patient status:** Patient reports continued effort on feeling abdominals working more, notes she did not work too much on HEP but is a lot more aware of daily posture. **Treatment provided today:** Therapeutic exercise Patient education **Provider Interactions With Patient During Visit**	143-163

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Educate on continued increase core control with use in varied disciples. **Assessment** Pt continues to show improvement with ability to maintain core control as she progress with use into twisting motions while keeping core control and increase use to UE's. Some VC's are still needed with timing of scapula re-ed as some limitations with T spine extension. Able to progress to T-spine Extension with upper body with chest of ball. A slow down and breaking down of motions does help with control. Will continue to benefit from PT to increase functional activities. **Plan:** Continue per plan of care: **Reviewer's comments: The interim visits are summarized with significant events. Further physical therapy records and physical therapy discharge summary are not available for review.*	
08/17/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** None recorded. **Medications:** Cyclobenzaprine 5 mg tablet - Take 1 tablet(s) twice a day by oral route as needed for 30 days. Fluticasone propionate 50 mcg/actuation nasal spray, suspension - Spray 1 to 2 sprays into each nostril 2 times a day Ketotifen 0.025 % (0.035 %) eye drops Meloxicam 15 mg tablet - Take 1 tablet in the morning with food as needed for pain. Tacrolimus 0.1 % topical ointment - Apply to affected area every weekend Triamcinolone acetonide 0.1 % dental paste - Apply to affected area 4 times daily **History of present illness:** Patient presents today for further evaluation. In the interim, she has been evaluated by ortho hand - Dr. XXXX on 07/31/YYYY following recommendation by our office and was noted with Left arm and hand pain with numbness following motor vehicle accident with plan for nerve conduction studies to evaluate her for possible carpal tunnel syndrome and physical therapy for left lateral epicondylitis. Patient reports she has plateaued with physical therapy and is frustrated as she does not feel PT is engaged enough with her. **Physical examination:** **Extremities:** Left Upper extremity no edema, erythema, or change in skin color and normal temperature. Right Upper Extremity no edema, erythema, or change in skin color and normal temperature. Left Lower extremity no edema, erythema, or change in skin color and normal temperature. Right Lower Extremity no edema, erythema, or change in skin color and normal temperature. **Neurological System:** Gait and station steady and upright and no antalgic gait. Upper Extremity neurologically grossly intact without changes. Lower Extremity neurologically grossly intact without changes.	164-167

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Musculoskeletal System: Thoracic Spine Noted with ropy muscle spasm in the bilateral paraspinal muscles and with twitch response and Facet loading positive over bilateral lower facet joints and AROM grossly functional. Lumbar Spine AROM grossly limited, Noted with ropy muscle spasm in the bilateral paraspinal muscle!$ and Facet loading positive over bilateral lower facet joints. Sacrum negative tenderness bilaterally. **Imaging/results:** *Reviewed.* **Assessment/plan:** **Low back pain** Clinical presentation today is consistent with diffuse lumbar facet joint pain, lower thoracic facet joint pain, and myalgia, and the underlying anatomy and pathophysiology was explained in detail. She reports minimal benefit with her PT as she describes her therapist as hands off. I strongly advised her to try a different location for therapy and agree she would benefit from more hands on approach to PT. She does not wish to pursue injections and would like to maximize benefit with therapy. Provided new script for PT. She has therapy scheduled through Dr. XXXX LT lateral epicondylitis and has upcoming EMG for LUE to assess for CTS as well and will follow up about occupational therapy as ordered by Dr. XXXX. Patient is taking meloxicam 15mg with benefit and without side effects. I will refill. Advised her to take this in the morning. If patient does not improve in 6 weeks we will discuss injection options her low back. She has previously been hesitant about injections. Low back pain, unspecified Physical therapist referral - Schedule Within: provider's discretion Note to Provider: Cervical traction - Please focus on use of Myofascial release and may include modalities, range of motion, stretching, stabilization exercises, provide Home Exercise Program Evaluate & Treat: Lumbar facet joint pain, lower thoracic facet joint pain, and myalgia, LT cervical radiculopathy Visits per Week: 2-3x/week, 4-6 weeks Meloxicam 15 mg tablet - Take 1 tablet in the morning with food as needed for pain. Qty: (30) tablet Refills: 1 **Neck pain** Patient will proceed with PT for low back and will include neck dxs. Cervicalgia **Cervical radiculopathy** Continues to show signs of cervical radiculopathy. She is scheduled for an EMG/NCS to distinguish between cervical radiculopathy and CTS. Radiculopathy, cervical region **Muscle pain**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient takes Flexeril muscle spasms as she is tolerating this medication well and without side effects. I will refill. Advised her to take this in the evening. Myalgia, other site Cyclobenzaprine 5 mg tablet - To be submitted on or around 08/18/YYYY Take 1 tablet(s) twice a day by oral route as needed for 30 days. Qty: (60) tablet Refills: 1 **Motor vehicle accident victim** Person injured in unspecified motor-vehicle accident, traffic, sequela **Return to Office** Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/21/YYYY at 1700 hours Rebecca Smith, PT for Therapy Re-evaluation at Easton PT on 08/28/YYYY at 1630 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 08/31/YYYY at 1730 hours Zachary Bohart, MD for EMG 30 at Easton on 09/05/YYYY at 1530 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 09/05/YYYY at 1700 hours Simon XXXX, MD for Follow Up 15 at Easton on 09/07/YYYY at 0900 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 09/07/YYYY at 1830 hours Joey Teixeira, PTA for Follow Up 30 at Easton PT on 09/11/YYYY at 1700 hours To see XXXX, MD at Mansfield Reservoir 2 on or around 09/28/YYYY XXXX, MD for Follow Up 15 at Raynham on 09/28/YYYY at 1445 hours.	
08/23/YYYY	Hospital/ Provider	**Physical Therapy Record – Initial Evaluation:** **Injury description:** Back **Diagnosis:** • Cervicalgia • Low back pain **Referring provider:** XXXX, M.D. **Subjective:** The patient comes to PT with low back and neck pain/LUE/ headache pain that started from a MVA May 10th YYYY. She states she went to her PCP the following day and has been following up with an Orthopedic for her spine. She has had a series of X-rays, MRI which showed per patient DDD of her lumbar spine and notes she will be undergoing a nerve test in the upcoming weeks. The patient reports she has been in PT since June 20th, however she has not made as drastic improvements as she has hoped and is looking to start treatment at our clinic. She states her low back and neck feel very tight and stiff, she has occasional L arm pain and tingling and notes occasional headaches. When asked about her previous treatment she notes she was doing a lot of core exercises which has helped but she is feeling very stiff and states she believes she needs more of a "hands on approach". She is currently taking muscle relaxers at night. **Aggravating symptoms:** Going to gym, housework, sleeping at night, recreational walking. **Alleviating factors:** Medication and stretching. **HPI/Chief Complaint:** Bilateral low back pain, L>R cervical spine pain with L shoulder and L arm tingling (1-3x a day). She states her headaches have seem to	168-173

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		subsite in the moment. **Follow up date with referring provider:** September 05 will be nerve testing, September 28th is her follow up with the Orthopedic. **Medical History:** Reviewed with patient. Pre-existing conditions that impact plan of care: Back pain, Previous accidents **Surgical History:** N/A **Diagnostic Tests:** MRI- DDD of Lumbar Spine, undergoing nerve testing next week. **Prior Level of Function:** Independent IADLS. **Patient Goals:** To be able to return to recreation fitness regimen and clean her house. **MIPS - 65+ Yrs - Fall Risk Screen required** **Has there been a history of 2 or more falls in the past year, OR any fall with injury in the past year:** No **Medical History Review** Low Complexity - The patient has a history of present problem without any personal factors and/or comorbidities that impact the plan of care **Objective analysis:** **Flow sheet completed exercises:** Lower Trunk Rotations (LTR) Home exercise program instruction – PPT Upper trap stretch Thoracic rotation sidelying/open books Levator scapulae stretch Piriformis stretch supine Cat and camel Patient instruction/education Manual therapy **General objective analysis:** **MIPS - FOTO functional status:** Score at Initial Evaluation: 36 Predicted Score in Expected# of Visits: 53 **Screening:** Cervical Screening: See below Thoracic Screening: Mildly limited Lumbar Screening: See below Hip Screening: WNL Knee Screening: WNL Foot/Ankle Screening: WNL	

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		Posture/observation: Guarded with moving spine. **Palpation:** TTP of L UT, L multifidi of C4-C6, BL QL, erector spinae of L3-L5 **Gait analysis:** Decreased trunk and cervical spine rotation **Neuro screen:** **Dermatomes:** WNL (+ ULTTA) **Myotomes:** WNL **Reflexes:** WNL **(-) Myelopathy/ Upper Motor Neuron Screening:** (Gait deviation, Hoffmann's test, Inverted supinator sign, Positive Babinski test, Age> 45 years) *Considered positive if 3 or more findings are present* **Lumbar AROM:** Flexion: A little below her knee painful Extension: 10% painful R Rotation: 10% painful L Rotation: 10% painful R Sidebend: 25% painful L Sidebend: **Range of motion (ROM)** Cervical Flexion: 70% Cervical Extension: 80% Cervical R Rotation: 50% Cervical L Rotation: 50% Cervical R Sidebend: 50% Cervical L Sidebend: 50% Thoracic Right Rotation: 75% Thoracic Left Rotation: 75% **Joint mobility assessment:** Hypomobility of C4-C6, Thoracic spine generalized hypomobility and L3-L5 hypomobility. **Diagnostic test clusters:** **Neck pain with mobility deficits:** (-) Central or unilateral local (shoulder or UE) referral without radicular symptoms (+) Cervical ROM limitations that consistently reproduce symptoms (+) Restricted cervical and/or thoracic segmental mobility (+) Symptoms reproduced with provocation of involved cervical or thoracic musculature (+) Cervical or scapular strength and motor control deficits **Neck pain with cervical radiculopathy** **Cervical Radiculopathy CPR:** (+) ULTT (+) Spurling's Test causes peripheralization of symptoms (+) Distraction Test causes centralization of symptoms (+) Cervical rotation < 60 degrees to involved side **Additional Nerve Root Compression Symptoms:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		(-) Arm/Neck pain with paresthesia in dermatomal distribution of affected nerve (-) Motor weakness present (-) Reflex changes present **Neck pain with cervicogenic headache** (-) Cervical Flexion-Rotation Test (-) Unilateral headache or ram's horn pattern (-) Exacerbated by neck movement or posture (-) Tenderness to the upper cervical spine (-) Trigger points noted in upper trapezius, levator scapulae, scalenes, suboccipitals (-) Weakness in the deep neck flexors (-) Cluster-Type: unilateral, severe, frequent, lasting minutes to hours. (-) Tension-Type: bilateral, mild to moderate, several days per month to> 3 months, lasting hours to continuous, symptoms of pressing, tightening, possible photophobia or mild nausea (-) Migraine Without Aura: unilateral, frontotemporal in adults, moderate to several, > 14 days/month, lasting 4-72 hours, associated with flickering lights/worse in vision, pulsating quality, nausea, photophobia. **Neck pain with Whiplash Associated Disorder (WAD)** (+) Motor dysfunction: Restricted ROM and/or altered patterns of muscle recruitment of the cervical spine or shoulder girdle regions (-) Sensorimotor dysfunction: Loss of balance or disturbed neck influence eye movement control (-) Sensory dysfunction: Psychological or post-traumatic distress, concentration and memory problems, sleep disturbances, anxiety or depression. (+) Deep Neck Flexor Endurance Test (+) Cranial Cervical Flexion Test **Joint mobility assessment:** **HIP Muscle Length Tests** (-) Thomas Test (-) 90-90 Hamstring Test (-) Ober's Test (-) Piriformis Test Abdominal Strength: 4/5 **Low back pain with mobility deficits due to acute or subacute sprain/strain** (+) Central or unilateral symptoms with local referral without radicular symptoms (+) ROM limitations that consistently reproduce symptoms (+) Restricted lumbar segmental mobility (+) Provocation of involved lumbar musculature reproduced symptoms **Low back pain with mobility deficits due to DJD and spinal stenosis** (-) Older age (>65y/o) (-) Back and LE symptoms below buttocks (-) Aggravated with standing/walking & eased with sitting/flexion (-) Neurogenic claudication (pain, tension, weakness with walking/standing/stairs)	

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		Low back pain with radiculopathy (Radicular/Discogenic Test Cluster) (-) SLR (-) Slump (-) Femoral Nerve Tension (-) Directional Preference **Low back pain with motor control and endurance deficits** (-) Chronic or recurrent (-) Worse with static postures & improved with activity **Lumbar Instability Test Cluster** (-) Age <40 years old (-) SLR >90 degrees (-) Aberrant Movement Patterns **Assessment** **Patient Assessment/ Diagnosis** Patient presents with findings consistent with neck pain and low back pain with whiplash associated disorders and possible radiculopathy of cervical spine. Supporting findings include motor dysfunction: restricted ROM and/or altered patterns of muscle recruitment of the cervical spine or shoulder girdle regions, + deep Neck Flexor Endurance, hypomobility of lumbar spine, cervical spine+ ULTTA, +compression,+ distraction test, limited AROM with aberrant movements patterns. Impairments & functional limitations include difficulty sleeping, sitting, turning neck, driving, reaching, pushing and pulling, bending, walking, prolong sit to stand. Participation restrictions include difficulty performing ADLs and self-care. Patient is appropriate for PT intervention to address the above limitations and promote return to prior activities. **PTA Communication:** Reviewed documentation and plan of care with physical therapy assistant. **Rehab Prognosis/Potential:** Excellent **Goals** **Short term/impairment goals:** 4 weeks Pain decreased to <2/10 Cervical ROM increased to full & pain-free Lumbar ROM increased to full & pain-free Patient is negative for stress testing to the affected area Cervical Flexor Endurance improved to >30s **Long term/functional goals:** 8 Weeks FOTO (Patient-Reported Outcome) Score: >MCII (Minimal Clinically Important Improvement) No difficulty with head turning/rotation for ADL's No difficulty with prolong ambulation No difficulty with prolonged sitting/driving (>1 hour). Able to reach forward/laterally and overhead without limitation.	

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		Able to lift/carry without limitation Able to participate fully in previously limited activities including: Independent with HEP, symptom management, and when to return for PT assessment. **Plan:** **Planned Procedures:** Manual Therapy, Therapeutic Exercise, Therapeutic Activity, Neuromuscular Re-education, Gait/Balance Assessment and Training, Self-Care and Home Management Training, Physical Performance Test or Measurement. **Possible Procedures:** Fall Prevention Interventions, Modalities, Aquatic Therapy, Dry Needling, Group Therapy, Mechanical Traction, DME and as needed **Possible Procedures Treated overfull course of treatment** • Therapeutic exercise • Neuromuscular reeducation • Manual therapy • Functional and dynamic activities • Unattended EMS treatment • Needle insertion(s) without injection; 1 or 2 muscle(s) • Needle insertion(s) without injection; 3 or more muscle(s) **Frequency of treatment:** 2 x every week **Duration of treatment:** Until 10/18/YYYY **Services provided during visit:** • Manual therapy • Therapy procedure using exercise to develop strength, endurance, range of motion and flexibility, each 15 minutes • Functional and dynamic activities • Physical therapy evaluation	
09/23/YYYY	Hospital/ Provider	**Office Visit:** **Reason for Appointment:** Neck and low back pain **History of present illness:** **Presentation:** Patient presents for initial orthopedic spine evaluation of neck and low back pain. The patient states their pain began after a motor vehicle accident on 05/10/YYYY. The patient was a restrained driver in a stopped vehicle that sustained a rear-end impact. Patient sought treatment at a local hospital, for further evaluation, later on that day. **Cervical:** The pain is intermittent. This pain is described as aching. The neck pain radiates into the left shoulder to the wrist. Numbness and tingling is present in the left shoulder down the arm with a burning	174-176

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		sensation. On average the pain is moderate to severe. The pain is improved by heat and changing positions. The pain is aggravated by activities of daily living. **Lumbar:** The pain is intermittent. The pain is described as stiff. Numbness and tingling is present in the left leg posteriorly. On average the pain is severe. The pain is improved by applying heat. The pain is aggravated by activities of daily living. **Treatment for Current Injury:** Physical Therapy completed without benefit. **Prior Injuries:** Patient states that no prior injuries have occurred; patient was asymptomatic at the time of the accident. **Current Medications** **Taking** Triamcinolone Acet & Lidocaine, Notes to Pharmacist: dental paste Tacrolimus Meloxicam Ketotifen Fumarate Fluticasone Propionate (Inhal) Cyclobenzaprine HCl Medication List reviewed and reconciled with the patient **Review of systems:** **Musculoskeletal:** Patient complains of neck and low back pain. *All other systems reviewed and are negative.* **Physical examination:** **Neck / thyroid:** Neck supple, thyroid swelling seen on the left found. Trachea is midline. Cervical pain with range of motion. Lumbar pain with range of motion. **Neurological:** **Cranial nerves:** No afferent pupil defect. No ptosis or nystagmus, Pinprick, light touch intact in all three divisions, I - Not Tested., II - Pupils 4mms reacting briskly to 2 mms. III, IV, VI - EOM were full with normal pursuit and saccade, V - Motor V intact, VII - No asymmetry or weakness, VIII - Acuity intact to finger nib bilaterally, IX, X- Palate rose in midline, XI -Sternocleidomastoid, trapezius strength intact., XII - Tongue protruded midline w/o atrophy or fasciculations. **Motor strength:** No focal deficit in the lower extremities. She has left wrist extension weakness at 4/5.. **Sensory:** With pain and numbness of the medial 1 and 1/2 fingers of the left hand.	

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		She describes right L5 dysesthesias. **Reflexes:** Bilaterally symmetrical, Babinski negative. **Tremors:** Absent. **Coordination:** Finger-to-nose and rapid alternating movements were intact. **Gait and station:** Within normal limits, Romberg was negative. **Speech:** Normal. **Imaging Review:** MRI of the cervical spine, dated 06/26/YYYY demonstrates a left C5-6 disc herniation with foraminal stenosis. MRI of the lumbar spine, dated 06/02/YYYY shows a right sided L4-5 foraminal protrusion. **Assessment:** Cervical disc herniation (Primary) Lumbar disc herniation Cervicalgia Back pain due to injury Motor vehicle accident victim, initial encounter **Treatment** **Others** **Clinical Notes:** Patient is a 61-year-old female patient who presents to the office for an initial orthopedic spine evaluation with complaints of neck and low back pain status post motor vehicle collision that occurred on 05/10/YYYY. History, clinical, and imaging findings were reviewed with the patient. Regarding her neck, I have discussed the potential benefits of an anterior cervical discectomy and fusion at C5-6. She also understands the potential benefits of a lumbar injection, L4 nerve root block, if her pain worsens. The patient states she is currently scheduled for a thyroidectomy. The treatment plan components and options were discussed in detail with the patient, including but not limited to potential risks, benefits, possible side effects, alternatives, and expected outcomes. All of her questions were answered to her satisfaction. Patient verbalizes understanding. She will consider her treatment options for now. Patient will follow up in 2 weeks for re-evaluation and further recommendations. Thank you for including me in the care and treatment of this patient. Please feel free to contact me with any questions or concerns. **Follow-up:** 2 weeks.	
10/25/YYYY	Hospital/ Provider	**Follow-up Visit:** **Chief complaint:** I got another opinion on my thyroid. **Assessment/plan:** 61-year-old female here for follow-up. **Multinodular goiter:** Again reiterated that it is reasonable to have her thyroid removed. She has sought several other opinions regarding this. Defer to her ENTs to determine next steps. **Colonic adenoma:** Colonoscopy done in YYYY, repeat in 2026 per GI recommendation.	177-178

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		Prediabetes: Check A1C today Return to clinic 1 year	
08/28/YYYY-11/01/YYYY	Hospital/ Provider	**Summary of interim Physical Therapy visits for low back pain and cervicalgia:** **Diagnosis**: • Cervicalgia • Low back pain • Pain in left elbow **Elbow ROM:** WNL **Elbow MMT:** Flexion: 4-/5 Extension: 5/5 Supination: 4-/5 Pronation:4-/5 **Wrist** MMT: Flexion :4/5 Extension:3+ (painful) Radial Deviation:4/5 Ulnar Deviation:4/5 **Wrist ROM:**WNL **Diagnostic test clusters**: **Lateral Epicondylalgia** (+) Cozen's Test (+) Mill's Test (+) Pain Pressure Threshold **Joint mobility assessment:** Hypomobility of C4-C6, spine generalized hypomobility and L3-L5 hypomobility. **Treatment dates:** 08/28/YYYY, 08/30/YYYY, 09/06/YYYY, 09/11/YYYY, 09/13/YYYY, 09/18/YYYY, 09/21/YYYY, 09/25/YYYY, 09/27/YYYY, 10/04/YYYY, 10/09/YYYY, 10/11/YYYY, 10/16/YYYY, 10/18/YYYY, 10/23/YYYY, 10/25/YYYY, 10/30/YYYY, 11/01/YYYY **Treatment provided:** • Manual therapy • Therapeutic Exercise • Therapeutic Activity • Neuromuscular Re-education • Gait/Balance Assessment and Training • Self-Care and Home Management Training • Physical Performance Test or Measurement. • Therapy procedure using exercise to develop strength, endurance, range of motion and flexibility, each 15 minutes	179-264

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		• Functional and dynamic activities **As of 11/01/YYYY:** **Subjective analysis:** **Patient self-report:** Patient reports she is going to Florida and won't be back for a while. She states that today will be her last day here because she will be leaving at least for 2 months. **Objective analysis:** **Flow sheet completed exercises:** Re-evaluation Postural training/re-education Home exercise program instruction Reverse march Lateral walks with resistance band (thighs) Patient instruction/education Bird dog – Quadraped position Pallof press TRX squat Bridge with march Manual therapy techniques: Performed manual therapy on the left back **General objective analysis:** **MIPS - FOTO functional status:** Score at Initial Evaluation: 36 Predicted Score in Expected# of Visits: 53 Subsequent Scores: 62 **Screening:** Cervical Screening: See below Thoracic Screening: Mildly limited Lumbar Screening: See below Hip Screening: WNL Knee Screening: WNL Foot/Ankle Screening: WNL **Posture/observation:** Guarded with moving spine. **Palpation:** TTP of L UT, L multifidi of C4-C6, BL QL, erector spinae of L3-L5 **Gait analysis:** Decreased trunk and cervical spine rotation **Neuro screen:** Dermatomes: WNL (+ ULTTA) Myotomes: WNL Reflexes: WNL (-) Myelopathy/ Upper Motor Neuron Screening: (Gait deviation, Hoffmann's test, Inverted supinator sign, Positive Babinski test, Age> 45 years) *Considered positive if 3 or more findings are present*	

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		Lumbar AROM: Flexion: A little below her knee painful Extension: 75% painful R Rotation: 75% painful L Rotation: 80% painful R Sidebend: 75% painful L Sidebend: **Range of motion (ROM)** Cervical Flexion: 70% Cervical Extension: 80% Cervical R Rotation: 75% Cervical L Rotation: 75% Cervical R Sidebend: 575% Cervical L Sidebend: 75% Thoracic Right Rotation: 75% Thoracic Left Rotation: 75% **Elbow ROM:** WNL **Elbow MMT:** Flexion: 4-/5 Extension:5/5 Supination: 4-/5 Pronation:4-/5 **Wrist MMT:** Flexion :4/5 Extension:4 (painful) Radial Deviation:4/5 Ulnar Deviation:4/5 **Wrist ROM:** WNL **Diagnostic test clusters:** **Lateral Epicondylalgia** (+) Cozen's Test (+) Mill's Test (+) Pain Pressure Threshold **Joint mobility assessment:** Hypomobility of C4-C6, Thoracic spine generalized hypomobility and L3-L5 hypomobility. **Diagnostic test clusters:** **Neck pain with mobility deficits:** (-) Central or unilateral local (shoulder or UE) referral without radicular symptoms (+) Cervical ROM limitations that consistently reproduce symptoms (+) Restricted cervical and/or thoracic segmental mobility (+) Symptoms reproduced with provocation of involved cervical or thoracic	

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		musculature (+) Cervical or scapular strength and motor control deficits **Neck pain with cervical radiculopathy** **Cervical Radiculopathy CPR:** (-)ULTT (-) Spurling's Test causes peripheralization of symptoms (-) Distraction Test causes centralization of symptoms (-) Cervical rotation< 60 degrees to involved side **Additional Nerve Root Compression Symptoms:** (-) Arm/Neck pain with paresthesia in dermatomal distribution of affected nerve (-) Motor weakness present (-) Reflex changes present **Neck pain with cervicogenic headache** (-) Cervical Flexion-Rotation Test (-) Unilateral headache or ram's horn pattern (-) Exacerbated by neck movement or posture (-) Tenderness to the upper cervical spine (-) Trigger points noted in upper trapezius, levator scapulae, scalenes, suboccipitals (-) Weakness in the deep neck flexors (-) Cluster-Type: unilateral, severe, frequent, lasting minutes to hours. (-) Tension-Type: bilateral, mild to moderate, several days per month to> 3 months, lasting hours to continuous, symptoms of pressing, tightening, possible photophobia or mild nausea (-) Migraine Without Aura: unilateral, frontotemporal in adults, moderate to several, > 14 days/month, lasting 4-72 hours, associated with flickering lights/worse in vision, pulsating quality, nausea, photophobia. **Neck pain with whiplash associated disorder (WAD)** (+) Motor dysfunction: restricted ROM and/or altered patterns of muscle recruitment of the cervical spine or shoulder girdle regions (-) Sensorimotor dysfunction: loss of balance or disturbed neck influence eye movement control (-) Sensory dysfunction: psychological or post-traumatic distress, concentration and memory problems, sleep disturbances, anxiety or depression. (-) Deep Neck Flexor Endurance Test (-) Cranial Cervical Flexion Test **Joint mobility assessment:** **HIP Muscle Length Tests** (-) Thomas Test (-) 90-90 Hamstring Test (-) Ober's Test (-) Piriformis Test Abdominal Strength: 4/5 **Low back pain with mobility deficits due to acute or subacute sprain/strain**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		(-) Central or unilateral symptoms with local referral without radicular symptoms (-) ROM limitations that consistently reproduce symptoms (+) Restricted lumbar segmental mobility (+) Provocation of involved lumbar musculature reproduced symptoms **Low back pain with mobility deficits due to DJD and spinal stenosis** (-) Older age (>65y/o) (-) Back and LE symptoms below buttocks (-) Aggravated with standing/walking & eased with sitting/flexion (-) Neurogenic claudication (pain, tension, weakness with walking/standing/stairs) **Low back pain with radiculopathy** (Radicular/Discogenic Test Cluster) (-) SLR (-) Slump (-) Femoral Nerve Tension (-) Directional Preference **Low back pain with motor control and endurance deficits** (-) Chronic or recurrent (-) Worse with static postures & improved with activity **Lumbar Instability Test Cluster** (-) Age <40 years old (-) SLR >90 degrees (-) Aberrant Movement Patterns **Assessment:** **Patient Assessment/ Diagnosis** Patient line has been seen 19 visits of PT services at this time and in those visits she has made great gains. She has improved AROM of Lumbar Spine, no complaints of Cervical spine radicular symptoms and is steadily improvements with her LUE and core stabilization. Functionally she has improvements in her ability to prolong stand, bend and lift and reach/grip objects. Despite improvements she continues to have the most difficulty with prolong sitting and complains of back pain. The patient will be leaving for 2 months in Florida and will no longer have PT services at our facility. She has met all of her short term goals and is progressing towards her long term goals at this time. **Rehab Prognosis/Potential:** Excellent **Goals:** **Short term/impairment goals:** 4 weeks Pain decreased to <2/10 Cervical ROM increased to full & pain-free Lumbar ROM increased to full & pain-free Patient is negative for stress testing to the affected area Cervical Flexor Endurance improved to >30s **Long term/functional goals:** 8 Weeks	

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		FOTO (Patient-Reported Outcome) Score: >MCII (Minimal Clinically Important Improvement) No difficulty with head turning/rotation for ADL's No difficulty with prolong ambulation No difficulty with prolonged sitting/driving (>1 hour). Able to reach forward/laterally and overhead without limitation. Able to lift/carry without limitation Able to participate fully in previously limited activities including: Independent with HEP, symptom management, and when to return for PT assessment. **Plan:** **Notes on Plan** **Planned Procedures:** Manual Therapy, Therapeutic Exercise, Therapeutic Activity, Neuromuscular Re-education, Gait/Balance Assessment and Training, Self-Care and Home Management Training, Physical Performance Test or Measurement. **Possible Procedures:** Fall Prevention Interventions, Modalities, Aquatic Therapy, Dry Needling, Group Therapy, Mechanical Traction, DME and as needed **Possible procedures treated over full course of treatment:** Therapeutic exercise Neuromuscular reeducation Manual therapy Functional and dynamic activities Unattended EMS treatment Needle insertion(s) without injection; 1 or 2 muscle(s). Needle insertion(s) without injection; 3 or more muscle(s) **Frequency of treatment:** 2 x every week **Duration of treatment:** Until 12/06/YYYY **Services provided during visit:** Therapeutic exercise Neuromuscular reeducation Manual therapy Functional and dynamic activities **Reviewer's comments: The interim visits are summarized with significant events.*	
12/13/YYYY	Hospital/ Provider	**Assessment:** **Pain description:** **Pain level:** Moderate-severe **My pain is:** Intermittent **Onset of pain:** Due to MVA: Yes **Are you having any symptoms of concussion afterward?** Headache **Are you currently experiencing any of the following problems that may be related to a head injury or concussion?** Yes	265-267

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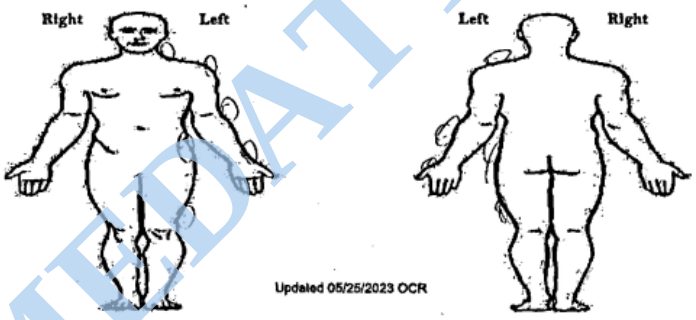
		Are you currently experiencing any of the following problems that may be related to a head injury or concussion? Balance problems, sleep problems **Describe your pain:** Pins/needles/tingling, hot/burning **What activities makes pain worse:** Sitting, standing, walking, bending, lifting **What activities makes pain better:** ___ **Associated symptoms:** Stiffness, fatigue, balance problems **Auto accident injury:** **Date of injury:** 05/10/YYYY **Have you had previous injuries?** No **Have you seen other providers?** Yes **The patient was the:** Driver **Patient was wearing seat belt:** Yes **Patient was holding the steering wheel:** Yes **Patient's air bags deployed:** No **Patient hit head/suffered a head trauma:** No **Patient reports loss of consciousness:** No **Patient's vehicle was:** Stopped **Type of accident:** Rear end **Post-accident, the patient went where:** Home **Type of treatment:** Doctor visits, X-ray, MRI, PT, OT  **Prior treatments:** Physical therapy: No change Heat: Better **Current medications:** Pain killer **Review of systems:** **General:** Loss of appetite **Endocrine:** Thyroid nodule **Respiratory:** Chronic cough **Eyes:** Blurred vision **Neurological:** Headache, dizziness **Gastrointestinal:** Heartburn	

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		Vitals: HR: 75, BP: 109/79, weight: 110 lbs, height: 5 feet 2 inches	
12/13/YYYY	Hospital/ Provider	**Office Visit:** **Reason for Appointment:** Neck pain, mid back pain, low back pain, left elbow pain, left buttock pain **History of present illness:** The patient is a 61-year-old female who presents to the office with a chief complaint of neck pain, lower back pain, left buttock pain, and left elbow pain. The symptoms are moderate to severe and started after motor vehicle accident on 05/10/YYYY. She was the restrained driver when her car was rear-ended while stopped at an intersection. She denies any loss of consciousness or head trauma, also the airbags did not deploy. After the accident, the patient has undergone imaging studies and has received occupational and physical therapies. She has also been assessed by other physicians. Currently, she describes her neck pain as hot/burning in nature along with paresthesias/pins and needle sensations affecting the neck and lower back. The pain will radiate from the neck into the shoulder blade area. She denies any pain radiating from the neck into the arms or from the back into the legs. She also denies any weakness in the extremities. Symptoms worsen with sitting, standing, walking, bending, lifting and improve with over-the-counter medications like Tylenol and Advil. Symptoms also improved with application of heat. Physical therapy did not improve or worsen symptoms. **Image Results:** **MRI abdomen with and without contrast 06/12/YYYY** Several hepatic and angiomas, 1 of which corresponds to the abnormality seen on prior MRI lumbar spine. **MRI lumbar spine 06/02/YYYY** L4-L5 right foraminal disc protrusion impinges upon the right exiting L4 nerve root. Multilevel disc herniations without significant central canal stenosis. No fracture or ligamentous injury. Incompletely characterized right hepatic lobe lesion. Tumor cannot be excluded. Further evaluation with gadolinium enhanced MRI abdomen recommended. **MRI thoracic spine 06/26/YYYY** There is a very small central disc protrusion at T1-T2 and T2-T3 Mild facet hypertrophic degenerative changes are seen at T9-T10 and T11-T12. No other disc herniations noted. **Cervical spine MRI 06/26/YYYY** (Study is incomplete) C3-C4 minimal broad-based disc protrusion minimally indenting the thecal sac. Neuroforamina are patent. C4-C5 mild broad-based disc protrusion mildly indenting the thecal sac. The neuroforamina are patent. C5-C6 there is a left paracentral/left intraforaminal disc extrusion/uncinate the	268-277

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		complex which mildly narrows the left lateral recess and moderate to severely narrows the left neural foramen. Right paracentral disc protrusion/uncinate vertebral hypertrophy complex mildly narrows the right lateral recess and mildly narrows the right neural foramen. **Review of systems:** **Musculoskeletal:** Comments: See HPI for details. *All other systems reviewed and are negative.* **Vitals:** RR: 14, HR: 75, BP: 109/79, weight: 110 lbs, height: 62 inches, BMI: 20.12 **Physical examination:** **Musculoskeletal:** **Cervical spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain, AROM with rotation also decreased due to pain **Palpation:** TTP over posterior c-spine (mostly lower segments) and bilat paraspinal and upper trapezius muscles. **Sensation:** Grossly intact to light touch in dermatomal distributions of C6, C7, C8. Grossly intact sensation to light touch in the peripheral nerve distributions of the radial, ulnar, and median nerves. **Motor: R/L** Deltoid Abduction (C5): 5/5 bilat Elbow Flexion (C5/6): 5/5" Wrist Extension (C6): 5/5" Wrist Flexion (C7): 5/5" Elbow Extension (C7): 5/5" Finger flexion (C8): 5/5" Finger Abduction (T1): 5/5" DTR (0-4+) R/L Biceps (C5): 2/4 bilat Brachioradialis (C6): 2/4 " **Special tests** **Spurling:** Negative bilaterally. **Hoffmann's Sign:** Absent bilaterally **Thoracic spine** **Inspection:** No edema, erythema or ecchymosis. **ROM:** Full AROM flexion and extension w/o pain **Palpation:** No tenderness to palpation over posterior spine and bilateral thoracic paraspinal muscles **Lumbar spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain **Palpation:** Tenderness to palpation over posterior lower lumbar spine and bilateral paraspinal muscles	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Sensation: grossly intact to light touch at dermatomal distributions (L4, L5, S1) bilaterally **Motor: R/L** Hip Flexion (L2-3): 5/5 bilateral Knee Extension (L4): 5/5" Knee Flexion (L5-S1)): 5/5 " Ankle Dorsiflexion (L5): 5/5" Ankle Plantarflexion (S1): 5/5" DTR (0-4+) R / L Patellar (L4): 2/4 Achilles (S1): 2/4 Clonus (S1/2): Negative bilateral Gait: Normal. **Special tests:** SLR negative bilaterally. **Extremities:** No obvious size difference (in upper or lower extremity), no concern for erythema, drainage. **Assessments** Cervicalgia Bulging of cervical intervertebral disc Left elbow pain Mid back pain Bulging of lumbar intervertebral disc Vertebrogenic low back pain MVA (motor vehicle accident) **Treatment** **Cervicalgia** Start Meloxicam Tablet, 7.5 MG, 1 tablet, Orally, Once a day, 30 day(s), 30 Start Feximid Tablet, 7.5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30 Start Lidozen Gel, 4-1 %, as directed, Externally **Imaging: MRI:** Cervical without Contrast **Procedure:** Back Brace LSO **Procedure:** Tens Unit **Notes:** MRI cervical spine reordered to reevaluate for discal pathology status post MVA. Pending image review, patient may be candidate for injections given failed therapies. Initial study indicates herniations at C5 and C6, given distribution of pain could consider C5-C7 bilateral medial branch blocks. If patient achieves pain relief after this injection, she may be candidate for RFA of the same levels. See below regarding as needed medications. **Left elbow pain** **Notes:** MRI left elbow ordered given physical exam findings to rule out inflammation/edema at the elbow joint/common tendons. Could consider PRP injection at lateral epicondyle given physical exam findings.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Mid back pain **Notes:** MRI thoracic spine MRI reviewed 12/13/YYYY Continue to monitor - not patient's primary pain generator today. **Vertebrogenic low back pain** **Notes:** MRI lumbar spine reviewed 12/13/YYYY TENS unit dispensed in office, education/tutorial regarding use of this device was given prior to the patient leaving. Lidocaine gel dispensed in office, to be applied to areas of pain 3-4 times a day as needed. Meloxicam 7.5 mg daily as needed for pain dispensed in office-taken with food. Fexmid 7.5 mg nightly as needed pain dispensed in office. LSO brace dispensed in office, education/tutorial regarding use of this device given prior to the patient leaving-to be worn with activity. Pending symptom relief from medication/modalities, could consider bilateral L4-S1 medial branch blocks followed by RFA if the patient's pain improves with blocks. The prescribed medications were discussed with patient, including indications, risks, benefits, possible a.e., alternatives and proper use. Also discussed taking as needed only and tapering as pain improves. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. **MVA (motor vehicle accident)** **Notes:** I am a physician licensed under chapter 458 of the Florida Statutes. I examined patient XXXX and determined that she had an emergency medical condition. An emergency medical condition is defined pursuant to Florida Statute 627.736 as "a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, and/or serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part." **Others** **Notes:** MRI abdomen reviewed 12/13/YYYY advised patient to visit PCP regarding findings.	
01/03/YYYY	Hospital/ Provider	**Follow-up Visit:** **Reason for Appointment:** Neck pain, low back pain, left wrist/left hand pain, left elbow pain	278-287

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of present illness: **Follow up HPI:** **01/03/YYYY** The patient is a 61-year-old female who presents to the office with a chief complaint of neck pain, left elbow pain, left wrist and hand pain, lower back pain status post MVA. She currently rates her symptoms as moderate today. She presents wondering what we can do to try to improve her moderate pain today. She denies any weakness or radiating pain in the legs or arms. She also notes increased pain at the left wrist/left hand since her last assessment. **Consult HPI:** The patient is a 61-year-old female who presents to the office with a chief complaint of neck pain, lower back pain, left buttock pain, and left elbow pain. The symptoms are moderate to severe and started after motor vehicle accident on 05/10/YYYY. She was the restrained driver when her car was rear-ended while stopped at an intersection. She denies any loss of consciousness or head trauma, also the airbags did not deploy. After the accident, the patient has undergone imaging studies and has received occupational and physical therapies. She has also been assessed by other physicians. Currently, she describes her neck pain as hot/burning in nature along with paresthesias/pins and needle sensations affecting the neck and lower back. The pain will radiate from the neck into the shoulder blade area. She denies any pain radiating from the neck into the arms or from the back into the legs. She also denies any weakness in the extremities. Symptoms worsen with sitting, standing, walking, bending, lifting and improve with over-the-counter medications like Tylenol and Advil. Symptoms also improved with application of heat. Physical therapy did not improve or worsen symptoms. **Image Results:** *Reviewed.* **Vitals:** RR: 18, oxygen saturation: 98%, HR: 83, BP: 110/78, weight: 126 lbs, height: 62 inches, temperature: 96.9 F, BMI: 23.04 **Current Medications** **Taking** • Meloxicam 7.5 MG Tablet 1 tablet Orally Once a day , stop date 01/12/YYYY • Fexmid 7.5 MG Tablet 1 tablet at bedtime Orally Once a day , stop date 01/12/YYYY • Lidozen Gel 4-1 % Gel as directed Externally • Medication List reviewed and reconciled with the patient **Review of systems:** **Musculoskeletal:** Comments: See HPI for details. **Physical examination:** **Musculoskeletal:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Cervical spine **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain, AROM with rotation also decreased due to pain **Palpation:** TTP over posterior c-spine (mostly lower segments) and bilat paraspinal and upper trapezius muscles. **Sensation:** Grossly intact to light touch in dermatomal distributions of C6, C7, C8. Grossly intact sensation to light touch in the peripheral nerve distributions of the radial, ulnar, and median nerves. **Motor:** R/L Deltoid Abduction (C5): 5/5 bilat Elbow Flexion (C5/6): 5/5 " Wrist Extension (C6): 5/5 " Wrist Flexion (C7): 5/5 " Elbow Extension (C7): 5/5 " Finger flexion (C8): 5/5 " Finger Abduction (T1): 5/5 " DTR (0-4+) R/L Biceps (C5): 2/4 bilat Brachioradialis (C6): 2/4 " **Special tests** **Spurling:** Negative bilaterally. **Hoffmann's Sign:** Absent bilaterally **Thoracic spine** **Inspection:** No edema, erythema or ecchymosis. **ROM:** Full AROM flexion and extension w/o pain **Palpation:** No tenderness to palpation over posterior spine and b/l thoracic paraspinal muscles **Lumbar spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain **Palpation:** Tenderness to palpation over posterior lower lumbar spine and bilateral paraspinal muscles **Sensation:** Grossly intact to light touch at dermatomal distributions (L4, L5, S1) bilaterally **Motor:** R/L Hip Flexion (L2-3): 5/5 bilat Knee Extension (L4): 5/5 " Knee Flexion (L5-S1)): 5/5 " Ankle Dorsiflexion (L5): 5/5 " Ankle Plantarflexion (S1): 5/5 " DTR (0-4+) R / L Patellar (L4): 2/4 Achilles (S1): 2/4 Clonus (S1/2): Neg bilat	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Gait: Normal. **Special tests:** SLR negative bilaterally. **Extremities:** Tenderness to palpation noted at the anatomical snuffbox of the left wrist and at the first CMC joint of the left hand first digit. No signs of erythema, edema, ecchymoses at these areas. **Assessments** Cervicalgia Bulging of cervical intervertebral disc Left elbow pain Mid back pain Bulging of lumbar intervertebral disc Vertebrogenic low back pain MVA (motor vehicle accident) Hand pain, left Wrist pain, left **Treatment** **Cervicalgia** **Notes:** Our office does not have a full MRI report of the cervical spine, given symptoms and the levels reported on incomplete study, patient is a candidate for chiropractic care without high velocity manipulations. Pending image review, patient may be candidate for injections given failed therapies. Initial study indicates herniations at C5 and C6, given distribution of pain could consider C5-C7 bilateral medial branch blocks. If patient achieves pain relief after this injection, she may be candidate for RFA of the same levels. See below regarding as needed medications. Referral To: Brian Muto Chiropractor **Reason:** Evaluate and Treat for Neck and Back Pain **Left elbow pain** **Notes:** MRI left elbow ordered given physical exam findings to rule out inflammation/edema at the elbow joint/common tendons. Could consider PRP injection at lateral epicondyle given physical exam findings. **Mid back pain** **Notes:** MRI thoracic spine MRI reviewed 12/13/YYYY Continue to monitor - not patient's primary pain generator today. **Vertebrogenic low back pain** **Notes:** MRI lumbar spine reviewed 12/13/YYYY Continue as needed TENS unit. Continue as needed medications like Lidocaine, Meloxicam, Fexmid. Continue as needed LSO brace (with activity).	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Referral placed for chiropractic care. Pending symptom relief from medication/modalities, could consider bilateral L4-S1 medial branch blocks followed by RFA if the patient's pain improves with blocks. The prescribed medications were discussed with patient, including indications, risks, benefits, possible a.e., alternatives and proper use. Also discussed taking as needed only and tapering as pain improves. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. Referral To: Brian Muto Chiropractor Reason: Evaluate and Treat for Neck and Back Pain **MVA (motor vehicle accident)** Referral To: Brian Muto Chiropractor Reason: Evaluate and Treat for Neck and Back Pain **Hand pain, left** **Imaging:** X ray: Hand, left **Notes:** X-rays left wrist and hand ordered. Continue as needed medications like Meloxicam, Fexmid, Lidocaine gel. **Wrist pain, left:** **Imaging:** X-ray of left wrist	
01/03/YYYY	Hospital/ Provider	**X-Ray of the Left Wrist:** **Referring physician:** Elverman **History:** Wrist pain following a motor vehicle collision on 05/10/YYYY. **Findings:** Moderate radiocarpal joint arthrosis. No acute fractures or dislocations are identified. No osteolytic or sclerotic lesions. There is no fracture or dislocation. No lytic lesion of bone is seen. The soft tissues are unremarkable. **Impression:** • Moderate radiocarpal joint arthrosis. • No acute fractures or dislocations are identified. No osteolytic or sclerotic lesion. • If there is concern for acute internal derangement, recommend MRI of the left wrist.	288-290
01/03/YYYY	Hospital/ Provider	**X-Ray of the Left Hand:** **Referring physician:** Elverman **History:** Hand pain following a motor vehicle collision on 05/10/YYYY.	291-293

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: Mild radiocarpal joint arthrosis. Mild thumb carpometacarpal joint arthrosis. No acute fractures or dislocations are identified. No osteolytic or sclerotic lesion. **Impression:** • Mild radiocarpal joint arthrosis. • No acute fractures or dislocations. ***Related records:*** *Others* *(PDF Ref: 294-298)*	
01/10/YYYY	Hospital/ Provider	**MRI od Cervical Spine:** **Referring physician:** Elverman **History:** Neck pain following a motor vehicle collision on 05/10/23. **Findings:** The posterior fossa structures are normal. The cervical cord structures are normal. The lordotic curvature is preserved. No prevertebral or paravertebral masses or fluid collections are identified. Segmental analysis of the cervical spine is as follows: At C2-3, there is bulging of the disc. This results in an anterior impression on the thecal sac. There is no central canal stenosis or foraminal stenosis. At C3-4, there is a right posterior central disc herniation superimposed on a disc bulge. There are anterior vertebral osteophytes, no posterior vertebral osteophytes. There is mild spinal canal stenosis. There is no foraminal stenosis. At C4-5, there is a posterior central disc herniation superimposed on a disc bulge. There are vertebral osteophytes present, the disc herniation extends beyond the osteophytes and indents the ventral thecal sac. There is moderate spinal canal stenosis. There is no foraminal stenosis. At C5-6, there is a posterior central disc herniation superimposed on a disc bulge. There are vertebral osteophytes present, the disc herniation extends beyond the osteophytes and indents the ventral thecal sac. There is severe spinal canal stenosis. There is moderate bilateral foraminal stenosis. At C6-7, there is bulging of the disc. This results in an anterior impression on the thecal sac. There is no central canal stenosis or foraminal stenosis. At C7-T1, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis. At T1-2, there is a posterior central disc herniation that indents the ventral thecal sac. There is no spinal canal or foraminal stenosis. At T2-3, there is a posterior central disc herniation that indents the ventral thecal sac. There is mild spinal canal stenosis. There is no foraminal stenosis.	299-306

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: • At C2-3, there is bulging of the disc. This results in an anterior impression on the thecal sac. • At C3-4, there is a right posterior central disc herniation superimposed on a disc bulge. There is mild spinal canal stenosis. See figure 1, series 5005, image 7. The arrow points to the C3-4 disc herniation. • At C4-5, there is a posterior central disc herniation superimposed on a disc bulge. There are vertebral osteophytes present, the disc herniation extends beyond the osteophytes and indents the ventral thecal sac. There is moderate spinal canal stenosis. See figure 2, series 5005, image 6. The first arrow points to the C4-5 disc herniation. • At C5-6, there is a posterior central disc herniation superimposed on a disc bulge. There are vertebral osteophytes present, the disc herniation extends beyond the osteophytes and indents the ventral thecal sac. There is severe spinal canal stenosis. There is moderate bilateral foraminal stenosis. See figure 2, series 5005, image 6. The second arrow points to the C5-6 disc herniation. • At C6-7, there is bulging of the disc. This results in an anterior impression on the thecal sac. • At T1-2, there is a posterior central disc herniation that indents the ventral thecal sac. See figure 2, series 5005, image 6. The third arrow points to the T1-2 disc herniation. • At T2-3, there is a posterior central disc herniation that indents the ventral thecal sac. There is mild spinal canal stenosis. See figure 3, series 5005, image 5. The arrow points to the T2-3 disc herniation.	
01/10/YYYY	Hospital/ Provider	**MRI of the left elbow:** **Referring physician:** Elverman **History:** Elbow pain following a motor vehicle collision of 05/10/YYYY. **Findings:** **Tendons:** There is intermediate grade tear involving the origin fibers of the common extensor tendons measuring 0.9 craniocaudal dimension with 40-60% depth. This occurs on a background of severe tendinosis. The common flexor and common extensor The biceps and brachialis tendons and insertion sites are normal. **Ligaments:** The lateral collateral ligament complex is intact. The ulnar collateral ligament is intact. **Osseous structures and soft tissues:** There is a small elbow joint effusion. No fractures or dislocations are identified. No marrow destructive lesions are identified. The anterior and posterior myofascial compartments of the elbow are within normal limits. The ulnar nerve lies within the cubital tunnel without abnormality. **Impression:** • Common extensor tear. Intermediate grade tear involving the origin fibers measuring 0.9 craniocaudal dimension with 40-60% depth. See Figure 1, series 5009, image 10 and see Figure 2, series 5004, image 17. The arrows point to the tear.	307-318

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Small elbow joint effusion. ***Related records:*** *Others* *(PDF Ref: 319-326)*	
01/24/YYYY	Hospital/ Provider	**Follow-up Visit:** **Reason for Appointment:** IMG Review **History of present illness:** **Follow up HPI:** 01/24/YYYY:Patient presents for neck, low back and left wrist pain following a motor vehicle accident. She denies any radicular symptoms in bilateral upper or lower extremities. Patient reports neck pain is mostly left-sided. She is attending chiropractic therapy twice a week. *Images reviewed.* **Consult HPI:** The patient is a 61-year-old female who presents to the office with a chief complaint of neck pain, lower back pain, left buttock pain, and left elbow pain. The symptoms are moderate to severe and started after motor vehicle accident on 5/10/YYYY. She was the restrained driver when her car was rear-ended while stopped at an intersection. She denies any loss of consciousness or head trauma, also the airbags did not deploy. After the accident, the patient has undergone imaging studies and has received occupational and physical therapies. She has also been assessed by other physicians. Currently, she describes her neck pain as hot/burning in nature along with paresthesias/pins and needle sensations affecting the neck and lower back. The pain will radiate from the neck into the shoulder blade area. She denies any pain radiating from the neck into the arms or from the back into the legs. She also denies any weakness in the extremities. Symptoms worsen with sitting, standing, walking, bending, lifting and improve with over-the-counter medications like Tylenol and Advil. Symptoms also improved with application of heat. Physical therapy did not improve or worsen symptoms. **Image Results:** *Reviewed.* **Vitals:** RR: 18, oxygen saturation: 98%, HR: 90, BP: 118/78, weight: 126 lbs, height: 62 inches, temperature: 96.9F, BMI: 23.04 **Current Medications** **Taking** Lidozen Gel 4-1 % Gel as directed Externally Medication List reviewed and reconciled with the patient **Review of systems:** **Musculoskeletal:** Comments: See HPI for details. *All other systems reviewed and are negative.* **Physical examination:**	327-344

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Musculoskeletal: **Cervical spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain, AROM with rotation also decreased due to pain **Palpation:** TTP over posterior c-spine (mostly lower segments) and bilat paraspinal and upper trapezius muscles. **Sensation:** Grossly intact to light touch in dermatomal distributions of C6, C7, C8. Grossly intact sensation to light touch in the peripheral nerve distributions of the radial, ulnar, and median nerves. **Motor:** R/L Deltoid Abduction (C5): 5/5 bilat Elbow Flexion (C5/6): 5/5 " Wrist Extension (C6): 5/5 " Wrist Flexion (C7): 5/5 " Elbow Extension (C7): 5/5 " Finger flexion (C8): 5/5 " Finger Abduction (T1): 5/5 " DTR (0-4+) R/L Biceps (C5): 2/4 bilat Brachioradialis (C6): 2/4 " **Special tests** **Spurling:** Negative bilaterally. **Hoffmann's Sign:** Absent bilaterally **Thoracic spine** **Inspection:** No edema, erythema or ecchymosis. **ROM:** Full AROM flexion and extension w/o pain **Palpation:** No tenderness to palpation over posterior spine and b/l thoracic paraspinal muscles **Lumbar spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain **Palpation:** Tenderness to palpation over posterior lower lumbar spine and bilateral paraspinal muscles **Sensation:** Grossly intact to light touch at dermatomal distributions (L4, L5, S1) bilaterally **Motor:** R/L Hip Flexion (L2-3): 5/5 bilat Knee Extension (L4): 5/5 " Knee Flexion (L5-S1)): 5/5 " Ankle Dorsiflexion (L5): 5/5 " Ankle Plantarflexion (S1): 5/5 " DTR (0-4+) R / L Patellar (L4): 2/4 Achilles (S1): 2/4	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Clonus (S1/2): Neg bilat Gait: Normal. **Special tests:** SLR negative bilaterally. **Extremities:** Tenderness to palpation noted at the anatomical snuffbox of the left wrist and at the first CMC joint of the left hand first digit. No signs of erythema, edema, ecchymoses at these areas. **Assessments** Cervicalgia (Primary) Cervical herniated disc Mid back pain Vertebrogenic low back pain Bulging of lumbar intervertebral disc Left elbow pain Wrist pain, left Hand pain, left MVA (motor vehicle accident) **Treatment** **Cervicalgia** **Notes:** Reviewed and discussed C-spine MRI 01/24/YYYY. **Cervical herniated disc** **Procedure:** Medial branch block C/T injection bilateral C3-6 **Notes:** Order bilateral cervical medial branch blocks facet levels C3-6. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. Proceed with bilateral CRFA if good relief with CMBB. **Mid back pain** **Notes:** MRI thoracic spine MRI reviewed 12/13/YYYY Continue to monitor - not patient's primary pain generator today. **Vertebrogenic low back pain** **Notes:** MRI lumbar spine reviewed 12/13/YYYY Continue as needed TENS unit. Continue as needed medications like Lidocaine, Meloxicam, Fexmid. Continue as needed LSO brace (with activity). Continue chiropractic care as scheduled. Order bilateral L4-S1 medial branch blocks. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there	

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		are no guarantees made when undertaking the procedure. Proceed with bilateral LRFA if good relief with LMBB. **Bulging of lumbar intervertebral disc** **Procedure:** Medial branch block L/S injection - Bilateral L4-5 and L5-S1 **Left elbow pain** **Procedure:** Elbow injection PRP lateral epicondyle **Notes:** Reviewed left elbow MRI 01/24/YYYY. Could consider PRP injection at lateral epicondyle. **Wrist pain, left** **Imaging:** MRI : Wrist, left Order LT Wrist MRI **Notes:** Order left wrist MRI. **Hand pain, left** **Notes:** Reviewed left hand and wrist X-rays 01/24/YYYY. Continue as needed medications like Meloxicam, Fexmid, Lidocaine gel. **Others** **Notes:** Patient was seen, evaluated and treatment plan formulated by Jenna Fox, PA-C under the direct supervision of Dr. Rodrigo. **Follow Up** 2 Weeks (Reason: Review Imaging).	
02/19/YYYY	Hospital/ Provider	**MRI of the Left Wrist:** **Referring physician:** Jenna Fox, PA **History:** Wrist pain following a motor vehicle collision on 05/10/YYYY. **Comparison:** Wrist radiograph 01/03/YYYY. **Findings:** There is moderate radiocarpal joint arthrosis. No acute fractures or dislocations are identified. No marrow destructive lesions. There are patchy areas of bone marrow edema involving the thumb metacarpal base, hamate, distal pole of the scaphoid, and capitate. There is an interstitial tear involving the membranous portion of the scapholunate ligament. Volar and dorsal components remain intact. The lunotriquetral ligament is intact. There is no significant effusion or chondral injury detected. The triangular fibrocartilage complex appears grossly intact without tear or	345-350

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		perforation. The extensor carpi radialis brevis and longus are normal. There is a multilobulated ganglion cyst along the volar aspect of the radiocarpal joint measuring 1.1 cm in diameter. **Impression:** • Scapholunate ligament interstitial tear. See figure 1, series 5008, image 6. The arrow points to the tear involving the membranous portion of the scapholunate ligament. Volar and dorsal components are intact. • Ganglion cyst. See figure 2, series 5008, image 4 and see figure 3, series 5012, image 7. The arrows are pointing to the multilobulated ganglion cyst along the volar aspect of the radiocarpal joint. • Moderate radiocarpal joint arthrosis. • Multifocal bone marrow edema. It involves the base of the thumb metacarpal, hamate, distal pole of the scaphoid, and capitate. Clinically correlate with history as one or more of these may represent a bone contusion. ***Related record:*** *Others* *(PDF Ref: 351-358)*	
04/03/YYYY	Hospital/ Provider	**Follow-up Visit:** **Reason for Appointment:** Left wrist pain **History of present illness:** **Follow up HPI:** **April 03, YYYY** The patient is a 62-year-old female who presents to the office with a chief complaint of left wrist pain. She reports that the use of a brace provides minimal functional/analgesic benefit at this time. She desires to know the MRI findings at the left wrist. She continues to have neck pain and lower back pain, however, symptoms improve temporarily with regular chiropractic care. She currently rates all of her symptoms as moderate in severity. **Vitals:** RR: 17, oxygen saturation: 97%, HR: 72, BP: 92/67, weight: 126 lbs, height: 62 inches, BMI: 23.04 **Physical examination:** **Musculoskeletal:** **Cervical spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain, AROM with rotation also decreased due to pain **Palpation:** TTP over posterior c-spine (mostly lower segments) and bilat paraspinal and upper trapezius muscles. **Thoracic spine**	359-364

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Inspection: No edema, erythema or ecchymosis. **ROM:** Full AROM flexion and extension w/o pain **Palpation:** No tenderness to palpation over posterior spine and b/l thoracic paraspinal muscles **Lumbar spine** **Inspection:** No edema, erythema or ecchymosis **ROM:** AROM flexion and extension decreased due to pain **Palpation:** Tenderness to palpation over posterior lower lumbar spine and bilateral paraspinal muscles **Left wrist:** The right and left wrist appear similar in size. There is tenderness to palpation at the volar lateral aspect and the anatomical snuffbox of the left wrist. No erythema or ecchymoses noted either. There is decreased active range of motion with wrist flexion and extension due to pain in the left wrist. **Assessments** Cervicalgia - (Primary) Cervical herniated disc Mid back pain Vertebrogenic low back pain Bulging of lumbar intervertebral disc Left elbow pain Wrist pain, left Hand pain, left MVA (motor vehicle accident) **Treatment** **Cervicalgia** **Notes:** Reviewed and discussed C-spine MRI 01/24/YYYY. **Cervical herniated disc** **Notes:** The patient would like to continue additional chiropractic care prior to the below mentioned injections. Order bilateral cervical medial branch blocks facet levels C3-6. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. Proceed with b/l CRFA if good relief with CMBB. **Mid back pain** **Notes:** MRI thoracic spine MRI reviewed 12/13/YYYY Continue to monitor - not patient's primary pain generator today. **Vertebrogenic low back pain**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Notes: MRI lumbar spine reviewed 12/13/YYYY Continue as needed TENS unit. Continue as needed medications like lidocaine, meloxicam, Fexmid. The patient would like to continue additional chiropractic care prior to the below mentioned injections. Order bilateral L4-S1 medial branch blocks. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. Proceed with b/l LRFA if good relief with LMBB. **Left elbow pain** **Notes:** Reviewed left elbow MRI 01/24/YYYY. Continue to monitor, if symptoms worsen, consider PRP injection at lateral epicondyle. **Wrist pain, left** **Notes:** MRI left wrist reviewed 04/03/YYYY Referral placed for surgical assessment given continued symptoms and MRI findings. Continue left wrist bracing (the patient has a brace provided by outside provider). **Referral To:** George Bahri Orthopedic Surgery **Reason:** Evaluation and treatment **Hand pain, left** **Notes:** Reviewed left hand and wrist X-rays 01/24/YYYY. Continue as needed medications like meloxicam, Fexmid, lidocaine gel. **MVA (motor vehicle accident)** **Referral To:** George Bahri Orthopedic Surgery **Reason:** Evaluation and treatment.	
04/11/YYYY	Hospital/ Provider	**Chiropractic Therapy Record – Initial Evaluation:** **Initial Evaluation and Examination** This patient presented to this office for consultation, evaluation, and continued treatment for injuries sustained in a vehicular collision on 05/11/YYYY. The collision occurred in West Bridgewater, MA. This evaluation was performed on 04/11/YYYY. In their own words, the patient provided the following information regarding the particulars of the incident: "Rear-ended by school bus sized van at a stop light." The weather was clear. The patient was the DRIVER going an approximate speed of 0 miles per hour. The vehicle was struck on the rear side by another vehicle and the air bag did not deploy. The patient was surprised by the collision and was looking straight forward. As a result of the collision, the patient's body struck the headrest, seat back, and WHAT. The patient did not lose consciousness but did report being	365-369

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		dazed. The patient did see other doctors for treatment of injuries sustained in this collision. Since the accident, the patient has had difficulty sleeping and pain inhibits activities of daily life. **Subjective** The patient presents with a chief complaints of neck pain, cervicothoracic junction pain, upper back pain, thoracolumbar junction pain, lower back pain, and shoulder pain. **Chief Complaints pain scale ratings** The patient reports that their chief complaint is cervical pain, lumbar pain, and left shoulder pain, which they rate as 8/10 with 10 being the worst and thoracic pain, which they rate as 7/10 with 10 being the worst. **Severity of Pain** Patient reports that the severity of pain is moderate-severe at the time of this visit. **Quality of Pain** Patient reports the quality of pain as constant pain, stiffness, tightness, sharp, and throbbing sensation. **Pain Frequency** Pain Frequency: 100% of the time **Radicular or Symptoms:** Yes - Radiates to: Left shoulder into arm to the hand experiencing tingling sensations and shooting pains. **Aggravating/Alleviating Factors** The patient's pain is worse when sitting (prolonged), standing (prolonged), carrying items, lifting items, moving, bending, twisting, stressed, the act of lying down, increasing activity, and picking up items, the same when walking, resting/sleeping, driving, and taking OTC medication, and better when applying ice, applying heat, and taking prescribed medication. **Relief of Symptoms** Patient states as of right now there has been minimal factors that has given them relief with their symptoms. **Associated Symptoms:** No **Note** **Previous Episodes:** No **Previous Care:** Yes Patient confirms recent diagnostic testing. Patient was most recently treated by Florida Accident and Injury for approximately 15 visits. She is also under orthopedic medical care who ordered multiple MRIs; records to be provided. **Review of Systems**	

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		Patient reports status of condition(s) below which may relate to complaint(s): **Musculoskeletal:** Other than presenting musculoskeletal complaints, patients report no additional musculoskeletal complaints and deny the following: implants, pins or screws. **Neurological:** Other than prescribing complaints, patients report no additional neurological complaints and denies: temporary loss of smell, vision, or hearing. *All other systems reviewed and are negative.* **Objective:** **Musculoskeletal exam:** **Asymmetry/Misalignment and/or Postural Analysis:** Anterior Head Carriage, Internal Rotation of the Shoulder - R, Internal Rotation of the Shoulder - L, and Iliac Crest Elevation - L **Posture Analysis** Head rotation: Left High shoulder: Left High hip: Left Short leg: Right Gait Abnormalities:: No gait abnormalities **Neurological Exam** Evaluation performed and the patient was observed to be alert and oriented x3. **Sensory: (Evaluations performed bilaterally, if individual level checked: hypo-esthesia) (If unchecked, tested as WNL)** Upper Extremities WNL (Sharp/Dull, Light Touch, Vibration Intact) Lower Extremities WNL (Sharp/Dull, Light Touch, Vibration Intact) **Upper Extremity Deep Tendon Reflexes (Normal 2/2)** Upper extremity reflexes WNL: 2+ (Normal Response) Lower extremity reflexes WNL: 2+ (Normal Response) **Pathological Reflexes:** (Evaluation performed bilaterally) (Click if positive): DNP **Resistive Isometric Motor Testing:** (Evaluations performed bilaterally): All upper and lower extremities levels WNL **Note** **Cranial Nerve Exam:** **Normal:** DNP **Cerebellar Testing:** **Normal/Negative:** DNP **Range Of Motion** **Cervical Spine Range of Motion** Cervical spine range of motion testing of flexion, right rotation, and right lateral flex revealed elicited symptoms bilaterally, caused a feeling of tightness, and	

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		moderate decreased and extension, left rotation, and left lateral flexion revealed elicited symptoms bilaterally, caused a feeling of tightness, severe decreased, and elicited sharp pain. **Thoracic Spine Range of Motion** Lumbar spine range of motion testing of flexion, right rotation, and left rotation revealed elicited symptoms bilaterally, caused a feeling of tightness, and moderate decreased and extension, right lateral flexion, and left lateral flexion revealed elicited symptoms bilaterally, caused a feeling of tightness, severe decreased, and elicited sharp pain. **Lumbar Spine Range of Motion** Lumbar spine range of motion testing of flexion, right rotation, and left rotation revealed elicited symptoms bilaterally, caused a feeling of tightness, and moderate decreased and extension, right lateral flexion, and left lateral flexion revealed elicited symptoms bilaterally, caused a feeling of tightness, severe decreased, and elicited sharp pain. **Active Range of Motion:** Upper Extremities - Normal ROM degree and patients relative limitation. Limitation Categories: Mild 25%, Moderate 50%, Severe 75+% Patient indicated moderate to severe pain in left shoulder and minimal pain in right shoulder. **Active Range of Motion:** Lower Extremities - Normal ROM degree and patients relative limitation. Limitation Categories: Mild 25%, Moderate 50%, Severe 75+% **Orthopedic Exam** **Cervical Examination** An orthopedic evaluation of the cervical spine was performed with the following findings: foraminal compression test and shoulder depression test: revealed left positive, O'Donoghue test, cervical compression test, and cervical distraction test: revealed bilaterally positive, and Valsalva test: revealed negative. **Lumbar Examination** An orthopedic evaluation of the lumbar spine was performed with the following findings: yeoman test, kemps test, straight leg raise test, and braggards test: left positive and minors sign: negative. **Upper Extremity Examination** An orthopedic evaluation of the upper extremities was performed with the following findings: Cozen's test for the elbow, adduction stress test of the elbow, abduction stress test of the elbow, speeds test, and apley's test: left positive. **Muscular Palpation and Evaluation** Palpation of the bilateral muscles of the cervical spine, muscles of the thoracic spine, muscles of the lumbar spine, and muscles of the bony pelvis reveal increased tension, spasm and trigger points which elicit pain directly over the affected area and/or cause radiation of pain toward a zone of reference and a local twitch response. **Head and Neck**	

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		Palpation of bilateral suboccipitals, scalenes, sternocleidomastoid, splenius capitis, cervical erector spinae, and levator scapulae reveal increased tension, spasm and trigger points which elicit pain directly over the affected area and/or cause radiation of pain toward a zone of reference and a local twitch response. **Upper Extremities** Palpation of the left deltoid, muscles of the rotator cuff, biceps brachii, pronator teres, supinator, and wrist extensors reveal increased tension, spasm and trigger points which elicit pain directly over the affected area and/or cause radiation of pain toward a zone of reference and a local twitch response. **Lumbar Spine and Pelvis** Palpation of bilateral lumbar erector spinae, multifidus, psoas, quadratus lumborum, gluteus medius, and piriformis reveal increased tension, spasm and trigger points which elicit pain directly over the affected area and/or cause radiation of pain toward a zone of reference and a local twitch response. **Assessment:** **Complicating Factor(s):** Duration of current episode longer than 1 month **Treatment Plan** The patient is advised to apply ice over the areas of pain no more than 15 min in duration or until the area is numb, chiropractic treatment and manual therapies, avoid activities/postures that aggravate pain and tightness, and use a 4 lead tens unit over the affected areas of pain and tightness. Due to the nature of the patient's injury, the current treatment plan will consist of 3 visits a week; after which, we will reassess the injury. **Duration:** For 2-4 weeks **Consent to Treatment** DDX, Rx plans, Risks, Benefits, and Options were discussed with the patient. Cross-Up Chiropractic care protocols were explained. The patient verbalized understanding and consents to care. Based on the patient's intake forms and comprehensive evaluation, there are no contraindications to care. **Prognosis:** There is reasonable expectation of patient recovery and/or improvement of function with patient compliance and participation in duration of the treatment plan. **Working Diagnosis:** Cervicalgia Low back pain, unspecified Pain in left shoulder Pain in the thoracic spine Muscle spasm of back	

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		Plan: **Type of Care:** Sub-Acute Care **Goals of Treatment:** **Short-term:** Decrease pain by 50% within 4 weeks. Decrease swelling and inflammation to the affected regions Improve core strength and stability Improve patient's tolerance for the activities of daily living Reduce muscle pain and spasm Increase range of motion **Intermediate goals:** Increase flexibility/ROM, Improve mechanics/movement patterns, Prevent de-conditioning. **Long-term:** Pain free ROM Increase flexibility, proprioception, strength, endurance, and aerobic capacity **Final goals:** Attain pre-condition/pre-injury status Restore functional independence and tolerance for normal activities of daily living Restore strength and stability to affected regions. **Additional Recommendations:** Work limitations/restrictions.	
04/15/YYYY	Hospital/ Provider	**Follow-up Visit:** **Reason for Appointment:** Left wrist pain **History of present illness:** **Follow up HPI:** **04/15/YYYY:** Patient presents for consult of left elbow and wrist pain. Discussed cortisone injection of left elbow but patient would like to proceed with physical therapy at this time. **Vitals:** RR: 16, oxygen saturation: 99%, HR: 60, BP: 126/83, weight: 126, height: 62 inches, BMI: 23.04 **Physical examination:** **Musculoskeletal:** **Left upper extremity:** Full ROM left fingers/wrist/elbow, no swelling, TTP lateral epicondyle, painful resisted wrist extension, TTP scapholunate joint, no swelling, - Watson test. **Assessments** Wrist pain, left Left elbow pain - (Primary) Hand pain, left MVA (motor vehicle accident)	370-374

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		Treatment **Left elbow pain** **Procedure:** Elbow injection (Ordered for 04/15/YYYY) **Notes:** Left lateral epicondyle cortisone injection **Notes:** Reviewed left elbow MRI 01/24/YYYY. Refer to physical therapy. Order left lateral epicondyle cortisone injection. The procedure was discussed in detail with the patient, including indications, risks, benefits, potential a.e., description of procedure (including anatomy) and alternatives. The patient was made aware there are no guarantees made when undertaking the procedure. Patient would like to try PT first. Referral To: Physical Therapy Physical Therapist **Reason:** Evaluation and treatment **Wrist pain, left** **Procedure:** Wrist brace (Ordered for 04/15/YYYY) **Notes:** MRI left wrist reviewed 04/03/YYYY. Dispensed in office left wrist brace. **Referral To:** Physical Therapy Physical Therapist **Reason:** Evaluation and treatment **Hand pain, left** **Notes:** Reviewed left hand and wrist X-rays 01/24/YYYY. Continue as needed medications like meloxicam, Fexmid, lidocaine gel. **MVA (motor vehicle accident)** Referral To Physical Therapy Physical Therapist **Reason:** Evaluation and treatment	
04/15/YYYY-04/29/YYYY	Hospital/ Provider	**Summary of interim Chiropractic Therapy visits for pain:** **Diagnosis**: Cervicalgia Low back pain, unspecified Pain in left shoulder Pain in the thoracic spine Muscle spasm of back **Treatment dates:** 04/15/YYYY, 04/18/YYYY, 04/22/YYYY, 04/26/YYYY, 04/29/YYYY **Treatment provided:** • CMT 3-4 Spinal Regions • CMT Extraspinal Regions	375-383

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		• Manual Techniques performed by physician to decrease tissue congestion, prevent formation of adhesions, and break up muscle spasms • Mechanical traction therapy cervical, thoracic, lumbar, and sacrum • Hot/cold packs at the level of the neck and low back for 13 minutes • Electrical muscle stimulation therapy for 13 minutes applied to the neck and low back **As of 04/29/YYYY:** **Subjective** Patient reports improvement is a reduction in symptoms since the last visit. The patient presents with a chief complaints of neck pain, cervicothoracic junction pain, upper back pain, thoracolumbar junction pain, lower back pain, and shoulder pain. **Chief Complaints pain scale ratings** The patient reports that their chief complaint is cervical pain, lumbar pain, and left shoulder pain, which they rate as 8/10 with 10 being the worst and thoracic pain, which they rate as 7/10 with 10 being the worst. **Severity of Pain** Patient reports that the severity of pain is moderate-severe at the time of this visit. **Quality of Pain** Patient reports the quality of pain as stiffness, constant pain, tightness, and sharp sensation. **Pain Frequency** Pain Frequency: 100% of the time Patient had no change in VAS rating today but states she is feeling better. **Objective Findings** **Examination today revealed the following positive findings:** Segmental joint dysfunction/vertebral subluxation at the level of cervical, thoracic, lumbar, and sacrum, and left GH joint disfunction. Tenderness on palpation of the cervical, thoracic, lumbar, sacrum areas and associated musculature. Restricted range of motion in cervical, thoracic, lumbar, and sacrum spine, and left shoulder. **Assessment** **Patient is progressing as expected.** Goals are consistent with the last examination. **Consent to Treatment** DDX, Rx plans, Risks, Benefits, and Options were discussed with the patient. Cross-Up Chiropractic care protocols were explained. The patient verbalized	

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		understanding and consents to care. Based on the patient's intake forms and comprehensive evaluation, there are no contraindications to care. **Prognosis:** There is reasonable expectation of patient recovery and/or improvement of function with patient compliance and participation in duration of the treatment plan. **Working diagnosis:** Cervicalgia Low back pain, unspecified Pain in left shoulder Pain in the thoracic spine Muscular spasm of back **Treatment:** **Procedure:** CMT 3-4 Spinal Regions CMT Extraspinal Regions of left AC joint Manual Techniques performed by physician to decrease tissue congestion, prevent formation of adhesions, and break up muscle spasms in both shoulders and associated musculature Mechanical traction therapy cervical, thoracic, lumbar, and sacrum Hot/cold packs at the level of the neck and low back for 13 minutes Electrical muscle stimulation therapy for 13 minutes applied to the neck and low back **Patient Response to Care:** Patient reported an improvement in function and reduction of pain. **Reviewer's comments: The interim visits are summarized with significant events. Further chiropractic therapy records and chiropractic therapy discharge summary are not available for review.*	

Related records:

Others, medical bills, assessment

PDF REF: *388-490*

****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 they are not elaborated.*