Narrative summary

Motor Vehicle Collision on 09/12/YYYY

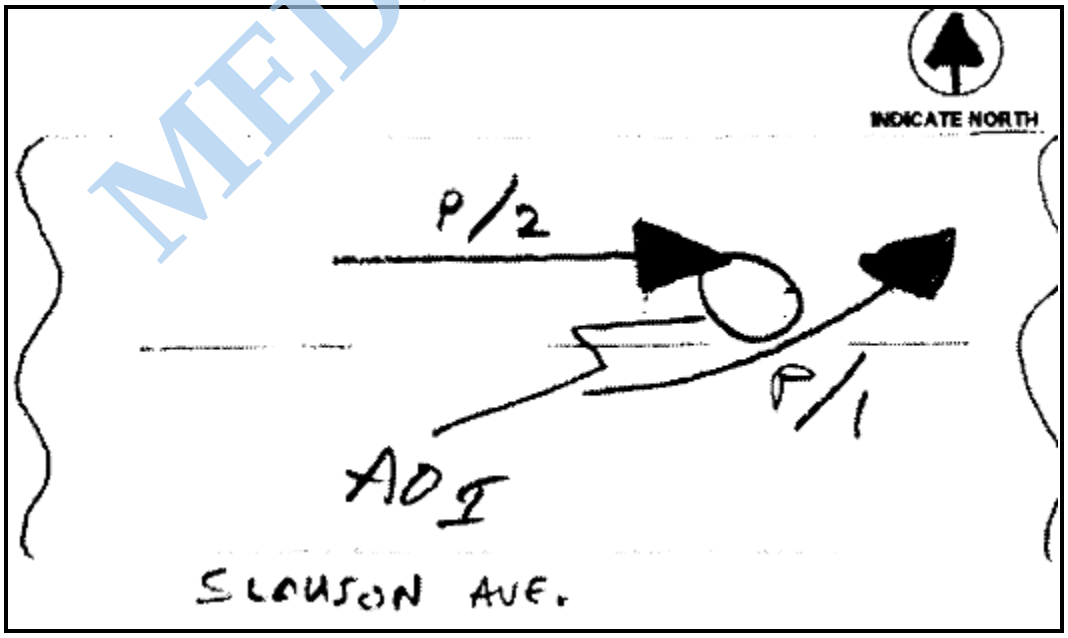
XXXX, a 53-year-old male, a real estate agent was involved in a motor vehicle collision. He was in good health prior to this collision. As a result of this collision, he experienced shock and was unable to return to work for at least two weeks. He continued to experience difficulties with activities of daily living, including trouble sleeping, concentrating, putting on his socks and shoes, and lying down or sitting for prolonged periods, which made it difficult for him to sit through movies.

Mechanism of Injury:

On September 12, YYYY, at 04:30 p.m., XXXX, the properly restrained driver of his 2011 BMW Z4, was traveling eastbound in the first lane of Slauson Avenue, west of the west curb line of Loma Vista Avenue, in Maywood City, Los Angeles County, California. At that time, Gustavo XXXX had parked his 2008 Toyota Tundra on the south curb line of Slauson Avenue. As Mr. XXXX approached Loma Vista Avenue, Mr. XXXX suddenly entered the first lane of Slauson Avenue and began turning into the second lane, colliding on the driver's side of Mr. XXXX's vehicle.

A State of California Traffic Crash report was prepared by XXXX, J. (ID # 000019) determined that Mr. XXXX caused this collision due to unsafe turning movement in violation of California vehicle codes XXXX *(No person shall turn a vehicle from a direct course or move right or left upon a roadway until such movement can be made with reasonable safety and then only after the giving of an appropriate signal in the manner provided in this chapter in the event any other vehicle may be affected by the movement)*

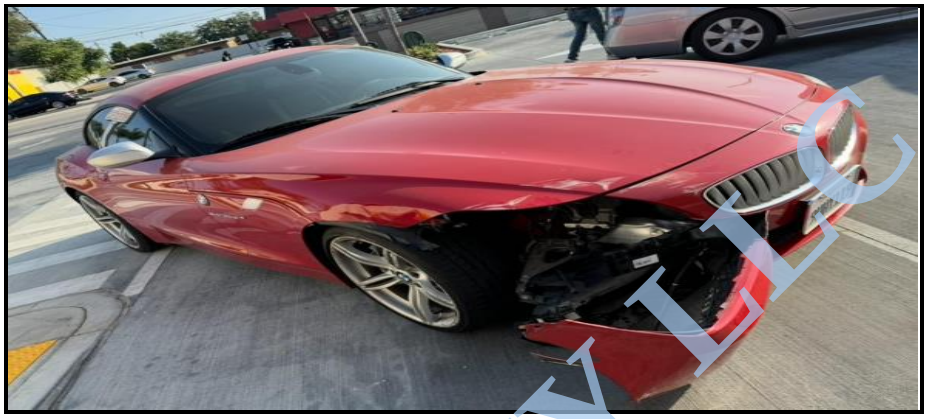
Below is the accident diagram for better understanding:



PROPERTY DAMAGE

On September 12, YYYY, the 2011 BMW Z4 that Mr. XXXX was driving sustained moderate damage to the right front end as a result of the collision. The net settlement amount was determined to be $21,739.06. **(2)**

PHOTOGRAPHS OF MR. XXXX'S DAMAGED VEHICLE



INJURIES AND MEDICAL CARE TO MR. XXXX

Following the motor vehicle collision, Mr. XXXX sought medical treatment, and the sequence is as described below:

A. ABC Rehabilitation & AB, Inc

October 2, YYYY-February 25, YYYY

October 2, YYYY

Mr. XXXX had his initial chiropractic treatment evaluation with XXXX, D.C., for complaints of pain in his neck, mid-back, and lower back following the collision. He reported He reported that the vehicle was in motion when it was struck on the right side, subjecting him to an acceleration-deceleration force. He was unprepared at the time of the collision and recalled feeling confused and shocked afterward. He developed neck and back pain approximately three hours later. He reported that the vehicle was a total loss. He complained of neck pain radiating to his right shoulder, upper back pain, and lower back pain. On examination, he had suboccipital muscle tenderness and spasm, tenderness of the ligamentous nuchae and paraspinal structures, and tenderness over the spinous processes from C3 to T1. The right upper trapezius muscle was tender with spasm, and he exhibited painful and decreased ranges of motion. In the thoracic region, there was tenderness over the spinous processes from T1 to T6, as well as right paraspinal muscle tenderness and spasm. In the lumbar region, right straight leg raise testing elicited lumbar pain, and bilateral Kemp's test was painful. There was tenderness over the spinous processes from T11 to S1, tenderness over the right sacroiliac joint, and pain with right sacroiliac joint compression. Additionally, the right paraspinal musculature was tender and in spasm, and he exhibited painful and decreased ranges of motion. He was diagnosed with cervical sprain and strain, thoracic sprain and strain, and lumbar sprain and strain. Dr. XXXX opined that the findings were consistent with his history, symptoms, and complaints, as well as the type of injury and the objective findings were consistent with the diagnoses. He was started on a course of multi-modality physiotherapy and chiropractic care, which consisted of specific chiropractic manipulation therapy, electrical muscle stimulation, therapeutic ultrasound, inter-segmental traction, and hydrocollator and infrared heat therapy to aid in the healing process.

October 4, YYYY- February 25, YYYY

Mr. XXXX received chiropractic treatment as needed from October 4, YYYY, through February 25, YYYY, for ongoing complaints of pain in his neck, mid-back, and lower back following the collision. He received chiropractic manipulation therapy, electrical muscle stimulation, therapeutic ultrasound, inter-segmental traction, and hydrocollator and infrared heat therapy. During the later phases of treatment, he was instructed in therapeutic home exercises to help stabilize and strengthen the injured regions and was advised to continue performing the exercises. He was advised to obtain an MRI of his cervical spine, and he was referred for pain management care. His prognosis was considered guarded, and he was discharged with residual pain. His conditions often required several months of home care and exercise to resolve, and his injuries would follow an unpredictable course of recovery. He could therefore remain symptomatic for a prolonged period, potentially requiring additional treatment. Dr. XXXX opined that the need for such additional treatment was causally related to the injuries sustained and would not have been necessary if the accident had not occurred. He was advised to continue with the prescribed exercise program and was instructed to return to the office should any significant flare-up occur. Any flare-up would require approximately twelve additional chiropractic treatments. Additionally, the likelihood of Mr. XXXX requiring another MRI study was high in the event of a flare-up. Depending on the MRI results, orthopedic care might be required. Therefore, future considerations for medical care were required for Mr. XXXX.

B. ACB Institute.

February 13, YYYY-April 24, YYYY

February 13, YYYY

Mr. XXXX presented to XXXX, M.D., at Advanced Pain Institute for a pain management consultation for complaints of headaches and pain in his neck and lower back regions. He reported that he was the restrained driver of his 2011 BMW Z4. He was traveling eastbound on Slauson Street in the City of Vernon with a green light at an intersection when a Toyota Tundra pickup truck ran a red light while turning left, colliding with the front quarter panel of his vehicle. Upon impact, he reported that the front suspension of his vehicle was completely dismantled, and the tires were blown. His vehicle was rendered undrivable and had to be towed. His car was declared total loss. He reported that he experienced a shock following the collision and was unable to return to work for at least two weeks. He was self-employed in the real estate industry. Since the collision, he reported difficulty sleeping and episodes of panic. He experienced muscle spasms that caused his back to lock up, along with difficulty concentrating. He noted weakness in his right upper extremity, tingling sensations in his right arm and right leg, and worsening lower back pain, particularly when lying down or sitting for prolonged periods, which made it difficult for him to sit through movies. Additionally, he reported decreased grip strength in his right upper extremity and an increase in headache frequency compared to before the collision. He also reported a decreased appetite since the collision and experienced significant weight loss, estimating a total loss of at least 30 pounds. He noted anxiety and panic attacks, which he had not experienced prior to the collision. He reported increased awareness of his surroundings and environment while driving. On examination, he had tenderness to palpation over the right cervical facet joints at C5, C6, and C7. He also had pain to percussion over the lower lumbar region from L1 to S1. Regarding the extremities, he exhibited decreased sensation to pinprick in the right upper extremity at C6, C7, and C8, including the hand. He also had decreased sensation to pinprick in the dermatomes of the right lower extremity at L4 and S1. He demonstrated a positive straight leg raise on the right lower extremity at 45 degrees. Additionally, he experienced some pain with internal rotation of his right shoulder. He was diagnosed with post-traumatic stress disorder, cervical C5-C6 discopathy, and lumbar discopathy at L4-L5 and L5-S1 levels. Dr. XXXX said that Mr. XXXX was found to be quite symptomatic in the injured areas and demonstrated physical signs consistent with the diagnoses. His clinical condition had not reached Maximal Medical Improvement from a pain management standpoint. Dr. YYYY opined that, based on the available medical evidence, Mr. XXXX's reported symptomatology and disability were causally related to the collision. Dr. XXXX also opined that, in the absence of any prior relevant medical information, the apportionment determination was 100% attributed to the personal injury discussed in the report. MRIs of his cervical and lumbar spine were ordered to rule out annular fissures or tears. Additionally, analgesic creams were prescribed to help manage pain and discomfort. He was scheduled to be reassessed in four weeks to monitor progress and determine any necessary adjustments to the treatment plan.

March 11, YYYY

Mr. XXXX returned to Dr. YYYY, at Advanced Pain Institute for complaints of headaches and pain in his neck and lower back regions. He reported headaches, neck and lower back pain, and stiffness that had persisted since the collision. He stated that the pain worsened with turning his neck side to side and with prolonged sitting. He rated the pain level as 5/10 and he noted anxiety and panic attacks, which he had not experienced prior to the collision. He reported increased awareness of his surroundings and environment while driving. On examination, he had tenderness to palpation over the right cervical facet

joints at C5, C6, and C7. Examination of the back revealed pain to percussion over the lower lumbar region from L1 to S1. Regarding the extremities, he exhibited decreased sensation to pinprick in the right upper extremity at C6, C7, and C8, including the hand. He also had decreased sensation to pinprick in the dermatomes of the right lower extremity at L4 and S1. He demonstrated a positive straight leg raise on the right lower extremity at 45 degrees and experienced some pain with internal rotation of his right shoulder. He was diagnosed with post-traumatic stress disorder, cervical C5-C6 discopathy, and lumbar discopathy at L4-L5 and L5-S1 levels. MRIs of his cervical and lumbar spine were ordered to rule out annular fissures or tears. He was advised to follow the home exercise program instructions and to avoid heavy duties while performing his activities of daily living. Additionally, analgesic creams were prescribed to help manage pain and discomfort. He was scheduled to be reassessed in four weeks to monitor progress and determine any necessary adjustments to the treatment plan.

April 24, YYYY

Mr. XXXX returned to Dr. YYYY, at Advanced Pain Institute for complaints of persistent headaches and pain in his neck and lower back regions. The MRI of his cervical spine revealed a broad-based disc protrusion at C6-C7, which indented the thecal sac and caused mild canal stenosis and mild bilateral foraminal stenosis. The MRI of his lumbar spine showed mild degenerative changes with small disc protrusions causing minimal canal narrowing and mild bilateral foraminal stenosis at L4-L5 and L5-S1. He reported experiencing headaches, neck and lower back pain, and stiffness since the collision. The symptoms persisted and worsened with turning his neck side to side, as well as with prolonged sitting and standing. He also reported occasional difficulty putting on his socks and shoes. He rated the pain level as 5-6/10. The MRIs of his cervical and lumbar spine dated March 31, YYYY, were reviewed. On examination, he had tenderness to palpation over the right cervical facet joints at C5, C6, and C7. Examination of the back revealed pain to percussion over the lower lumbar region from L1 to S1. Regarding the extremities, he exhibited decreased sensation to pinprick in the right upper extremity at C6, C7, and C8, including the hand, as well as decreased sensation to pinprick in the dermatomes of the right lower extremity at L4 and S1. His biceps, triceps, and patellar reflexes were symmetrical. He demonstrated a positive straight leg raise on the right lower extremity at 45 degrees and experienced some pain with internal rotation of his right shoulder. He was diagnosed with post-traumatic stress disorder, cervical C5-C6 discopathy, and lumbar discopathy at L4-L5 and L5-S1 levels. He was recommended to undergo a three-level diagnostic and therapeutic disc injection, along with a lumbar epidural injection for post-procedure pain at the injection site. Regarding the cervical spine, he was advised to undergo a cervical epidural injection under fluoroscopy. If pain persisted, he was advised to consider a cervical disc injection with platelet-rich plasma, along with a cervical epidural injection for post-procedure pain at the injection site. He was advised to follow the home exercise program instructions and to avoid heavy duties while performing his activities of daily living. Additionally, analgesic creams were prescribed to help manage pain and discomfort. He was scheduled to be reassessed in four weeks to monitor progress and determine any necessary adjustments to the treatment plan.

C. ABC Imaging

March 31, YYYY

Pursuant to the recommendations of Dr. YYYY, Mr. XXXX had MRIs of his cervical spine and lumbar spine. The study obtained by XXXX, M.D., revealed the following: loss of intervertebral disc height and disc desiccation at the C6-C7 disc level and posterior broad-based disc protrusion measuring 2.7 mm indenting the thecal sac with minimal narrowing of the spinal canal and mild stenosis of the neural foramina bilaterally. The MRI of his lumbar spine revealed loss of intervertebral disc height and disc desiccation at the L5-S1 disc level, posterior broad-based disc protrusion measuring 2.0 mm indenting the thecal sac with minimal narrowing of the spinal canal and minimal stenosis of the neural foramina bilaterally, and posterior broad-based disc protrusion measuring 2.6 mm indenting the thecal sac with minimal narrowing of the spinal canal and mild stenosis of the neural foramina bilaterally.

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