June 24, 2010

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RE: DOE, Jane
DOI: 09-11-10

Dear Mr. Smith:

Pursuant to your request, I am providing you with a comprehensive summation regarding the injuries sustained by your client.

HISTORY:
Ms. Doe first presented herself at this clinic on September 13, 2010 for evaluation and treatment of injuries she sustained in a motor vehicle accident which occurred on the above captioned date.

Ms. Doe stated she was driving her 2010 Toyota Corolla in a parking structure. She was in the process of looking for a parking space when a car coming in the opposite direction made a wide turn and struck her car nearly head on. At the time of the accident, Ms. Doe was wearing her seatbelt. She was initially dazed and very nervous after the accident, she then began to feel severe neck pain. An ambulance was summoned to the scene and she was transported to Mission Community Hospital emergency room. She was examined, X-rays where taken, and she was released with instructions to follow up with her own doctors should symptoms persist. Ms. Doe was referred to my office for evaluation and treatment.

CHIEF COMPLAINTS:
1. Neck pain - throbbing, burning pain that occurs frequently. Pain increased with head flexion, extension or rotation. Patient rated her pain at the time of examination an 8 on a 1-10 scale (1 being mild, 10 being extreme pain). Headaches occur when her neck pain is at its worse.

2. Upper back pain - described as achy and stiff. Pain worsens upon prolonged sitting.

3. Lower back pain - achy, sometimes sharp pain. Patient has difficulty sleeping due to pain. The pain is constant to some degree, at its worse it is rated an 5/10.

Past trauma or medical history relevant to the injury:
Ms. Doe' past medical history is not relevant to present injuries. She has no history of previous auto accidents.

Physical Exam:
Ms. Doe appeared as a normal, well-developed female of her stated age of 59. She was alert and conscious of time, person and place. Inspection of left knee revealed a contusion approximately 1" round. There were no diagnostic skin lesions observed or noted.

Patients stated height is 5'05", and she weighs 161 pounds. She is left hand dominant.

Regional exams limited to positive findings only:

ORTHOPEDIC EVALUATION:

Cervical Spine:
Inspection was unremarkable. Palpation of the cervical paraspinal muscles revealed +2 tenderness and swelling bilaterally. Palpation of the upper Trapezius revealed pain, swelling and hypertonicity on the right, and pain and hypertonicity on the left. Palpation of Anterior Scalene revealed pain, swelling and hypertoncity on the right and pain on the left. The patient's SCM's were painful and hypertonic bilaterally. Shoulder Depression test was performed and the test to right produced achy left neck pain. Depression to the left caused a sharp, burning pain on the right neck and upper trapezius. Cervical Compression caused burning pain along the cervical paraspinal muscles.

Range of motion maneuvers were performed as follows:

Flexion	50/50
Extension	55/60
Left Rotation:	75/80
Right Rotation:	70/80
Left Lateral Flexion:	40/45
Right Lateral Flexion:	40/45

Flexion, and extension maneuvers produced a pulling pain along her cervical paraspinals. Patient complains of her neck feeling "loose" when she extends her neck.

Lumbar Spine:
Inspection was unremarkable. Palpation of the lumbar paraspinals L1-L5 bilaterally and the lower Latisimus Dorsi revealed pain and hypertonicity bilaterally.

Milgram's test caused an achy pain over entire lower back area. Patient points across entire lumbar region.

Range of motion maneuvers were performed as follows:

Flexion:	55/60
Extension:	20/25
Left Lateral Flexion:	20/25
Right Lateral Flexion:	25/25

Flexion and extension produced burning lower back pain.

DIAGNOSTIC IMPRESSION:	**ICD-9**
1. Acute traumatic cervical sprain/strain	847.0
2. Acute traumatic thoracic strain	847.1
3. Acute traumatic lumbar sprain/strain	847.2
4. Contusion to knee	924.4
5. Headaches	784.0
6. Ligament Laxity of cervical spine	728.4
7. Cervical Spine disc protrusion	722.10

Clinical Course:
An assessment of the patient's condition based on examination, history and complaints indicated injuries, consistent (in my opinion) with the type of accident the patient described.

Posttraumatic management was both palliative and supportive. The early aggressive management to improve outcome and focus on minimizing scar tissue. This began in a course of therapy which included chiropractic manipulative therapy to improve joint motion and function. Supportive therapy included moist heat, electric muscle stimulation, ultrasound, myofascial release, and stretching exercises. Avoidance of strenuous physical activities was recommended. The patient was instructed to advise this office of any changes in her symptomatology. Back pain improved, however, her neck complaints had not changed. I referred her for an MRI

examination for her C/S on October 3, 2010 which revealed 2 to 3 mm disc protrusions at C5-C6, and C6-C7 with impingement.

Reevaluations were performed regularly and the patient begun a course of rehabilitative exercises designed to strengthen her injured muscles and return her to her pre-injury state. She was also provided a home stretching routine to enhance her treatment program.

A gradual improvement was accomplished and the patient was discharged from our care with instructions in home management.

Review of Medical Records:

A report from Dr. Adrian Peterson, M.D. for MRI of C/S on October 3, 2010. Notes cervical muscular spasms and 2 to 3mm disc protrusions with impingement on the thecal sac and spinal cord at C5-C6, C6-C7 levels.

PROGNOSIS:

The patient was asymptomatic in her back at the time of this report . The patient does complain of residual neck pain from time to time, especially during prolonged sitting. The patient has been counseled with reference to the possible exacerbation of symptoms as is common in cases of this sort, and has been advised to seek further care and treatment should there be any future recurrence. As a result of the patient’s present condition, no further treatment is indicated and this patient is capable of resuming all normal activities and duties.

Sincerely

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Fernando A. Rey, D.C.