Patient name: Mr. Lyle
Date of Visit: Not specified
Medical Record Number: Not specified

Subjective
- Mr. Lyle, a 36-year-old Caucasian male, visited due to a 7-day history of headache following a head-to-head collision during a soccer game. - He did not seek immediate treatment post-incident but scheduled an appointment after several days of ongoing headache. - He denies any history of concussion or head trauma and reported feeling well before the incident, with no chronic diagnosed health conditions.

Observation
- Mr. Lyle appeared his stated age, well-groomed, and appropriately dressed. - His vital signs were within normal range. - Neurological examination showed he was awake, alert, and oriented. - His cranial nerves, motor system, sensory system, and coordination were all normal. - His head, eye, ear, nose, throat exam showed a 2 by 2 centimeter area of tenderness at the left lateral frontal parietal junction area, but no other abnormalities.

Assessment
- Mr. Lyle presented with a 7-day history of headache, post a head-to-head collision during a soccer game. - He rates his pain as 2 out of 10, increasing to 4 out of 10 with aggravating factors such as prolonged screen time, excessive lights, excessive noise, and exercise. - He has a history of tension headaches, getting one every few months relieved by medication.

Plan
- Mr. Lyle is currently taking over-the-counter medication, ibuprofen, 400 milligrams, 2 tabs, once to twice a day for headache relief. - Further treatment options were not specified in the report.