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. - He denies any history of concussion or head trauma. - He was feeling well before the incident, taking no medication, and had no chronic diagnosed health conditions. **Observation** - Mr. Lyle appeared his stated age, well-groomed, and dressed appropriately. - His vital signs were within normal range. - Neurological exam showed he was awake, alert, and oriented. - His cranial nerves, motor system, sensory system, and coordination were all normal. - He had a 2 by 2 centimeter area of tenderness upon palpation at the left lateral frontal parietal junction area. - His head, eye, ear, nose, throat exam showed no significant abnormalities. **Assessment** - Mr. Lyle presents 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. - He has a history of tension headaches, getting one every few months relieved by medication. - On physical exam, there was an area 2 by 2 centimeters noted in the left lateral frontal parietal junction that was tender on palpation. **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 will be determined based on ongoing assessment and response to current medication.