Patient's 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 was feeling well before the incident.
- He has no chronic diagnosed health conditions and was not on any medication prior to the incident.

Observation
- Mr. Lyle appeared his stated age, well-groomed, and dressed appropriately.
- His vital signs were normal: temperature 36.8 degrees, respiratory rate 16, blood pressure 122 over 84, heart rate 77, oxygen saturation 99% on room air.
- Neurological exam showed he was awake, alert, and oriented times three.
- His cranial nerves, motor system, sensory system, coordination, and gait were all normal.
- His head, eye, ear, nose, throat exam showed a 2 by 2 centimeter area of tenderness upon palpation at the left lateral frontal parietal junction area.

Assessment
- Mr. Lyle is presenting 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 will be determined based on the progression of his symptoms and response to the current medication.