Medical Specialty:Consult - History and Phy.

Sample Name: Neck & Lower Back Pain - Consult

Description: Patient status post vehicular trauma. Low Back syndrome and Cervicalgia.

(Medical Transcription Sample Report)

CHIEF COMPLAINT: Neck and lower back pain.VEHICULAR TRAUMA HISTORY: Date of incident: 1/15/2001. The patient was the driver of a small sports utility vehicle and was wearing a seatbelt. The patient's vehicle was proceeding through an intersection and was struck by another vehicle from the left side and forced off the road into a utility pole. The other vehicle had reportedly been driven by a drunk driver and ran a traffic signal. Estimated impact speed was 80 m.p.h. The driver of the other vehicle was reportedly cited by police. The patient was transiently unconscious and came to the scene. There was immediate onset of headaches, neck and lower back pain. The patient was able to exit the vehicle and was subsequently transported by Rescue Squad to St. Thomas Memorial Hospital, evaluated in the emergency room and released.NECK AND LOWER BACK PAIN HISTORY: The patient relates the persistence of pain since the motor vehicle accident. Symptoms began immediately following the MVA. Because of persistent symptoms, the patient subsequently sought chiropractic treatment. Neck pain is described as severe. Neck pain remains localized and is non-radiating. There are no associated paresthesias. Back pain originates in the lumbar region and radiates down both lower extremities. Back pain is characterized as worse than the neck pain. There are no associated paresthesias. Stiffness is provoked by attempts at strenuous activity. The patient also reports difficulty sleeping, unable to find a comfortable position. The patient denies any previous back problems. During the day, the pain is exacerbated by strenuous activities. Pain may be eased by resting or recumbency and sitting. The patient's activity level has been significantly restricted. Some improvement has been noted with chiropractic treatment. Since the onset of the problem, the pain has continued at more less the same level. The patient reports that, prior to the present problem described above, there had been no episodes of neck or lower back pain.PAST MEDICAL HISTORY: Negative.PAST SURGICAL HISTORY: Hysterectomy (3/20/99). PERSONAL/SOCIAL HISTORY: The patient is right-handed. She does not smoke and does not drink alcohol.REVIEW OF SYSTEMS:ROS Ears Nose and Throat: Patient has no problems related to the ears, nose or throat.ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.ROS Cardiovascular: Chest pain in the retrosternal area, occasional anginal pain that patient describes as a sensation of tightness. Pain radiates to the left shoulder. Patient denies any palpitation, syncope, paroxysmal nocturnal dyspnea and orthopnea.ROS Gastrointestinal: Patient denies any nausea, vomiting, abdominal pain, dysphagia or any altered bowel movements.
CURRENT MEDICATIONS: Darvocet N100. Flexeril. Allergies: There are no known drug allergies.EXAMINATION: The patient is well-developed, well-nourished, black female. The patient was pleasant and cooperative.Mental Status: Evaluation unremarkable. Affect was appropriate.Neck: The cervical lordosis was flattened, with the head held in flexion. There was no appreciable cervical muscle spasm. There was moderate tenderness over both supraclavicular fossae. Cervical range of motion was slightly restricted in all planes. Spurling's maneuver was negative bilaterally. There were no foraminal compression signs.Back:

The lumbar lordosis was well-maintained. There was no appreciable lumbar paravertebral muscle spasm. There was focal tenderness over both sciatic notches and the left popliteal fossa. Lumbar range of motion was full in all planes. Straight leg raising was negative to 90 degrees bilaterally.
Cranial Nerves: Evaluation was unremarkable. Fundi were benign OU.Motor: Individual muscle and group-function testing showed no appreciable deficit or asymmetry of performance in either upper or lower extremities.Reflexes: DTRs were normoactive and symmetrical. There were no pathologic responses.Sensory: Patchy sensory deficits were appreciated over the right upper extremity. There was no dermatomal sensory deficit.RADIOLOGY (CX SPINE): Films of the relevant radiologic studies of the cervical spine were reviewed: Cervical MRI scan (1/15/2001). There is loss of cervical lordosis and straightening of the cervical spine. There is no apparent intervertebral disc protrusion.
RADIOLOGY (TLS SPINE): Films of the relevant lumbar neuroradiologic procedures were reviewed: Lumbar MRI scan (1/15/2001). The study is unremarkable. The lumbar lordosis is well-maintained.ASSESSMENT: S/P vehicular trauma 1/15/2001. Low Back syndrome (724.2). Cervicalgia (723.1).COMMENTS: The clinical picture and neurodiagnostic studies indicate that the patient has sustained significant injuries as a direct result of vehicular trauma. There is no indication for surgical intervention. Continued chiropractic treatment should be of benefit, with an emphasis on soft tissue techniques and mobilization. Physiatry consultation may be considered.TREATMENT RECOMMENDATIONS: The patient was advised to gradually and progressively increase activity levels, as tolerated, while continuing to avoid anything unduly strenuous.