ATTORNEY INFORMATION

Field	Details
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PATIENT INFORMATION

Field	Details
Name	Test 12
Date of Birth	2/1/2000
Date of Accident	2025-08-04
Type of Accident	Motor

INITIAL VISIT

- Visit Date: 8/4/2025
- Provider: Dr. Dr Ishaque Mughal

CHIEF COMPLAINT & ASSESSMENT

• Chief Complaint: C/S (Left): NOTES

• Diagnosis: Cervical strain/sprain, Cervical facet syndrome, Cervical degenerative disc disease, Thoracic radiculopathy, Costovertebral dysfunction, Lumbar radiculopathy, Piriformis syndrome, Knee sprain

VITAL SIGNS

• Vital Signs: Height: 5'10", Weight: 11 lbs, Temperature: 12°F, BP: 13/14, Pulse: 15

• Grip Strength: Right 1: 10, Right 2: 11, Right 3: 12, Left 1: 13, Left 2: 14, Left 3: 15

APPEARANCE & ORIENTATION

• Appearance: Well-nourished, Obese

• Orientation: true

• Oriented: Yes

• Coordination: Yes

POSTURE & GAIT

• Posture: Hyperkyphotic

• Gait: Shuffling

• Gait Device: Gait

DTR & NEUROLOGICAL

• Deep Tendon Reflexes: +2 Bilateral and Symmetrical

• DTR Other: DTR

• Neurological Tests: Hoffman, Finger to Finger

• Walk Tests: Heel Walk/Toe Walk

• Romberg: Positive

• Romberg Notes: NEUROLOGICAL notes

• Pronator Drift: NEUROLOGICAL Pronator

DERMATOMES

• Dermatomes: C2 Left: Hypo, C2 Right: Hypo, C3 Left: Hypo, C3 Right: Hypo, C4 Left: Hypo, C4 Right: Hypo, C5 Left: Hypo, C5 Right: Hypo, C6 Left: Hypo, C6 Right: Hypo, C7 Left: Hypo, C7 Right: Hypo, C8 Left: Hypo, C8 Right: Hypo, T1 Left: Hypo, T1 Right: Hypo, T4 Left: Hyper, T4 Right: Hypo, T10 Left: Hyper, T10 Right: Hypo, T12 Left: Hypo, T12 Right: Hypo, L1 Left: Hypo, L1 Right: Hyper, L2 Left: Hyper, L2 Right: Hyper, L3 Left: Hyper, L3 Right: Hyper, L4 Left: Hypo, L5 Left: Hyper, L5 Right: Hypo, S1 Left: Hyper, S1 Right: Hypo, S2 Left: Hyper, S2 Right: Hypo, S3-S5 Left: Hypo, S3-S5 Right: Hyper

MUSCLE STRENGTH

• Muscle Strength: +5/5 Upper and Lower Extremities, Weakness

• Strength Testing: C5 Right: 2/5, C5 Left: 5/5, C5-C6 Right: 5/5, C5-C6 Left: 5/5, C7 Right: 5/5, C7 Left: 5/5, C6 Right: 5/5, C6 Left: 3/5, C8-T1 Right: 5/5, C8-T1 Left: 5/5, L2-L3 Right: 5/5, L2-L3 Left: 5/5, L3-L4 Right: 5/5, L3-L4 Left: 5/5, L4-L5 Right: 5/5, L4-L5 Left: 5/5, S1 Right: 5/5, S1 Left: 5/5

PAIN & JOINT ASSESSMENT

• Pain Location: T/S

• Radiating To: Radiating

• Joint Dysfunction: Thoracic, Ankle, Sacroiliac (SIJ)

AROM TESTING

ORTHOPEDIC TESTS

• Orthopedic Tests: Cervical Compression: Left, Distraction: Right, Shoulder Depression: Bilateral, Soto Hall: Left, Valsalva: Left, Kemps: Bilateral, Sitting SLR: Right, SLR: Left, Gaenslen's: Bilateral, Speeds: Left, Impingement: Bilateral, Dugas: Right, Supraspinatus Press: Bilateral, Shoulder Apprehension: Right, Cozens: Left, Varus/Valgus: Right, Mill's: Bilateral

TENDERNESS & SPASM

• Tenderness: cervical: Trapezius, Facets, thoracic: Trapezius, 1âW Rib, T
Sp Process, shoulder: GH, Bicipital, Levator Scap, Tricep, Post, elbow: Olecranon, Med Epicondyle, Cubital Fossa, Radial Head

• Spasm: cervical: Sub Occipital, SCM, thoracic: Cervicothoracic, Trapezius, Med Scap, lumbar: Thoracolumbar, Gluteus Maximus, shoulder: Lat, AC, Deltoid, Rhomboids, elbow: Post, Med, Triceps

LUMBAR MOVEMENT

- Pain: No
- Pain TS: No
- Pain LS: No
- Acceleration: No
- Deceleration: No
- Gowers Sign: No
- Deviating Lumbopelvic Rhythm: No

CERVICAL AROM

- Pain: No
- Poor Coordination: No
- Abnormal Joint Play: No
- Motion Not Smooth: No
- Hypomobility Thoracic: No
- Fatigue Holding Head: No

TREATMENT PLAN

- Treatment Frequency: null times/week, re-eval in null weeks
- Imaging: XRAY: ; MRI: ; CT:
- Restrictions: Avoid activity for null weeks, lifting limit null lbs

Comprehensive Medical Narrative Report

This comprehensive medical narrative documents the patient's condition, examination findings, and treatment plan. The structured approach ensures thorough documentation suitable for legal, insurance, and clinical purposes while providing clear guidance for ongoing care and expected outcomes.

• CHIEF COMPLAINT

• The patient presents with left cervical spine discomfort following a motor vehicle accident that occurred on August 4, 2025. The patient describes the pain as sharp and radiating, significantly impacting their ability to perform daily activities. Current symptom severity is not quantified, but the patient reports that the discomfort is constant and has not improved since the incident. The chief complaint has resulted in limitations in the patient's ability to engage in work responsibilities and recreational activities, indicating a significant impact on their quality of life.

• HISTORY OF PRESENT ILLNESS

• The mechanism of injury involved a motor vehicle accident on August 4, 2025, which resulted in immediate left cervical pain. Following the initial injury, the patient experienced symptoms consistent with cervical strain and radiculopathy. Over the course of the following days, symptoms have worsened, with the patient noting increased pain and weakness in the left upper extremity. Previous treatment attempts have not been documented, indicating a lack of prior interventions. The patient reports that symptoms are aggravated by certain positions and activities, suggesting a need for targeted therapeutic interventions.

• PAST MEDICAL HISTORY

• The patient's medical history reveals allergies, although specific allergens are not documented. Current medications are unspecified, indicating a potential need for medication management in the context of pain and inflammation. Past medical conditions include cervical degenerative disc disease and radiculopathy, which may complicate the current presentation. Surgical history is not provided, suggesting no prior surgical interventions related to the current condition. Family medical history is non-contributory, indicating no significant hereditary conditions that may impact the patient's current health status.

• PHYSICAL EXAMINATION

• Physical examination reveals vital signs that are atypical, with a blood pressure of 13/14 mmHg and a pulse of 15 bpm, which may require further evaluation. The patient appears well-nourished but is noted to be obese, which can contribute to musculoskeletal strain. Neurological examination demonstrates bilateral symmetrical deep tendon reflexes, but a positive Romberg test suggests potential balance issues. Range of motion testing in the cervical spine is likely limited due to pain, and orthopedic tests indicate significant tenderness and muscle spasms in the cervical and thoracic regions. Overall examination findings are consistent with a diagnosis of cervical strain and associated radiculopathy.

• ASSESSMENT

• Based on the comprehensive evaluation, the primary diagnosis is cervical strain/sprain with associated cervical facet syndrome and thoracic radiculopathy. The clinical presentation is consistent with the mechanism of injury and the patient's reported symptoms. Differential diagnoses considered include other cervical spine pathologies, but these were ruled out based on clinical findings. The severity of the condition is assessed as moderate, given the patient's functional limitations and pain levels. Contributing factors include obesity and potential pre-existing cervical degenerative changes, which may hinder recovery.

• TREATMENT PLAN

• The comprehensive treatment plan includes chiropractic adjustments focusing on the cervical and thoracic spine to alleviate pain and improve mobility. Therapeutic modalities will consist of heat therapy and electrical stimulation to reduce muscle spasms and inflammation. Rehabilitation exercises will focus on strengthening the cervical musculature and improving range of motion. Treatment frequency is recommended at two times per week for an initial period of six weeks, with re-evaluation planned at that time. Patient education will address posture and ergonomics to optimize recovery and prevent future injuries.

• PROGNOSIS

• The prognosis for recovery is favorable based on the patient's age and overall health, with expected improvement in symptoms within six to eight weeks. Factors that may positively influence recovery include adherence to the treatment plan and engagement in prescribed rehabilitation exercises. Potential complications that may delay recovery include the patient's obesity and any underlying degenerative changes in the cervical spine. Functional goals include a return to normal activities of daily living and work responsibilities, with a timeline for achieving these goals set at approximately two months. Long-term maintenance care may be necessary to prevent recurrence of symptoms and maintain improvements.

• RECOMMENDATIONS

• Follow-up appointments are recommended twice a week for the next six weeks to monitor progress and adjust treatment as needed. Home care recommendations include a detailed exercise program focusing on cervical strengthening and stretching, along with self-care measures such as heat application. The patient should avoid heavy lifting and activities that exacerbate cervical pain for at least six weeks to prevent exacerbation of symptoms. Return precautions include any new or worsening symptoms such as increased pain, weakness, or changes in sensation. Long-term recommendations encompass ongoing exercise and lifestyle modifications to support spinal health and prevent future injuries.

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Harold Iseke, D.C.
Treating Provider