ATTORNEY INFORMATION

Field	Details
Attorney Name	Advocate Michael
Firm	NJ llc
Phone	03126600971
Email	testUnnon2701@gmail.com
Case Number	P-027
Address	13979 Darchance Rd, Windermere, NJ 34786

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 a chief complaint related to cervical spine issues, specifically affecting the left side. The onset of symptoms occurred following a motor vehicle accident on 2025-08-04, which has led to significant discomfort and functional limitations. The patient describes the pain as sharp and radiating, primarily localized to the cervical and thoracic regions, which significantly impacts their daily functioning. Current symptom severity is not explicitly rated, but the patient experiences constant discomfort that interferes with activities of daily living, work responsibilities, and recreational activities.

• HISTORY OF PRESENT ILLNESS

• The mechanism of injury involved a motor vehicle accident that occurred on 2025-08-04. Following the initial injury, the patient experienced immediate symptoms of pain and discomfort in the cervical region, which have progressively worsened over time. The patient notes that symptoms have evolved to include radiating pain and weakness in the upper extremities, particularly on the left side. Previous treatment attempts have not been documented, but the patient reports that symptoms are aggravated by activities involving neck movement and relieved by rest, indicating a significant impact on their functional capacity.

• PAST MEDICAL HISTORY

• The patient's medical history reveals allergies, although specific allergens are not detailed. Current medications are unspecified, indicating a potential need for further evaluation of pharmacological management. The past medical conditions include cervical strain/sprain, cervical facet syndrome, and degenerative disc disease, which may contribute to the current presentation. Surgical history is not provided, suggesting no prior surgical interventions that could impact the current condition. Family medical history is also unspecified, which may limit understanding of hereditary factors that could influence the patient's recovery.

• PHYSICAL EXAMINATION

• Physical examination reveals vital signs that are atypical, with a blood pressure of 13/14 mmHg and a pulse of 15 bpm, suggesting potential measurement errors or significant underlying issues. The general appearance shows the patient as well-nourished but obese, with a hyperkyphotic posture that may contribute to musculoskeletal strain. Neurological examination demonstrates bilateral symmetrical deep tendon reflexes, but a positive Romberg test indicates potential balance issues. Range of motion testing is not documented, but orthopedic tests reveal multiple positive findings, indicating significant cervical and thoracic involvement. Palpation findings show tenderness and muscle spasms in various regions, including the cervical, thoracic, and lumbar areas, consistent with the diagnoses of cervical strain and radiculopathy.

• ASSESSMENT

• Based on the comprehensive evaluation, the primary diagnosis is cervical strain/sprain, with associated conditions including cervical facet syndrome and thoracic radiculopathy. The clinical presentation is consistent with the mechanism of injury, indicating a complex interplay of musculoskeletal and neurological factors. Differential diagnoses considered include other forms of radiculopathy and musculoskeletal disorders, which 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 postural abnormalities, which may hinder recovery and rehabilitation efforts.

• TREATMENT PLAN

• The comprehensive treatment plan includes chiropractic adjustments focusing on the cervical and thoracic regions to alleviate pain and restore function. Therapeutic modalities will consist of heat therapy and electrical stimulation to reduce muscle spasms and improve circulation. Rehabilitation exercises will focus on strengthening the cervical and upper extremity muscles, as well as 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 to assess progress. Patient education will address posture correction and ergonomic adjustments to optimize recovery and prevent recurrence of symptoms.

• PROGNOSIS

• The prognosis for recovery is favorable based on the patient's age and overall health, with expected improvement within six to eight weeks of initiating treatment. 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 persistent pain and muscle weakness, which could necessitate further intervention. Functional goals include a return to normal activities of daily living and work responsibilities, with expected milestones set for the next few months. Long-term maintenance care may be necessary to prevent recurrence and maintain improvements in function.

• 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 stretching and strengthening the cervical and upper back muscles, along with self-care measures such as heat application. The patient should avoid heavy lifting and activities that exacerbate symptoms for at least four weeks to prevent exacerbation of the condition. Return precautions include immediate medical attention if symptoms worsen or if new neurological deficits arise. 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