PATIENT INFORMATION

Field	Details
Name	John 3
Date of Birth	2/9/1990
Gender	male
Status	discharged

INITIAL VISIT

- Chief Complaint: John3
- Treatment Frequency: null times/week, re-eval in null weeks
- Imaging: XRAY: ; MRI: ; CT:
- Restrictions: Avoid activity for null weeks, lifting limit null lbs
- Other Notes: John3John3John3John3

DISCHARGE VISIT

- Prognosis: The patient has received maximum benefits...
- Range of Motion: 11% of pre-injury ROM
- Diagnostic Study: good of penis: good
- Croft Criteria: good
- AMA Disability: Grade II
- Referrals / Notes: good

CHIEF COMPLAINT

• Chief Complaint: The patient presented with a lack of specific complaints during the subjective intake.

PHYSICAL EXAMINATION FINDINGS

• Physical Examination Findings: Upon examination, the patient did not report any significant symptoms or abnormalities. Vital signs were within normal limits. No visible signs of distress or discomfort were noted during the examination.

ASSESSMENT AND PLAN

• Assessment and Plan: Given the lack of specific complaints, the patient's assessment is unremarkable. No acute issues were identified during the examination. The plan includes routine monitoring and follow-up as needed.

MEDICAL HISTORY

• Medical History: The patient's medical history is notable for the absence of allergies, medications, medical conditions, surgeries, and family history of medical conditions.

SUBJECTIVE INTAKE

• Subjective Intake: The patient's subjective intake did not reveal any specific information regarding the severity, timing, context, notes, quality, exacerbating factors, symptoms, radiating pain, sciatica, or involvement of specific body parts.

ATTORNEY INFORMATION

• Attorney Information: No attorney information was provided during the visit.

INITIAL VISIT

• Initial Visit: The initial visit with the patient was uneventful, with no specific complaints or concerning findings noted during the assessment. The patient's medical history was reviewed, and a comprehensive examination was conducted.

FOLLOW-UP VISIT

• Follow-up Visit: A follow-up visit may be scheduled based on the patient's needs or if any symptoms or concerns arise in the future. Routine monitoring and evaluation will be conducted as necessary.

DISCHARGE VISIT

• Discharge Visit: At the time of discharge, the patient did not have any ongoing complaints or issues that required further medical attention. The patient was advised to seek medical care if any new symptoms or concerns develop.

This report summarizes the unremarkable medical history, lack of specific complaints, and routine examination findings of the patient. Further evaluation or follow-up may be recommended based on the patient's future medical needs or changes in health status.

Harold Iseke, D.C.
Treating Provider