PATIENT INFORMATION

Field	Details
Name	TEST Houston
Date of Birth	2/1/2000
Gender	male
Status	active

INITIAL VISIT

• Chief Complaint: Chief Complaint

• Treatment Frequency: null times/week, re-eval in null weeks

• Imaging: XRAY: ; MRI: ; CT:

• Restrictions: Avoid activity for null weeks, lifting limit null lbs

CHIEF COMPLAINT

• Chief Complaint: The patient presents with a chief complaint of moderate, occasional headaches described as achy and stabbing in nature. The symptoms are worsened by rest, school activities, overhead reach, walking, and bending. Additionally, the patient reports associated symptoms of occipital soreness, loss of motion, popping sensation, joint redness, swelling, hearing loss, and difficulty in gripping objects. The pain is noted to radiate to the right arm and exhibit sciatica-like symptoms on the left side, affecting the thoracic spine and left elbow.

PHYSICAL EXAMINATION FINDINGS

• Physical Examination Findings: Upon examination, the patient demonstrated limited range of motion in the thoracic spine and left elbow. There was redness and swelling noted in the affected joints. The patient also exhibited signs of hearing loss and reported difficulty in gripping objects. Neurological examination revealed radiating pain to the right arm and sciatica-like symptoms on the left side.

ASSESSMENT AND PLAN

• Assessment and Plan: Based on the patient's subjective intake and physical examination findings, the initial assessment suggests a musculoskeletal issue affecting the thoracic spine and left elbow, with associated neurological symptoms. To further evaluate the condition, diagnostic imaging studies such as X-rays or MRI may be warranted. The treatment plan includes pain management strategies, physical therapy, and possible referral to a specialist for further evaluation and management.

MEDICAL HISTORY

• Medical History: The patient has no known allergies, medications, medical conditions, surgeries, or significant family history of medical conditions.

ATTORNEY INFORMATION

• Attorney Information: No attorney information provided.

INITIAL VISIT

• Initial Visit: During the initial visit, the patient reported moderate, occasional headaches with associated musculoskeletal symptoms affecting the thoracic spine and left elbow. The subjective intake highlighted worsening symptoms exacerbated by various activities. Physical examination findings supported the presence of joint inflammation, limited range of motion, and neurological symptoms.

FOLLOW-UP VISIT

• Follow-up Visit: A follow-up visit is recommended to assess the response to the initial treatment plan, monitor symptom progression, and adjust management strategies as needed. Further diagnostic tests or specialist consultations may be scheduled based on the patient's response to treatment.

DISCHARGE VISIT

• Discharge Visit: At the discharge visit, the patient's condition should be re-evaluated to determine treatment efficacy, functional improvement, and overall well-being. A comprehensive summary of the treatment course and recommendations for future care will be provided to the patient.

This narrative report summarizes the patient's presentation, examination findings, assessment, and proposed plan for further evaluation and management of the musculoskeletal and neurological symptoms reported.

Harold Iseke, D.C.
Treating Provider