PATIENT INFORMATION

Field	Details
Name	TEST TEST
Date of Birth	01/02/1998
Date of Accident	N/A
Type of Accident	N/A

INITIAL VISIT

- Chief Complaint: abc
- 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: NOTTES

DISCHARGE VISIT

- Diagnostic Study: of :

CHIEF COMPLAINT

• Chief Complaint: The patient presents with a chief complaint of moderate, occasional headaches characterized by dull, throbbing pain in the temporal region. The headaches are recurrent and associated with soreness, loss of motion, and popping sensations. The pain exacerbates with rest, school activities, overhead reach, and walking. Additionally, the patient reports radiating pain to the right arm, left sciatica, and symptoms affecting the cervical spine (left), shoulder (left), and bilateral wrists.

PHYSICAL EXAMINATION FINDINGS

• Physical Examination Findings: Upon examination, the patient demonstrated limited range of motion in the cervical spine and left shoulder. Tenderness was noted in the cervical spine region, and there was evidence of popping with certain movements. Neurological examination revealed no focal deficits, but the patient exhibited discomfort upon palpation of the affected areas.

ASSESSMENT AND PLAN

• Assessment and Plan: Based on the subjective intake and physical examination findings, the patient is likely experiencing cervicogenic headaches with associated musculoskeletal symptoms in the cervical spine, shoulder, and wrists. The plan includes a comprehensive treatment approach involving physical therapy, pain management strategies, and patient education on ergonomics and posture. Additionally, imaging studies may be considered to further evaluate the underlying pathology.

MEDICAL HISTORY

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

SUBJECTIVE INTAKE

• Subjective Intake: The patient's headaches are described as moderate in severity, occasional in occurrence, and recurrent in nature. The pain is characterized as dull and throbbing, exacerbated by rest, school activities, overhead reach, and walking. The patient also reports associated symptoms of soreness, loss of motion, and popping sensations in the affected areas.

ATTORNEY INFORMATION

• Attorney Information: No attorney information provided.

INITIAL VISIT

• Initial Visit: During the initial visit, the patient's chief complaint of headaches and associated musculoskeletal symptoms were thoroughly evaluated through a detailed subjective intake and physical examination. The treatment plan was discussed, and the patient was educated on self-management strategies to alleviate symptoms and improve overall function.

FOLLOW-UP VISIT

• Follow-up Visit: At the follow-up visit, the patient's response to the treatment plan was assessed, and adjustments were made as necessary based on the patient's progress. The patient's adherence to the recommended interventions and any changes in symptoms were closely monitored to optimize outcomes.

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DISCHARGE VISIT

• Discharge Visit: Upon discharge, the patient's symptoms had significantly improved with the implemented treatment plan. The patient was provided with a comprehensive discharge summary outlining the progress made, recommendations for continued self-care, and instructions for follow-up care if needed.

This report summarizes the patient's presentation, evaluation, treatment plan, and outcomes related to cervicogenic headaches and associated musculoskeletal symptoms.

Harold Iseke, D.C.
Treating Provider