PATIENT INFORMATION

Field	Details
Name	John 4
Date of Birth	2/1/2000
Date of Accident	N/A
Type of Accident	N/A

INITIAL VISIT

• Chief Complaint: Chief Complaint *

• Chiropractic Adjustment: Cervical Spine, Sacroiliac Spine, Ankle R / L

• Acupuncture: Thoracic Spine, Hip R / L, Shoulder (GHJ) R / L

• Physiotherapy: EMS, NMR, Paraffin Wax

• Rehabilitation Exercises: Sacroiliac Spine

• Treatment Frequency: 2 times/week, re-eval in 3 weeks

• Referrals: Orthopedist, Neurologist, Pain Management

• Imaging: XRAY: T/S, Sacroiliac Joint L, Knee R, Ankle L; MRI: C/S, Sacroiliac Joint R, Hip L, Ankle R; CT: Elbow R, Hip R, L/S, Knee L, Shoulder R

• Diagnostic Ultrasound: Diagnostic Ultrasound

• Nerve Study: EMG/NCV upper

• Restrictions: Avoid activity for 2 weeks, lifting limit 3 lbs

• Disability Duration: 1 week

• Other Notes: john4444john4444john4444john4444john4444

FOLLOW-UP VISIT

• Areas Status: ' Improving ' Exacerbated

• Muscle Palpation: Muscle Palpation:

• Pain Radiating: Pain Radiating:

• Range of Motion: ' WNL (No Pain) & WNL (With Pain) !‘ Improved

• Orthopedic Tests: Pain Radiating:Pain Radiating: - Pain Radiating:

• Activities Causing Pain: Pain Radiating: Pain Radiating:

• Treatment Plan: Pain Radiating: (Pain Radiating: times/week)

• Overall Response: !‘ Improving

• Diagnostic Study: Pain Radiating: of Pain Radiating:: Pain Radiating:

• Home Care: Pain Radiating:

DISCHARGE VISIT

• Range of Motion: 10% of pre-injury ROM

• Diagnostic Study: of :

CHIEF COMPLAINT

• Chief Complaint: The patient, identified as John4, presented with a chief complaint of undefined body parts, characterized by a severity level of 6, intermittent timing, and worsening context. The patient reported John4John4 in the subjective intake.

PHYSICAL EXAMINATION FINDINGS

• Physical Examination Findings: Upon examination, the patient did not report any specific symptoms related to the chief complaint. There were no observable signs of radiating pain, sciatica, or exacerbation of symptoms by any specific activities or positions.

ASSESSMENT AND PLAN

• Assessment and Plan: Given the limited information available from the subjective intake and physical examination, further evaluation and diagnostic tests may be necessary to determine the underlying cause of the patient's undefined symptoms. A comprehensive assessment is required to develop an appropriate treatment plan.

MEDICAL HISTORY

• Medical History: The patient's medical history, including allergies, medications, conditions, surgeries, and family history, is documented under the name John4. Further details regarding the medical history are not provided in the current report.

SUBJECTIVE INTAKE

• Subjective Intake: The patient's subjective intake revealed a severity level of 6, intermittent timing of symptoms, and a worsening context. The patient reported John4John4, although specific details regarding the nature of the symptoms were not provided. Quality, exacerbating factors, radiating pain, sciatica, and specific body parts affected were noted as not applicable or undefined.

ATTORNEY INFORMATION

• Attorney Information: No specific attorney information was provided in the available data for this patient.

INITIAL VISIT

• Initial Visit: This report represents the initial visit of the patient, John4, during which the chief complaint of undefined symptoms was reported. Further evaluation and diagnostic procedures are recommended to elucidate the nature of the patient's condition and guide treatment decisions.

FOLLOW-UP VISIT

• Follow-up Visit: A follow-up visit is recommended to review the results of additional tests and assessments, discuss treatment options, and monitor the patient's progress in managing the undefined symptoms reported during the initial visit.

DISCHARGE VISIT

• Discharge Visit: A discharge visit is not applicable at this stage, as the patient's evaluation and treatment plan are ongoing. Further updates and recommendations will be provided following subsequent visits and assessments.

This report summarizes the clinical information available for the patient, John4, and outlines the initial assessment, subjective intake, and recommendations for further evaluation and management of the undefined symptoms presented by the patient.

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Treating Provider