

INITIAL EXAMINATION

PATIENT'S NAME

DATE OF ACCIDENT

DATE OF EXAMINATION

DATE OF BIRTH

HISTORY OF PRESENT ILLNESS:

Based on the patient's history, where and how did the injury/illness happen :

How did you learn about the injury/illness (check one)

Patient

Medical Records

Other (Specify)

Did another health provider treat this injury/illness including hospitalization and/or surgery ? Yes No If yes, give details

Have you previously treated this patient for a similar work-related injury/illness? Yes No If yes, when

TREATMENT RENDERED TODAY

99201/99241 – Community Medical Care of N.Y., P.C. OR OTHER OUTPATIENT VISIT / CONSULTATION

99202 / 99242 – Community Medical Care of N.Y., P.C. OR OTHER OUTPATIENT VISIT / CONSULTATION

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99204 / 99244 – Community Medical Care of N.Y., P.C. OR OTHER OUTPATIENT VISIT / CONSULTATION

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CURRENT COMPLAINTS

Patient's subjective complaints: Check all that apply and identify specific affected body part(s).

Numbness/Tingling

Swelling

Pain

Weakness

Stiffness

Other (specify)

PATIENT'S NAME

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HEADACHES	RT / LT KNEE PAIN
DISSINESS	RT / LT SHOULDER PAIN
JAW PAIN	LOWER BACK PAIN & STIFFNESS
NECK PAIN AND STIFFNESS	UPPER BACK PAIN & STIFFNESS
CHEST PAIN	UNABLE TO LIFT HEAVY OBJECTS
DIFFICULTY IN BREATHING	SHOOTING PAIN DOWN THE RT / LT LEG
RESTRICTION OF NECK MOTION	DIFFICULTY IN RISING TO WALK AFTER SITTING
NUBNESS / TINGLING IN FINGERS / TOES	DIFFICULTY IN PROLONGED RIDING IN AN AUTOMOBILE
ANXIETY / STRESS	INSOMNIA
VISUAL PROBLEMS	MEMORY PROBLEMS
FATIGUE	CONCENTRATION PROBLEMS

Patient **states denied** loss of consciousness but was **dazed** **dizzy** **nervous.**

After the accident the patient **went home to rest** **was taken by ambulance** **took self to** the Emergency Room at hospital. Patient was hospitalized.

Patient was evaluated in the emergency room where multiple X-rays were taken of

Patient was medicated and was released on

Patient treated by **himself herself** with analgesic with mild effect and next day **within a few days** HE/SHE came to my office seeking medical attention.

Information was obtained from the patient by his/her own description **through an interpreter.**

Numbness / tingling in upper / **lower** extremities.

Pain was described as constant **sharp** **intermittent** **stabbing** **burning** **dull** **shooting**

Pain was radiating from neck to right left both shoulder and right left both scapular region / upper extremities.

Pain was radiating from lower back to right left both lower extremities / buttocks.

PAIN SCALE RATING 0 - No Pain 10 - Worst Pain

VISUAL ANALOG SCALE Pain on scale of 0 to 10

PAIN IS EXACERBATED BY

Going up / down stairs	Carrying heavy objects
Bending down	Prolonged standing
Squatting	Lying down
Pushing	Prolonged sitting
Pulling	Standing up from a sitting position
Lifting	Prolonged walking
Deep breathing	Weather change

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Type/nature of injury: Check all that apply and identify specific affected body part(s).

Abrasions	Infectious Disease
Amputation	Inhalation Exposure
Avulsion	Laceration
Bite	Needle Stick
Burn	Poisoning/Toxic Effects
Contusion/Hematoma	Psychological
Crush Injury	Puncture Wound
Dermatitis	Repetitive Strain Injury
Dislocation	Spinal Cord Injury
Fracture	Sprain/Strain
Hearing Loss	Torn Ligament, Tendon or Muscle
Hernia	Vision Loss
Other (specify)	

MEDICAL HISTORY

Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis?

Yes

No If Yes, list and describe

MEDICAL

None

Diabetes	Heart Attack	Seizures
High Blood Pressure	Angina/Chest Pain	Phlebitis
Mitral Valve Prolapse	Angioplasty	Hepatitis
Bleeding Disorder	Stroke/TIA's	Ulcers
Circulation Disorder	Anemia	Hiatal Hernia
Back Pain	Arthritis	Osteoporosis
Scar Former	Thyroid Disorder	Asthma
Kidney Disorder	Cirrhosis	Cancer

ALLERGIES

None	Penicillin	Aspirin	Codeine
Novocaine	Iodine	Tape	Other

MEDICATION

- 1.
- 2.
- 3.
- 4.
- 5.
6. None

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PREVIOUS SURGERIES AND HOSPITALIZATIONS

- | | | |
|----|----|---------|
| 1. | 3. | 5. |
| 2. | 4. | 6. None |

FAMILY HISTORY

None

Diabetes	High Blood Pressure	Bleeding Tendencies
Cancer	Orthopedics Disease	Bone or Joint Problems

SOCIAL HISTORY

Smoking Packs Per day for years.

Quit Smoking this year/<1 year 1-5 years >10 years

Alcohol	Daily	1-2 x/week	1-2 x/month	1-2 x/year	Quantity
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Recreational drugs What?

VITAL SIGNS	Pulse	Height	Blood Pressure	Weight
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PHYSICAL EXAMINATION

GENERAL APPEARANCE

WELL DEVELOPED

WELL NOURISHED

MILD DISTRESS

MODERATE DISTRESS

SEVERE DISTRESS SECONDARY TO PAIN

BRIEF ASSESSMENT OF MENTAL STATUS (ORIENTED TO TIME, PLACE AND PERSON)

HEAD

Normocephalic, Atraumatic

Eyes : Pupils were equal and reacted to light and accommodation

Extraocular muscles were intact.

Ears : No blood noted in the external auditory canal.

CHEST

No deformities.

Positive / Negative pain upon palpation.

HEART

The heart was in regular rhythm and rate; normal S1, S2.

Other:

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DATE OF ACCIDENT

DATE OF EXAMINATION

LUNGS

Clear to auscultation bilaterally.

Other:

ABDOMEN

Soft, normoactive bowel sounds.

Positive / Negative tenderness.

BACK

No kyphoscoliosis.

Normal / Increased lumbar lordosis.

EXTREMITIES

No edema.

Edema at:

Pulses 2+ throughout

EXAMINATION

SHOULDER	NORMAL ROM	PATIENT'S ROM / STRENGTH			- LEFT	- RIGHT		
FLEXION	150					S	S	I
EXTENSION	150				D	H	P	N
ABDUCTION	150				U	A	A	F
ADDITION	30				L	R	S	L
INTERNAL ROTATION	40				L	P	M	A
EXTERNAL ROTATION	90							M
		LEFT	RIGHT	BOTH				
PAIN IN JOINT					SHOULDERS	- SYMMETRICAL	- ASYMMETRICAL	
PAIN ACROSS SHOULDER					- MILD	- MODERATE	- SEVERE	PAIN
LIMITATION OF MOVEMENT					ON PALPATION			
(+)	(-) - CREPITIS PRESENT	(+)	(-) - DROP ARM TEST	(+)	(-) - APPREHENSION SIGN			
(+)	(-) - PAINFUL ARC / IMPINGEMENT SIGN							

CERVICAL SPINE	NORMAL ROM	PATIENT'S ROM / STRENGTH			
FLEXION	60				S
EXTENSION	50				D
LEFT ROTATION	80				U
RIGHT ROTATION	80				L
LT LATERAL FLEXION	40				P
RT LATERAL FLEXION	40				M

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FORWARD MOVEMENT - BACKWORD MOVEMENT -

ROTATE HEAD LEFT - ROTATE HEAD RIGHT -

BEND NECK LEFT - BEND NECK RIGHT -

CERVICAL MUSCLES APPEAR SYMMETRICAL / ASSYMETRICAL WITH / WITHOUT MODERATE / SEVERE
 TENDERNESS / MUSCLE SPASM TO UPPER TRAPEZIUS AND PARASPINAL MUSCLES.

LUMBOSACRAL SPINE NORMAL ROM PATIENT'S ROM / STRENGTH

FLEXION	90		S	S	I
EXTENSION	30		D	H	P
LEFT ROTATION	30		U	A	A
RIGHT ROTATION	30		L	R	S
LT LATERAL FLEXION	20		L	P	M
RT LATERAL FLEXION	20				M
	RIGHT	LEFT	BOTH		

UPPER LUMBAR PAIN

LOWER LUMBAR PAIN

SACRO-ILIAC PAIN

MUSCLE SPASM

STRAIGHT LEG RAISING TEST SUPINE (+) (-) RIGHT (+) (-) LEFT

HIP	NORMAL ROM	PATIENT'S ROM / STRENGTH				
FLEXION	100		S	S	I	
EXTENSION	100		D	H	P	N
ABDUCTION	40		U	A	A	F
ADDITION	30		L	R	S	L
INTERNAL ROTATION	40		L	P	M	A
EXTERNAL ROTATION	40					M

TENDERNESS OVER ANTERIOR / LATERAL / POSTERIOR ASPECTS.

KNEE NORMAL ROM PATIENT'S ROM / STRENGTH

FLEXION 135

EXTENSION 0-15

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POINT TENDERNESS	POSITIVE /	NEGATIVE		
CREPITUS	POSITIVE /	NEGATIVE		
EFFUSION	POSITIVE /	NEGATIVE		
JOINT LINE PAIN	POSITIVE /	NEGATIVE		
SWELLING	POSITIVE /	NEGATIVE		
VALGUS TEST	(+)	(-) - RIGHT	(+)	(-) - LEFT
VARUS TEST	(+)	(-) - RIGHT	(+)	(-) - LEFT
MCMURRAY'S TEST	(+)	(-) - RIGHT	(+)	(-) - LEFT
ANTERIOR DRAWER SIGN	(+)	(-) - RIGHT	(+)	(-) - LEFT
POSTERIOR DRAWER SIGN	(+)	(-) - RIGHT	(+)	(-) - LEFT

ARM AND HAND

RIGHT	LEFT	BOTH	RIGHT	LEFT	BOTH
PAIN IN UPPER ARM			PAIN IN WRIST		
PAIN N ELBOW			PAIN IN HAND		
PAIN IN FOREARM			PAIN & NEEDLESS (HAND)		
PAIN & NEEDLESS (ARM)			NUMBNESS IN HAND		
PAIN & NEEDLESS (FOREARM)					
NUMBNESS IN ARM					
NUMBNESS IN FOREARM					

FEET

	RIGHT	LEFT	BOTH
ANKLE PAIN			
SWOLLEN ANKLE			
FOOT PAIN			
NUMBNESS OF FOOT			
SWOLLEN FOOT			

GAIT : Normal / Slow gait / Antalgic / Foot drop (steppage) / Hemiplegic.

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DATE OF ACCIDENT

DATE OF EXAMINATION

NEUROLOGICAL EXAMINATION

CEREBRAL :

CEREBELLAR : Rhomberg test was – Positive / Negative.

FUNCTIONAL : ADL transfer / Ambulating independently / With assistance.

Physical examination: Check all relevant objective findings and identify specific affected body part(s).

None at present

Bruising	Neuromuscular Findings
Burns	Abnormal/Restricted ROM
Crepitation	Active ROM
Deformity	Passive ROM
Edema	Gait
Hematoma/Lump/Swelling	Palpable Muscle Spasm
Joint Effusion	Reflexes
Laceration/Sutures	Sensation
Pain/Tenderness	Strength (Weakness)
Scar	Wasting/Muscle Atrophy
Other Findings	

Described any diagnostic test(s) rendered at this visit:

DIAGNOSTIC IMPRESSION

- (920.0) SCALP CONTUSION
- (784.0) HEADACHES
- (780.4) DIZZINESS
- (850.0) CONCUSSION WITHOUT LOSS OF CONCIOUSNESS
- (850.1) CONCUSSION WITH BRIEF LOSS OF CONCIOUSNESS
- (847.0) CERVICAL SPRAIN/STRAIN
- (723.4) CERVICAL RADICULITIS
- (722.0) CERVICAL DISC DISPLACEMENT

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- (847.1) THORACIC SPRAIN/STRAIN
- (847.2) LUMBAR SPRAIN/STRAIN
- (846.0) LUMBASACRAL SPRAIN/STRAIN
- (724.4) R/O LUMBAR RADICULITIS
- (722.1) R/O LUMBAR DISC DISPLACEMENT
- (923.0) RIGHT/LEFT SHOULDER CONTUSION
- (840.9) RIGHT/LEFT SHOULDER SPRAIN/STRAIN
- (718.31) R/O INTERNAL DERANGEMENT, SHOULDER
- (840.6) R/O TEAR SUPRASPINATUS MUSCLE
- (924.11) RIGHT/LEFT KNEE CONTUSION
- (844.1 / 844.0 / 844.2) KNEE MCL / LCL/ ACL STRAIN
- (718.36) R/O KNEE INTERNAL DERANGEMENT
- (836.0 / 836.1) R/O MEDIAL / LATERAL MENISCUS TEAR
- (922.1) CONTUSION OF THE CHEST WALL
- (845.0) RIGHT / LEFT ANKLE SPRAIN / STRAIN
- (924.21) RIGHT / LEFT ANKLE CONTUSION
- (841.9) RIGHT / LEFT ELBOW SPRAIN / STRAIN
- (923.11) RIGHT / LEFT ELBOW CONTUSION
- (845.1) RIGHT / LEFT FOOT SPRAIN / STRAIN
- (924.2) RIGHT / LEFT FOOT CONTUSION
- (843.9) RIGHT / LEFT HIP / THIGH SPRAIN / STRAIN
- (924.01) RIGHT / LEFT HIP CONTUSION
- (842.00) RIGHT / LEFT WRIST SPRAIN / STRAIN
- (842.1) RIGHT / LEFT HAND SPRAIN / STRAIN
- (736.32) RIGHT / LEFT ELBOW EPICONDYLITIS

DIAGNOSTIC PLAN AND RECOMMENDATION

'S OPINION

In your opinion, was the incident that the patient described the competent medical cause of this injury/illness?

Yes No

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DATE OF ACCIDENT

DATE OF EXAMINATION

Are the patient's complaints consistent with his/her history of the injury/illness? Yes No
Is the patient's history of the injury/illness consistent with your objective findings? Yes No
N/A (no findings at this time)

What is the percentage (0-100%) of temporary impairment? %

Describe findings and relevant diagnostic test results:

Described prognosis for recovery:

PLAN OF CARE

What is your proposed treatment?

Medication(s): (a) list medications prescribed:

(b) list over-the-counter medications advised:

Medication restrictions: None May affect patient's ability to return to work, make patient drowsy, or other issue.

Explain:

Does the patient need diagnostic tests or referrals? Yes No If Yes, check all that apply:

Tests

CT Scan

EMG/NCS

MRI (Specify)

Labs (Specify)

X-ray (Specify)

Other (Specify)

Referrals

Chiropractor

Internist/Family Physician

Occupational Therapist

Physical Therapist

Specialist in

Other (Specify)

Assistive devices prescribed for this patient: CANE Crutches Orthotics Walker

Wheelchair Other

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WHEN IS PATIENT'S NEXT FOLLOW-UP VISIT?

- | | | | | | |
|-----------------|-----------|-----------|-------------|-----------|------------|
| - WITHIN A WEEK | - 1-2 WKS | - 3-4 WKS | - 5-6 WEEKS | - 7-8 WKS | MONTHS WKS |
| - AS NEEDED | | | | | |

WORK STATUS

HAS THE PATIENT MISSED WORK BECAUSE OF THE INJURY / ILLNESS? Yes No IF YES, DATE PATIENT FIRST MISSED WORK :

IS THE PATIENT CURRENTLY WORKING? Yes No IF YES, DID THE PATIENT RETURN TO:

- USUAL WORK ACTIVITIES - LIMITED WORK ACTIVITIES

CAN PATIENT RETURN TO WORK?

- THE PATIENT CANNOT RETURN TO WORK BECAUSE (EXPLAIN)

- THE PATIENT CAN RETURN TO WORK WITHOUT LIMITATIONS ON
- THE PATIENT CAN RETURN TO WORK WITH THE FOLLOWING LIMITATIONS ON
- | | | |
|----------------------------|---------------------------------|--------------------------------|
| - BENDING/TWISTING | - LIFTING | - SITTING |
| - CLIMBING STAIRS/LADDERS | - OPERATING HEAVY EQUIPMENT | - STANDING |
| - ENVIRONMENTAL CONDITIONS | - OPERATION OF MOTOR VEHICLES | - USE OF PUBLIC TRANSPORTATION |
| - KNEELING | - PERSONAL PROTECTIVE EQUIPMENT | - USE OF UPPER EXTREMITIES |
| - OTHER | | |

DESCRIBE / QUANTIFY THE LIMITATIONS:

HOW LONG WILL THESE LIMITATIONS APPLY? - 1-2 DAYS - 3-7 DAYS - 8-14 DAYS - 15+ DAYS - UNKNOWN

WITH WHOM WILL YOU DISCUSS THE PATIENT'S RETURNING TO WORK AND /OR LIMITATION?

- WITH PATIENT - WITH PATIENT'S EMPLOYER - N/A

- I PROVIDED THE SERVICES LISTED ABOVE.

- I ACTIVELY SUPERVISED THE HEALTH-CARE PROVIDER NAMED BELOW WHO PROVIDED THESE SERVICES.

SINCERELY,