PAIN RELIEF CENTERS
5129 Dixie Hwy, Suite 201
Louisville, KY 40216
PHONE: (502) 430-6223, FAX: 502-369-5229

FOLLOW-UP VISIT via **In-Office**

PATIENT NAME: DEMETRIUS WEATHERS
DATE OF BIRTH: 04/14/1980
DATE OF EVALUATION: 07/22/2025
DATE OF DICTATION: 07/22/2025
PHYSICIAN: Robert Klickovich, M.D

Provider: Lauren Ellis, APRN
Referring Physician: Shields
Insurance: Humana, Medicaid

Location: Louisville
CMA: Melanie
Room #: 6

CHIEF COMPLAINT: The patients worst pain complaint today is located in their low back in addition to their other left hip, bilateral shoulder, neck pain complaints and presents today to the clinic today for a routine f/u of their usual pain complaints and/or medication refill; flare up of known pain complaints especially pain in the low back.

HISTORY OF PRESENT ILLNESS: Since their last visit, the:
Pain is: Less tolerable
Activity level/functioning is: The same
Social Relationships are: The same
Job Performance is (if working): The same
Sleep Patterns are: The same

CHARACTERISTICS OF PAIN INCLUDE:
Temporally it is: continuous baseline pain with frequent painful exacerbations.
Qualitatively it is: Burning, Stabbing, Numb, Dull, Aching, Throbbing, Deep, Crampy
Numeric Scale rating of (?/10): Average: 8/10. Best: 10/10. W/meds: 7 1/2/10. W/o meds: 10/10.

Social Hx significant for:
Working status of: Unemployed

REVIEW OF SYSTEMS:

ALLERGIC SYMPTOMS INCLUDE:
Allergies to new Meds/Foods: No.
Hives and Itchy skin: No.
Sneezing: No.
Hay fever: No.
Red Itchy eyes: No.

NEUROLOGICAL SYMPTOMS INCLUDE:
Worsening Weakness in limbs: No.
Worsening Sensation in limbs: No.
Numbness/tingling sensations: No.
Loss of Bowel or Bladder: No.
New convulsions or seizures: No.

Patient Compliance with Treatment Plan

	Yes	No	N.A.	Comments
U-tox and/or Pill Count O.K.?		No		06/23/2025 negative meds exp positive THC
KASPER report O.K.?	Yes			06/23/2025 LFD
Participates in PT or home exercise prgm	Yes			HEP 2 years + . Number of sessions done: Ongoing
Ordered imaging studies completed			NA	
Participated in Weight Loss Prgm		No		Increased 1 lbs. BMI: 17.7. Weight: Loss
Participated with Counselor if recommended			NA	not ordered

PHYSICAL EXAMINATION:

Vitals: BP: 127/100. Ht: 6 feet 0 inches. Wt: 130.6 lbs. BMI: 17.7
General appearance is: Well groomed and content
Orientation to person, place, and time is: Correct
Mood and Affect are: Appropriate
Gait is: Within normal limits, and with No assistive device
Station (stance) is: unsteady
Cardiovascularly ankle swelling is: Not present
Lymphadenopathy in the cervical and or inguinal lymph node chain is? Not present
Coordination and Balance shows Romberg test is: Negative
Motor Function: No stated and observed change in motor and/or sensory function since last visit.

Date: 05/20/2025
Pre-existing
CC: low back

Palpation revealed:
Positive muscle tenderness
Positive joint tenderness

R.O.M. revealed:
Positive decrease in gross movement

Date: 06/23/2025
Pre-existing
CC: neck

Palpation revealed:
Positive muscle tenderness
Positive joint tenderness

R.O.M. revealed:
Positive decrease in gross movement

Date: 07/22/2025
Pre-existing
CC: low back

Palpation revealed:
Positive muscle tenderness
Positive joint tenderness

R.O.M. revealed:
Positive decrease in gross movement

The following findings of ESTABLISHED complaints were positive:
Cervical spine tenderness of paraspinal muscles on bilaterally.
Traps/levator scapula tenderness bilaterally.
Cervical facet loading signs on bilaterally at C5-T1.
Pain (worst) with extension.

Lumbar spine tenderness of paraspinal and or quadratus muscles bilaterally.
Gluteal tenderness bilaterally.
Lumbar facet loading signs bilaterally at L2-L5.
Quadrant test bilaterally.
Slump/SLR bilaterally.
Patrick bilaterally.
SIJ tenderness bilaterally.

Apley scratch bilaterally.
Crossover test bilaterally.
ROM is grossly decreased bilaterally.
Subacromial tenderness on left.
Neer Impingement on left.
Empty Can Test on left.

(hip) Squat test
Trochanteric bursa tenderness bilaterally.
ROM is grossly decreased on left.
Patrick on left.
FADIR (flexion, adduction and medial hip rotation) on left.

ASSESSMENT:
1. Cervicalgia – M54.2
2. Facet Arthropathy – M46.92
3. Spondylosis-Cervical – M47.812
4. Shoulder-Left-DJD – M19.012
5. Shoulder-Left Bursitis – M75.52
6. Humerus (Arm) Pain (R and L) – M79.609
7. Facet Arthropathy, Lumbar – M46.96
8. Facet Spondylosis – M47.816
9. Lumbago NOS/Low Back Pain – M54.50
10. Hip-Bursitis Trochanteric- Left – M70.62
11. Hip-Left DJD – M16.12
12. Arthritis, Osteo – M15.9
13. Chronic Pain – G89.29
14. Myalgia (Myofascial) Pain – M79.18

Follow-Up Plan:
F/u severity of non-compliance per history is: None

F/u Review completed for: U-Tox/ORT, KASPER Report, Medication list, Nursing/chart notes, Treatment goals, plan and U-Tox log.

As discussed during the initial consultation with the patient and as monitored during subsequent clinic visits, the patient will:

1. Engage physical therapy with an initial evaluation and then learn their recommended treatment exercises. The learned exercises will continue at the patient home as part of a home based exercise program. Additionally, if spinal column problems exist then learning and implementing the McKenzie stabilization exercises is consistently recommended.
2. Participate in a weight loss program if their BMI=30. This includes learning the Myfitnesspal.com free application for which user instructions were given to the patient during the initial visit. A consultation with a dietician was also recommended initially if they are diabetic.
3. Participate in a behavioral health program if diagnosed with either depression, bipolar, or other mental disorders with an emphasis on learning coping skill. Specifically, mastery of the techniques employing distraction and guided-imagery is encouraged.
4. Unless noted elsewhere, all other problems (diagnosis) have been stable/addressed and current treatment is to continue (eg O.A., D.M., BMI, Neuropathy)

If the patient received 50% pain relief from their last procedure, then this intervention will be continued. Otherwise, the current treatment plan and procedures will be changed as appropriate

F/u Orders:
Will not order a Urine Drug Test (UDT)

MEDICATION MANAGEMENT:
1. Due to acceptable ADL, efficacy tolerance the C.S. dosing was unchanged (or no additional C.S.).
2. No NSAIDs, GERD.
3. Continue Gabapentin 300 mg, t.i.d. #90 (50% pain relief obtained)
4. Continue tizanidine 4 mg, q.h.s p.r.n. #30 (50% pain relief obtained)

INJECTIONS:
1. Later schedule trigger point injection at lumbar spine

Other Plans:
1. lumbar brace ordered
2. patient currently 240 care giver for S.O s/p stroke 2 months ago

For the planned procedure(s), if any, considerable time was spent explaining the risks, benefits and alternatives. All questions were answered including common complications to planned procedure along with remedies for the potential complications. Handouts were also given to the patient as appropriate including procedure and educational videos at www.tinyurl.com/PROCEDURE-Oct2022. if applicable, the patient was told to stop taking all anti coagulant medications for 3-5 days. The specific cessation interval depends on both the anti coagulants they are on and the type of procedure scheduled.

Once the patient has fully engaged and completed the initial treatment plan as documented over the course of multiple clinic visits, then Maximum Medical Improvement (MMI) will be achieved. Additionally, if the patient is taking narcotics, then this will be tapered down over a 3-6 month period as tolerated by patient.

Follow-up Appointment in: Four weeks

Lauren Ellis, APRN personally performed todays follow-up evaluation and treatment plan of the patient, while Dr. Robert Klickovich (or different Physician noted/documented above) provided direct supervision of the APRN and was immediately available to assist if needed during todays follow-up patient encounter. A clinic physician had previously performed the initial service evaluation of the patient while Dr. Robert Klickovich currently remains actively involved in the patient's progress and treatment plan including approving changes in medication type, strength, or dosing interval or any other aspect of their care plan.

This document(s) was dictated, transcribed, but not read and is subject to review and confirmation. Please contact the author if you have any concerns/clarifications.

Robert Klickovich, MD

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RK/
07/23/2025