FOLLOW-UP OFFICE VISIT

Patient Name: Theodore Angel **Date of Injury: 02/23/23**
Date of Birth: 09/15/75 **Date of Visit: April 7, 2023**

SUBJECTIVE:
Theodore Angel presents today to follow up on injuries sustained in a motor vehicle collision.

CURRENT CONCERNS/CHANGES FROM LAST VISIT-per patient report:
The patient completed a pain diagram and reports their overall pain level, since the collision, as 6/10 presently. Mr. Angel continues to have upper back pain and pain between the shoulders that is sharp and stabbing. These spasms come about twice a week. The right leg pain, which did run to his foot, now goes to the right mid-calf. He has had MRIs of the cervical and lumbar spine. He is here for those results. The patient relates a little more to me about his positioning during the collision. He states that he was sitting twisted "watching the collision happen." He is using Flexeril and over-the-counter analgesics for pain. The pain is still affecting his sleep. Mr. Angel is still experiencing difficulties with anxiety in vehicles. His ankle and foot and shoulders are doing better. He is improving as far as his cognitive concerns are concerned.

Care since last visit:
The patient has been participating in chiropractic care, massage therapy, physical therapy, and acupuncture.

DIAGNOSTICS:
A Radiograph/X-ray of the left shoulder was performed on 02/23/23 at North Suburban Hospital and read as: Normal.
A CT scan of the head and cervical spine was performed on 02/23/23 at North Suburban Hospital and read as: No acute intracranial abnormality. Chronic left maxillary sinus favor odontogenic. No acute fracture or traumatic malalignment in the cervical spine.
An MRI of the cervical spine was performed on 04/07/23 at Health Images North Denver and read as: Mild annular bulging C4-5, C5-6, and C6-7. No high-grade central canal stenosis or foraminal narrowing identify given motion limitation.
An MRI of the lumbar spine was performed on 04/07/23 at Health Images North Denver and read as: Transitional lumbosacral anatomy with current nomenclatures assuming a transitional as one segment. Multilevel lumbar spondylosis appearing most significant at L5-S1 where the right > left L5-S1 neuroforaminal narrowing and right subarticular recess stenosis secondary to a right central disc extrusion. Mild bilateral foraminal narrowing at L4-5. Mild right foraminal narrowing at L3-4.

REVIEW OF MEDICAL RECORDS AND DOCUMENTS:
The chiropractic and/or physical therapy notes from Synergy Health Partners were reviewed and appreciated.

PAST MEDICAL/SURGICAL HISTORY:
Reviewed initial history, additions/changes as documented below.

REVIEW OF SYSTEMS:
Please see the CURRENT COMPLAINTS PER PATIENT REPORT above for the Musculoskeletal Review of Systems.

PHYSICAL EXAMINATION:
GENERAL IMPRESSION:
This is a well-developed, well-nourished patient. The patient did complain of pain and did not appear to be comfortable throughout the entire examination.

MENTAL STATUS:
The patient was alert, pleasant, cooperative, and answered posed questions appropriately.

HEENT: Without acute pathology and was able to hear normal conversation.

CERVICAL, THORACIC, AND LUMBAR SPINE:
The patient had reduced range of motion in flexion, extension, and side bending with pain behaviors and complaints.
There was palpable hypertonicity over the bilateral paraspinal muscles.
There was tenderness to palpation over the bilateral paraspinal muscles right > left.

OSTEOPATHIC/MUSCULOSKELETAL EXAMINATION:
TRIGGER OR TENDER POINTS:
There are taut bands of muscle that radiate pain with pressure/palpation, particularly in the gluteal/piriformis area.

UPPER EXTREMITIES:
Shoulder:
Nontender to palpation over the deltoids.
Range of motion is normal by visual inspection.
Range of motion is accompanied by pain complaints in the right side periscapular and trapezius muscles.

NEUROLOGIC/GAIT:
Grossly intact. Speech is fluent without aphasia or dysarthria.
Cranial nerves II-XII grossly intact.
His gait is normal on straight-away walking.
He moved easily up and down from the chair and exam table.
Reflexes +2/4 patella and Achilles bilateral.

DIAGNOSES-Trauma Related: Persistent:
1. Lumbar Disc Rupture L5-S1 (S33.0XXA).
2. Lumbosacral Radiculopathy, Right Leg (M54.17).
3. Cervical Sprain/Strain (S13.4XXA, S16.1XXA).
4. Lumbar Sprain/Strain (S33.5XXA, S39.012A).
5. Thoracic Sprain/Strain (S23.3XXA, S29.012A).
6. Leg Pain, Right (R20.9).

7. Hip Pain, Right (M25.551).
8. Sleep Disturbance (G47.09).
9. Adjustment Disorder with Anxiety (F43.22).

DIAGNOSES-Trauma Related: Improving/No Symptoms Presently:
1. Posttraumatic Headache (G44.319).
2. Shoulder Sprain, Right (S43.401)/Left (S43.402A).
3. Ankle/Foot Sprain, Right (S96.911A).
4. Dizziness (R420).
5. Cognitive Changes (R41.9). Concussion/Traumatic Brain Injury without Loss of Consciousness (S06.0X0A).

CAUSALITY:
In my opinion, and with a reasonable degree of medical probability, the collision of 02/23/23 was the proximate cause of the injuries listed above. The findings on physical examination are consistent with the patient's complaints and the mechanism of injury.

DISCUSSION:
The cause for the pain in the thoracic area can often be radiating pain from the cervical spine. No cause for the radiating, stabbing pain on the right side of the thorax was found in the cervical MRI. With the information of his position at the time of impact being more clear, an MRI of the thoracic spine is ordered to rule out thoracic nerve root irritation and injury of the source of this right sided radiating pain.

TREATMENT PLAN AND RECOMMENDATIONS:
Pharmacotherapy: Continue over-the-counter medications and Flexeril. The patient did not fill the gabapentin prescription that I wrote.
Diagnostics: Thoracic spine MRI as above.
Rehabilitation Plan: Continue physical therapy, chiropractic care, massage, and acupuncture.
Education: Treatment plan and prognosis discussed with the patient; questions answered.
Consultations: With psychology. Referral pending approval. Consultation with injection specialist is requested after thoracic MRI is accomplished.
Work/Activity Status: I have warned the patient to use common sense and avoid any activities that increase pain or are poorly tolerated.
Follow-up: In four weeks.

CLOSING:
Thirty minutes were spent, face to face, on today's visit with the patient and 20 minutes were spent reviewing the chart, reviewing the imaging results, dictating, and documenting. At least 50% of the time with the patient was spent in treatment planning and patient education. I have attempted to answer all of the patient's questions and address their concerns in the office today. They appear to understand and be comfortable with the above plan. The above analysis is based upon the available information at this time including the history given by the examinee, the medical records and tests provided, and the physical findings. It is assumed that the information provided to me is correct. My opinions are based upon reasonable medical probability.

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