Movement Dynamics Physical Therapy, P.C.

Progress Note

DATE:	7/6/2023	INSURANCE:	None
PATIENT:	Angel, Theodore 'Jimmy'		
PATIENT #:	42372	DATE OF BIRTH:	9/15/1975
DIAGNOSIS:	Dx1: Acute post-traumatic headache, not intractable(G44.319), Dx2:Strain of muscle, fascia, and tendon at neck level(S16.1XXA), Dx3:Strain of muscle and tendon of back wall of thorax(S29.012A), Dx4:Strain of muscle, fascia, and tendon of lower back(S39.012A), Dx5:Strain of muscle, fascia, and tendon of RIGHT hip(S76.011A), Dx6:Paresthesia of skin(R20.2), Dx7:Radiculopathy, Lumbar(M54.16)		
PROBLEM SITE:	Spine - Cervical, Spine - Thoracic, Spine - Lumbar		
SITE DESCRIPTION:	Thornton PT		
REFERRAL:	Wallace, Bethany	VISIT DUR:	16 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	2:00 pm	END TIME:	2:16 pm
Visit #	9		
Total Visits:	9		

Subjective
Patient returns today for a re-evaluation and reports the following progress for all initial complaints.

HA - resolved
Neck - resolved
Upper back - resolved
Midback - resolved
Lower back - minor pain with prolonged sitting; overall "feels great"
Buttock - minor pain in R gluts/upper hamstring when driving specifically
R hip - resolved
R knee - resolved
R ankle - resolved
(B) shoulder - resolved
Dizziness/light-headed - resolved

Patient reports the following progress in regards to ADLs and functional activities:
Sleep- has returned to normal
ADLs- has returned to normal
Household duties- has returned to normal
Basic mobility- just prolonged sitting with driving
Recreational activities- has returned to normal

Patient reports that they no longer take any medications for pain related to the accident.

Patient has follow up appointment scheduled on 07/21.

Overall, patient reports feeling 95% better since the accident.

Patient reports working normal hours/ normal duties without increased pain.

Objective
GENERAL:

RANGE OF MOTION (CERVICAL):
Flexion: WNL no pain
Extension: WNL no pain
Right Lateral Flexion: WNL no pain
Left Lateral Flexion: WNL no pain
Right Rotation: WNL no pain
Left Rotation: WNL no pain

RANGE OF MOTION (LUMBAR):
Flexion: WNL no pain
Extension: WNL no pain

Right Lateral Flexion: WNL no pain
Left Lateral Flexion: WNL no pain
R rotation: WNL no pain
L rotation: WNL no pain

RANGE OF MOTION (UPPER EXTREMITIES):
Patient's upper extremity range of motion is WNL for all planes of motion with gross observation/assessment and without complaints of pain.

RANGE OF MOTION (LOWER EXTREMITIES):
Patient's lower extremity range of motion is WNL/back to preexisting range for all planes of motion with gross observation/assessment and without complaints of pain.

minor pinch on R SI with L FABER
thigh thrust + for SI pinch on R

MANUAL MUSCLE TESTING:
Patient had 5/5 strength with manual muscle testing of all major muscle groups without complaints of pain.

POSTURE:
Patient's posture is WFL with gross observation.

GAIT:
Patient's gait is WNL with gross observation.

PALPATION/OBSERVATION
No tenderness was noted today with palpation of all spinal musculature.

TREATMENT:
Reevaluation completed today. Plan for discharge from physical therapy was discussed with and agreed upon by the patient.

PATIENT EDUCATION:
(Patient was educated on the PT plan of care and the importance of compliance with physical therapy and the eventual transition to a home exercise program.)
Patient was educated on the importance of continuing exercises independently at home. Patient was provided with a handout which included pictures and written descriptions of exercises to be performed at home (HEP).

Limitation Test	Tot.Score	% Impaired	Modifier
Oswestry Disability Index (ODI)	11	22	CJ

Short-Term Goal	Met	Date Met
Patient will be independent with home exercise program.	X	7/6/2023
Patient will have full cervical range of motion without complaints of pain.	X	7/6/2023
Patient will have full lumbar range of motion without complaints of pain.	X	7/6/2023
Patient will have full upper extremity range of motion without complaints of pain.	X	7/6/2023
Patient will have full lower extremity range of motion without complaints of pain.		

Long-Term Goal	Met	Date Met
Patient will report ability to work full shift without pain.	X	7/6/2023
Patient will report ability to perform all ADLs without increased pain.	X	7/6/2023
Patient will report ability to perform all household duties without increased pain.	X	7/6/2023
Patient will report ability to participate in activities of enjoyment without increased pain.	X	7/6/2023
Patient will report ability to sleep through the night without waking from pain.	X	7/6/2023
Patient will report feeling at least 75% better overall.	X	7/6/2023

Assessment
The patient is independent in a home exercise program for continued stretching and strengthening of all areas treated in physical therapy.

The patient is appropriate for discharge from physical therapy at this time and is agreeable to this plan.

Please note, all information provided in this reevaluation is based on how the patient presents today. However, it is common and likely that the patient will continue to have fluctuations in pain. The patient's pain may continue to improve, especially with continued performance of the home exercise program. Conversely, it is likely that the patient will experience flare-ups of pain, especially as the patient returns to all normal activities and as the patient is weaned off active treatment. If the patient does experience flare-ups of pain, additional care may be necessary to return to patient to baseline. This patient may require an additional 6-8 PT visits over the course of the next 4-6 months. This patient will be instructed to call and schedule for "prn or as

needed visits" if a flare-up occurs.

Plan
Patient is discharged from physical therapy at this time. The patient has been instructed to continue the home exercise program and to call with any questions and concerns or to schedule any "prn/as needed" visits.

Billing Code	Modifiers	Billing Description	Units	Minutes
97164		PT Re-Evaluation	1	16

Date: 7/6/2023

Clint Tudahl, PT, DPT