Movement Dynamics Physical Therapy, P.C.

Progress Note

DATE:	3/16/2023	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)		
PROBLEM SITE:	<Problem Site Not Selected>		
SITE DESCRIPTION:	Thornton PT		
REFERRAL:	Wallace, Bethany	VISIT DUR:	57 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	2:31 pm	END TIME:	3:28 pm
Visit #	1		
Total Visits:	1		

Subjective
Patient was the unrestrained rear-passenger of a 4 door car that was involved in an accident on 02/23/2023. Patient states that he was traveling on E. Colorado in a Lyft when the driver of the vehicle and failed to follow a GPS and wasn't paying attention to other cars and a truck struck the vehicle. Patient denies airbag deployment. Patient reports hitting head on the headrest but denies loss of consciousness. At the time of impact, patient reports looking forward and thrown side to side. Following the collision, the patient reports feeling shaken, disoriented and dazed for 2 minutes. Patient states the police came to the scene and faulted the driver of the other vehicle. Patient was treated by paramedics at the scene of the accident. Patient was immediately taken to North Suburban Medical hospital by ambulance following the accident and treatment included evaluation & imaging. Patient reports no gap in care. Patient was referred by Dr.Wallace to physical therapy. Patient presents today for physical therapy evaluation.

PAST/CURRENT MEDICAL/SURGICAL HISTORY
Patient denies any significant medical history. Patient's surgical history is significant for jaw 10+ years ago.
Patient denies any previous car or work related injuries/accidents.
Patient has no known drug allergies and denies an allergy to latex or medical tape.
Patient's current medications include muscle relaxers for his pain.

WORK/SOCIAL HISTORY
Patient is currently employed as plumber but reports working
(normal hours/modified duties)
Patient reports his lower back and shoulder are painful, notes sharp stabbing pain.
Patient reports prolonged sitting and kneeling at work.

TESTS/PROCEDURES
North Suburban Medical Records reviewed
CT head/neck (-) findings

PRIMARY COMPLAINTS:
HA - remarks neck tightness, suboccipital pain that “shoots up around his head” from “beneath the shoulder blade”.
Neck pain - stiffness and difficulty with neck movement R > L, notes pain occurs when he has the R shoulder blade pain.
Upper back pain -tightness, pain.
Midback - tenderness, stiffness and pain (B). He remarks occasional stabbing pain in the midback.
Lower back - tightness and soreness, he remarks soreness and pain along the gluteals with numbness that goes from his back, gluteal to the R knee and 1-2x/day into the ankle.
Buttock - tenderness and pain along the gluteals R > L, “constant”
R hip pain - lateral aspect of the R hip, notes difficulty with hip mobility and remarks numbness as constant.
R knee pain - improvement in the area, remarks the numbness and shooting pain “goes past the knee”.
R ankle - only occurs with the shooting pain from the back
(B) shoulder - stiffness and “hurting” remarks diffuse pain through the upper trap and upper arm, remarking it as tender.
Dizziness/light-headed - positional changes light-headedness, sees spots.

Decreased ability to perform:
Sleep at night- patient reports waking 5-6 times per night
ADLs such as bathing/showering, dressing.
Household duties such as meal prep, cleaning, vacuuming, sweeping, yard work, managing medications, financial management.
Basic mobility such as walking, squatting/stooping, bending, STS, lying down, driving/riding, moving neck.
Childcare activities N/A
Recreational activities such as golf.

INCREASES SYMPTOMS:

Patient reports increased pain with sitting, standing, bending, lifting, work, lying down, reaching.

DECREASES SYMPTOMS:
Patient reports decreased pain with rest, hot shower, medications .

PATIENT GOALS:
Patient expresses wishes to feel better.

TELEHEALTH Q's:
Would you be willing to complete telehealth for future appointments? No

Objective
GENERAL:

RANGE OF MOTION (CERVICAL):
Flexion: WNL, R-side stiffness
Extension: 75%, R-sided pain and crepitus
Right Lateral Flexion: WNL, crepitus
Left Lateral Flexion: WNL, R-sided stiffness and discomfort
Right Rotation: WNL, crepitus
Left Rotation: WNL, R-sided stiffness and discomfort

RANGE OF MOTION (LUMBAR):
Flexion: WNL, LBP
Extension: WNL, LBP; direction of preference
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 (UPPER EXTREMITIES):
Patient's bilateral upper extremity range of motion is WNL for all planes of motion with gross observation/assessment with stiffness shoulder (B).

Patient's upper extremity range of motion is WFL for all planes of motion without pain except the following:
L shoulder flexion 160 degrees, stiffness (B)
L shoulder abduction 140 degrees, stiffness and pain
L shoulder IR (behind back) Sacrum, lift off, stiffness
L Shoulder ER (behind head) WNL, no pain

R shoulder flexion 160 degrees, stiffness (B)
R shoulder abduction 140 degrees, stiffness and pain
R shoulder IR (behind back) Sacrum, lift off, stiffness
R shoulder ER (behind head) WNL, no pain

RANGE OF MOTION (LOWER EXTREMITIES):
Patient's lower extremity range of motion is WFL for all planes of motion without pain except the following:
L Lower Extremity
90% of available hamstring ROM with LBP pain.
50% of ER in FABER position, clothing restriction, pain
0 - 120 degrees of passive hip flexion with LBP.

R Lower Extremity
75% of available hamstring ROM with LB pain.
50% of ER in FABER position, clothing restriction, pain
0 - 120 degrees of passive hip flexion with LBP.

MANUAL MUSCLE TESTING:
Patient's strength with manual muscle testing is 5/5 without complaints of pain for all muscle groups except the following:
Gross R UE 5-/5 no pain
Gross R LE 3+/5 R LB pain and guarding with all MMT
Gross L UE 5-/5 no pain
Gross L LE 4-/5 pain in the R-side LB

No sign of myotomal weakness

POSTURE:
forward head rounded shoulders

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

PALPATION/OBSERVATION:
Tightness and/or tenderness noted in the following muscle groups: (TTP - Tender to Palpation)
Upper traps, scapular stabilizing muscles, Cervical/thoracic/lumbar paraspinals, suboccipitals, Sacrum and lumbar spinous processes w/ posterior to anterior pressure, R hamstring tenderness, R gluteal medius, maximus, R piriformis.

SPECIAL TESTS:
Alar ligament testing
Transverse ligament testing(-)
Cervical flexion/Rot(-)
Cervical rot/SB(-)
Spurlings(-)
Cervical distraction(-)
FABER(-)
ASIS compression (+)
ASIS distraction (-)
Sacral thrust (+)
SLR (+)
Hawkins Kennedy (-)
Empty Can/Full Can (-)
Neers (-)

TREATMENT:
Evaluation completed today. Plan for physical therapy treatment was discussed with and agreed upon by the patient. Patient was provided with an HEP with shoulder squeezes, chin tucks and McKenzie extension with ample questions regarding each exercise. Patient was instructed to discontinue any exercise that increases the geography of their numbness or pain, or if pain levels significantly increase.

PATIENT EDUCATION:
Patient was educated on the PT plan of care and the purpose of PT.

Short-Term Goal	Met	Date Met
Patient will be independent with home exercise program.		
Patient will have full cervical range of motion without complaints of pain.		
Patient will have full lumbar range of motion without complaints of pain.		
Patient will have full upper extremity range of motion without complaints of pain.		
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.		
Patient will report ability to perform all ADLs without increased pain.		
Patient will report ability to perform all household duties without increased pain.		
Patient will report ability to participate in activities of enjoyment without increased pain.		
Patient will report ability to sleep through the night without waking from pain.		
Patient will report feeling at least 75% better overall.		

Assessment
Patient was injured in a motor vehicle accident on 02/23/2023 and presented to the clinic with the following complaints:
HA
Neck
Upper back
Midback
Lower back
Buttock
R hip
R knee
R ankle
(B) shoulder
Dizziness/light-headed

The mechanism of injury, patient's subjective complaints, and the objective findings are indicative of the following:
Acute post-traumatic headache, not intractable (ICD-10: G44.319; ICD-9: 784.0)
Strain of muscle, fascia, and tendon at neck level (ICD-10: S16.1XXA; ICD-9: 847.0)
Strain of muscle and tendon of back wall of thorax (ICD-10: S29.012A; ICD-9: 847.1)
Strain of muscle, fascia, and tendon of lower back (S39.012A)
Strain of muscle, fascia, and tendon of RIGHT hip (ICD-10: S76.011A; ICD-9: 843.9)

Paresthesia of skin (ICD-10: R20.2; ICD-9: 782.0)
Radiculopathy, Lumbar (ICD-10: M54.16; ICD-9: 729.2)
Car passenger injured in crash with SUV (ICD-10: V43.61XA; ICD-9: E819)
Local Residential or Business Street (ICD-10: Y92.414; ICD-9: E849.9)

The following problem list, comprised of impairments and functional limitations, supports medical necessity for skilled physical therapy:
Pain
Decreased ROM
Decreased flexibility
Decreased strength
Decreased core strength and endurance
Tight and tender musculature
Decreased postural awareness
Decreased ability to perform ADL's
Decreased ability to perform basic mobility
Decreased ability to participate in household duties
Decreased ability to sleep
Decreased ability to work
Decreased ability to participate in activities of enjoyment

Factors Considered for Evaluation CPT Code:
Patient has the following Personal/Complicating Factors and/or comorbidities that may affect progression of treatment:

Patient's evaluation today included examination of the musculoskeletal body system including range of motion, strength, and palpatory findings. Evaluation today also included examination of the neuromuscular system with general assessment of posture and gait (see Objective findings.) Evaluation also included participation restrictions and activity limitations (see listing of functional limitations.)

Clinical Presentation:
The patient's clinical presentation is evolving with changing characteristics.
Based on the patient's history, examination, and clinical presentation, the complexity of the clinical decision making is MODERATE. Therefore, this Physical Therapy Initial Evaluation will be billed with the code of 97162.

Plan
Patient will be seen for physical therapy initially at rate of 2x/week with re-evaluations as necessary. Patient's program will focus on core/cervical/scapular stabilization, manual therapy as needed, neuromuscular re-education, modalities as needed, strengthening and stretching exercises, instruction in home exercise program, correct posture, and biomechanics. The patient's program will be progressed/advanced as tolerated. The patient is in agreement with this plan.

RESTRICTIONS: none

Billing Code	Modifiers	Billing Description	Units	Minutes
97162		PT Initial Evaluation (Moderate)	1	47
97110		Therapeutic Exercise	1	10

_____ Date: 3/16/2023

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