

SYNERGY CHIROPRACTIC

Chiropractic Final Evaluation

Patient: Angel, Theodore (Jimmy)

Visit #: 11

Date: 2023-08-11

Jimmy was seen at this office for final evaluation as he is feeling much better since his low back injections. A report and findings follows below.

Subjective Complaints: Rated from 0-100% improvement since the accident (0% = no improvement, 100% = complete recovery)

1. Headaches 100%
2. Neck pain 100%
3. Upper back pain 100%
4. Mid back pain 100%
5. Low back pain 100%
6. SI/gluteus pain 95%
7. Shooting pain down right leg to calf and on occasion to foot 80%
8. Left shoulder pain 100%
9. Dizziness/light headed 100%

Sleep – not waking due to pain

ADL's – sitting or driving for a long duration causes tingling

Work – Plumber. He is working normal hours and duties without much pain

Overall, he feels about 95% improved.

Medication: None

ROM: (Restrictions rated as mild +1, mild-moderate +2, moderate +3, severe +4)

C-SPINE:

Flexion: WNL

Extension: WNL

Right rotation: WNL

Left rotation: WNL

Right lateral flexion: WNL

Left lateral flexion: WNL

T/L-SPINE:

Flexion: WNL

Extension: WNL

Right rotation: WNL

Left rotation: WNL

Right lateral flexion: WNL

Left lateral flexion: WNL

Orthopedic tests:

Cervical/thoracic

Cervical Compression (-)
Cervical Distraction (-)
Right shoulder depression (-)
Left shoulder depression (-)

Thoracic/lumbar

SLR (-) with the right leg (-) with the left leg
FABERE (-) with the right leg (-) with the left leg
Yeoman's (-) with the right leg (-) with the left leg (-) with both legs

OTHER FINDINGS: Muscle Spasms rated as follows: (+1 = mild; +2 = mild-moderate; +3 moderate; +4 severe); (TrP's = trigger points)

Taut and non-tender
cervical paraspinals +0-1
upper trapezius +1
levator scapulae +1
thoracic paraspinals +1-2
lumbar paraspinals +1-2
QL's +1-2
Non-tender to palpation of PSIS
Joint restrictions in cervical, thoracic, and lumbar spine.

ASSESSMENT/DIAGNOSIS:

At present, still has the following working diagnoses:

Headache: acute, not intractable G44.319
Cervical sprain S13.4XXA
Cervical strain S16.1XXA
Thoracic sprain S23.3XXA
Thoracic strain S29.012A
Lumbar sprain S33.5XXA
Lumbar strain S39.012A
SI joint sprain S33.6XXA
SI joint strain S39.013A
Myalgia M79.1
Muscle spasm of back M62.830
Injury of unspecified nerve at abs/low back/pelvis S34.9XXA
Dizziness R42
Segmental Dysfunction – Cervical M99.01
Segmental Dysfunction – Thoracic M99.02
Segmental Dysfunction – Lumbar M99.03
Segmental Dysfunction – Sacrum M99.04
Segmental Dysfunction – Pelvis M99.05

PLAN/RECOMMENDATIONS:

Mr. Angel has neared a plateau for acute chiropractic treatment. He may require supportive care at PRN status for the next 3-6 months, consisting of 6-10 more visits at an estimated cost of \$150-\$300 per visit, in allowance of sufficient healing time. In the absence of further aggravation/injury, I believe he will reach a plateau for chiropractic following this course of care.

COMMENTS:

It is my professional opinion that Mr. Angel's present injuries and symptoms are consistent with direct involvement in the accident on record. Due to these injuries he may be predisposed to degenerative changes which in the future may be more susceptible to further injury and/or exacerbation of symptoms, ie; pain, numbness/tingling, and muscle spasm.

If you have any further questions regarding this patient's care please contact this office.

TREATMENT PROVIDED TODAY:

Established patient evaluation 99212
TENS Unit with instructions for home use

Kevin B. Duncan, D.C.

Compiled, but not reviewed.

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

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

Date: 3/16/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.**Progress Note**

DATE:	3/31/2023	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:	39 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	1:58 pm	END TIME:	2:37 pm
Visit #	2		
Total Visits:	2		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that lower back and pain down into the R LE is/are the area(s) of primary complaint.

Patient reports that this radicular symptoms he is experiencing feels constant, he does note that over the weekend he did experience a muscle spasm in the middle of the back.

Patient is taking prescription pain medication nightly.

Patient reports waking 4-5 times per night due to pain.

Objective

GENERAL:

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:

Shoulder rolls

shoulder squeezes

thoracic rotation QP

QP cat/cow

TB Pull apart ER

TB Up & Over

Manual therapy: scapular mobilizations protraction/retraction, upward glide, downward glide

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient reports that he did experience very sensitive tissue upon palpation of the rhomboids, upper traps in particular feeling it with varying pressure applied. However, the patient could tolerate the palpation well enough to tolerate the introduction of the scapular mobilizations as well as the self-administered tennis ball release over the areas that the patient commented as sensitive. The patient commented having some relief in tension following the scapular mobilizations.

Overall, the patient would continue to benefit further from thoracic mobility as well as cervical ROM exercises to promote decreased muscle tension across the midback and posterior cervical musculature.

Plan

Continue physical therapy 2 times a week to decrease pain and improve functional capabilities.

Assess tolerance to first exercise visits and progress as tolerated.

Consider: thoracic rotation head still, cervical AROM

RESTRICTIONS: none

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97110		Therapeutic Exercise	3	39

Date: 3/31/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.

Progress Note

DATE:	4/7/2023	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:	38 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	2:01 pm	END TIME:	2:39 pm
Visit #	3		
Total Visits:	3		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that lower back and pain down into the R LE is/are the area(s) of primary complaint.

Patient states he is feeling fairly good today "because [he] rested majority of the day".

Patient reports that this radicular symptoms he is experiences feels constant, he does note that over the weekend he did experience a muscle spasm in the middle of the back. The spasms he is experiencing has decreased in frequency.

Patient is taking prescription pain medication nightly.

Patient reports waking 4-5 times per night due to pain.

Objective

GENERAL:

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:

GTB serving brownies

Lat stretch arm clock

Chin tucks

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment. He did remark positive response again to the tennis ball release that was initiated along the with the sidelying arm clock stretch, he did display decreased mobility when lying to the R and moving the L UE compared to the contralateral side in regards to being able to maintain the UE to the table. Continuation of mobility ther-ex should be resumed and additional ther-ex provided to the patient.

Plan

Continue physical therapy 2 times a week to decrease pain and improve functional capabilities.

Continue thoracic mobility

RESTRICTIONS: none

Billing Code	Modifiers	Billing Description	Units	Minutes
97110		Therapeutic Exercise	3	38

Date: 4/7/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.**Progress Note**

DATE:	4/21/2023	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:	38 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	1:57 pm	END TIME:	2:35 pm
Visit #	4		
Total Visits:	4		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that lower back and pain down into the R LE is/are the area(s) of primary complaint.

Patient reports he has working normal hours, modified duties.

Patient states he did review his MRI with the referring physician, and did discuss potential injections for the lumbar as well as MRI for his thoracic.

Patient reports that this radicular symptoms he is experiences feels constant, however, the spasms have significantly improved and has not had any spasms present since his last visit, he denies any HA onset as well.

Patient is taking prescription pain medication nightly.

Patient reports waking 4-5 times per night due to pain.

Objective

GENERAL:

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:

BTB serving brownies - increased resist. & reps

Chin tucks increased reps

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment.

Patient showed good progress for the repetition progressions made today and demonstrates improvement in pain and mobility compared to last session. The patient did voice readiness to progress into strengthening therefore this was discussed with the patient to perform next session pending their response the progressions made today.

Plan

Continue physical therapy 1-2 times a week to decrease pain and improve functional capabilities.

Pulleys mid row
Pulleys lat pulldown
Pulleys paloff press

RESTRICTIONS: none

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97110		Therapeutic Exercise	3	38

Date: 4/21/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.**Progress Note**

DATE:	4/28/2023	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:	30 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	11:53 am	END TIME:	12:23 pm
Visit #	5		
Total Visits:	5		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that lower back and pain down into the R LE is/are the area(s) of primary complaint.

Patient reports he has working normal hours, modified duties.No change

Patient reports that this radicular symptoms he is experiences feels constant, however, the spasms have significantly improved and has not had any spasms present since his last visit, he denies any HA onset as well.

Patient is taking prescription pain medication nightly. No change

Patient reports waking 3-4 times per night due to pain. Reports this is a nightly occurrence but reports some of the times waking are to use the restroom.

Patient reports having MRI this morning and states he is particularly tired today due to having to wake up for MRI.

Denies having HA currently. Reports HAs have been resolved for a couple weeks at this point. States it coincided with starting to use tennis ball mob under shoulder blade.

Objective

Patient was asked screening questions today related to COVID-19 and has been cleared to treat in our office.

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:
supine marching
seated sciatic nerve glide
Paloff Press
seated ball 3-way

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment.

Today's session focused on low back/radicular symptoms per patient reports of this being most irritating factor currently. Patient was provided with print out of sciatic nerve glide and encouraged to perform frequently throughout the day, similar to lumbar extension. Patient was progressed with strengthening this visit with good overall tolerance. Returning to golf was discussed with patient. Patient was advised that it's completely normal to notice fluctuations in pain as he is getting back to his usual activities and it would not be considered a step backwards should he notice increased pain following. Patient was encouraged to listen to his body and adjust accordingly should he experience flair up following first trial of returning to golf.

Plan

Continue physical therapy 1-2 times a week to decrease pain and improve functional capabilities.

Pulleys mid row
Pulleys lat pulldown

RESTRICTIONS: none

Billing Code	Modifiers	Billing Description	Units	Minutes
97110		Therapeutic Exercise	2	30

 PT, DPT

Date: 4/28/2023

Clint Tudahl, PT, DPT

Movement Dynamics Physical Therapy, P.C.**Progress Note**

DATE:	5/5/2023	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:	39 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	3:09 pm	END TIME:	3:48 pm
Visit #	6		
Total Visits:	6		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that lower back and pain down into the R LE is/are the area(s) of primary complaint.

Patient reports he has working normal hours, modified duties.No change

Patient reports that this radicular symptoms he is experiences feels constant but the spasms have subsided and has had no HA for approx. 3 weeks.

Patient is taking prescription pain medication nightly. No change

Patient reports waking 3-4 times per night due to pain. Reports this is a nightly occurrence but reports some of the times waking are to use the restroom.

Patient reports he has to schedule injections for the lumbar.

He endorses he was able to play 9 holes of golf with slight discomfort in the lumbar, however, no other area was problematic.

Objective

Patient was asked screening questions today related to COVID-19 and has been cleared to treat in our office.

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:
seated tennis ball release gluteals
Re-introduced: shoulder rolls, shoulder squeezes,

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment. Patient was provided with tennis ball release for the gluteals with good benefit, while still commenting radicular symptoms as such he was encouraged to complete it at home to his tolerance free of any increased pain or radicular symptoms. The patient was able to complete all ther-ex provided today to which, he responded positively towards.

Plan

Continue physical therapy 1-2 times a week to decrease pain and improve functional capabilities.

Due to unrelated medical procedure, the patient will be missing 1-2 weeks of treatment.

Pulleys mid row
Pulleys lat pulldown

RESTRICTIONS: none

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97110		Therapeutic Exercise	3	39

Date: 5/5/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.

Progress Note

DATE:	5/19/2023	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:	39 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	2:00 pm	END TIME:	2:39 pm
Visit #	7		
Total Visits:	7		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that pain down into the R LE is/are the area(s) of primary complaint.

Patient reports he has working normal hours, modified duties.No change

Patient reports that this radicular symptoms he is experiences feels constant but not as intense.

He reports HAs have largely resolved at this point.

Patient is taking prescription pain medication PRN at night. He has not taken anything for approx. 1 week.

Patient reports waking 3-4 times per night due to pain. Reports this is a nightly occurrence but reports some of the times waking are to use the restroom.

He reports he has been able to golf for the past 2 weeks without much issue.

Objective

Patient was asked screening questions today related to COVID-19 and has been cleared to treat in our office.

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

The following new exercises and/or treatments were initiated today:

Supine bridges
Sidelying clamshells

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment. Patient was tolerated the glute focused exercise of the sidelying clamshells and sidelying hip abduction very well, voicing only muscular fatigue rather than pain being the limitation they experienced. They are progressing well towards their goals, however, still note the radicular symptoms appear constant for the patient based on their subjective. It should be noted these symptoms do not worsen during treatment sessions.

Plan

Continue physical therapy 1-2 times a week to decrease pain and improve functional capabilities.

Pulleys mid row
Pulleys lat pulldown

RESTRICTIONS: none

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97110		Therapeutic Exercise	3	39

Date: 5/19/2023

Kacper Kazibut, PT, DPT

Movement Dynamics Physical Therapy, P.C.

Progress Note

DATE:	6/9/2023	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:	30 minutes
DATE OF ONSET:	2/23/2023		
START TIME:	2:00 pm	END TIME:	2:30 pm
Visit #	8		
Total Visits:	8		

Subjective

Patient presents to physical therapy today for continuation of care. Patient had the following list of complaints reported at the initial evaluation.

HA

Neck

Upper back

Midback

Lower back

Buttock

R hip

R knee

R ankle

(B) shoulder

Dizziness/light-headed

Any changes to these complaints will be documented below.

Today, patient reports that pain down into the R LE is/are the area(s) of primary complaint.

Patient reports he has working normal hours and reports has progressed in his work duties gradually.

Patient reports that this radicular symptoms he is experiences that it is not as constant or intense as it was previously.

He reports HAs have largely resolved at this point.

Patient he is no longer taking prescribed medication, he notes OTC pain meds PRN.

Patient reports normal sleeping patterns.

He reports he has been able to golf for the past 2 weeks without much issue.

Objective

Patient was asked screening questions today related to COVID-19 and has been cleared to treat in our office.

CLINICAL OBSERVATION:

Patient displays fair body mechanics during PT.

Patient has decreased postural awareness. Patient displays poor posture with forward head, rounded shoulders, and increased thoracic kyphosis.

PATIENT EDUCATION:

Patient was educated on correct posture today.

Patient was educated on correct form and muscle recruitment throughout each exercise today.

TREATMENT:

Therapeutic exercise per flow sheet

Assessment

Patient gave verbal consent for and verbalized understanding of all treatment provided today.

All new exercises/treatments were thoroughly demonstrated and explained today. Patient expressed understanding of the purpose of all new exercises/treatments.

Patient tolerated entire PT session well today and had no complaints of increased pain with any exercise/treatment. Patient notes some improvement in the radicular symptom frequency he was experiencing. However, he noted that he is receiving injections and would like to pause therapy between injections and his next session to "give them time to work". Therefore it was discussed between the patient and provider to go every other week to therapy after his injections.

Plan

Continue physical therapy 1-2 times a week to decrease pain and improve functional capabilities.

Pulleys mid row
Pulleys lat pulldown

RESTRICTIONS: none

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97110		Therapeutic Exercise	2	30

Date: 6/9/2023

Kacper Kazibut, PT, DPT

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.

<u>Billing Code</u>	<u>Modifiers</u>	<u>Billing Description</u>	<u>Units</u>	<u>Minutes</u>
97164		PT Re-Evaluation	1	16

 PT, DPT

Date: 7/6/2023

Clint Tudahl, PT, DPT

Please mark all areas of pain with the symbols below.

▽ ▽ ▽ ▽

=====

X X X X

////

ACHING

NUBBNESS

PINS & NEEDLES

BURNING

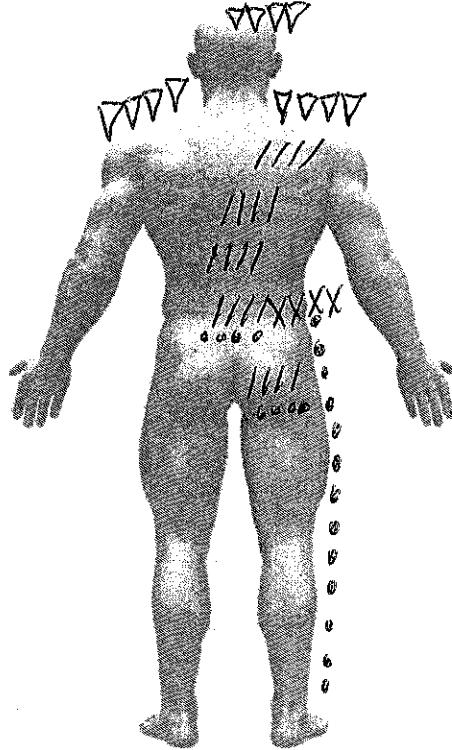
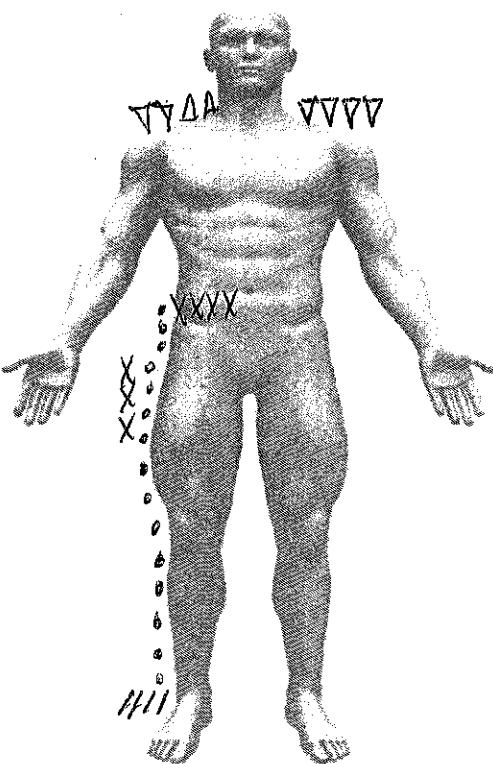
STABBING

Right

Left

Left

Right



**DO YOU HAVE
ANY OF THE
FOLLOWING:**

- Loss of Bowel/
Bladder Function
- Dizziness/Light
Headed
- Vision Changes
(Blurred/Double)
- Headache
(Draw on person)
- None

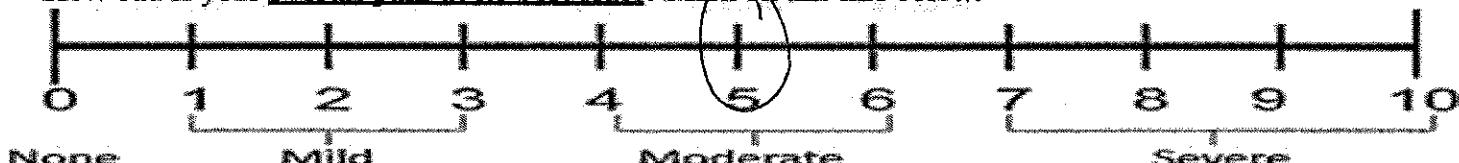
How bad is your overall pain now? Mark on this line below.



How bad is your overall pain at its worst? Mark on this line below.



How bad is your overall pain at its best/least? Mark on this line below.



Signature:

Date: 03/10/23

AURORA: 14111 E. Alameda Avenue | Suite 200 | Aurora, CO 80012 | P: (303) 343-1357 | F: (303) 343-3056

THORNTON: 8515 Pearl Street | Suite 100 | Thornton, CO 80229 | P: (303) 630-0400 | F: (303) 630-0405

DENVER: 1250 S. Sheridan Blvd. | Denver, CO 80232 | P: (303) 927-7119 | F: (303) 568-9331

Injury Care Network, LLC

Provider **WALLACE D.O.**
Patient **ANGEL, THEODORE**
DOB **09/15/1975** DOL **02/23/2023**
DOS **03/10/2023**

REFERRAL

- AURORA:** 14111 E. Alameda Avenue | Suite 200 | Aurora, CO 80012 P: (303) 343-1357 | F: (303) 343-3036
 THORNTON: 8515 Pearl Street | Suite 100 | Thornton, CO 80229 P: (303) 630-0400 | F: (303) 630-0405
 DENVER: 1250 Sheridan Blvd. | Denver, CO 80232 P: (303) 927-7119 | F: (303) 568-9331

DIAGNOSES:

1. Concussion
2. C-T-L Strain
3. Bilat - shoulder Strain
4. R/T leg pain
5. HA -
6. Anxiety

DISCHARGED

RECORDS REQUESTED:

- | | | |
|---|--|--|
| <input type="checkbox"/> St. Anthony's Central | <input type="checkbox"/> Good Samaritan Medical Center | <input type="checkbox"/> Denver Health |
| <input type="checkbox"/> University Hospital | <input type="checkbox"/> North Suburban Medical Center | <input type="checkbox"/> St. Anthony North |
| <input type="checkbox"/> Swedish Medical Center | <input type="checkbox"/> Littleton Adventist Hospital | <input type="checkbox"/> Kaiser Permanente |
| <input type="checkbox"/> Sky Ridge Medical Center | <input type="checkbox"/> Lutheran Medical Center | <input type="checkbox"/> St. Joseph's Hospital |
| <input type="checkbox"/> Medical Center of Aurora | <input type="checkbox"/> Rose Medical Center | <input type="checkbox"/> Porter Adventist Hospital |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Specialist: _____ | <input type="checkbox"/> PCP: _____ |
| <input type="checkbox"/> Other: _____ | | |

REFERRAL FOR ADDITIONAL SERVICES (IN OFFICE):

- Physical Therapy: Evaluate and Treat
 PT-Vestibular
 Acupuncture: Evaluate and Treat
 Psychology Driving Anxiety Biofeedback TBI
 Neuro Optometrist
 Podiatrist
 BrainCheck 1 2 3
 BrainCheck Anxiety/Depression 1 2
 BrainCheck Vision 1 2
- Chiropractic: Evaluate and Treat
 Massage Therapy
 Neuropsych Eval Cognitive Screening
 Occulogica - EyeBox
 Consult for Delayed Healing Assess for Trigger Point
 Regenerative Medicine - PRP Knee Shoulder
 DO/MD Medication Eval
 Other: _____

RESTRICTIONS OR SPECIAL INSTRUCTIONS:

REFERRAL FOR ADDITIONAL SERVICES (OUTSIDE OFFICE):

- | | |
|---|---|
| <input type="checkbox"/> Spine Surgeon | <input type="checkbox"/> Injection Specialist |
| <input type="checkbox"/> Pain Specialist Consultation | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> TMJ Specialist | <input type="checkbox"/> Hand Specialist |
| <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Podiatrist Surgeon | |
| <input type="checkbox"/> Orthopedic Consultation for: _____ | |
| <input type="checkbox"/> Neurologist | |

REFERRAL FOR DIAGNOSTIC STUDIES:

- MRI/Type: Lumbar spine Cervical spine C-Spine Flex/Ext 3T/TBI DTI SWI NeuroQuant
 CT: _____
 Other: _____ (VNG, Ultrasound, Labs, Etc.)
 X-Rays: _____

Follow up in 2 weeks. Next appointment is scheduled for 3/23/23 at 10:00 AM/PM.

(PROVIDER)

WALLACE

(DATE)

3-10-23

Bethany Wallace, D.O.

FOLLOW-UP OFFICE VISIT

Patient Name: Theodore Angel
Date of Birth: 09/15/75

Date of Injury: 02/23/23
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.

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Patient: Theodore Angel
Date of Visit: April 7, 2023

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).

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Patient: Theodore Angel
Date of Visit: April 7, 2023

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.

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Patient: Theodore Angel
Date of Visit: April 7, 2023

Bethany Wallace, DO

Bethany A. Wallace, D.O., CIME
Level II Certified – Occupational Medicine (a State of Colorado Certification)

BW:kll
VF#: 0414-020

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Injury Care Network, LLC

Provider **WALLACE, D.O.**
Patient **ANGEL, THEODORE**
DOB **09/15/1975** DOL **02/23/2023**
DOS **04/07/2023**

FOLLOW UP QUESTIONNAIRE

SINCE LAST VISIT, I AM FEELING:

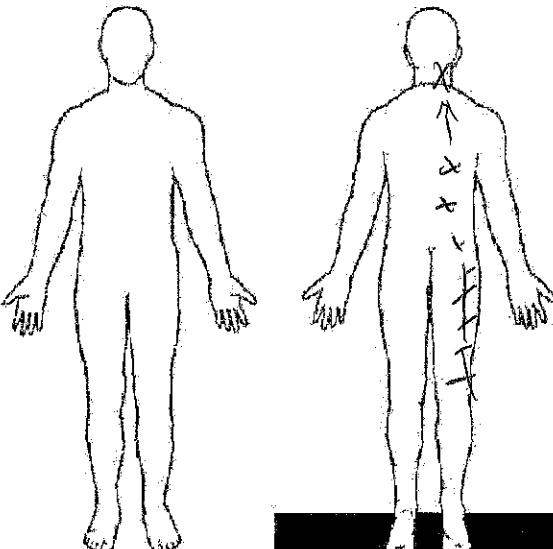
- Same — %
 Better — %
 Worse — %

PLEASE RATE YOUR PAIN ON A
SCALE OF ZERO TO TEN:

0-1-2-3-4-5-6-7-8-9-10
(NO PAIN) (SEVERE PAIN)

NEW CONCERNS: None

SPECIFIC ISSUES YOU WOULD LIKE
TO ADDRESS TODAY:



PLEASE INDICATE ON THE DIAGRAM WHERE YOU ARE
CURRENTLY HAVING PAIN

PLEASE LIST ALL YOUR CURRENT MEDICATIONS
(INCLUDING OVER THE COUNTER MEDICATIONS)

MEDICATION:

PROBLEMS WITH YOUR CURRENT MEDICATION?

No Yes, PLEASE EXPLAIN: _____

Are you having any stomach pain? Yes No

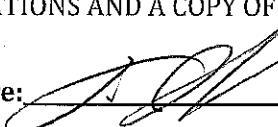
How often are you doing your home program? _____

Any problem with your home program? _____

WORK STATUS:

- Working Full Duty
 Working Restricted Duty
 Off Work (Restricted Duty Not Available)
 Off Work (Other Reason)

PLEASE BRING A LIST OF MEDICATIONS AND A COPY OF YOUR EXERCISE SHEETS TO EACH VISIT

Signature: 

Date: 9/17/23

Veronica Reza, FNP

PATIENT:
DATE OF INJURY:
DATE OF BIRTH:

THEODORE "JIMMY" ANGEL
FEBRUARY 23, 2023
SEPTEMBER 15, 1975

May 5, 2023

INTERIM/TELEHEALTH VISIT

OVERVIEW: Mr. Theodore "Jimmy" Angel is a 47-year-old, ambidextrous male who presents to Injury Care Network Services for evaluation and disposition of injuries sustained in a motor vehicle collision that occurred on 02/23/23.

PHYSICAL THERAPY AND CHIROPRACTIC: Mr. Angel has continued a course of physical therapy and chiropractic for a total of five and six sessions respectively with the last session of both modalities on 04/28/23. He does feel these are of benefit to him and has some improvement in his interscapular shoulder blade area pain and continues to have sessions scheduled out.

ACUPUNCTURE: Mr. Angel had an initial evaluation on 04/27/23 but states that the dates and scheduling do not work for him, so he has not had a follow up and, as such, he is not able to pursue at this time.

PAIN MANAGEMENT/INJECTION SPECIALIST: Mr. Angel has been referred for an initial consultation with pain management/injection specialist. This is pending scheduling, and he is waiting to have the call so he can schedule the initial consultation.

MRI OF THE THORACIC SPINE (04/28/23): Unremarkable thoracic spine MRI.

COUNSELING: Mr. Angel has been referred for a course of counseling. This has not been scheduled but, at this time, he states he is doing better and does not feel that he needs it and would like to place this on hold.

PRESENT SYMPTOMS: Mr. Angel states that he is not having any dizziness. He states the headaches have subsided and states the only time he has a headache is when he is having really sharp pain in his shoulder blade area, but that has gone away with physical therapy and states that he has not had that in one to two weeks at least. He does continue to have occasional right shoulder area pain, but it is not intense shoulder blade area symptoms that would cause the headaches. He states his neck pain is also getting better in the interim as well. His thoracic spine pain is still somewhat there but also improved. His lower lumbar symptoms are still quite persistent and still rates these at 5-6/10, stating that has never gone away, and the sciatic pain that keeps occurring shoots down to his right knee most of the time and occasionally sometimes all the way down to his right foot. He states that pain has been persistent and constant, and he has had this pain since after the motor vehicle collision from 02/23/23. His right hip pain is still quite bothersome as well. He states that his sleep is somewhat improved with a muscle relaxer, and the anxiety with driving and being in traffic is improving and is getting better, although he still occasionally is on high alert when someone else is driving but doing much better.

PAST MEDICAL, SOCIAL, AND FAMILY/CONTRIBUTORY HISTORY: He endorses herniated discs about 25 years ago in his lumbar area when he was in his 20s. He did not have any leg pain at that time. It was actual low back pain and was treated with epidural steroids and

has had no problems since that one episode approximately 25 years ago. He has a history of a jaw surgery ten years ago. He denies any prior motor vehicle collision or work-related injuries. He is negative for systemic illnesses. He is a nonsmoker, and his family history is noncontributory.

CURRENT MEDICATIONS: He was given a prescription for ibuprofen and Flexeril by Dr. Bethany Wallace, which he has been taking and has refills for both medications.

ALLERGIES: No known drug allergies.

REVIEW OF SYSTEMS: Please see above Present Symptoms for musculoskeletal review of systems. Mr. Angel is alert and oriented to person, time, place, and purpose. He is pleasant and able to hear and engage in normal conversation via telephone without difficulty. He denies any cardiovascular or pulmonary complaints. He denies any bowel or bladder dysfunction. No other concerns are voiced at this time.

OBJECTIVE: Vital signs are not obtained as this is a telehealth/telephone encounter with Mr. Theodore "Jimmy" Angel in his home environment and Veronica Reza, FNP, in the office location setting.

Mr. Angel has previously been noted to be a well-developed, well-nourished male appearing his approximate stated age.

HEENT – he is able to speak in full sentences without respiratory distress. He is not having any cough or having to pause for completion of sentences.

Cervical spine – he endorses full range of motion of the cervical spine with pain behaviors at endpoints of movement and does endorse some pain still present in the bilateral paraspinous muscles extending into the upper trapezius muscles bilaterally.

Thoracic spine – he endorses pain previously palpated over the right paraspinous muscles and right parascapular muscles, although much improved.

Lumbar spine – he endorses full range of motion of the lumbar spine with pain behaviors at endpoints of movement and continues to endorse pain previously palpated over the bilateral paraspinous muscles as well as the right SI joint hip area and endorses pain previously palpated over the lumbosacral junction. He was previously noted to have complaints of radiating pain into the foot at 30° with straight leg raising.

Upper extremities – he endorses full range of motion of the bilateral upper extremities but endorses pain in the right and left trapezius areas.

He endorses a nonantalgic gait and is otherwise neurologically grossly intact.

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.

MRI of the thoracic spine (04/28/23) – unremarkable thoracic spine MRI.

MEDICAL DECISION MAKING: At this time, we did review Mr. Angel's MRI of the thoracic spine as well as his ongoing symptoms and improvement in some areas. He is awaiting scheduling with a pain management/injection specialist and, as such, once he is able to schedule that, he should hopefully discuss his options in regards to his cervical and lumbar pain. He has had improvement in his anxiety and stress with driving and being in traffic and, at this time, we will place counseling on hold. We will go ahead and continue with acupuncture and hopefully he is able to get that scheduled on Fridays, which the day that he is able to get all of his appointments, as he is not able to take much time off of work and is only able to take one day and would like to get all of his appointments scheduled on the same day to avoid missing more work.

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).

PLAN:

1. Mr. Theodore "Jimmy" Angel will continue his course of physical therapy.
2. He will continue his course of chiropractic with massage.
3. He may continue acupuncture should he be able to get that scheduled on days that he is able to present for this.
4. He is still pending consultation with pain management/injection specialist, and we will try to facilitate if he has not heard from them in the next few days.
5. Counseling is placed on hold due to interim improvement.
6. Mr. Angel may continue medications as previously prescribed.

7. He will remain on information restrictions of avoiding heavy lifting, avoiding excessive bending, and change positions frequently. He is encouraged to use common sense and avoid any activities that exacerbate his symptoms or are poorly tolerated.
8. He will follow up with Injury Care Network Services in four to five weeks' time for interim evaluation and disposition.

Greater than 35 minutes were spent in conjunction with this visit with more than 50% of the time spent directly with the patient in telehealth/telephone education and counseling regarding the pathophysiology of associated diagnoses including review of efficacy of interim evaluations and treatments as well as review of associated notes and diagnostics. Additional time was spent in discussing the available evaluation and treatment options and, after answering all posed questions and utilization of shared decision making, we did agree to the regimen of care as indicated above.

Veronica Reza FNP-C

Veronica Reza, FNP

Bethany Wallace, D.O., CIME
Level II Certified – Occupational Medicine (a State of Colorado Certification)

VR:BW:ade
VF#: 0505-001

Veronica Reza, FNP

PATIENT: THEODORE "JIMMY" ANGEL June 23, 2023
DATE OF INJURY: FEBRUARY 23, 2023
DATE OF BIRTH: SEPTEMBER 15, 1975

INTERIM/TELEHEALTH VISIT

OVERVIEW: Mr. Theodore "Jimmy" Angel is a 47-year-old, ambidextrous male who presents to Injury Care Network Services for evaluation and disposition of injuries sustained in a motor vehicle collision that occurred on 02/23/23.

PHYSICAL THERAPY AND CHIROPRACTIC: Mr. Angel has continued a course of physical therapy and chiropractic for a total of eight and nine sessions respectively. The last session of both modalities was on 06/09/23. He did have an appointment today but got confused and so he has rescheduled for the following week. He is very happy with his progress thus far.

ACUPUNCTURE: Mr. Angel had an initial evaluation on 04/27/23 but states that the dates and scheduling do not work for him, so he has not had a follow up and, as such, he is not able to pursue at this time.

PAIN MANAGEMENT/INJECTION SPECIALIST: Mr. Angel did have an initial consultation with pain management/injection specialist at the office of Dr. Rentz and has had a subsequent follow-up for recommended injections on the right L5-S1 transforaminal epidural steroid injections and does have a subsequent follow-up on 07/12/23 following those injections. He is doing very well at this time. All office visits from Dr. Rentz's office notes have been reviewed and are in the chart.

PRESENT SYMPTOMS: Mr. Angel states that his neck and upper back are good. He has not had any issues in over three weeks. He is not having any issues with the shoulder. He got some treatments and follow-up therapies with physical therapy and chiropractor and has had significant improvement in this having no pain in the right shoulder area. He states that since the injections, he is doing much better than he has, only some pain in his mid-lower back that does not go past his right hip. He is no longer having shooting pains and states that now his pain is at a 2/10 at its worst, previously up to a 6-7/10. He is doing more activities, able to take his pets walking and doing much better and is very happy since having the injections. His sleep has returned to baseline as well and anxiety with driving and being in traffic is significantly improved overall.

PAST MEDICAL, SOCIAL, AND FAMILY/CONTRIBUTORY HISTORY: He endorses herniated discs about 25 years ago in his lumbar area when he was in his 20s. He did not have any leg pain at that time. It was actual low back pain and was treated with epidural steroids and has had no problems since that one episode approximately 25 years ago. He has a history of a jaw surgery ten years ago. He denies any prior motor vehicle collision or work-related injuries. He is negative for systemic illnesses. He is a nonsmoker, and his family history is noncontributory.

CURRENT MEDICATIONS: He was given a prescription for ibuprofen and Flexeril by Dr. Bethany Wallace, which he has been taking and has refills for both medications.

ALLERGIES: No known drug allergies.

SYNERGY Health Partners
14111 E. Alameda Ave, Suite 200, Aurora, CO 80012
(303) 343-1357 (303) 343-3036 fax

REVIEW OF SYSTEMS: Please see above Present Symptoms for musculoskeletal review of systems. Mr. Angel is alert and oriented to person, time, place, and purpose. He is pleasant and able to hear and engage in normal conversation via telephone without difficulty. He denies any cardiovascular or pulmonary complaints. He denies any bowel or bladder dysfunction. No other concerns are voiced at this time.

OBJECTIVE: Vital signs are not obtained as this a telehealth/telephone encounter with Mr. Theodore "Jimmy" Angel in his home environment and Veronica Reza, FNP, in the office location setting.

Mr. Angel was previously noted to be a well-developed, well-nourished male appearing his approximate stated age.

He endorses full range of motion of the cervical spine and upper extremities with no pain behaviors at this time. He denies pain previously palpated at the superior to mid-trapezius or right shoulder area.

He endorses full range of motion of the lumbar spine with only mild pain behaviors at endpoints of movement and endorses pain previously palpated only in the mid-lumbar segment and into the right hip.

He endorses nonantalgic gait and is otherwise neurologically grossly intact.

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.

MRI of the thoracic spine (04/28/23) – unremarkable thoracic spine MRI.

DIAGNOSES-Trauma Related: Persistent:

1. Lumbar Disc Rupture L5-S1 (S33.0XXA).
2. Lumbosacral Radiculopathy, Right Leg (M54.17).
3. Lumbar Sprain/Strain (S33.5XXA, S39.012A).
4. Hip Pain, Right (M25.551).

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).
5. Cervical Sprain/Strain (S13.4XXA, S16.1XXA).
6. Thoracic Sprain/Strain (S23.3XXA, S29.012A).
7. Leg Pain, Right (R20.9).
8. Sleep Disturbance (G47.09).
9. Adjustment Disorder with Anxiety (F43.22).

PLAN:

1. Mr. Theodore "Jimmy" Angel will continue a course of physical therapy.
2. He will continue a course of chiropractic with massage.
3. He will follow up with pain management/injection specialist on 07/12/23 for follow up and to discuss any further recommended treatments.
4. Acupuncture will remain on hold due to scheduling conflicts.
5. He will continue to increase his overall activity as tolerated and he is encouraged to use common sense and avoid any activities that exacerbate his symptoms or are poorly tolerated.
6. He will follow up with Injury Care Network Services in four to five weeks' time for interim evaluation and disposition.

Greater than 45 minutes were spent in conjunction with this visit with more than 50% of the time spent direct with the patient in telehealth/telephone education and counseling regarding pathophysiology of associated diagnoses including review of efficacy of interim evaluations and treatments as well as review of associated notes. Additional time was spent in discussing available evaluation and treatment options and, after answering all posed questions and utilization of shared decision making, we did agree to the regimen of care as noted above.

Veronica Reza FNP-C

Veronica Reza, FNP

Bethany Wallace, D.O., CIME

Level II Certified – Occupational Medicine (a State of Colorado Certification)

VR:BW: mvs

VF#: 0623-020

Bethany Wallace, D.O.

FOLLOW-UP OFFICE VISIT

Patient Name: Theodore "Jimmy" Angel
Date of Birth: 09/15/75

Date of Injury: 02/23/23
Date of Visit: July 21, 2023

SUBJECTIVE:

Jimmy 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 1-2/10 presently. Mr. Angel has been doing well since the epidural steroid injection. He will have a little pain that radiates like a cramp into his buttocks. He has some slight pain on the outside of his right hip/leg but nothing radiating down the leg into the foot like it was previously. The rest of his injuries have improved. He is not using any medication for his injuries. This week, he had a wisdom tooth removed and developed a small fistula between his mouth and his sinus. He is presently on antibiotics and oral steroids for the dental problem. Mr. Angel can now sit comfortably for the half hour it takes him to get to work. When he is sitting for longer periods, he will have pain that radiates into the buttocks and to the lateral right buttock/thigh area. The electrical stim units that the physical therapists use are very helpful. He wonders if those are available for home use.

Care since last visit:

The patient has been participating in chiropractic care, massage therapy, and physical therapy. He has been discharged from formal physical therapy and is doing a home exercise program.

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.

MRI of the thoracic spine (04/28/23) – unremarkable thoracic spine MRI.

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Patient: Theodore "Jimmy" Angel

Date of Visit: July 21, 2023

REVIEW OF MEDICAL RECORDS AND DOCUMENTS:

The chiropractic and/or physical therapy notes from Synergy Health Partners were reviewed and appreciated.

Notes from Dr. Rentz were reviewed.

Notes from nurse practitioner Veronica Reza were reviewed.

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 appear to be comfortable throughout the entire examination.

VITAL SIGNS: HR: 95. Pulse Ox: 95% RA. Temp: 96.8 °F.

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 full range of motion in flexion, extension, and rotation without pain behaviors and pain complaints.

OSTEOPATHIC/MUSCULOSKELETAL EXAMINATION:

TRIGGER OR TENDER POINTS:

There are very mild trigger points in the right gluteal/piriformis area.

LOWER EXTREMITIES:

Hip: Right.

No tenderness to palpation over the greater trochanter.

NEUROLOGIC/GAIT:

Grossly intact. Speech is fluent without aphasia or dysarthria.

Cranial nerves II-XII grossly intact.

There were not complaints of dizziness with movement.

Gait is normal on straight-away walking.

Patient: Theodore "Jimmy" Angel

Date of Visit: July 21, 2023

DIAGNOSES – Trauma Related, Persistent:

1. Lumbar Disc Rupture L5-S1 (S33.0XXA).
2. Lumbosacral Radiculopathy, Right Leg (M54.17).
3. Lumbar Sprain/Strain (S33.5XXA, S39.012A).
4. Hip Pain, Right (M25.551).

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).
5. Cervical Sprain/Strain (S13.4XXA, S16.1XXA).
6. Thoracic Sprain/Strain (S23.3XXA, S29.012A).
7. Leg Pain, Right (R20.9).
8. Sleep Disturbance (G47.09).
9. Adjustment Disorder with Anxiety (F43.22).

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.

MEDICAL DECISION MAKING:

Mr. Angel needs to finish up with his chiropractic treatment. He does have an appointment today; however, with the swelling on the side of his face, I would postpone this treatment. He has an appointment with Dr. Rentz scheduled next week to follow up on the injection, at which point it is my opinion that Dr. Rentz will discharge him to p.r.n. treatment. Mr. Angel is on oral steroids today which will also help the lumbar radiculopathy. It is his second day of oral steroids, and he feels "great." I would like to reevaluate him in about four weeks for a formal discharge. Discharging him now would be premature due to the effects of the medication that he is on for his wisdom teeth removal and fistula into the sinus.

TREATMENT PLAN AND RECOMMENDATIONS:

Pharmacotherapy: OTC medicines as needed.

Diagnostics: None at this time.

Rehabilitation Plan: I referred him back to physical therapy for an electrical stim unit that he can use when the discomfort radiates into the buttocks such as when he has to drive for long periods.

Education: Treatment plan and prognosis discussed with the patient; questions answered.

Consultations: Follow up with Dr. Rentz as planned.

Work/Activity Status: Increase activity as tolerated to all normal activity for the patient.

Follow-up: In four weeks.

Patient: Theodore "Jimmy" Angel
Date of Visit: July 21, 2023

CLOSING:

Thirty minutes were spent, face to face, on today's visit with the patient and 15 minutes were spent 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.

Bethany Wallace, DO

Bethany A. Wallace, D.O., CIME
Level II Certified – Occupational Medicine (a State of Colorado Certification)

BW:hck
VF#: 0721-002

Synergy Health Partners
14111 E. Alameda Ave. Ste. 200
Aurora, CO 80012
Phone: 303-343-1357
Fax: 303-343-3036

Injury Care Network, LLC

Provider **WALLACE, D.O.**
Patient **ANGEL, THEODORE**
DOB **9/15/1975** DOL **2/23/2023**
DOS **07/21/2023**

FOLLOW UP QUESTIONNAIRE

SINCE LAST VISIT I AM FEELING:

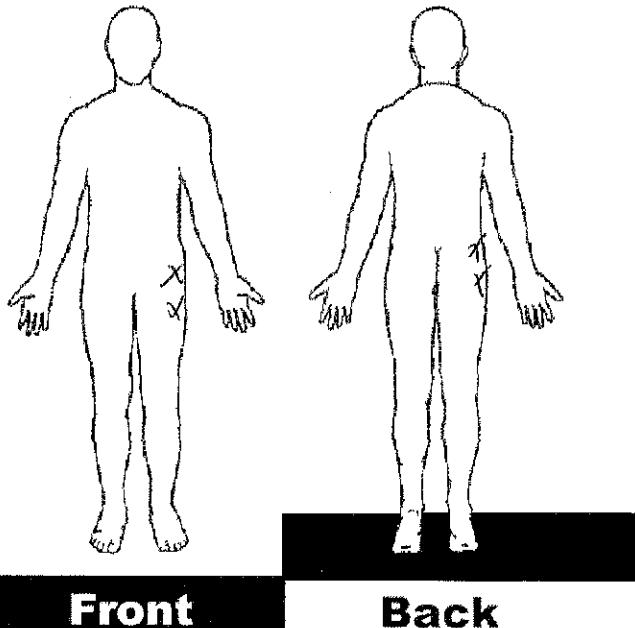
- Same %
Better ✓ % 90
Worse — %

**PLEASE RATE YOUR PAIN ON A
SCALE OF ZERO TO TEN:**

0-12-3-4-5-6-7-8-9-10
(NO PAIN) (SEVERE PAIN)

NEW CONCERNs: Alnig

SPECIFIC ISSUES YOU WOULD LIKE TO ADDRESS TODAY:



**PLEASE INDICATE ON THE DIAGRAM WHERE YOU ARE
CURRENTLY HAVING PAIN**

**PLEASE LIST ALL YOUR CURRENT MEDICATIONS
(INCLUDING OVER THE COUNTER MEDICATIONS)**

MEDICATION:

PROBLEMS WITH YOUR CURRENT MEDICATION?

No Yes, PLEASE EXPLAIN: _____

Are you having any stomach pain?

How often are you doing your home program?

Any problem with your home program?

Yes No

WORK STATUS:

- Working Full Duty
 - Working Restricted Duty
 - Off Work (Restricted Duty Not Available)
 - Off Work (Other Reason)

PLEASE BRING A LIST OF MEDICATIONS AND A COPY OF YOUR EXERCISE SHEETS TO EACH VISIT.

Signature:

Date: 7/21/23

Injury Care Network, LLCProvider **WALLACE, D.O.**
Patient **ANGEL, THEODORE**DOB 09/15/1975 DOL 02/23/2023
DOS 08/11/2023**REFERRAL**

- AURORA:** 14111 E. Alameda Avenue | Suite 200 | Aurora, CO 80012 P: (303) 343-1357 | F: (303) 343-3036
 THORNTON: 8515 Pearl Street | Suite 100 | Thornton, CO 80229 P: (303) 630-0400 | F: (303) 630-0405
 DENVER: 1250 Sheridan Blvd. | Denver, CO 80232 P: (303) 927-7119 | F: (303) 568-9331

DIAGNOSES:

1. L5 radiculopathy R
2. L5-S1 disc Herniation
3. Right back pain

DISCHARGED

4. _____
5. _____
6. _____

RECORDS REQUESTED:

- | | | |
|---|--|--|
| <input type="checkbox"/> St. Anthony's Central | <input type="checkbox"/> Good Samaritan Medical Center | <input type="checkbox"/> Denver Health |
| <input type="checkbox"/> University Hospital | <input type="checkbox"/> North Suburban Medical Center | <input type="checkbox"/> St. Anthony North |
| <input type="checkbox"/> Swedish Medical Center | <input type="checkbox"/> Littleton Adventist Hospital | <input type="checkbox"/> Kaiser Permanente |
| <input type="checkbox"/> Sky Ridge Medical Center | <input type="checkbox"/> Lutheran Medical Center | <input type="checkbox"/> St. Joseph's Hospital |
| <input type="checkbox"/> Medical Center of Aurora | <input type="checkbox"/> Rose Medical Center | <input type="checkbox"/> Porter Adventist Hospital |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Specialist: _____ | <input type="checkbox"/> PCP: _____ |
| <input type="checkbox"/> Other: _____ | | |

REFERRAL FOR ADDITIONAL SERVICES (IN OFFICE):

- | | |
|--|--|
| <input type="checkbox"/> Physical Therapy: Evaluate and Treat | <input type="checkbox"/> Chiropractic: Evaluate and Treat |
| <input type="checkbox"/> PT-Vestibular | <input checked="" type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Acupuncture: Evaluate and Treat | <input type="checkbox"/> Neuropsych Eval |
| <input type="checkbox"/> Psychology <input type="checkbox"/> Driving Anxiety <input type="checkbox"/> Biofeedback <input type="checkbox"/> TBI | <input type="checkbox"/> Occulogica - EyeBox 1 <input type="checkbox"/> 2 <input type="checkbox"/> |
| <input type="checkbox"/> BrainView: Evaluate and Treat <input type="checkbox"/> DANA | <input type="checkbox"/> Assess for Trigger Point |
| <input type="checkbox"/> BrainCheck 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> | <input type="checkbox"/> Regenerative Medicine-PRP <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> BrainCheck Anxiety/Depression <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> | <input type="checkbox"/> DO/MD Medication Eval |
| <input type="checkbox"/> BrainCheck Vision <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |

RESTRICTIONS OR SPECIAL INSTRUCTIONS:Muscular stim unit**REFERRAL FOR ADDITIONAL SERVICES (OUTSIDE OFFICE):**

- | | |
|---|---|
| <input type="checkbox"/> Spine Surgeon | <input checked="" type="checkbox"/> Injection Specialist <u>11-9-23</u> |
| <input type="checkbox"/> Pain Specialist Consultation | <input type="checkbox"/> Dentist/TMJ Specialist |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Hand Specialist |
| <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Podiatrist Surgeon | <input type="checkbox"/> Neuro Optometrist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Orthopedic Consultation for: _____ | |

REFERRAL FOR DIAGNOSTIC STUDIES:

MRI/Type: _____ C-Spine Flex/Ext 3T/TBI DTI SWI NeuroQuant

CT: _____
 Other: _____ (VNG, Ultrasound, Labs, Etc.)
 X-Rays: _____

Follow up in _____ weeks. Next appointment is scheduled for _____ / _____ / _____ at _____ : _____ AM / PM.

WALLACE8-11-23**(PROVIDER)****(DATE)**

Injury Care Network, LLC

Provider **WALLACE, D.O.**
Patient **ANGEL, THEODORE**
DOB **09/15/1975** DOL **02/23/2023**
DOS **08/11/2023**

FOLLOW UP QUESTIONNAIRE

SINCE LAST VISI' , I AM FE LING:

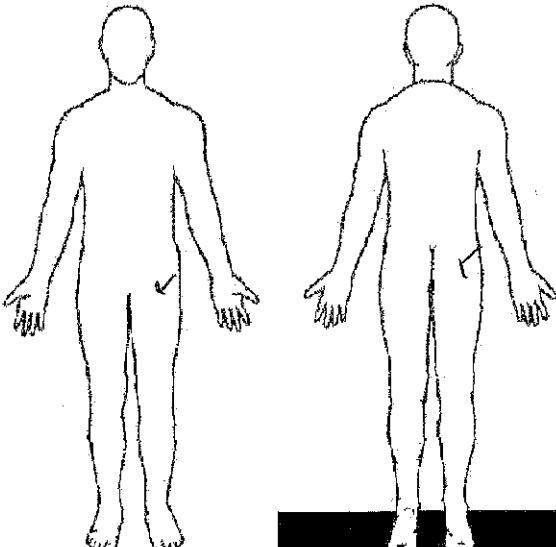
- Same %
 Better 95 %
 Worse _____ %

**PLEASE RATE YOUR PAIN ON A
SCALE OF ZERO TO TEN:**

0-1-2-3-4-5-6-7-8-9-10
(NO PAIN) (SEVERE PAIN)

NEW CONCERNS: _____

SPECIFIC ISSUES YOU WOULD LIKE TO ADDRESS TODAY:



Front

Back

PLEASE INDICATE ON THE DIAGRAM WHERE YOU ARE
CURRENTLY HAVING PAIN

**PLEASE LIST ALL YOUR CURRENT MEDICATIONS
(INCLUDING OVER THE COUNTER MEDICATIONS)**

MEDICATION:

Page

PROBLEMS WITH YOUR CURRENT MEDICATION?

No Yes, PLEASE EXPLAIN: _____

Are you having any stomach pain?

How often are you doing your home program?

Any problem with your home program?

Yes No

N

WORK STATUS:

- Working Full Duty
 - Working Restricted Duty
 - Off Work (Restricted Duty Not Available)
 - Off Work (Other Reason)

PLEASE BRING A LIST OF MEDICATIONS AND A COPY OF YOUR EXERCISE SHEETS TO EACH VISIT

Signature:

Date: / /

Summarization of Encounter

March 2, 2023 - March 2, 2023

Created: March 10, 2023

Patient:	ANGEL, THEODORE J 5471 RARTAIN WAY DENVER, CO 80221 Tel: (303) 455-7359 (HP) Tel: (720) 620-6575 (HP) Tel: (720) 461-0920 (HP) Tel: (303) 428-7865 (WP)	Patient ID: Support:	CEUL0154987 NEXT OF KIN ANGEL, KAYLA Address: Unknown
Date of Birth:	September 15, 1975	Author:	Tel: (520) 240-6564 (HP) Castorena Garcia, Mayra
Gender:	Male	Author Organization:	Synergy Health Partners
Race:	Caucasian	Confidentiality:	Normal
Ethnicity:	Hispanic Or Latino		
Religion:	Roman Catholic Church		
Language:	EN		

Table of Contents

- PROBLEMS
- PROCEDURES
- VITAL SIGNS
- RESULTS
- ALLERGIES
- ENCOUNTERS
- FUNCTIONAL STATUS
- EQUIPMENT
- PROVIDERS
- PAYERS
- SOCIAL HISTORY
- FAMILY HISTORY
- ADVANCE DIRECTIVES

PROBLEMS

DATE	TYPE	CONDITION / CODE	ATTENDING	STATUS	SOURCE
03/02/2023 8:58 AM	Working Diagnosis	Back Pain / 12 ()	ORTEGA, SHEILA ROSE	Active	Centura Health 5 Repository

PROCEDURES

No Procedure Records Found

VITAL SIGNS

No Vital Signs Records Found

RESULTS

No Result Records Found

ALLERGIES

DATE	TYPE / CODE	NAME / CODE	REACTION	SEVERITY	SOURCE
	DRUG/ 419511003 (SNOMED CT)	NO KNOWN ALLERGIES			Centura Health 5 Repository

ENCOUNTERS

ADMIT/DISCHARGE	ACCOUNT NUMBER	ADMITTING	ENCOUNTER CLASS	LOCATION	SOURCE
03/02/2023 8:58 AM/03/02/2023 9:48 AM	211522028		Ambulatory	Building:FHFCN	Centura Health 5 Repository

PROGRESS NOTE | **Observed: 03/02/2023 9:20 AM** | **Status: COMPLETED** | **Source: CENTURA HEALTH 5 REPOSITORY**
 CEUL0154987 Angel, Theodore J 09/15/1975 M

St Anthony North 84th Ave Neighborhood Health Center
 2551 W 84th Ave
 Westminster CO 80031-3807

Attestation signed by Megan W Eliassen, MD at 3/2/2023 10:21 AM
 I was present in clinic at the time of the patient's visit on 3/2/23. I reviewed the resident's note and I agree with the resident's plan.

Assessment/Plan:

Problem List Items Addressed This Visit

Back pain

Neck, thoracic, and lumbar pain worse on R side due to MVA on 2/23/23. Went to North Suburban with normal Head CT and L shoulder XR. Continues to have muscle pain in back with radiation to R buttock and leg. No bowel or bladder dysfunction. Tried ibuprofen only.

-Flexeril 5mg PRN

-Scheduled ibuprofen tid with meals

-Ice and heating pads

-Icy hot

-OMT with dry needling

-Follow up in 1 month, if no improvement referral to PT

Preceptor Dr. Eliassen

Subjective:

Theodore J Angel is a 47 y.o. male

HPI

Involved in MVA on 2/23/23, other car hit rear passenger side, which he was sitting on. He was twisting towards the right when the other car hit him and he was jolted forward where his face hit the dashboard

Sharp pains in neck with associated headaches. Stiff and tight back muscles with radiating pain to buttock and R leg.

Taking ibuprofen without relief.

Current Outpatient Medications:

cyclobenzaprine (FLEXERIL) 5 MG tablet, Take 1 tablet (5 mg) by mouth every 8 hours as needed for muscle spasms for up to 10 days., Disp: 30 tablet, Rfl: 0

No past medical history on file.

No past surgical history on file.

No family history on file.

Social History

Tobacco Use

Smoking status: Never

Passive exposure: Never

Smokeless tobacco: Never

Substance Use Topics

Alcohol use: Yes
 Alcohol/week: 12.0 standard drinks
 Types: 12 Cans of beer per week
 Drug use: Never

No Known Allergies**Objective:**

Vital signs were reviewed.

Vital Signs

BP 120/74 (BP Location: Left arm, Patient Position: Sitting, BP Cuff Size:

Adult)

Pulse 89

Temp 36.3 C (97.3 F) (Temporal)

Resp 16

Ht 167.6 cm (5' 5.98")

Wt 116 kg (256 lb 2.8 oz)

SpO2 92%

BMI 41.37 kg/m

Physical Exam**Physical Exam**

Constitutional: WDNM male. NAD

HENT/Head: Normocephalic, atraumatic.

Eyes: Normal conjunctivae. EOMI.

Neck: Neck supple.

Cardiovascular: Normal rate. No murmurs rubs or gallops.

Pulmonary/Chest: Normal respiratory effort. Lungs CTAB.

Abdominal: Soft, nondistended. No hepatosplenomegaly, nontender to palpation.

Musculoskeletal: Restricted ROM in cervical spine with flexion and b/l rotation.

Tenderness over R occiput and scalenes. Restricted ROM in thoracic and lumbar spine with extension and b/l rotation and sidebending. Hypertonic paraspinal muscles R>L.

Neurological: Alert and oriented.

Skin: No pallor, erythema, rash.

Psychiatric: Normal affect and mood.

Electronically signed by Sheila Rose Ortega, DO Resident at 3/2/2023 10:05 AM

Electronically signed by Megan W Eliassen, MD at 3/2/2023 10:21 AM

FUNCTIONAL STATUS

No Functional Status Records Found

EQUIPMENT

No Equipment Records Found

PROVIDERS

ADMIT DATE	TYPE	Name / ID	SOURCE
03/02/2023	ATTENDING	ORTEGA, SHEILA ROSE ID:104122	Centura Health
03/02/2023	PRIMARY CARE	DEAN, JEREMY ID:107348	Centura Health

PAYERS

ENCOUNTER	GUARANTOR	PAYER	SUBSCRIBER	SOURCE
03/02/2023 8:58 AM	THEODORE J ANGEL DOB: 1975-09-15 5471 RARTAIN WAY DENVER, CO 80221 Tel: (720) 461-0920 (HP)	Primary Insurance: MEDICAID Policy Number: I919978 Effective Date: 2022-11-01 PO BOX 30 DENVER, CO 80201-0030 WP: (844) 235-2387	THEODORE J ANGEL DOB: 1975-09-15 SELF 5471 RARTAIN WAY DENVER, CO 80221 Tel: (720) 461-0920 (HP)	Centura Health 5 Repository

SOCIAL HISTORY

No Social History Records Found

FAMILY HISTORY

No Family History Records Found

ADVANCE DIRECTIVES

No Advanced Directives Records Found

INFORMATION SOURCE

DATE CREATED	AUTHOR	AUTHOR'S ORGANIZATION
03/10/2023 2:43 PM	Mayra Castorena Garcia	Synergy Health Partners 14111 E Alameda Ave #200 Aurora, CO 80012

AFTER VISIT SUMMARY

Theodore J. Angel DoB: 9/15/1975

3/2/2023 9:20 AM St. Anthony North Family Medicine 84th 303-430-5560



Instructions from Sheila Rose Ortega, DO Resident



Read the attached information

1. Back Stretches on Floor (English)
2. Back Stretches Standing or Seated (English)

What's Next

You currently have no upcoming appointments scheduled.

Your input is important.

If it matters to you, it matters to us.

At Centura Health, we believe in providing compassionate care and excellent service through all aspects of your experience. If you receive a patient experience survey, please take a moment to share your feedback.

We value your comments.
We want to exceed your expectations.

Today's Visit

You saw Sheila Rose Ortega, DO Resident on Thursday March 2, 2023 for: Back Pain.

Blood Pressure
120/74

BMI
41.37

Weight
256 lb
2.8 oz

Height
5' 5.98"

Temperature
(Temporal)
97.3 °F

Pulse
89

Respiration
16

Oxygen Saturation
92%

Suicide hot line 1-800-273-TALK (8255) Or 1-800-SUICIDE (784-2433)

Medication Disclaimer

These are the medicines you have reported you are currently taking and any additional medicines prescribed or changes made during this visit. Please review it as soon as possible with your primary care provider and/or any other physicians you see for your outpatient care to be sure that is correct. Discard any old medicine lists.

When taking narcotics or muscle relaxants, do NOT drink alcohol, drive a car, or do anything that could hurt you. You may become very drowsy. Wait at least 8 hours after the last dose before doing these activities.

Always take antibiotics until all pills are gone.

Medication Disclaimer (continued)

If you are taking any medicines and develop a rash or hives or trouble breathing or swallowing, stop the medicine and see your doctor or go to the emergency room immediately.

MyCenturaHealth Signup

Our records indicate that you have an active MyCenturaHealth account.

You can view your After Visit Summary by going to <http://www.MyCenturaHealth.org> and logging in with your MyCenturaHealth username and password. If you don't have a MyCenturaHealth username and password but a parent or guardian has access to your record, the parent or guardian should login with their own MyCenturaHealth username and password and access your record to view the After Visit Summary.

If you have questions, you can e-mail MyCenturaHealth@Centura.org or call 866-414-1562 to talk to our MyCenturaHealth staff. Remember, MyCenturaHealth is NOT to be used for urgent needs. For medical emergencies, dial **911**.

Changes to Your Medication List as of March 2, 2023 9:48 AM

You have not been prescribed any medications.

Medication Plan

as of March 2, 2023 9:48 AM

You have not been prescribed any medications.

Back Stretches on Floor

About this topic

Keeping your back muscles flexible is important. Stretching exercises can help to lessen pain and stiffness, increase flexibility, and make your daily activities easier.

General

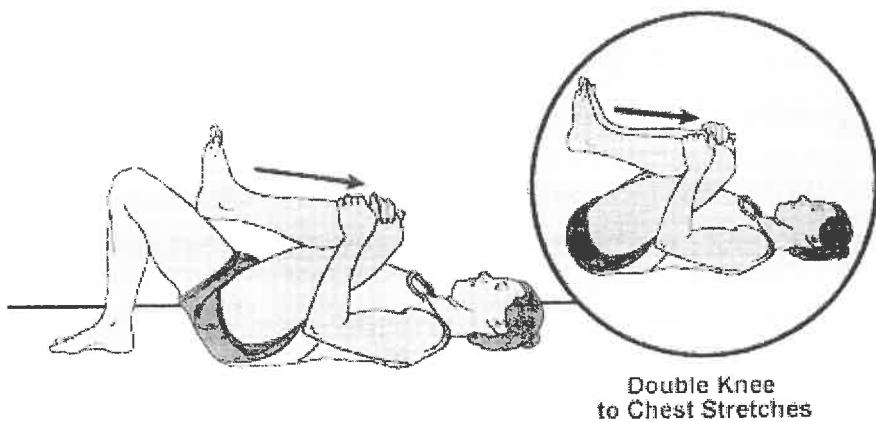
Before starting with a program, ask your doctor if you are healthy enough to do these exercises. Your doctor may have you work with a trainer, chiropractor or physical therapist to make a safe exercise program to meet your needs.

Stretching Exercises

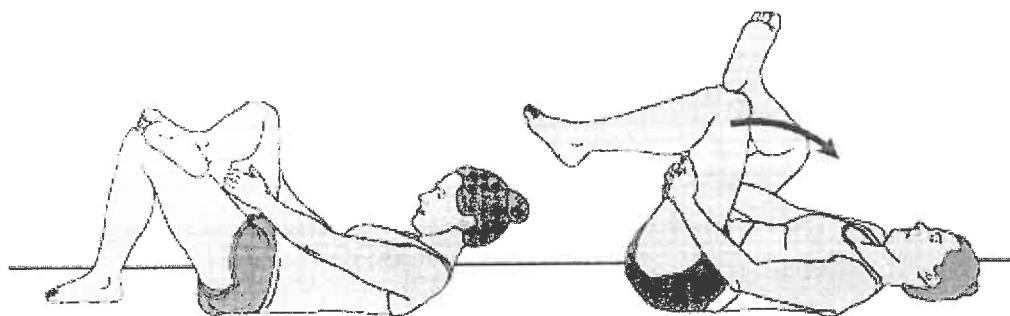
Stretching exercises keep your muscles flexible. They also stop them from getting tight. Start by doing each of these stretches 2 to 3 times. In order for your body to make changes, you will need to hold these stretches for 20 to 30 seconds. Try to do the stretches 2 to 3 times each day. Do all exercises slowly.

- Single knee to chest stretches – Lie on your back. Pull one knee towards your chest until you feel a stretch in your lower back and buttock area. Repeat with the other knee. If you have knee problems, pull your knee up by grabbing the back of your thigh instead of the front of your knee. You can also do this exercise by grabbing both knees at the same time.
- Deep hip stretches lying down – Lie on your back and bend one knee, keeping that foot flat on the floor. Cross the other leg over your knee. Slowly, pull the bottom leg towards your chest until you feel a stretch in the other buttock. Repeat using the opposite leg as the bottom leg.
- Elbow props on stomach – Lie on your stomach, resting on your lower arms. Rise up on your elbows as high as you are able. Keep your hips on the floor. Then, lower your back and shoulders down.
- Rounded back stretches – Start in the all fours position. Tuck your chin and tighten your stomach muscles to round your back.
- Back rotations:
 - Stretch 1 – Lie on your back. Bend your knees so your feet are flat on the bed. Gently, drop your knees to one side until you feel a stretch in your lower back. Be sure to keep both of your shoulders touching the bed until you feel a stretch in the muscles at the side of the back. Repeat on the other side.
 - Stretch 2 – Lie on your back. Keep your shoulders flat and put one thigh up and across your body to the opposite side. Use your hand to help and give extra pressure for the stretch. Repeat on the other side.
- Midback rotations – Start on all fours. Walk your hands to one side until you feel a good stretch on the opposite side. Then, walk your hands to the other side and hold. Now, start by sitting back on your heels. Walk your hands to one side until you feel a good stretch on the opposite side. Then, walk your hands to the other side and hold. You should feel this stretch in a slightly different area than when on all fours.

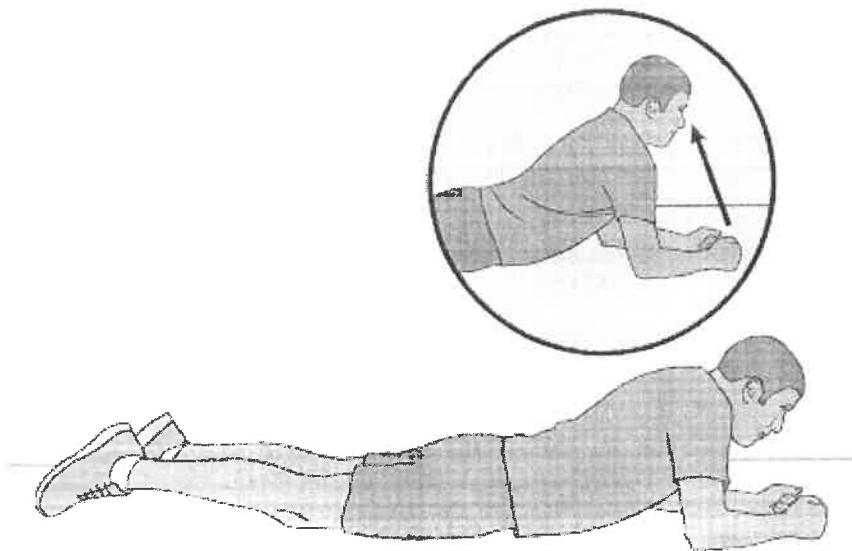
Single Knee to Chest Stretches



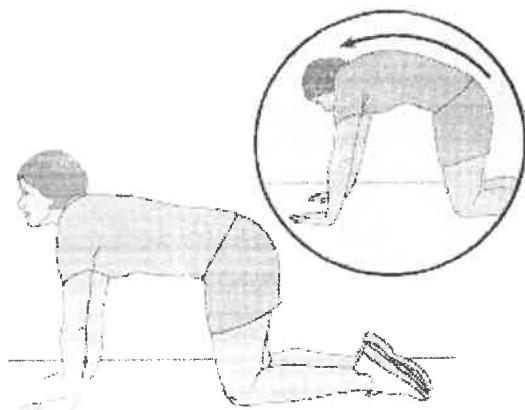
Deep Hip Stretches Lying Down



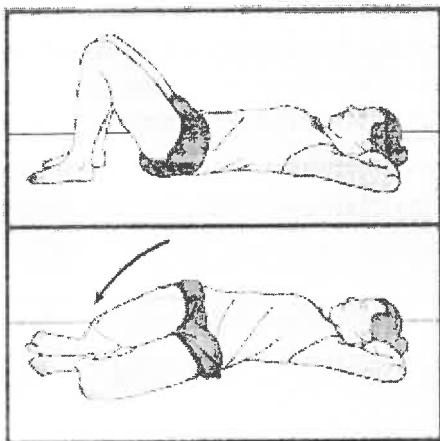
Elbow Props on Stomach



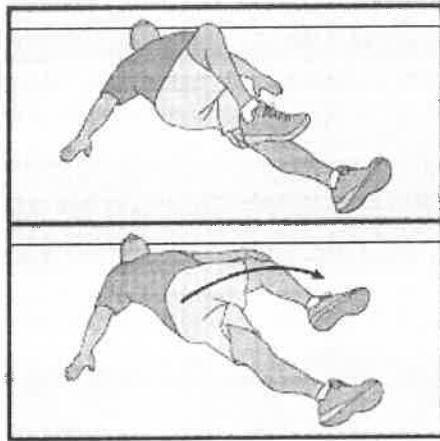
Rounded Back Stretches



Back Rotations

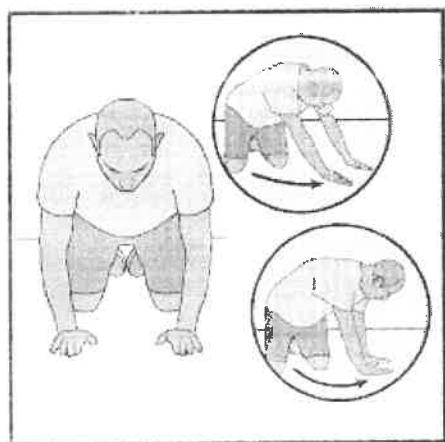


Lower Trunk Rotations 1

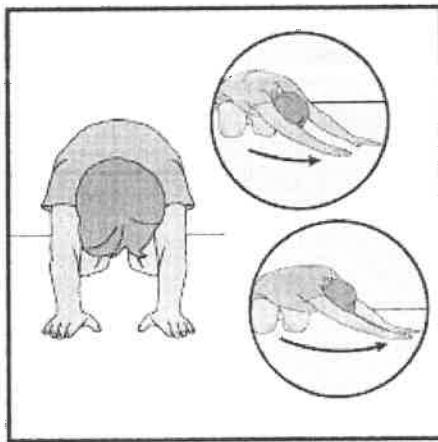


Lower Trunk Rotations 2

Midback Rotations



Midback Rotations on All Fours



Midback Rotations on Heels

What will the results be?

- Better flexibility and range of motion
- Less back pain
- Less muscle tightness
- Less back spasms
- Lessen leg numbness and tingling
- Easier to walk and do other activities

- Improved posture
- Improved sports performance

Helpful tips

- Stay active and work out to keep your muscles strong and flexible.
- Keep a healthy weight to avoid putting too much stress on your spine. Eat a healthy diet to keep your muscles healthy.
- Be sure you do not hold your breath when exercising. This can raise your blood pressure. If you tend to hold your breath, try counting out loud when exercising. If any exercise bothers you, stop right away.
- Always warm up before stretching. Heated muscles stretch much easier than cool muscles. Stretching cool muscles can lead to injury.
- Try walking or cycling at an easy pace for a few minutes to warm up your muscles. Do this again after exercising.
- Never bounce when doing stretches.
- Doing exercises before a meal may be a good way to get into a routine.
- Exercise may be slightly uncomfortable, but you should not have sharp pains. If you do get sharp pains, stop what you are doing. If the sharp pains continue, call your doctor.

Where can I learn more?

American Academy of Orthopaedic Surgeons

<http://orthoinfo.aaos.org/topic.cfm?topic=A00666>

Last Reviewed Date

2021-03-18

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Back Stretches Standing or Seated

About this topic

Keeping your back muscles flexible is important. Stretching exercises can help to lessen pain and stiffness, increase flexibility, and make your daily activities easier.

General

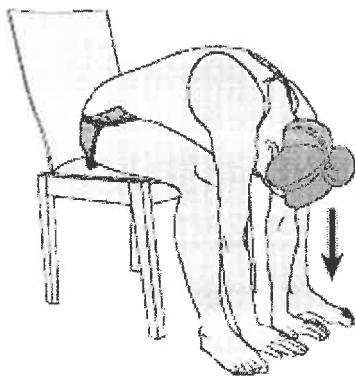
Before starting with a program, ask your doctor if you are healthy enough to do these exercises. Your doctor may have you work with a trainer, chiropractor or physical therapist to make a safe exercise program to meet your needs.

Stretching Exercises

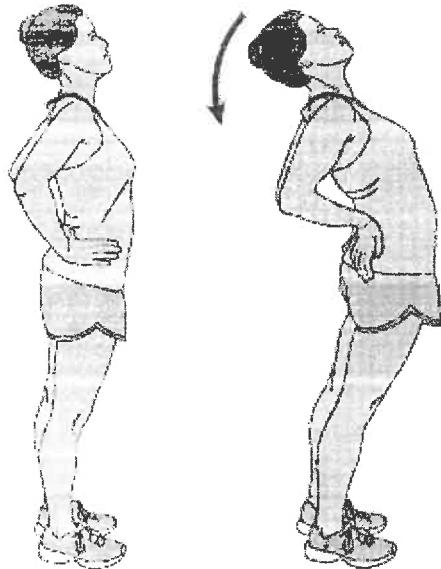
Stretching exercises keep your muscles flexible. They also stop them from getting tight. Start by doing each of these stretches 2 to 3 times. In order for your body to make changes, you will need to hold these stretches for 20 to 30 seconds. Try to do the stretches 2 to 3 times each day. Do all exercises slowly.

- Lower back stretches seated – Sit in a chair with your feet spread about shoulder width apart. Then, lean forward until you feel a stretch in your lower back.
- Back bends standing – Stand with feet slightly apart. Put your hands on your hips. Lean back and look towards the ceiling until you feel a stretch. For a disc problem, you can do this exercise without holding it for 10 times in a row.
- Side bends – Stand with your hands on your hips, feet shoulder width apart. Keep your left hand on your hip and lean to the right, sliding your right hand down the outside of your right leg. Stand up straight. Keep your right hand on your hip and lean to the left, sliding your left hand down your left leg.
- Opposite foot touches standing – Stand with your feet a little more than shoulder width apart. Reach your arms straight out from your sides. Bend forward at the waist and reach your right hand towards your left foot. Your other arm will reach behind you upwards towards the sky. Keep your arms and legs straight. Now, stand back up and repeat with the left hand reaching towards the right foot.
- Upper body twists – Put your hands on your hips and twist your upper body to the left. Now, twist to the right.

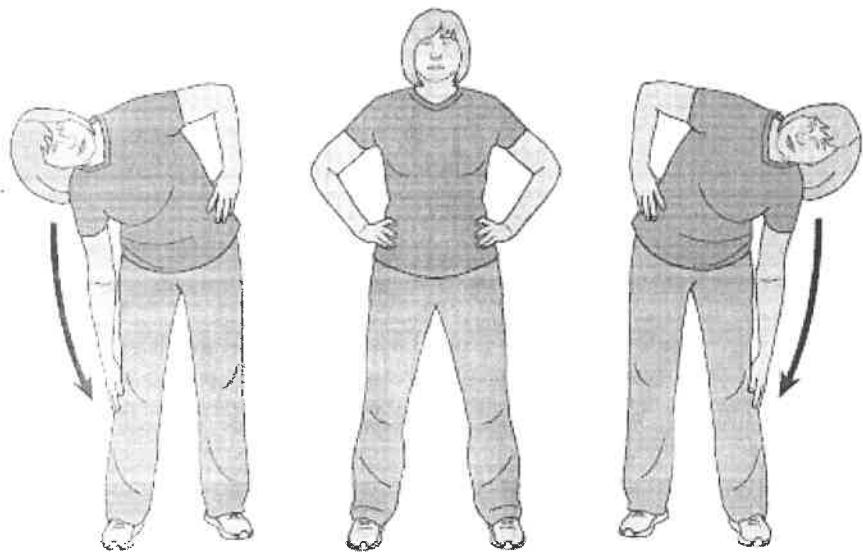
Lower Back Stretches Seated



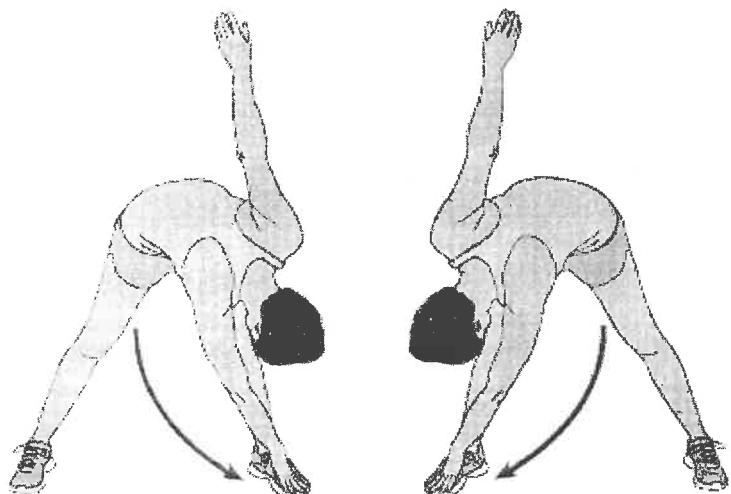
Back Bends Standing



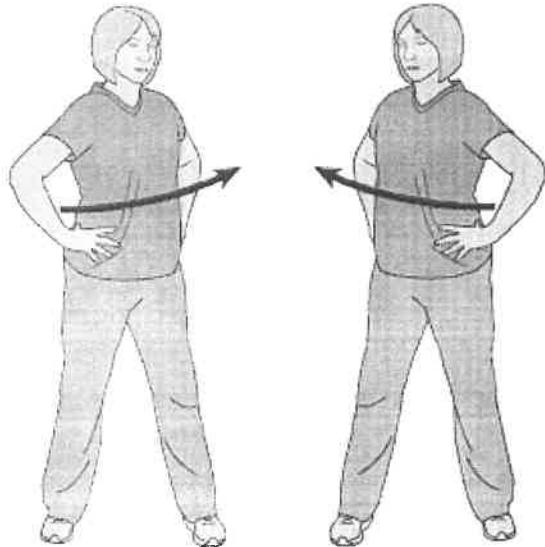
Side Bends



Opposite Foot Touches Standing



Upper Body Twists



What will the results be?

- Better flexibility and range of motion
- Less back pain
- Less muscle tightness
- Less back spasms
- Less leg numbness and tingling
- Easier to walk and do other activities
- Improved posture
- Improved sports performance

Helpful tips

- Stay active and work out to keep your muscles strong and flexible.
- Keep a healthy weight to avoid putting too much stress on your spine. Eat a healthy diet to keep your muscles healthy.
- Be sure you do not hold your breath when exercising. This can raise your blood pressure. If you tend to hold your breath, try counting out loud when exercising. If any exercise bothers you, stop right away.
- Always warm up before stretching. Heated muscles stretch much easier than cool muscles. Stretching cool muscles can lead to injury.
- Try walking or cycling at an easy pace for a few minutes to warm up your muscles. Do this again after exercising.

- Never bounce when doing stretches.
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- Exercise may be slightly uncomfortable, but you should not have sharp pains. If you do get sharp pains, stop what you are doing. If the sharp pains continue, call your doctor.

Where can I learn more?

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— D E N V E R —

DIAGNOSTIC PAIN

Jack Rentz

7800 E Orchard Road Ste 350 Greenwood Village, CO 80111-2550

Phone: (720) 598-0805 Fax: (720) 606-2905

Theodore ' Jimmy ' Angel DOB: 09/15/1975 47 year old,
6002 GRAPE DR
COMMERCE CITY, CO 80022
(720) 461-0920

Visit Date: 05/10/2023

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DENVER DIAGNOSTIC PAIN CORPORATION

Jack Rentz

7800 E Orchard Road Ste 350 Greenwood Village, CO 80111-2550

Phone: (720) 598-0805 Fax: (720) 606-2905

Theodore ' Jimmy ' Angel DOB: 09/15/1975 47 year old,

6002 GRAPE DR

COMMERCE CITY, CO 80022

(720) 461-0920

Visit Date: 05/10/2023

CHIEF COMPLAINT: Back and neck

REASON FOR VISIT: New Patient Encounter

HISTORY OF PRESENT ILLNESS:

5-10-2023:

Jimmy is a 47 yom that presents today following a motor vehicle accident on 2-23-2023. Patient was T-boned by the passenger side in Colorado Blvd. He reports constant shooting pain on the right side of his low back, numbness radiating down to his right foot. Patient reports severe pain when laying down, walking and bending. Patient reports doing chiro and PT 1 x at Synergy. He reports taking flexeril at night. Patient reports right after the accident he had neck pain and mid back pain, he reports improvement after conservative therapy.

LOCATION: back

RADIATION: right leg

QUALITY: shooting, numbness

TIMING: Constant, Progressively worsens throughout the day

SEVERITY: Best: 5 /10 NRS Average: 6 /10 NRS Worst: 7 /10 NRS

LIMITATIONS (Due to Pain): Ability to perform activities of daily living; Ability to engage in a normal lifestyle; Ability to achieve adequate sleep

EXACERBATING FACTORS: laying down, walking and bending

ALLEVIATING MEDICATIONS: Flexeril

ALLEVIATING TREATMENTS: PT

Chiro

ALLEVIATING INTERVENTIONS: n/a

DIAGNOSTIC STUDIES:

MRI Lumbar spine: 4-7-2023

MRI Cervical spine: 4-7-2023

MRI Thoracic spine: 4-28-2023

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Negative for fevers or chills.

EYES: Negative for eye pain or visual changes.

E/N/T: Negative for hearing loss, sore throat, and nosebleeds.

CARDIOVASCULAR: Negative for chest pain or palpitations.

RESPIRATORY: Negative for wheezing or difficulty breathing.

GASTROINTESTINAL: Negative for abdominal pain or fecal incontinence.

GENITOURINARY: Negative for blood in urine or bladder incontinence.

MUSCULOSKELETAL: Positive for neck pain and back pain.

NEUROLOGICAL: Negative for recent seizure or speech disturbance.

PSYCHIATRIC: Negative for suicidal ideation or hallucinations.

PAST HISTORY:

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Visit Date: 05/10/2023

MEDICAL:

PMHx:

n/a

Allergies:

NKDA

Medications:

Flexeril

Ibuprofen

MVA: 2-23-2023

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SURGICAL:

n/a.

PAIN PROCEDURES:

n/a.

FAMILY HISTORY:

n/a.

SOCIAL HISTORY:

Alcohol Use: Social.

SMOKING STATUS:

Never smoker.

ALLERGIES (reported):

No allergies on file

CURRENT MEDICATION (reported):

Patient has no known medications

VITAL SIGNS:

Pain Level: 5/10 NRS

Weight: 255 lbs. Height: 67 in.

BP Location: Arm

PHYSICAL EXAMINATION:

GENERAL: Well developed; Over nourished; Well groomed

EYES: EOMI; White conjunctiva

ENT: Normal external ears and nose; Hearing grossly normal

RESPIRATORY: Normal respiratory rate and pattern; No respiratory distress; No wheezing

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Visit Date: 05/10/2023

CARDIOVASCULAR: Normal rate; Normal rhythm

GASTROINTESTINAL: Non-distended; Non-tender

PSYCHIATRIC: Mental status: alert and oriented x 3; Appropriate affect and demeanor

MUSCULOSKELETAL:

---> Gait: Normal

---> Motor: 5/5 bilateral flex/ex Hips, Knees, Ankles, Toes, Add/Ab Thighs, 5/5 bilateral flex/ex Shoulders, Elbows, Wrists, Digits

---> Tone: Grossly normal tone in all extremities

---> Tenderness to Palpation: Low Back: Midline and Right Paramidline

---> Kemp's: (+) Right LUMBAR:

NEUROLOGICAL:

---> Cranial Nerves: 2-12 Intact

---> Sensory: Vibratory sensation decrease in Right S1 dermatome

---> Deep Tendon Reflexes: 2+ Bilateral Knee and Ankle

---> Straight Leg Raise: Positive Right

LABS:

ASSESSMENT/DIAGNOSIS:

Jimmy is a 47 yom that presents today following a motor vehicle accident on 2-23-2023. Patient reports constant shooting pain on the right side of his low back with numbness radiating down to his right foot. Neck and mid-back pain responded to conservative care. Low back pain has not responded fully or sufficiently to several months of conservative care treatments, including physical therapy, chiropractic, home exercise, NSAIDs and other medications.

MRI Lumbar Spine - L4-5, L5-S1 facet effusions, L5-S1 right subarticular recess narrowing with mild compression of the descending S1 nerve root

MRI Cervical Spine - mild annular bulging C4-7.

MRI Thoracic Spine - Unremarkable.

Reviewed the results of the patient's MRIs in detail with 3D model for educational purposes. Some of the findings may be chronic, but the MVA certainly may have exacerbated any underlying issues. Symptoms, exam, and MRI findings correlate with L5-S1 discogenic pain. We discussed treatment options to include conservative therapies, medications and injections. Discussed L5-S1 TFESI for diagnostic/therapeutic purposes. Injection reviewed again with the patient including risks, benefits, alternatives and expectations. All questions were answered and he was in agreement with the treatment plan.

It is my opinion, within a reasonable degree of medical certainty, that the objective and quantitative findings as described above and additionally in the patient file, include physical bodily damage and limitations which are a direct result of the injury caused on 2/23/23. The injuries are consistent with the patient's reported history of the collision

G89.11 Acute pain due to trauma

M54.12 Radiculopathy, cervical region

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M54.2 Cervicalgia

S13.4XXD Sprain of ligaments of cervical spine, subsequent encounter

S16.1XXD Strain of muscle, fascia and tendon at neck level, subs

M47.896 Other spondylosis, lumbar region

M51.26 Other intervertebral disc displacement, lumbar region

M54.16 Radiculopathy, lumbar region

M62.830 Muscle spasm of back

S33.5XXD Sprain of ligaments of lumbar spine, subsequent encounter

S39.012D Strain of muscle, fascia and tendon of lower back, subsG89.11 - ACUTE PAIN DUE TO TRAUMA

M54.12 - RADICULOPATHY, CERVICAL REGION

M54.2 - CERVICALGIA

S13.4XXD - SPRAIN OF LIGAMENTS OF CERVICAL SPINE, SUBSEQUENT EN

S16.1XXD - STRN MUSC FASC TENDON NECK LEVL SUB

M47.896 - OTHER Spondylosis, LUMBAR REGION

M51.26 - OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBAR REGION

M54.16 - RADICULOPATHY, LUMBAR REGION

M62.830 - MUSCLE SPASM OF BACK

S33.5XXD - SPRAIN OF LIGAMENTS OF LUMBAR SPINE, SUBSEQUENT ENCOUNTER

S39.012D - STRAIN MUSC FASC TENDON LW BACK SUB

PLAN:

RADIOLOGY:

Reviewed prior imaging:

---> MRI: Cervical Spine (no contrast)

---> MRI: Thoracic Spine (no contrast)

---> MRI: Lumbar Spine (no contrast)

REFERRALS:

---> Continue Physical Therapy/ Chiropractic care

PROCEDURES TO SCHEDULE: The risks, benefits, and alternatives of the following procedures were discussed today in clinic:

(Right)

---> Lumbar Epidural Steroid Injection TFESI L5-S1 Dx Lumbar Radiculopathy M54.16, Lumbar Disc Displacement M51.26, 64483

DISCUSSIONS / RECOMMENDATIONS:

---> Risk and benefits of the injections discussed.

--->Activity modification for wellness and improved function

FOLLOW-UP:

Follow up for injections and 2-4 weeks after injections.

No linked medications found

PHYSICIAN: Jack B. Rentz, M.D.

--

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(720) 461-0920

Visit Date: 05/10/2023

Electronically Signed: JACK RENTZ on/at 5/14/2023 10:11:53 AM



D I A G N O S T I C P A I N
DENVER DIAGNOSTIC PAIN CORPORATION

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Theodore ' Jimmy ' Angel DOB: 09/15/1975 47 year old, male

6002 GRAPE DR

COMMERCE CITY, CO 80022

(720) 461-0920

Visit Date: 06/14/2023

June 15, 2023

To Whom It May Concern,

For your records, attached is a copy of a note for the following patient:

Theodore ' Jimmy ' Angel
DOB: 09/15/1975

Please don't hesitate to contact me at any time if you have any questions or concerns.

Sincerely,

Jack B. Rentz, M.D.

NOTICE OF CONFIDENTIALITY

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PATIENT PRIVACY STATEMENT

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Theodore ' Jimmy ' Angel DOB: 09/15/1975 47 year old, male

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COMMERCE CITY, CO 80022

(720) 461-0920

Visit Date: 06/14/2023

Preoperative Diagnosis: (Right)

---> Lumbar Epidural Steroid Injection TFESI L5-S1 Dx Lumbar Radiculopathy M54.16, Lumbar Disc Displacement M51.26, 64483 ACUTE PAIN DUE TO TRAUMA - G89.11

RADICULOPATHY, CERVICAL REGION - M54.12

CERVICALGIA - M54.2

SPRAIN OF LIGAMENTS OF CERVICAL SPINE, SUBSEQUENT EN - S13.4XXD

STRN MUSC FASC TENDON NECK LEVL SUB - S16.1XXD

OTHER SPONDYLOYSIS, LUMBAR REGION - M47.896

OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBAR REGION - M51.26

RADICULOPATHY, LUMBAR REGION - M54.16

MUSCLE SPASM OF BACK - M62.830

SPRAIN OF LIGAMENTS OF LUMBAR SPINE, SUBSEQUENT ENCOUNTER - S33.5XXD

STRAIN MUSC FASC TENDON LW BACK SUB - S39.012D

Postoperative Diagnosis: Same

Procedure(s): Right L5/S1 Transforaminal Epidural Steroid Injection(s)

Facility: Infinity Imaging Northwest Hills Surgical Hospital

Surgeon: Jack B. Rentz, M.D.

Indication: 47 years Male presents with a history and exam consistent with the above diagnosis. The patient's NPO Status was acceptable. The patient denied active infections. The patient reported that any applicable blood thinners were held for an appropriate amount of time as specified by the surgeon. The patient's allergies were reviewed. The risks, benefits, and alternatives of the procedure were discussed with the patient. The patient agreed and wished to proceed.

Description of Procedure:

After informed consent was obtained, the patient was placed in a prone position. The patient, site, procedure, and allergies were verified. The patient was prepped and draped in the appropriate sterile fashion using Chlorhexadine. Vital signs were monitored throughout the procedure. The "Injectate" syringe contained the following: (Depo-Medrol 80mg) (0.25% Bupivacaine 3mL) . A 23ga 6" spinal needle was utilized as the procedure needle.

AP, Lateral, and Oblique fluoroscopic visualization was utilized to visualize the anatomy and direct the procedure needle to the superior/lateral aspect of the right neural foramen of L5/S1 Once the target was reached, aspiration was confirmed negative. 0.5 mL of Omnipaque was injected, showing no vascular or intrathecal uptake and confirming placement within the neural foramen. Subsequently, 1.5mL of Omnipaque was injected. Epidural spread along the right L5 nerve root was visualized. This was followed by a slow, easy injection of 3 mL of injectate. The needle was subsequently withdrawn.

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Upon completion of the procedure(s), a bandaid was placed over the skin at the entry point(s). Post-procedure, the patient was taken to the recovery room.

Anesthesia: Local Conscious Sedation (45) (Versed: 2mg) (Fentanyl: 100mcg)

Estimated Blood Loss: None

Complications: No evidence of complications at the time of the procedure or immediately post-operatively.

Condition: Good

Plan: Return to clinic in 2-4 weeks

Electronically Signed: JACK RENTZ on/at 6/14/2023 9:18:34 AM

Electronically Signed: JACK RENTZ on/at 6/14/2023 9:20:14 AM



— D E N V E R —

DIAGNOSTIC PAIN

Jack Rentz

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Visit Date: 06/28/2023

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6002 GRAPE DR

COMMERCE CITY, CO 80022

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Visit Date: 06/28/2023

CHIEF COMPLAINT: Back and neck

REASON FOR VISIT: Procedure follow up

HISTORY OF PRESENT ILLNESS:

6-28-2023:

Patient presents today through a phone call for s/p right L5-S1 TFESI on 6-14-2023 with a 75% of relief. Over all patient reports significant improvement. Patient had severe soreness around the surgical site for a couple of days only.

He reports some pins/needles when driving. Pain has been radiating around glute area. Patient is currently doing PT and chiro 1 x a week at Synergy. He reports taking muscle relaxers as needed. Patient denies any new symptoms or medical history changes.

DIAGNOSTIC STUDIES:

MRI Lumbar spine: 4-7-2023

MRI Cervical spine: 4-7-2023

MRI Thoracic spine: 4-28-2023

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Negative for fevers or chills.

EYES: Negative for eye pain or visual changes.

E/N/T: Negative for hearing loss, sore throat, and nosebleeds.

CARDIOVASCULAR: Negative for chest pain or palpitations.

RESPIRATORY: Negative for wheezing or difficulty breathing.

GASTROINTESTINAL: Negative for abdominal pain or fecal incontinence.

GENITOURINARY: Negative for blood in urine or bladder incontinence.

MUSCULOSKELETAL: Positive for neck pain and back pain.

NEUROLOGICAL: Negative for recent seizure or speech disturbance.

PSYCHIATRIC: Negative for suicidal ideation or hallucinations.

PAST HISTORY:

MEDICAL:

PMHx:

n/a

Allergies:

NKDA

Medications:

Flexeril

Ibuprofen

MVA: 2-23-2023.

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Visit Date: 06/28/2023

SURGICAL:

n/a.

PAIN PROCEDURES:

n/a.

FAMILY HISTORY:

n/a.

SOCIAL HISTORY:

Alcohol Use: Social.

SMOKING STATUS:

Never smoker.

ALLERGIES (reported):

No allergies on file

CURRENT MEDICATION (reported):

Patient has no known medications

VITAL SIGNS:

Pain Level: 2/10 NRS (Previous Pain Level: 5)

Weight: 255 lbs. (Previous Weight: 255 lbs.) Height: 67 in.

BP Location: Arm

PHYSICAL EXAMINATION:

GENERAL: Well developed; Over nourished; Well groomed

EYES: EOMI; White conjunctiva

ENT: Normal external ears and nose; Hearing grossly normal

RESPIRATORY: Normal respiratory rate and pattern; No respiratory distress; No wheezing

CARDIOVASCULAR: Normal rate; Normal rhythm

GASTROINTESTINAL: Non-distended; Non-tender

PSYCHIATRIC: Mental status: alert and oriented x 3; Appropriate affect and demeanor

MUSCULOSKELETAL:

---> Gait: Normal

---> Motor: 5/5 bilateral flex/ex Hips, Knees, Ankles, Toes, Add/Ab Thighs, 5/5 bilateral flex/ex Shoulders, Elbows, Wrists, Digits

---> Tone: Grossly normal tone in all extremities

---> Tenderness to Palpation: Low Back: Midline and Right Paramidline

---> Kemp's: (+) Right LUMBAR:

NEUROLOGICAL:

---> Cranial Nerves: 2-12 Intact

---> Sensory: Vibratory sensation decrease in Right S1 dermatome

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Visit Date: 06/28/2023

---> Deep Tendon Reflexes: 2+ Bilateral Knee and Ankle

---> Straight Leg Raise: Positive Right

LABS:

ASSESSMENT/DIAGNOSIS:

Jimmy is being seen today via telemedicine for eval S/P right L5-S1 TFESI. He reports 75% pain relief overall with leg symptoms almost resolved. He is more functional and is pleased with the results thus far. He is to continue with Chiro. and P.T. Discussed continued conservative care and knowing limitations and proper body mechanics. Will continue to monitor for advanced treatments &/or injections and assess for positive outcomes.

Jimmy is a 47 yom that presents today following a motor vehicle accident on 2-23-2023. Patient reports constant shooting pain on the right side of his low back with numbness radiating down to his right foot. Neck and mid-back pain responded to conservative care. Low back pain has not responded fully or sufficiently to several months of conservative care treatments, including physical therapy, chiropractic, home exercise, NSAIDs and other medications.

MRI Lumbar Spine - L4-5, L5-S1 facet effusions, L5-S1 right subarticular recess narrowing with mild compression of the descending S1 nerve root

MRI Cervical Spine - mild annular bulging C4-7.

MRI Thoracic Spine - Unremarkable.

Reviewed the results of the patient's MRIs in detail with 3D model for educational purposes. Some of the findings may be chronic, but the MVA certainly may have exacerbated any underlying issues. Symptoms, exam, and MRI findings correlate with L5-S1 discogenic pain. We discussed treatment options to include conservative therapies, medications and injections. Discussed L5-S1 TFESI for diagnostic/therapeutic purposes. Injection reviewed again with the patient including risks, benefits, alternatives and expectations. All questions were answered and he was in agreement with the treatment plan.

It is my opinion, within a reasonable degree of medical certainty, that the objective and quantitative findings as described above and additionally in the patient file, include physical bodily damage and limitations which are a direct result of the injury caused on 2/23/23. The injuries are consistent with the patient's reported history of the collision

G89.11 Acute pain due to trauma

M54.12 Radiculopathy, cervical region

M54.2 Cervicalgia

S13.4XXD Sprain of ligaments of cervical spine, subsequent encounter

S16.1XXD Strain of muscle, fascia and tendon at neck level, subs

M47.896 Other spondylosis, lumbar region

M51.26 Other intervertebral disc displacement, lumbar region

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Visit Date: 06/28/2023

M54.16 Radiculopathy, lumbar region

M62.830 Muscle spasm of back

S33.5XXD Sprain of ligaments of lumbar spine, subsequent encounter

S39.012D Strain of muscle, fascia and tendon of lower back, subsG89.11 - ACUTE PAIN DUE TO TRAUMA

M54.12 - RADICULOPATHY, CERVICAL REGION

M54.2 - CERVICALGIA

S13.4XXD - SPRAIN OF LIGAMENTS OF CERVICAL SPINE, SUBSEQUENT ENCOUNTER

S16.1XXD - STRAIN OF MUSCLE, FASCIA AND TENDON AT NECK LEVEL, SUBS

M47.896 - OTHER SPONDYLOYSIS, LUMBAR REGION

M51.26 - OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBAR REGION

M54.16 - RADICULOPATHY, LUMBAR REGION

M62.830 - MUSCLE SPASM OF BACK

S33.5XXD - SPRAIN OF LIGAMENTS OF LUMBAR SPINE, SUBSEQUENT ENCOUNTER

S39.012D - STRAIN OF MUSCLE, FASCIA AND TENDON OF LOWER BACK, SUBS

PLAN:

RADIOLOGY:

Reviewed prior imaging:

---> MRI: Cervical Spine (no contrast)

---> MRI: Thoracic Spine (no contrast)

---> MRI: Lumbar Spine (no contrast)

REFERRALS:

---> Continue Physical Therapy/ Chiropractic care

PROCEDURES TO CONSIDER: (The patient may benefit from the following procedures in the future, depending on the outcome of today's plan):
(Right)

---> Lumbar Epidural Steroid Injection TFESI L5-S1 Dx Lumbar Radiculopathy M54.16, Lumbar Disc Displacement M51.26, 64483

DISCUSSIONS / RECOMMENDATIONS:

---> Risk and benefits of the injections discussed.

--->Activity modification for wellness and improved function

FOLLOW-UP:

Return to clinic in 1 month.

No linked medications found

PHYSICIAN PRESENCE ATTESTATION: Jack B. Rentz, M.D. was physically present in the office suite and immediately available to render assistance during the patient encounter and/or saw the patient along with the mid-level provider.

--

Electronically Signed: Don Fresques on/at 6/28/2023 10:46:42 AM

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Visit Date: 08/02/2023

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COMMERCE CITY, CO 80022

(720) 461-0920

Visit Date: 08/02/2023

CHIEF COMPLAINT: Back and neck

REASON FOR VISIT: Follow up

HISTORY OF PRESENT ILLNESS:

8-2-2023:

Patient presents today for a follow up on low back pain. Patient continues having significant improvement. Patient continues doing PT and chiro sessions 1 x a week at Synergy. Patient reports taking muscle relaxers prescribed at PT. Patient has been able to do more activities without pain. He feels some tingling in the glute area with prolonged sitting. He denies having neck pain at the moment.

He denies any new symptoms or medical history changes.

6-28-2023:

Patient presents today through a phone call for s/p right L5-S1 TFESI on 6-14-2023 with a 75% of relief. Over all patient reports significant improvement. Patient had severe soreness around the surgical site for a couple of days only.

He reports some pins/needles when driving. Pain has been radiating around glute area. Patient is currently doing PT and chiro 1 x a week at Synergy. He reports taking muscle relaxers as needed. Patient denies any new symptoms or medical history changes.

DIAGNOSTIC STUDIES:

MRI Lumbar spine: 4-7-2023

MRI Cervical spine: 4-7-2023

MRI Thoracic spine: 4-28-2023

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Negative for fevers or chills.

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E/N/T: Negative for hearing loss, sore throat, and nosebleeds.

CARDIOVASCULAR: Negative for chest pain or palpitations.

RESPIRATORY: Negative for wheezing or difficulty breathing.

GASTROINTESTINAL: Negative for abdominal pain or fecal incontinence.

GENITOURINARY: Negative for blood in urine or bladder incontinence.

MUSCULOSKELETAL: Positive for neck pain and back pain.

NEUROLOGICAL: Negative for recent seizure or speech disturbance.

PSYCHIATRIC: Negative for suicidal ideation or hallucinations.

PAST HISTORY:

MEDICAL:

PMHx:

n/a

DENVER DIAGNOSTIC PAIN CORPORATION

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Visit Date: 08/02/2023

Allergies:

NKDA

Medications:

Flexeril

Ibuprofen

MVA: 2-23-2023.

SURGICAL:

n/a.

PAIN PROCEDURES:

n/a.

FAMILY HISTORY:

n/a.

SOCIAL HISTORY:

Alcohol Use: Social.

SMOKING STATUS:

Never smoker.

ALLERGIES (reported):

No allergies on file

CURRENT MEDICATION (reported):

Patient has no known medications

VITAL SIGNS:

Pain Level: 0/10 NRS (Previous Pain Level: 2)

Weight: 255 lbs. (Previous Weight: 255 lbs.) Height: 67 in.

BP Location: Arm

PHYSICAL EXAMINATION:

GENERAL: Well developed; Over nourished; Well groomed

EYES: EOMI; White conjunctiva

ENT: Normal external ears and nose; Hearing grossly normal

RESPIRATORY: Normal respiratory rate and pattern; No respiratory distress; No wheezing

CARDIOVASCULAR: Normal rate; Normal rhythm

GASTROINTESTINAL: Non-distended; Non-tender

PSYCHIATRIC: Mental status: alert and oriented x 3; Appropriate affect and demeanor

MUSCULOSKELETAL:

---> Gait: Normal

DENVER DIAGNOSTIC PAIN CORPORATION

Jack Rentz

7800 E Orchard Road Ste 350 Greenwood Village, CO 80111-2550

Phone: (720) 598-0805 Fax: (720) 606-2905

Theodore Angel DOB: 09/15/1975 47 year old, male

6002 GRAPE DR

COMMERCE CITY, CO 80022

(720) 461-0920

Visit Date: 08/02/2023

---> Motor: 5/5 bilateral flex/ex Hips, Knees, Ankles, Toes, Add/Ab Thighs, 5/5 bilateral flex/ex Shoulders, Elbows, Wrists, Digits

---> Tone: Grossly normal tone in all extremities

---> Tenderness to Palpation: Low Back: Midline and Right Paramidline

---> Kemp's: (+) Right LUMBAR:

NEUROLOGICAL:

---> Cranial Nerves: 2-12 Intact

---> Sensory: Vibratory sensation decrease in Right S1 dermatome

---> Deep Tendon Reflexes: 2+ Bilateral Knee and Ankle

---> Straight Leg Raise: Positive Right

LABS:

ASSESSMENT/DIAGNOSIS:

Jimmy is being seen today via telemedicine for eval S/P right L5-S1 TFESI. He reports leg symptoms almost resolved and only notices it on long car drives for work. He is more functional and is pleased with the results thus far and is able to swing a golf club and play 18 holes. He is to continue with Chiro. and P.T. Discussed continued conservative care and knowing limitations and proper body mechanics. Will continue to monitor for advanced treatments &/or injections and assess for positive outcomes in 3 months.

Jimmy is a 47 yom that presents today following a motor vehicle accident on 2-23-2023. Patient reports constant shooting pain on the right side of his low back with numbness radiating down to his right foot. MRI Lumbar Spine - L4-5, L5-S1 facet effusions, L5-S1 right subarticular recess narrowing with mild compression of the descending S1 nerve root
MRI Cervical Spine - mild annular bulging C4-7.
MRI Thoracic Spine - Unremarkable.

It is my opinion, within a reasonable degree of medical certainty, that the objective and quantitative findings as described above and additionally in the patient file, include physical bodily damage and limitations which are a direct result of the injury caused on 2/23/23. The injuries are consistent with the patient's reported history of the collision

G89.21 CHRONIC PAIN DUE TO TRAUMA

M51.16 Intervertebral disc disorders w radiculopathy, lumbar region

M51.27 Other intervertebral disc displacement, lumbosacral region

G89.11 Acute pain due to trauma

M54.12 Radiculopathy, cervical region

M54.2 Cervicalgia

S13.4XXD Sprain of ligaments of cervical spine, subsequent encounter

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S16.1XXD Strain of muscle, fascia and tendon at neck level, subs

M47.896 Other spondylosis, lumbar region

M51.26 Other intervertebral disc displacement, lumbar region

M54.16 Radiculopathy, lumbar region

M62.830 Muscle spasm of back

S33.5XXD Sprain of ligaments of lumbar spine, subsequent encounter

S39.012D Strain of muscle, fascia and tendon of lower back, subs G89.11 - ACUTE PAIN DUE TO TRAUMA

M54.12 - RADICULOPATHY, CERVICAL REGION

M54.2 - CERVICALGIA

S13.4XXD - SPRAIN OF LIGAMENTS OF CERVICAL SPINE, SUBSEQUENT ENCOUNTER

S16.1XXD - STRAIN OF MUSCLE, FASCIA AND TENDON AT NECK LEVEL, SUBS

M47.896 - OTHER Spondylosis, LUMBAR REGION

M62.830 - MUSCLE SPASM OF BACK

S33.5XXD - SPRAIN OF LIGAMENTS OF LUMBAR SPINE, SUBSEQUENT ENCOUNTER

S39.012D - STRAIN OF MUSCLE, FASCIA AND TENDON OF LOWER BACK, SUBS

PLAN:

RADIOLOGY:

Reviewed prior imaging:

--> MRI: Cervical Spine (no contrast)

--> MRI: Thoracic Spine (no contrast)

--> MRI: Lumbar Spine (no contrast)

REFERRALS:

--> Continue Physical Therapy/ Chiropractic care

PROCEDURES TO CONSIDER: (The patient may benefit from the following procedures in the future, depending on the outcome of today's plan):

(Right)

--> Lumbar Epidural Steroid Injection TFESI L5-S1 Dx Lumbar Radiculopathy M54.16, Lumbar Disc Displacement M51.26, 64483

DISCUSSIONS / RECOMMENDATIONS:

--> Risk and benefits of the injections discussed.

--> Activity modification for wellness and improved function

FOLLOW-UP:

Return to clinic in 3 month.

No linked medications found

PHYSICIAN: Jack B. Rentz, M.D.

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Electronically Signed: JACK RENTZ on/at 8/2/2023 9:58:37 AM

Rebel Moon Acupuncture & Wellness

Name: Angel, Theodore "Jimmy" J

Date: 2023 04 07

Visit: 1- Initial Consultation

Chief Complaint: Trapezius, scapula, lumbar, and leg pain.

Subjective:

The patient was involved in a vehicle collision on February 23, 2023. The patient was a rear passenger of a 4 door LYFT vehicle. The road conditions were dry. The patient was not wearing a seatbelt. The airbags did not deploy. The patient states that he was heading East on Colorado Blvd and Brighton Blvd in a LYFT when the driver of the vehicle swerved and T-Boned another vehicle.

Upon impact, the patient was looking right. Upon impact, the patient was thrown side to side. The patient's head was hit on the headrest. The patient's whole body hit the inside of the vehicle. The patient received bruises and lacerations on the lip and teeth. The patient was shaken, disoriented and dazed for two minutes.

The patient did receive treatment by paramedics at the scene of the collision. The patient did go to the emergency room at North Suburban Medical. The patient was transported to the emergency room by ambulance. The patient received an X-Ray of the shoulder. The results were no fractures. The patient received a CT-Scan of the head. The results were no fractures. The patient also went to St. Anthony Family Medicine on March 2, 2023. The patient reports no gap in treatment. The patient began treatment at Synergy Health Partners on March 10, 2023.

The patient presents with moderate pain on the right scapula with spasms. The patient reports moderate pain along the right sciatic nerve which originates at the 5th lumbar vertebrae and radiates downward the posterior and lateral right leg and terminates at the right dorsal aspect of the foot with mild moderate pain. The patient reports right trapezius pain at a mild moderate level. The patient tosses and turns during sleep due to low back discomfort and pain. The patient sleeps five hours per night. The patient wakes 5-6 times per night. The patient is a plumber and states that he is unable to work due to pain. The patient is taking muscle relaxers as needed.

ADL:

Since the vehicle collision, the patient states that sitting, standing, bending, lifting, working, lying down, and reaching increase pain. The patient has help at home with cooking and cleaning.

Objective:

Upon palpation of the cervical, pain and knots are found. Upon palpation of the thoracic, pain and tenderness are noted. Upon palpation of the lumbar, pain and tightness are present.

Tongue:

Pale color and white coat

Pulse:

Right Side: Deep, Empty in Chi, Slippery in Guan Left Side: Wiry, Deep

Assessment:

Bladder Mai Qi & Xue Yu

Cervical Sprain {S13.4XXA} Cervical Strain {S16.1XXA} Thoracic Sprain {S23.3XXA} Thoracic Strain {S29.012A} Lumbar Sprain {S33.5XXA} Lumbar Strain {S39.012A} SI Joint Sprain {S33.6XXA}
Car Passenger Injured in Crash w/Car {V43.62XA}

Procedure:

The procedure is to move the qi and xue, clear stagnation in the channels and to reduce pain.
The treatment plan is to reduce pain in the cervical, thoracic and lumbar regions.

I will reevaluate the patient on the 6th visit.

Treatment:

Acupuncture Point Prescription:

- Ear: Shenmen, Point Zero
- Bilateral Points: Du 4, 16, 20, Gb 21, Anmien,
- Right Side : Gb30, Bl36, Gb34, Liv3, GB42, Bl 60, 40, 58, 23, 25, 41, 43, 45, 49, 51, SI 11, 12
14, 15
- Infrared Lamp: Cervical, Thoracic, & Lumbar Regions

Acupuncturist:

Ignacia Genco L.Ac., Diplomate of TCM., MSTCM

X	99202-25	Initial Consultation
	99212	Reevaluation Visit
X	97810	Acupuncture with One or More Needles
	97811	Acupuncture with One or More Needles with Extra Time
	97813	Electric Stimulation with Acupuncture
	97814	Electric Stimulation with Acupuncture with Extra Time
X	97026	Infrared Heat Lamp
	97016	Cupping

97124

Tui Na

97139

Moxibustion (Unlisted Therapeutic Procedure)

97039

Kinesio Tape