

UK Sinha Physician, P.C.

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September 20, 2022

Office seen at:
Renew Chiropractic P.C.
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Re: Jackson, Unique
DOB: 10/25/1988
DOA: 06/24/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, neck and low back pain.

HISTORY OF PRESENT ILLNESS: A 33-year-old right-hand dominant female involved in a motor vehicle accident on 06/24/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the rear, left side. The airbags did not deploy. The EMS did not arrive on the scene. The police were called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of left shoulder, neck and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 months with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Left shoulder arthroscopy on 03/08/2020 with Dr. Voleti.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol.

ADL CAPABILITIES: As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: driving, lifting heavy objects, carrying, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, and clicking. The patient is unable to reach overhead or behind the back and unable to sleep at night due to pain. Worse with range of motion and improves with rest, medication, physical therapy, and ice. The patient had left shoulder arthroscopy on 03/08/2020 with Dr. Voleti.

REVIEW OF SYSTEMS: Temperature taken at the time of exam was 98.6 degrees Fahrenheit.

General: No fever, chills, night sweats, weight gain, or weight loss.

HEENT: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nosebleeds, sore throat or hoarseness.

Endocrine: No cold intolerance, appetite changes or hair changes.

Skin: Clear, no rashes or lesions.

Neuro: No headaches, dizziness, vertigo or tremor.

Respiratory: No wheezing, coughing, shortness of breath or difficulty breathing.

Cardiovascular: No chest pain, murmurs, irregular heart rate or hypertension.

GI: No nausea, vomiting, diarrhea, constipation, jaundice or changes in bowel habits.

GU: No blood in urine, painful urination, loss of bladder control or urinary retention.

Hematology: No active bleeding, bruising, anemia or blood clotting disorders.

Psychiatric: No anxiety, change in sleep pattern, depression or suicidal thoughts.

PHYSICAL EXAMINATION: The patient's height is 5 feet 1 inch, weight is 155 pounds, and BMI is 29.3. The left shoulder reveals tenderness to palpation over supraspinatus tendon region. There is no swelling, heat, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 150/180 degrees, adduction 40/45 degrees, forward flexion 160/180 degrees, extension 50/60 degrees, internal rotation 80/90 degrees, and external rotation 80/90 degrees. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 09/02/2022, shows supraspinatus and subscapularis tendinosis/tendinopathy with heterogeneous intrasubstance signal abnormality distally. Trace fluid within the glenohumeral joint and subscapularis recess. Hypertrophic changes of the AC joint, ventrally and laterally downsloping acromion which abuts the bursal surface of the rotator cuff.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive capsulitis, left shoulder.
3. M75.42 Impingement, left shoulder.
4. M65.812 Tenosynovitis, left shoulder.
5. M75.52 Bursitis, left shoulder.
6. M25.512 Pain, left shoulder.
7. S49.92XA Injury, left shoulder.
8. M89.312 Acromioclavicular joint hypertrophy, left shoulder.

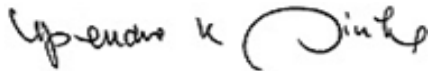
9. M25.412 Joint effusion, left shoulder.

PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder 3 days/week.
6. Follow up in 4 weeks.

CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.

AFFIRMATION: Being duly licensed to practice medicine in the state of New York, pursuant to the applicable provisions of the Civil Practice Laws and Rules, I hereby affirm under penalty of perjury that the statements contained herein are true and accurate.



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UKS/AEI