Initial Comprehensive Medical Evaluation  
  
Date: 07/23/2025   
  
RE:  Daniel Jose De Amorim   
DOB:  05/22/1987   
1st Evaluation  
  
HISTORY OF PRESENT ILLNESS:

On 07/23/2025, Mr. Daniel Jose De Amorim, a right handed 38-year-old male presents for the initial evaluation of the injuries sustained in a motor vehicle accident which occurred on 05/20/2025.  The patient states he was the restrained driver of a vehicle which was involved in a T-boned side swiped passenger side collision. Airbags were not deployed. Patient did not go to the hospital.  Due to the impact, patient complains of pain in neck, lowback and left shoulder. Patient has been receiving chiropractic therapy on the second day of injujry.  The patient reports no injury to the head and no loss of consciousness. During the accident, the patient reports injuries to neck, lowback and left shoulder.

CHIEF COMPLAINTS:   
The patient complains of neck pain that is 5/10 with medications, 10/10 without medication, with 10 being the worst, which is sharp, throbbing in nature.  Neck pain is associated with tingling.  Neck pain is worsened with stress,  sitting, standing, and lifting. Neck pain is improved with rest, ice, relaxation, changing position.  
  
The patient complains of lower back pain that is 5/10 with medications, 10/10 without medication, with 10 being the worst, which is sharp, throbbing in nature.  Lower back pain is associated with tingling. Lower back pain is worsened with stress,  sitting, standing, and lifting. Lower back pain is improved with rest, ice, relaxation, changing position.  
  
The patient complains of left shoulder pain that is rated at 5/10 with medications, 10/10 without medication, with 10 being the worst, which is sharp, throbbing in nature.  Left shoulder pain worsens with lifting objects. Left shoulder pain is improved with rest, ice, relaxation, changing position.  
  
REVIEW OF SYSTEMS:  The patient denies seizures, chest pain, shortness of breath, jaw pain, abdominal pain, fevers, night sweats, diarrhea, blood in urine, bowel/bladder incontinence, double vision, hearing loss, recent weight loss, episodic lightheadedness and rashes.  
  
PAST MEDICAL HISTORY: High blood pressure, diabetes.   
  
PAST SURGICAL/HOSPITALIZATION HISTORY: Noncontributory.  
  
MEDICATIONS: None.  
  
ALLERGIES: No known drug allergies.  
  
SOCIAL HISTORY:  Patient denies smoking, or illicit drug use. Patient drinks socially.  
  
FAMILY HISTORY:  High blood pressure, cancer, diabetes.  
  
PHYSICAL EXAM:   
General: The patient presents in an uncomfortable state.  
  
Neurological Examination: The patient is alert and cooperative and responding appropriately. Cranial nerves II-XII grossly intact.  
  
Deep Tendon Reflexes: Are 2+ and equal.  
  
Sensory Examination: It is intact.  
  
Manual Muscle Strength Testing:  Testing is 5/5 normal.  
  
Cervical Spine Examination: Reveals tenderness upon palpation at C2-C7 levels bilaterally. The Spurling's test is positive. The cervical distraction test is positive. There are palpable taut bands/trigger points at bilateral levator scapulae, bilateral trapezius and bilateral posterior scalenes..  
  
Lumbar Spine Examination: Reveals tenderness upon palpation at L1-S1 levels bilaterally with muscle spasm present. Trigger points with palpable taut bands were noted at bilateral paraspinal levels L3-S1 with referral patterns laterally to the region in a fan-like pattern. Range of motion is decreased secondary to pain.   
  
Left Shoulder Examination: Reveals tenderness upon palpation of the left AC joint. Neer's test is positive and Hawkins test is positive.   
  
Gait: Normal.  
  
Diagnostic Studies:    
05-27-2025 - MRI of the cervical spine reveals, HNP at C3-4, C4-5, C5-6.Annular fissure at C4-5.  
05-27-2025 - MRI of the lumbar spine reveals bulge at L2-3, L3-4, L4-5, L5-S1, HNP at L5-S1. Bilateral foraminal stenosis.  
  
The above diagnostic studies were reviewed.  
  
Diagnoses: 

Strain of muscle, fascia and tendon, initial encounter - S16.1XXA

Cervicalgia (neck pain). - M54.2

Sprain of ligaments, initial encounter - S13.4XXA

Lumbago - (low back pain). - M54.5

Spasm of back muscles - M62.830

Sprain of ligaments of lumbar spine, initial encounter - S33.5XXA

Strain (lumbar) - S39.012

Left shoulder pain - M25.512

Sprain/strain in left shoulder - S43.402A

Plan: 

1. Request MRI of the left shoulder.
2. Schedule NCV/EMG of the UE:

Request chiropractic care.  
  
Medications:

Voltaren 1 % gel externally sig: as directed twice per day 30 days, quantity: 100 grams

Tizanidine HCl 4 mg tablet orally sig: 1 tablet at bedtime as needed once a day 30 days quantity: 30 tablets.

Tramadol HCl 50 mg tablet orally sig: 1 tablet as needed once a day 14 days, quantity: 14 tablets.

Procedures: If the patient continues to have tender palpable taut bands/trigger points with referral patterns as noted in the future on examination, I will consider doing trigger point injections.  
  
Care: Acupuncture, chiropractic and physical therapy. Avoid heavy lifting, carrying, excessive bending and prolonged sitting and standing.  
  
Goals: To increase range of motion, strength, flexibility, to decrease pain and to improve body biomechanics and activities of daily living and improve the functional status.  
  
Precautions: Universal.  
  
Follow-up:  6 weeks for med and EMG review.  
  
#Sign  
#ProviderName  
#AssProviderName