MOUNTAIN VIEW PAIN & WELLNESS CENTER

1523 Mountain View Drive | Salt Lake City, UT 84102

Phone: (801) 555-0634 | Fax: (801) 555-0635

PATIENT INFORMATION

Patient Name: Anderson, Michelle Lynn

Date of Birth: 07/18/1974 (Age: 50 years)

Medical Record Number: MVP-2024-6271

Date of Service: September 23, 2024

Insurance: Medicare Part B | ID: 3RT-PL-8562A

CHIEF COMPLAINT

Chronic widespread pain, seeking advanced pain management options including neuromodulation.

HISTORY OF PRESENT ILLNESS

Ms. Anderson is a 50-year-old female with long-standing history of chronic widespread pain syndrome. Patient reports pain onset in 2016 (8 years ago), gradually progressive, now affecting multiple body regions including neck, shoulders, upper and lower back, hips, and extremities bilaterally.

Pain is described as constant, aching, burning quality with baseline intensity of 6-7/10, worsening to 8-9/10 with activity or stress. Pain is diffuse and migratory - no single predominant location. Associated symptoms include severe fatigue, non-restorative sleep (wakes frequently, feels unrefreshed), cognitive difficulties ("fibro fog"), stiffness worse in mornings, and multiple tender points throughout body.

Initial evaluation by rheumatology in 2016 led to diagnosis of fibromyalgia based on widespread pain index and symptom severity scale. Subsequent workups including inflammatory markers (ESR, CRP), rheumatoid factor, ANA, thyroid function tests were all within normal limits, ruling out other rheumatologic or systemic conditions.

Patient reports significant functional impairment - difficulty with household chores, cannot work (previously employed as administrative assistant, on disability since 2018), limited social activities. Pain exacerbated by physical activity, stress, cold weather, and poor sleep.

Treatment History:

- **Duloxetine:** 60mg daily for 18 months (2017-2018) - moderate improvement in pain (approximately 30% reduction) but plateaued, discontinued due to nausea •

Pregabalin: Titrated to 300mg BID for 14 months (2019-2020) - minimal benefit, caused weight gain

- **Amitriptyline:** 50mg qhs for 6 months (2020) - helped sleep initially but insufficient pain control
- **Milnacipran:** 100mg BID for 8 months (2021) - insufficient relief
- **Cyclobenzaprine:** 10mg qhs PRN - occasional use for muscle spasms
- **NSAIDs:** Multiple trials (ibuprofen, naproxen, meloxicam) - minimal sustained
- benefit **Tramadol:** 50mg TID PRN for 12 months (2022) - modest benefit but patient prefers to avoid opioid-type medications

- **Physical Therapy:** Two separate courses (2017, 2020) - 8 weeks each, gentle exercises and stretching, temporary mild improvement but pain returned
- **Aquatic Therapy:** 12 weeks (2019) - enjoyed but limited long-term benefit
- **Cognitive Behavioral Therapy:** 6 months (2020-2021) - helpful for coping strategies but pain unchanged
- **Massage Therapy:** Regular sessions 2018-2020 - temporary relief only
- **Acupuncture:** 15 sessions (2021) - no significant improvement

Patient has read about neuromodulation techniques including peripheral nerve stimulation and is interested in exploring this option, having heard of success stories from online support groups. She inquires specifically about peripheral nerve stimulation targeting areas of most severe pain.

PAST MEDICAL HISTORY

- Fibromyalgia syndrome (diagnosed 2016)
- Chronic fatigue syndrome
- Irritable bowel syndrome
- Migraine headaches (occasional, well-controlled)
- Depression (history, currently stable)
- Anxiety disorder (managed with therapy and medication)

- Hypothyroidism (controlled on levothyroxine)

CURRENT MEDICATIONS

- Duloxetine 30mg daily
- Cyclobenzaprine 10mg qhs PRN
- Levothyroxine 75mcg daily
- Buspirone 15mg BID
- Ibuprofen 600mg TID PRN
- Zolpidem 10mg qhs PRN

ALLERGIES

No known drug allergies

SOCIAL HISTORY

Non-smoker. Drinks alcohol rarely (1-2 glasses wine per month). Denies illicit drug use. Married, supportive husband. Two teenage children. On disability since 2018 due to fibromyalgia - previously worked as administrative assistant. High school graduate with some college coursework. Active in online fibromyalgia support groups.

REVIEW OF SYSTEMS

Constitutional: Positive for chronic fatigue, non-restorative sleep, low-grade subjective fevers occasionally. Denies unintentional weight changes.
Musculoskeletal: Positive for widespread pain as described, morning stiffness, multiple tender points. No joint swelling.
Neurological: Positive for cognitive difficulties ("fibro fog"), occasional headaches. Denies weakness, numbness, or tingling.
Psychiatric: History of depression and anxiety, currently stable on medications. Denies suicidal ideation.
GI: History of IBS with alternating diarrhea/constipation, currently managed.
All other systems reviewed and negative.

PHYSICAL EXAMINATION

Vital Signs: BP 118/72, HR 76, RR 14, Temp 98.4°F, Weight 168 lbs, Height

5'5"

General: Alert and oriented x3, pleasant, appears fatigued
Musculoskeletal: No visible joint deformities or swelling. Full range of motion all joints but patient reports pain throughout with movement. Fibromyalgia tender point examination: 16 of 18 tender points positive to palpation including occiput, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, and knee bilaterally. Widespread allodynia noted - light touch causes discomfort in multiple areas.

Neurological: Alert, appropriate affect. Cranial nerves II-XII intact. Motor strength 5/5 all extremities though patient reports pain with testing. Sensation intact to light touch throughout. Deep tendon reflexes 2+ and symmetric. No focal neurological deficits. Gait normal.

Skin: No rashes, lesions, or abnormalities noted

DIAGNOSTIC STUDIES

Laboratory Studies (06/2024):
CBC: WNL
CMP: WNL
ESR: 8 mm/hr (normal)
CRP: 0.4 mg/L (normal)
Rheumatoid Factor: Negative
ANA: Negative
TSH: 2.1 mIU/L (normal, on levothyroxine)
Vitamin D: 28 ng/mL (mildly low, started supplementation)

Imaging: Multiple prior imaging studies over years (cervical spine, lumbar spine, shoulders) - all showing only mild age-appropriate degenerative changes, no significant pathology identified

PSYCHOLOGICAL EVALUATION

Date: August 10, 2024
Evaluator: Dr. Patricia Reynolds, Licensed Clinical Psychologist

Summary: Patient underwent psychological screening in preparation for potential neuromodulation therapy. Assessment included clinical interview and standardized

measures (BDI-II, BAI, MMPI-2). Patient demonstrates mild depression (BDI-II: 18) and mild anxiety (BAI: 15), both well-managed with current treatment. No substance abuse history or current concerns verified. Good social support from family. Patient has appropriate coping mechanisms developed through CBT. However, evaluation notes patient has very high expectations for pain relief from neuromodulation and may benefit from additional counseling regarding realistic outcomes. Overall cleared from psychological standpoint with recommendation for ongoing support and expectation management.