

Back To Chiropractic Continuing Education Seminars **Hx & Exam for P.I. Narratives – 4 Hours**

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.

(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

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Exam Process: Please read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.
3. On the new window or new tab you just opened, go to: backtochiropractic.net website.
4. Go directly to the Online section. DON'T register again.
5. Click on the Exam for the course you want to take. No passwords needed.
6. Follow the Exam instructions.
7. Upon passing the exam you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you can repeat the exam at no charge.

Please retain the certificate for 4 years.

If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC

Back To Chiropractic CE Seminars

Hx & Exam for P.I. Narratives – 4 Hours
Syllabus, Outline & Learning Objectives
Presented by: Steven C Eggleston, DC, Esq.
Back To Chiropractic CE Seminars

Dear Doctors:

Your patient history & exam is FAR more important than writing a narrative report. Your narrative report is supposed to be based on your history & exam findings so it is very difficult to do a proper med-legal narrative if you failed miserably to WRITE down the important facts from the initial exam, re-exams and final exams. My advice is to FOCUS on writing down efficiently and concisely the patient's history and exam findings and the narrative will write itself. While technically this course is teaching you history & examination, following the advice in this course will save you hours of time writing personal injury narrative reports.

I practiced chiropractic for 20 years and testified many times in depositions and court. I have practiced personal injury law since 2007. Now I see chiropractic reports all the time and use them to win personal injury cases. Frankly, most of them do not help me because they are filled with useless information and devoid of legally significant facts that could help me win the case. You are about to read what a chiropractor learned about personal injury reports after he became an attorney and started using them to argue with claim adjusters.

Attorneys and claim adjusters do NOT understand medical tests. Period. I assure you that 98% of them NEVER read the body of any narrative report. They just skip to the last few pages and read the "Opinions and Conclusions" section. They do not read the ranges of motions. They do not read the examination findings. They just don't understand them. All they care about is your opinions and conclusions so **I suggest writing a brief 2-3 pages narrative report** that only includes your opinions. Then send in your entire patient file upon which your opinions are based. You will ALSO send the attorney ALL of your patient records from each and every history, consultation and exam. The patient CHART is where all the legally significant facts should be located. The patient CHART is what backs up your opinions and conclusions in the narrative report. Don't waste your time "fabricating" a narrative report out of thin air many months after you saw the patient. Focus on collecting the facts, just the IMPORTANT facts during each exam and re-exam and then your narrative will write itself. These first two pages explain how to get the most out of this course.

First, you will find 95 numbered pages following these first two pages of instructions. **The test for this course is based on the information contained in this sample narrative report and the supporting documentation included in the 95 pages.** Pages 1-3 contain the sample narrative report that I suggest you begin to use. Notice that the first page of the report simply tells the reader how you gathered the information and directs them to look in the supporting documentation (basically, your chart). Be sure that your patient chart has a lot of legally significant facts and not just a lot of pabulum. The forms that are used in this sample are available free on my website, www.hbtinstitute.com. Go to Doctor Forms. The user name is "great" and the password is "doctor" (both are lower case and don't use the quotation marks, just the words inside the quotation marks.)

The second page of the sample narrative is the beginning of the “Opinions and Conclusions” section. Notice that you **CANNOT** do this in a canned, pre-written manner. Rather, you simply keep good records each time you do a history and exam of the patient and then send them to the attorney with your opinions about what is in those records.

You must address FOUR things in your opinions section. First, **did the car accident cause the injuries** described in your report. The standards are “To a reasonable medical certainty” (76% to 100%) and “To a reasonable medical probability” (51% to 75%). Anything of which you are not at least 51% sure is legally insignificant. Possibility, maybe and perhaps are mere conjecture according to the law and are worthless in a legal case. Second, are there any **pre-existing injuries that require your opinion regarding Apportionment?** (See my 2 hour course, Essentials of P.I. Narratives) Third, was your **treatment “essential” and “necessary”** to help this patient heal from the injuries *caused by* this accident? Fourth, a brief (emphasize brief) **summary of treatment** (yours and all other doctors involved.)

Notice that the forms I use to gather and record patient data are **EASY** to understand and do not contain a bunch of chiropractor jargon or medical terminology. **You need to dumb down your records intentionally in P.I. cases so that claim adjusters and lawyers can understand them.** If they understand your records, you don’t have to re-type all your data into a “report.” Basically, make your records easy to understand, full of legally useful data (facts) and then save a LOT of time when you have to “write” a P.I. narrative. It might take you a while to integrate some better forms into your practice so that you actually have a lot of legally useful facts in your records. Once you begin using forms like the ones you will see on these 95 pages of patient records, the simple 2-3 page narrative report writes itself.

Finally, **be sure to send ALL pages in your records to the attorney.** In my example, there are 95 pages of records. Send in all the records you have. You don’t have to number them like I did in this sample. Send the 2-3 page P.I. narrative **AND** all of your patient chart. Stop coming in to your office on your day off to write P.I. narratives. Use my forms to let the patient write most of the data you’ll need later when writing the narrative. Remember that you get paid for Evaluation and Management CPT codes for the work you do when “face to face” with the patient. Fill out these history and exam forms with the patient **in the room** with you and get paid for your time to collect it, write it down and make decisions about what tests and treatment you’ll do and where to refer the patient. As a P.I. lawyer, I can use a report like this to get the patient a good and fair settlement for their injuries without having to “argue” with the claim adjuster. I only have to argue when the treating chiropractor gives me very little useful data or legally significant facts in their records or narrative report.

Steven C Eggleston
27 La Plaza Penthouse
Palm Springs, CA 92262
(877) 424-4765

Main Street Chiropractic

1234 Main Street
Pleasantville, CA 98725
(714) 555-1212

May 12, 2019

Eggleston & Ramirez Law Office
27 La Plaza, Penthouse
Palm Springs, CA 92262

RE: Maria Teresa Cruz
DOI: February 1, 2019

Dear Mr. Eggleston:

I have concluded my active treatment plan for Maria Cruz. I have included with this narrative report a copy of my entire patient chart as well as a billing statement. My patient chart is easy to understand and includes numerous forms with titles such as "Symptoms", "Symptoms Update", "Neck Consultation", "Upper Back Consultation", "Low Back Consultation", various extremity consultation and exam forms, various concussion and PTSD questionnaires and tests, homecare instructions and various other pertinent forms.

You will find multiples of many of these forms because some of them were completed approximately every thirty days during the active phase of patient care while others were only completed once. Each form has the patient's name, the date of the injury and the date that form was completed in my office. I have not re-typed all this voluminous data into this narrative report because my original data forms and notes are simple to understand by anyone even if he or she is not a doctor.

I have also included all of the medical records that I collected, reviewed and relied upon for my opinions and decisions when providing care to this patient. I was able to obtain and review Ms. Cruz's last five years of medical records preceding this accident and I found only one injury in her past that is relevant to this accident. Ms. Cruz injured her right shoulder on July 4, 2018, some seven months before this car accident. Her shoulder was not yet healed from that prior right shoulder injury and I will discuss apportionment in my opinions section below.

1

OPINIONS AND CONCLUSIONS

Maria Cruz was injured in a car accident on February 1, 2019. The forces from this accident that caused \$2,835 damage to the rear of her car were sufficient to cause the injuries described in my recorded patient data. I also believe this accident was the sole cause of Maria's injuries and treatment EXCEPT for her right shoulder which was previously injured on July 4, 2018 and had not fully healed at the time of this accident. I reviewed the records of her primary care physician for the last five years and found reference to this July 4, 2018 right shoulder injury which was diagnosed as a "sprain/strain" by her medical doctor. I will discuss apportionment of the right shoulder injury below. I found no other relevant prior injuries in the last five years of her medical records and, thus, all of the injuries I describe in my patient records except the right shoulder injury are completely, 100% caused by and attributable to the car accident on February 1, 2019.

I did my best as a chiropractor to provide essential treatment necessary to heal Maria from injuries that resulted from this accident. I provided treatment as documented by the "Treatment Plan" forms you will find in my records. Other doctors and specialists provided treatment as well because Maria was too severely injured to be healed by chiropractic care alone. For example, I cannot heal torn neck ligaments, brain concussions, PTSD, torn rotator cuff tendons or a torn knee meniscus with chiropractic care. I tried to heal the injuries that are within my scope of practice and made appropriate referrals to other doctors and specialists for the injuries that cannot be cured by chiropractic methods.

My "Symptoms" form provided me a road map to Ms. Cruz's injuries. She and I consulted at length about her injuries and her various symptoms were recorded on this form on February 4, 2019. There are three "Symptoms Update" forms each done approximately every thirty days. I was greatly concerned with her radicular neurological symptoms into her left hand and left foot, her brain concussion, her sleep disruptions and evaluated for them and formulated treatment plans for them as well as all her injuries.

One of the most severe injuries was to her right shoulder which had been "sprained" on July 4, 2018 and was not 100% better when this accident occurred. She still had mild, intermittent right shoulder pain which was controlled before this accident with non-steroidal anti-inflammatory medications, massage and exercise. After this accident wherein her right supraspinatus tendon was torn in a full thickness tear, she had to have right rotator cuff surgery. She would not have needed right shoulder surgery but for this car accident. Therefore, I attribute 90% of her chiropractic treatment and 100% of her surgical treatment to the accident of 2/1/2019 to a reasonable medical certainty.

As of the date of this report, she has a torn meniscus in her right knee and is awaiting right knee surgery. She has had neck injections into her left C5-6 facet ligament to attempt to repair the torn ligament and facet capsule. She is currently under the care of Mortimer Snerd, DDS for her TMJ injury, pain management physician Woody Guthrie, MD, for her torn neck ligaments, neuropsychologist Wilhelm Roentgen, Ph.D. and psychiatrist Marie Curie, M.D. for concussion and PTSD, hand surgeon William Shakespeare, MD, and is awaiting left wrist

surgery and orthopedic surgeon Rhonda McMillan, MD, who has already done right shoulder surgery and will be doing right knee surgery very soon.

The rest of my records should be reasonably easy to understand but feel free to call if you need additional clarification.

Sincerely,

A handwritten signature in black ink, appearing to be 'A. Gud', with a stylized, cursive-like script.

A. Gud Chiropractor

PATIENT INFORMATION

Name <u>MARIA TERESA CRUZ</u>		Today's Date <u>2/4/19</u>	
Date of Birth <u>7/4/80</u>	Height <u>5'4"</u>	Weight <u>122</u>	Dominant Hand? <u>(R)</u> L
Address <u>1234 MAIN ST</u>		City <u>COSTA MESA</u>	Zip <u>92626</u>
Phone (cell) <u>(714) 555-1212</u>		Phone (other) _____	
email <u>MTCRUZ@YAHOO.COM</u>		DL# <u>M0712647</u>	

Health Insurance Company <u>AETNA</u>		Policy# <u>CBL123478</u>	
Address _____		City _____	Zip _____
Adjuster _____		Phone <u>(800) 555-1212</u>	
Car Insurance Company <u>STATE FARM</u>			
Address _____		City _____	Zip _____
Adjuster <u>MARY SMITH</u>		Phone <u>(888) 555-1212</u>	
Agent _____		Phone _____	
Policy # <u>C127-D882</u>		Claim # <u>2019 012478</u>	
What Medical Payments Coverage? _____		What Uninsured Motorist Coverage? _____	
What Law Firm Represents You? <u>NONE</u>			
Address _____		City _____	Zip _____
Your Lawyer's Name? _____		Phone _____	

Name of Insured on your Car Policy <u>JOHN & MARIA CRUZ</u>		For office use only Patient # _____
Date of Loss/Accident? <u>2/1/19</u>	Date you first saw any Doctor after accident <u>2/1/19</u>	
Cost of all medical treatment since the accident? \$ <u>DON'T KNOW</u>		
How much income have you lost since the accident \$ <u>MISSED WORK PAST 4 DAYS</u>		
What is the property damage (repair amount) of your car? \$ <u>2,740</u>		

Name of your Personal M.D. <u>PAUL REVERE, M.D.</u>		Phone <u>(877) 555-1212</u>	
Address <u>42 MAIN ST</u>		City <u>COSTA MESA</u>	Zip <u>92626</u>
Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident			
Name	Type	Phone#	Amount of Bill
<u>AMBULANCE (DON'T KNOW WHICH)</u>			<u>?</u>
<u>HAG HOSPITAL</u>	<u>E.R.</u>		<u>?</u>

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Please use other side of page to write additional doctors & hospitals

IRREVOCABLE ASSIGNMENT OF BENEFITS

Patient Name: MARIA TERESA CRUZ

Claim # ABC1234 DOI: FEB. 1, 2019

SSN/ID # 627-13-1479

Insured's Name MARIA TERESA CRUZ Relation to Insured SELF

I hereby instruct and direct the ALL STATE
Insurance Company to pay the benefits of my policy by check made out to and mailed directly to
Steven C Eggleston, D.C.
2601 Main St., Suite 800
Irvine, CA 92614
OR

If my policy prohibits direct payment to a doctor, then I hereby also instruct and direct
you, my insurance company, to make the check out to me and mail it as follows:

C/O Steven C Eggleston, D.C.
2601 Main St., Suite 800
Irvine, CA 92614

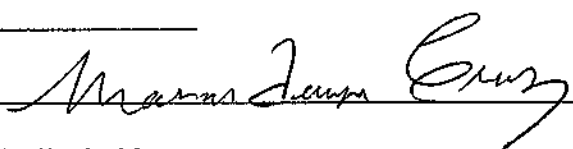
For the professional or chiropractic/medical benefits allowable and otherwise payable to me
under my current insurance policy as payment toward the total charges for professional services
rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER
THIS POLICY AND IS IRREVOCABLE, EVEN BY MY ATTORNEY. DO NOT PAY THE
BENEFITS OF THIS POLICY TO MY ATTORNEY AND DO NOT MAIL ANY BENEFIT
CHECKS TO MY ATTORNEY. Said payment will not exceed my indebtedness to Dr.

Eggleston and I have agreed to pay, in a current manner, any balance of said professional
services fees over and above this insurance payment. If my policy is an indemnity policy, I
hereby direct you, my insurance company, to indemnify me against the harm that would occur
should Dr. Eggleston have to balance bill me for professional fees that I contracted for and that
you, my insurance company, fail to pay or fail to pay in full.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize Dr. Eggleston to release any information pertinent to my case to any insurance
company, adjuster, or attorney involved in this case. I further authorize Dr. Eggleston to file a
complaint on my behalf with the California Insurance Commissioner or the California
Department of Managed Health Care.

Date: 2/4/2019

Signature of Policyholder: 

Signature of Claimant, if other than Policyholder: _____

aob.doc

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize Steven C Eggleston, DC to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about February 1, 2019, for which you have been retained.

I understand that all bills incurred by me at Steven C Eggleston, DC's office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with Steven C Eggleston, DC. I also understand that, unlike my attorney, Steven C Eggleston, DC does not work on a contingency fee and I must pay for his services at the time of his rendering of them and that this lien is only to protect his interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed Steven C Eggleston, DC for my health care in connection with this accident and pay it directly and promptly to Steven C Eggleston, DC at:

Steven C Eggleston, DC
2601 Main St., Suite 800
Irvine, CA 92614

I am granting Steven C Eggleston, DC an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add Steven C Eggleston, DC as a payee on the settlement draft.

MARIA TERESA CRUZ
Print Name

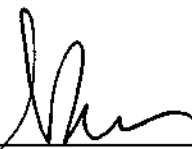

Patient's Signature

Date of Signature 2/4/2019

Date of Accident 2/1/2019

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

DEWEY CHETUM & HOWE
Print Name of Attorney


Attorney's Signature

2/17/19
Date

Symptoms

Patient MARIA CRUZ Date 2/4/19 Date of Injury 2/1/19

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☒ "Clunk" sound with neck movements
- ☒ Neck pain
- ☒ Upper back pain
- ☒ Low back pain
- ☒ Shoulder pain ☒ Left ☒ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☒ Elbow pain ☐ Left ☒ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☒ Wrist pain ☒ Left ☒ Right
- ☒ Hand pain ☒ Left ☐ Right
- ☒ Hip pain ☐ Left ☒ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☒ Knee pain ☒ Left ☒ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☒ Ankle pain ☒ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☒ Jaw pain
- ☐ Clicking in Jaw
- ☒ Pain when chewing
- ☐ Face pain
- ☒ Chest pain LEFT COLLAR BONE, RIBS
- ☐ Stomach pain
- ☒ Bruise to (R) KNEE, (R) FOREARM (R) HIP
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☒ Numb/Tingling Arm / Hand ☒ L ☐ R
- ☒ Numb/Tingling Leg / Foot ☒ L ☐ R
- ☒ Weakness Arm / Hand ☒ L ☐ R
- ☐ Weakness Leg / Foot ☐ L ☐ R

Symptoms Associated with Injuries

- ☒ Stiffness or limited movement in joint(s)
- ☒ Headaches
- ☒ Muscle spasms/sore muscles
- ☒ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☒ Sleep changes/disruption of patterns
- ☒ Pain radiates from one place to another
- ☒ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☒ I am taking the following medications FLEXAL, IBUPROFEN

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☒ I am sleepy, tired during day or doze off easily
- ☒ Upset stomach, nausea, heartburn or vomiting
- ☒ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☒ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☒ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☒ I have difficulty finding some words when talking
- ☒ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☒ I am eating more or less than normal
- ☒ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☒ I feel like my head is "Foggy"
- ☒ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☒ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☒ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☒ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☒ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☒ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☒ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☒ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Patient Signature Maria Cruz

Dr. Signature [Signature]

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Symptoms Update

Patient MARIA CRUZDate 3/5/19 Date of Injury 2/1/19

	Never Had	100% Healed	Still Have	Improved A Little	Improved Medium	Improved A Lot	Not Improving	Getting Worse
"Clunk" sound with neck movements			X				X	
Neck pain			X	X				
Upper back pain			X	X				
Low back pain			X	X				
Shoulder pain (left)			X				X	
Shoulder pain (right)			X					X
Elbow pain (left)	X							
Elbow pain (right)			X	X				
Wrist pain (left)			X					X
Wrist pain (right)			X		X			X NO
Hand/finger pain (left)			X		X			
Hand/finger pain (right)	X							
Hip pain (left)	X							
Hip pain (right)			X	X				
Knee pain (left)		X						
Knee pain (right)			X					X
Ankle/foot pain (left)			X			X		
Ankle/foot pain (right)	X							
Jaw/chewing pain (left)			X					X
Jaw/chewing pain (right)	X							
Face pain	X							
Chest/ribs pain			X		X			
Stomach pain	X							
Bruises on <u>ALL GONE</u>		X						
Cuts/scrapes on	X							
Scars on	X							
Numb/tingling arm/hand (left)			X				X	
Numb/tingling arm/hand (right)	X							
Numb/tingling leg/foot (left)		X						
Numb/tingling leg/foot (right)	X							
Weak/clumsy arm/hand (left)			X				X	
Weak/clumsy arm/hand (right)	X							
Weak/clumsy leg/foot (left)	X							
Weak/clumsy leg/foot (right)	X							
Stiffness in joints			X		X			
Headaches			X			X		
Sore or spasm in muscles			X			X		
Dizzy/lightheaded/woozy			X				X	
Vision changes	X							
Sleep changes			X					X
Radiating pain			X				X	
Anxiety/nervousness			X					X
Lack of enthusiasm for life			X					X

I take these medications ADUIL DAILY 3-4 TIMES

Patient Signature

Dr. Signature

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Symptoms Update

Patient MARIA CRUZDate 4/8/19 Date of Injury 2/1/19

	Never Had	100% Healed	Still Have	Improved A Little	Improved Medium	Improved A Lot	Not Improving	Getting Worse
"Clunk" sound with neck movements			X				X	
Neck pain			X		X			
Upper back pain			X			X		
Low back pain			X			X		
Shoulder pain (left)			X				X	
Shoulder pain (right) ORTHO = ROT CUFF TORN			X	SCHEDULED FOR SURGERY			4/24/19	
Elbow pain (left)	X							
Elbow pain (right)			X	X				
Wrist pain (left) HAND SURGEON = TORN LIGT			X				X	
Wrist pain (right)			X			X		
Hand/finger pain (left) STIFF			X			X		
Hand/finger pain (right)	X							
Hip pain (left)	X							
Hip pain (right)			X				X	
Knee pain (left)		X						
Knee pain (right) ORTHO = MENISCUS TORN			X	HAD CORTISONE SHOT			3/26/19	
Ankle/foot pain (left)		X						
Ankle/foot pain (right)	X							
Jaw/chewing pain (left)			X	DENTIST PUT HER INTO A SPLINT				
Jaw/chewing pain (right)	X							
Face pain	X							
Chest/ribs pain		X						
Stomach pain	X							
Bruises on		X						
Cuts/scrapes on	X							
Scars on	X							
Numb/tingling arm/hand (left)			X	PAIN MGMT = PRP			LEFT C5/6 FACET CAPSULE	3/2
Numb/tingling arm/hand (right)	X							
Numb/tingling leg/foot (left)		X						
Numb/tingling leg/foot (right)	X							
Weak/clumsy arm/hand (left)			X			X	SINCE PRP	
Weak/clumsy arm/hand (right)	X							
Weak/clumsy leg/foot (left)	X							
Weak/clumsy leg/foot (right)	X							
Stiffness in joints			X	X				
Headaches		X						
Sore or spasm in muscles ACHE			X	X				
Dizzy/lightheaded/woozy			X	X ML			X	
Vision changes	X							
Sleep changes			X					X
Radiating pain			X		X			
Anxiety/nervousness			X				X	
Lack of enthusiasm for life			X					X
I take these medications	ADRIAL EVERY DAY							
Patient Signature	<i>Maria Cruz</i>			Dr. Signature	<i>[Signature]</i>			

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Symptoms Update

Patient

MARIA CRUZ

Date

5/12/19

Date of Injury

2/1/19

	Never Had	100% Healed	Still Have	Improved A Little	Improved Medium	Improved A Lot	Not Improving	Getting Worse
“Clunk” sound with neck movements			X	X				
Neck pain			X			X		
Upper back pain		X						
Low back pain		X						
Shoulder pain (left)			X			X	AFTER PRP CS-6	
Shoulder pain (right)			X	ROT-CUFF SURGERY 4/21/19 SUCCESSFUL - STILL PAINFUL				
Elbow pain (left)	X							
Elbow pain (right)			X			X		
Wrist pain (left)			X	AWAITING WRIST SURGERY				
Wrist pain (right)		X						
Hand/finger pain (left)	DUPUYTREN'S CONTRACTURE OBSERVED IN PALM TENDONS - SEE M.D.							
Hand/finger pain (right)	X							
Hip pain (left)	X							
Hip pain (right)			X	Refer to PAIN MANAGEMENT DR.			X	
Knee pain (left)		X						
Knee pain (right)			X	AWAITING KNEE SURGERY			X	
Ankle/foot pain (left)		X						
Ankle/foot pain (right)	X							
Jaw/chewing pain (left)			X			X	DENTIST HELPING	
Jaw/chewing pain (right)	X							
Face pain	X							
Chest/ribs pain		X						
Stomach pain	X							
Bruises on		X						
Cuts/scrapes on	X							
Scars on	X							
Numb/tingling arm/hand (left)			X	PRP HELPED, UNDER CARE OF MD				
Numb/tingling arm/hand (right)	X							
Numb/tingling leg/foot (left)		X						
Numb/tingling leg/foot (right)	X							
Weak/clumsy arm/hand (left)			X			X	UNDER MD CARE	
Weak/clumsy arm/hand (right)	X							
Weak/clumsy leg/foot (left)	X							
Weak/clumsy leg/foot (right)	X							
Stiffness in joints			X		X			
Headaches		X						
Sore or spasm in muscles		X						
Dizzy/lightheaded/woozy			X		X			
Vision changes	X							
Sleep changes			X	Refer for SLEEP STUDY				X
Radiating pain			X			X		
Anxiety/nervousness			X	UNDER NEUROLOGIC CARE			X	
Lack of enthusiasm for life			X	X				

I take these medications ADVA, ANTI ANXIETY, ANTI-DEPRESSANT

Patient Signature

Maria Cruz

Dr. Signature

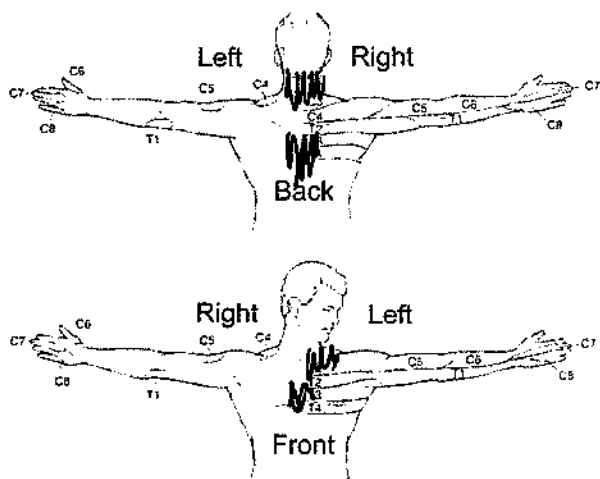
[Signature]

10

Neck Area Consultation

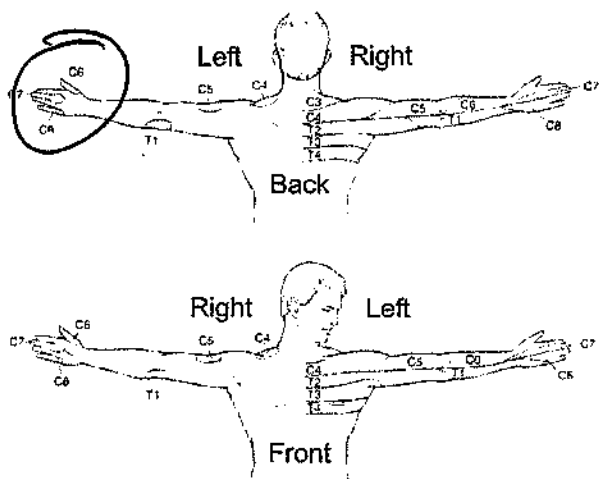
Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



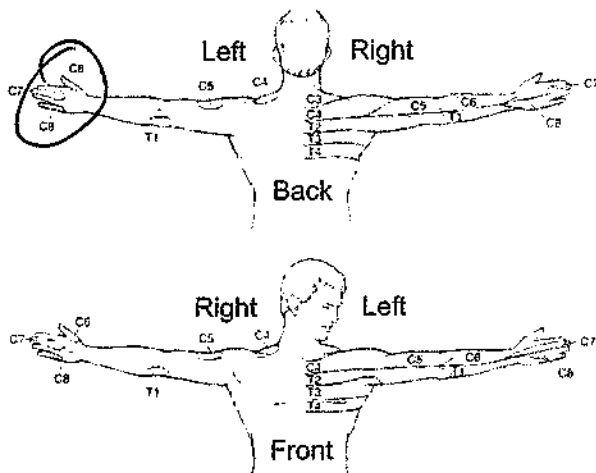
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
C4	/10	%				
C5	/10	%				
C6	6 /10	100 %	X		X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
C4	/10	%				
C5	/10	%				
C6	6 /10	5-10 %	X		X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** in the past 7 days



Area	Severity	% of Time	Weak	Clumsy	Drop Things	Other
C4	/10	%				
C5	/10	%				
C6	3 /10	100 %		X	X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Neck Area Consultation

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

☒ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities MOVEMENT OF NECK
HURTS

EXACERBATING FACTORS (Check all below that make your NECK hurt *more*)

- ☒ Laying on pillow ☒ Turning neck ☐ Looking UP ☒ Looking DOWN ☐ Combing Hair
☒ Computer at Work ☒ Computer at Home ☒ Working ☐ Sports ☐ Driving
☐ Others (please list other things that make your neck hurt) _____

ALLEVIATING FACTORS (Check all below that make your NECK feel *better*)

- | | | | | | |
|---|--------------------|-------|------|-------|--------|
| <input type="checkbox"/> Doctor Treatments | Helps for _____ | Hours | Days | Weeks | Months |
| <input checked="" type="checkbox"/> Medications | Helps for <u>4</u> | Hours | Days | Weeks | Months |
| <input type="checkbox"/> Home Exercises | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |

Cerv. Compression = \oplus Local neck pain C5-6 Facet \odot
Cerv. Distraction = \oplus Local neck pain C5-6 Facet \odot
Point Tenderness C5/6 \odot Facet Capsule
Generalized swelling \odot side of neck

Patient Signature

Maria Cruz

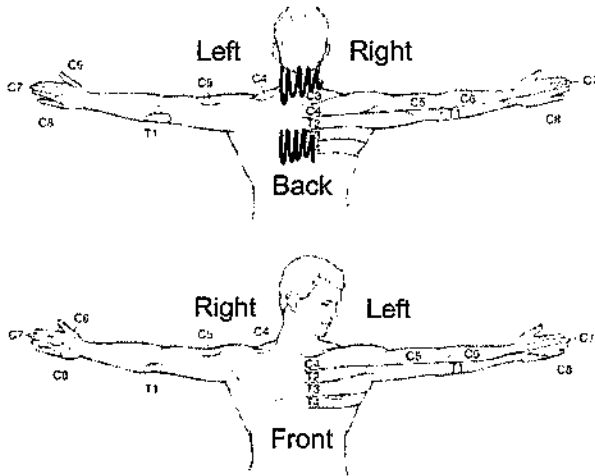
Dr. Signature

[Signature]

Neck Area Consultation

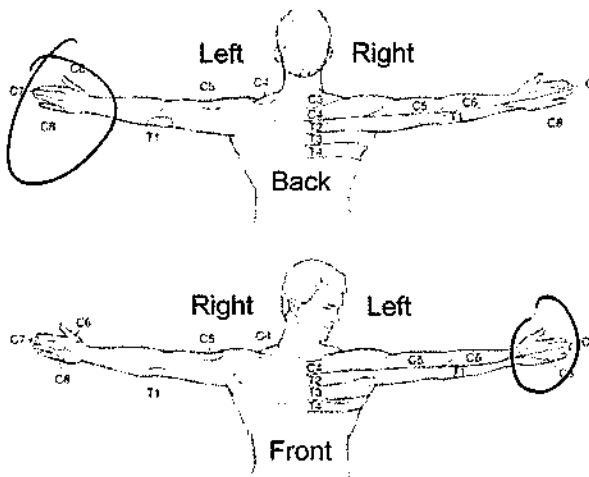
Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



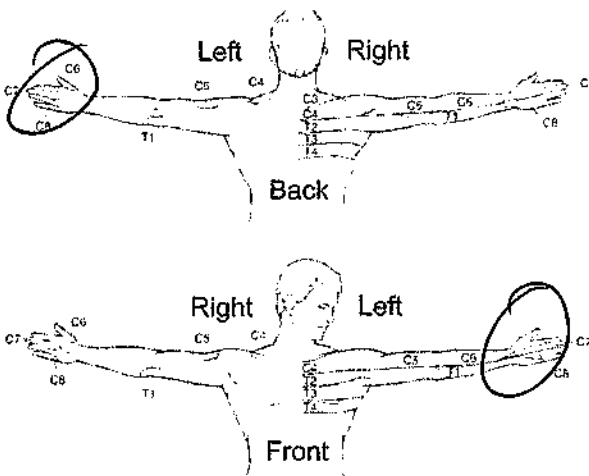
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
C4	/10	%				
C5	/10	%				
C6	6 /10	100 %	WITH MOVEMENT	X	X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
C4	/10	%				
C5	/10	%				
C6	5 /10	5 %	X		X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** in the past 7 days



Area	Severity	% of Time	Weak	Clumsy	Drop Things	Other
C4	/10	%				
C5	/10	%				
C6	3 /10	100 %		X	X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Neck Area Consultation

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

☒ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities LOOKING UP OR
LOOKING DOWN HURTS, MY NECK HURTS WHEN I LOOK
TO THE LEFT

EXACERBATING FACTORS (Check all below that make your NECK hurt *more*)

- ☐ Laying on pillow ☒ Turning neck ☒ Looking UP ☒ Looking DOWN ☒ Combing Hair
☒ Computer at Work ☒ Computer at Home ☒ Working ☐ Sports ☐ Driving
☐ Others (please list other things that make your neck hurt) _____

ALLEVIATING FACTORS (Check all below that make your NECK feel *better*)

- | | | | | | |
|---|-----------------------------------|-------|-------|--------|--------|
| <input checked="" type="checkbox"/> Doctor Treatments | Helps for <u>2-3</u> <u>Hours</u> | Days | Weeks | Months | |
| <input checked="" type="checkbox"/> Medications | Helps for <u>4</u> <u>Hours</u> | Days | Weeks | Months | |
| <input type="checkbox"/> Home Exercises | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks | Months |

- (+) CERVICAL COMPRESSION - C5-6 Facet Pain (L) side
(+) C/S DISTRACTION - LOCAL C5-6 Facet Pain (L)

MARKED TENDERNESS (L) FACET CAPSULE C5-6

Patient Signature

Maria Teresa Cruz

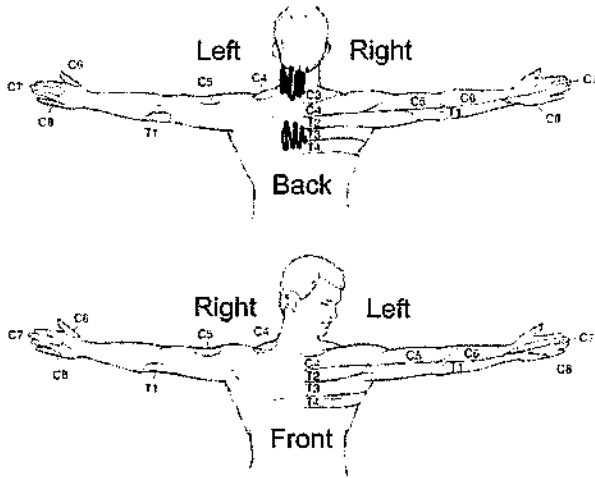
Dr. Signature

[Signature]

Neck Area Consultation

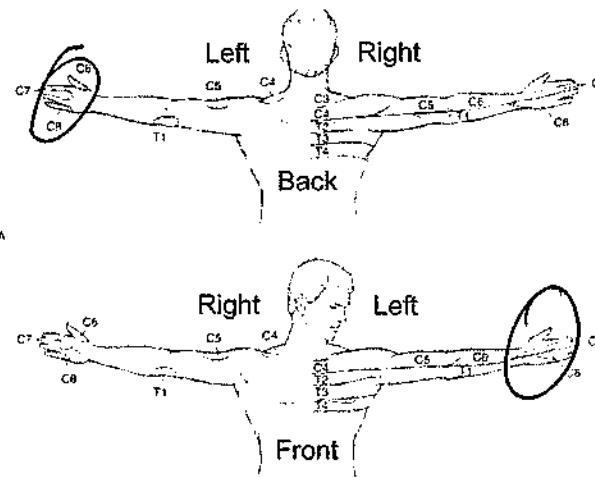
Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



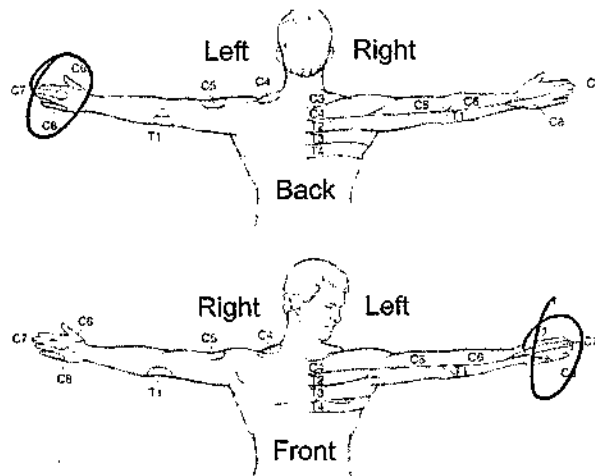
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
C4	/10	%				
C5	/10	%				
C6	7 /10	80 %	✓	✓	✓	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
C4	/10	%				
C5	/10	%				
C6	7 /10	10 %	✓		✓	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** in the past 7 days



Area	Severity	% of Time	Weak	Clumsy	Drop Things	Other
C4	/10	%				
C5	/10	%				
C6	4 /10	80 %		✓	✓	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Neck Area Consultation

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

☒ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities MOVEMENT OF NECK
HURTS- ESPECIALLY DRIVING & READING

EXACERBATING FACTORS (Check all below that make your NECK hurt *more*)

- ☐ Laying on pillow ☒ Turning neck ☒ Looking UP ☒ Looking DOWN ☐ Combing Hair
☒ Computer at Work ☐ Computer at Home ☒ Working ☐ Sports ☐ Driving
☐ Others (please list other things that make your neck hurt) _____

ALLEVIATING FACTORS (Check all below that make your NECK feel *better*)

- | | | | | |
|---|-----------------------------------|-------|-------|---------------------|
| <input checked="" type="checkbox"/> Doctor Treatments | Helps for <u>3</u> <u>Hours</u> | Days | Weeks | Months |
| <input checked="" type="checkbox"/> Medications | Helps for <u>3-4</u> <u>Hours</u> | Days | Weeks | Months |
| <input checked="" type="checkbox"/> Home Exercises | Helps for <u>4</u> <u>Hours</u> | Days | Weeks | Months |
| <input checked="" type="checkbox"/> <u>SHOT IN NECK</u> | Helps for _____ | Hours | Days | <u>Weeks</u> Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks Months |
| <input type="checkbox"/> _____ | Helps for _____ | Hours | Days | Weeks Months |

(+) COM COMT & DIST - LOCAL C5.6 PAIN (L)

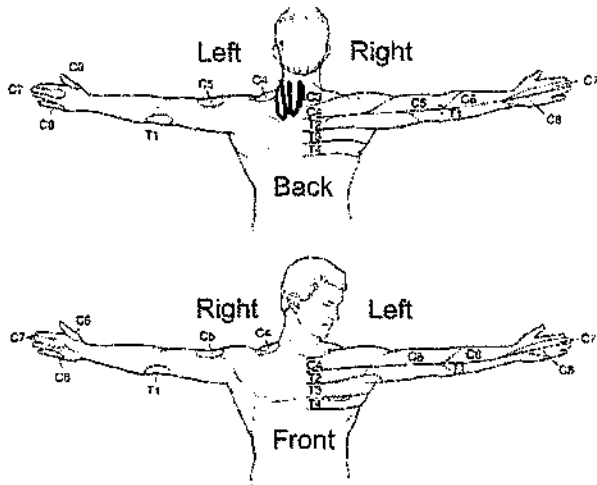
Tender (L) C5.6 FINGER LIGAMENT WHICH WAS TORN

Patient Signature Maria Cruz Dr. Signature [Signature]

Neck Area Consultation

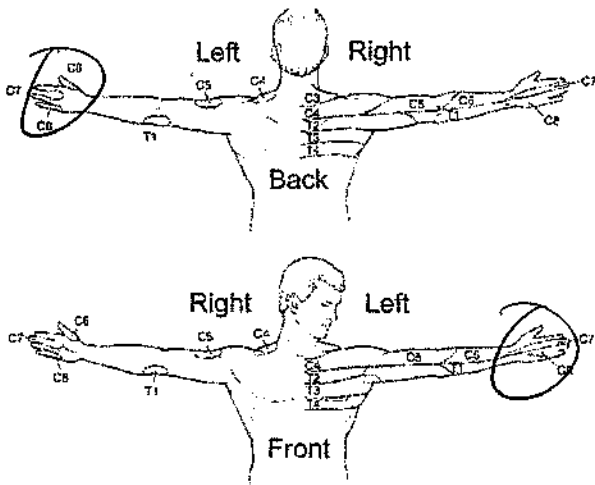
Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/2019

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



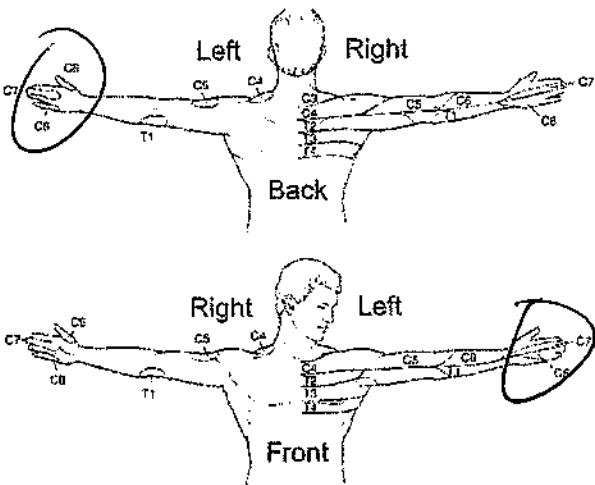
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
C4	/10	%				
C5	/10	%				
C6	2 /10	25 %		X	X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
C4	/10	%				
C5	/10	%				
C6	3 /10	5 %	X		X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** in the past 7 days



Area	Severity	% of Time	Weak	Clumsy	Drop Things	Other
C4	/10	%				
C5	/10	%				
C6	1 /10	40 %		X	X	
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Neck Area Consultation

Patient MARIA CRUZ Today's Date 5/19/19 Date of Injury 2/1/19

☒ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities AT WORK I HAVE
TO TAKE MORE BREAKS, STRETCH MY NECK

EXACERBATING FACTORS (Check all below that make your NECK hurt more)

- ☐ Laying on pillow ☐ Turning neck ☒ Looking UP ☐ Looking DOWN ☐ Combing Hair
☒ Computer at Work ☐ Computer at Home ☒ Working ☐ Sports ☐ Driving
☐ Others (please list other things that make your neck hurt) _____

ALLEVIATING FACTORS (Check all below that make your NECK feel better)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Doctor Treatments | Helps for <u>3</u> Hours <u>Days</u> Weeks Months |
| <input checked="" type="checkbox"/> Medications | Helps for <u>6</u> Hours <u>Days</u> Weeks Months |
| <input checked="" type="checkbox"/> Home Exercises | Helps for <u>10</u> Hours <u>Days</u> Weeks Months |
| <input checked="" type="checkbox"/> <u>SHOT IN NECK</u> | Helps for <u>6</u> Hours <u>Days</u> <u>Weeks</u> Months |
| <input type="checkbox"/> _____ | Helps for _____ Hours <u>Days</u> Weeks Months |
| <input type="checkbox"/> _____ | Helps for _____ Hours <u>Days</u> Weeks Months |

TORN (U) FACET CAPSULE HEALING NICELY AFTER PRP.
STILL UNDER MD CARE - ANOTHER NECK INJECTION
NEXT WEEK IS SCHEDULED.

Patient Signature

Maria Cruz

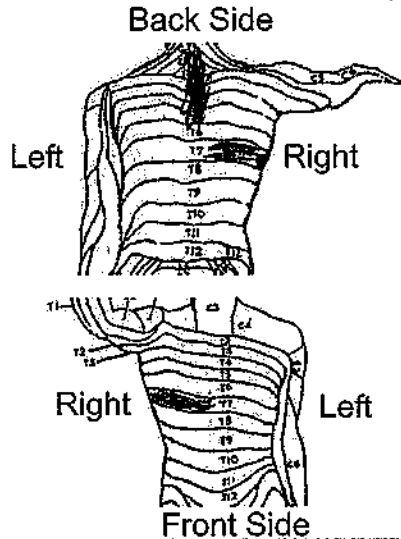
Dr. Signature

[Signature]

Upper Back Area Consultation

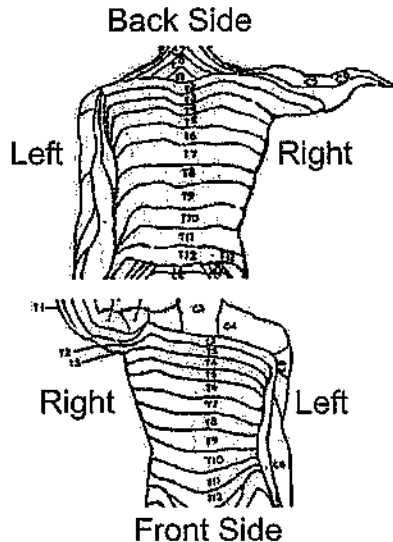
Patient MARIA CRUZ Today's Date 2-4-2019 Date of Injury 2-6-2019

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T2	4 /10	100 %		X	X	
T3	4 /10	100 %		X	X	
T4	4 /10	100 %		X	X	
T5	4 /10	100 %		X	X	
T6	/10	%				
T7	6 /10	100 %		X	X	
T8	/10	%				
T9	/10	%				
T10	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

☒ I am having **FUNCTIONAL DIFFICULTIES** because of **UPPER BACK PAIN** in the past 7 days
Describe how UPPER BACK PAIN is affecting your normal daily activities _____

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt *more*)

- ☐ Laying in Bed
 ☐ Sitting
 ☒ Bending
 ☒ Twisting
 ☒ Dressing
 ☒ Computer at Work
 ☒ Computer at Home
 ☒ Working
 ☐ Sports
 ☒ Driving
 ☐ Others (please list other things that make your UPPER BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel *better*)

- ☐ In-Office Treatments Helps for _____ Hours Days Weeks Months
☒ Medications Helps for 4 Hours Days Weeks Months
☐ Home Exercises Helps for _____ Hours Days Weeks Months
☒ HOT SHOWERS Helps for 1 Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months

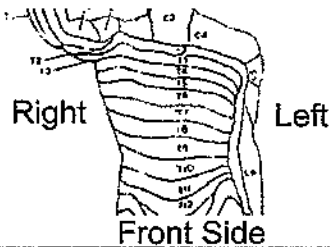
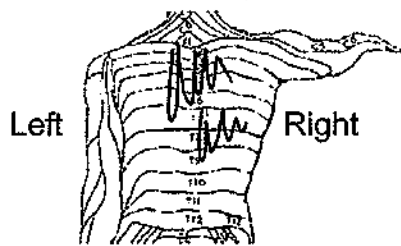
Patient Signature Maria Cruz Dr. Signature [Signature] 19

Upper Back Area Consultation

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days

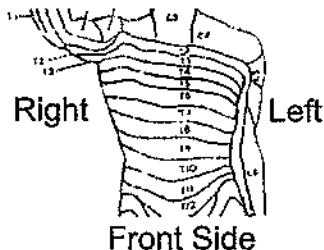
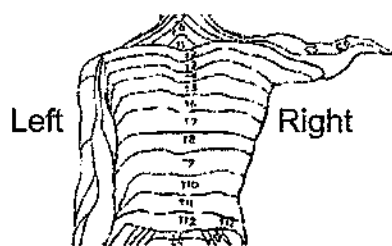
Back Side



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T2	/10	%				
T3	2 /10	50 %		X	X	
T4	2 /10	50 %		X	X	
T5	2 /10	50 %		X	X	
T6	/10	%				
T7	4 /10	80 %		X	X	
T8	/10	%				
T9	/10	%				
T10	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days

Back Side



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

☒ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN in the past 7 days
Describe how UPPER BACK PAIN is affecting your normal daily activities HURTS TO SIT, LIFT.

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt *more*)

- ☐ Laying in Bed
 ☒ Sitting
 ☐ Bending
 ☐ Twisting
 ☐ Dressing
☒ Computer at Work
 ☐ Computer at Home
 ☒ Working
 ☐ Sports
 ☐ Driving
☐ Others (please list other things that make your UPPER BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel *better*)

- ☒ In-Office Treatments Helps for 2 Hours Days Weeks Months
☒ Medications Helps for 4 Hours Days Weeks Months
☒ Home Exercises Helps for 4 Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months

Patient Signature Maria Cruz

Dr. Signature [Signature]

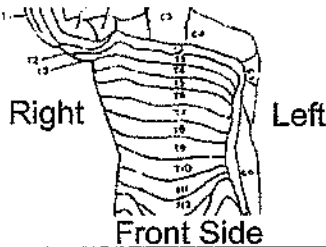
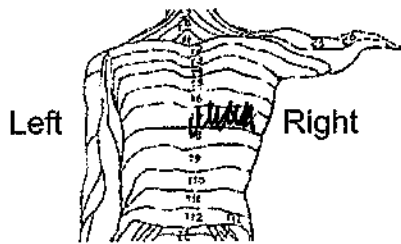
20

Upper Back Area Consultation

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days

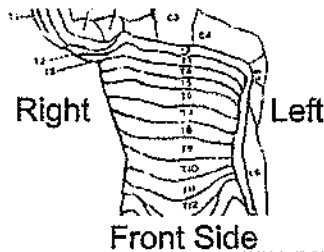
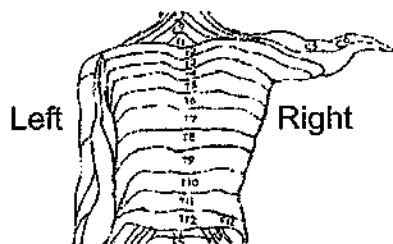
Back Side



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	2 /10	25 %		X	X	
T8	/10	%				
T9	/10	%				
T10	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days

Back Side



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

☒ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN in the past 7 days
Describe how UPPER BACK PAIN is affecting your normal daily activities _____

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt *more*)

- ☐ Laying in Bed
 ☐ Sitting
 ☐ Bending
 ☐ Twisting
 ☐ Dressing
☒ Computer at Work
 ☐ Computer at Home
☒ Working
 ☐ Sports
 ☐ Driving
☐ Others (please list other things that make your UPPER BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel *better*)

- ☒ In-Office Treatments Helps for 1 Hours Days Weeks Months
☒ Medications Helps for 4 Hours Days Weeks Months
☒ Home Exercises Helps for 8 Hours Days Weeks Months
 _____ Helps for _____ Hours Days _____ Weeks Months
 _____ Helps for _____ Hours Days _____ Weeks Months

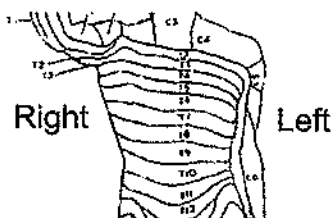
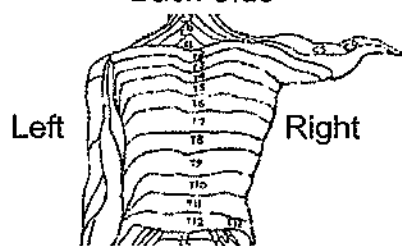
Patient Signature Maria Cruz Dr. Signature [Signature] **21**

Upper Back Area Consultation

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days

Back Side

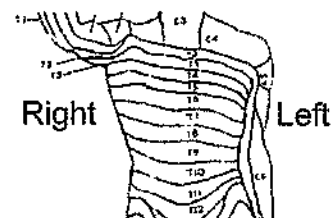
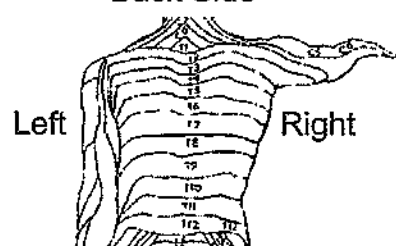


Front Side

Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days

Back Side



Front Side

Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

☐ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN in the past 7 days
Describe how UPPER BACK PAIN is affecting your normal daily activities _____

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt *more*)

- ☐ Laying in Bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Dressing
☐ Computer at Work ☐ Computer at Home ☐ Working ☐ Sports ☐ Driving
☐ Others (please list other things that make your UPPER BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel *better*)

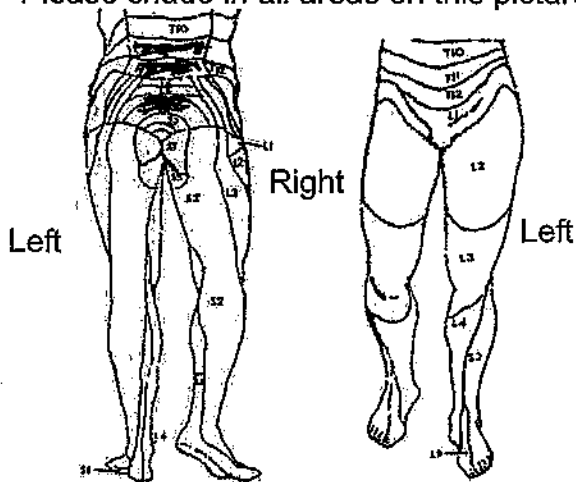
- ☒ In-Office Treatments Helps for 2 Hours Days Weeks Months
☐ Medications Helps for _____ Hours Days _____ Weeks Months
☒ Home Exercises Helps for 1 Hours Days Days Weeks Months
 _____ Helps for _____ Hours Days _____ Weeks Months
 _____ Helps for _____ Hours Days _____ Weeks Months

Patient Signature Maria Cruz Dr. Signature [Signature] **22**

Low Back & Pelvis Area Consultation

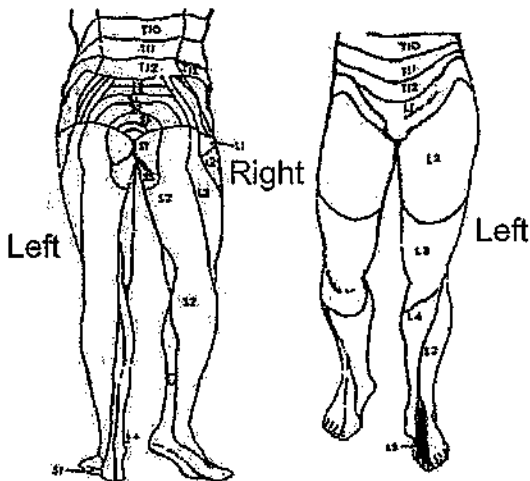
Patient MARIA CRUZ Today's Date 2-4-19 Date of Injury 2-1-19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T11	7 /10	100 %				
T12	7 /10	100 %				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	8 /10	100 %	X		X	
L5	9 /10	100 %	X		X	
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	6 /10	100 %	X		X	
S1	/10	%				
S2-5	/10	%				

☒ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☒ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days

Describe how LOW BACK PAIN is affecting your normal daily activities I TOOK 4 DAYS OFF WORK BECAUSE I HURT TOO MUCH TO SIT AT WORK

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt more)

☒ Laying in Bed ☒ Sitting ☒ Bending ☒ Twisting ☒ Lifting ☒ Pushing/Pulling

☐ Computer at Work ☒ Computer at Home ☒ Working ☐ Sports ☒ Driving

☒ Others (please list other things that make your LOW BACK hurt) IT HURTS DOING NOTHING AT ALL

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

☐ In-Office Treatments Helps for _____ Hours Days Weeks Months

☒ Medications Helps for 2-4 Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

Helps for _____ Hours Days Weeks Months

Helps for _____ Hours Days Weeks Months

Patient Signature

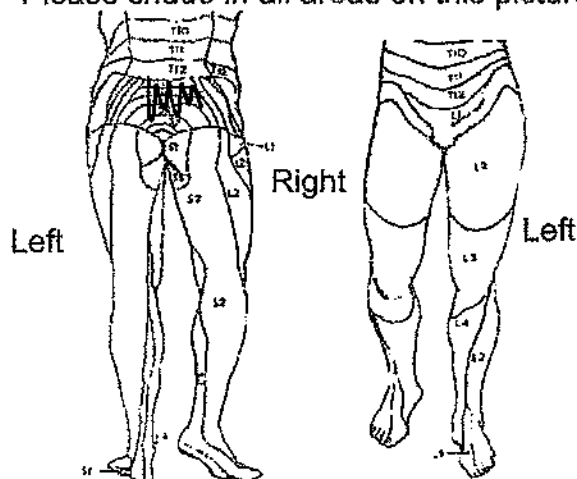
Maria Cruz

Dr. Signature

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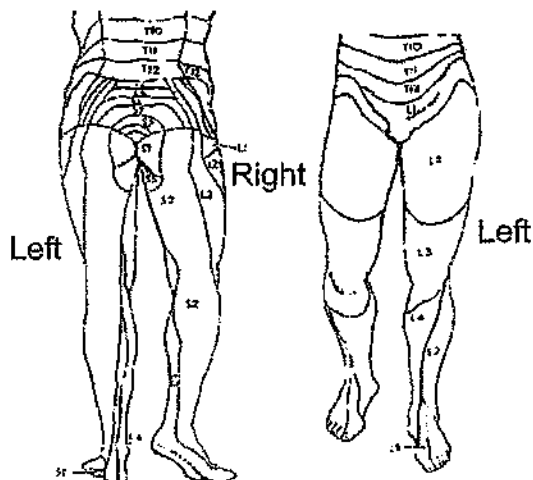
Low Back & Pelvis Area Consultation

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19
 Please shade in all areas on this picture where you have **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	6 /10	100 %		X	X	
L5	7 /10	100 %		X	X	
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☒ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days

Describe how LOW BACK PAIN is affecting your normal daily activities SITTING AT WORK HURTS SO MUCH I HAVE TO STAND UP EVERY 30 MINUTES & STRETCH

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt more)

- ☐ Laying in Bed
 ☒ Sitting
 ☒ Bending
 ☒ Twisting
 ☒ Lifting
 ☐ Pushing/Pulling
☒ Computer at Work
☐ Computer at Home
☒ Working
☐ Sports
☐ Driving
☐ Others (please list other things that make your LOW BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

- ☒ In-Office Treatments Helps for 2 Hours Days Weeks Months
☒ Medications Helps for 4 Hours Days Weeks Months
☒ Home Exercises Helps for 4 Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months

Maria Cruz

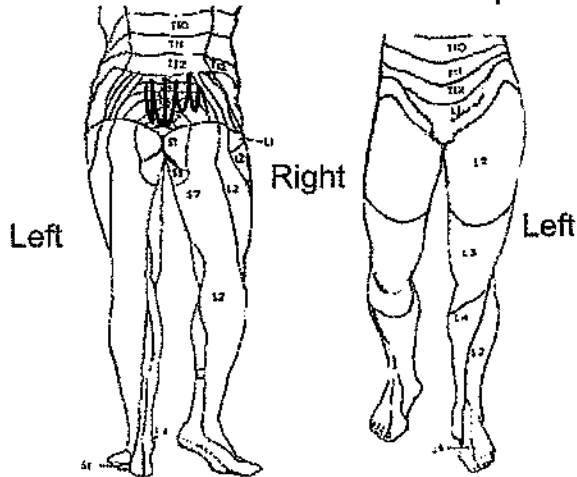
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Low Back & Pelvis Area Consultation

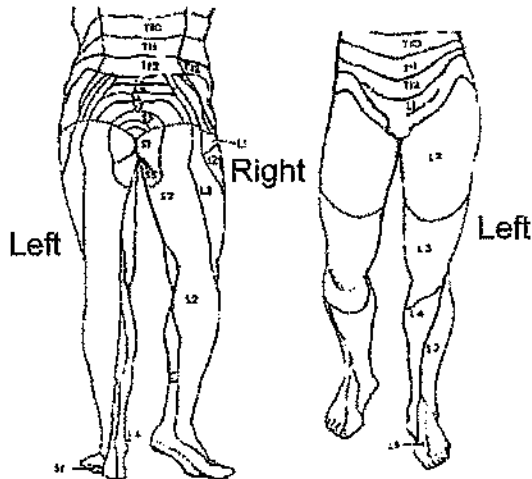
Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	4 /10	30 %		X	X	
L5	4 /10	30 %		X	X	
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☒ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days
Describe how LOW BACK PAIN is affecting your normal daily activities SITTING, LIFTING

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt *more*)

- ☐ Laying in Bed
 ☒ Sitting
 ☐ Bending
 ☐ Twisting
 ☐ Lifting
 ☐ Pushing/Pulling
☒ Computer at Work
 ☐ Computer at Home
 ☒ Working
 ☐ Sports
 ☐ Driving
☐ Others (please list other things that make your LOW BACK hurt) _____

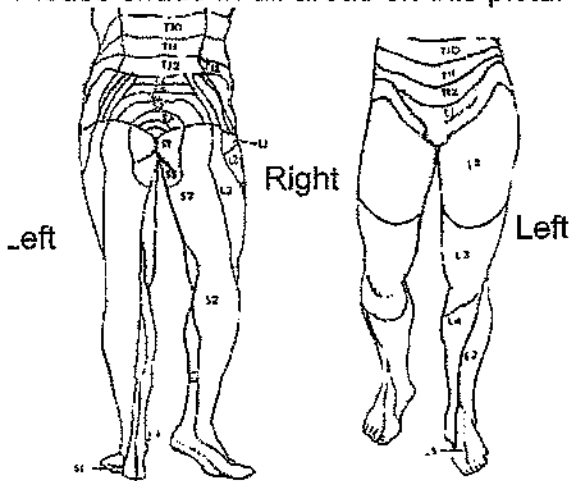
ALLEVIATING FACTORS (Check all below that make your LOW BACK feel *better*)

- ☒ In-Office Treatments Helps for 1 Hours Days Weeks Months
☒ Medications Helps for 4 Hours Days Weeks Months
☒ Home Exercises Helps for 8 Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months

Low Back & Pelvis Area Consultation

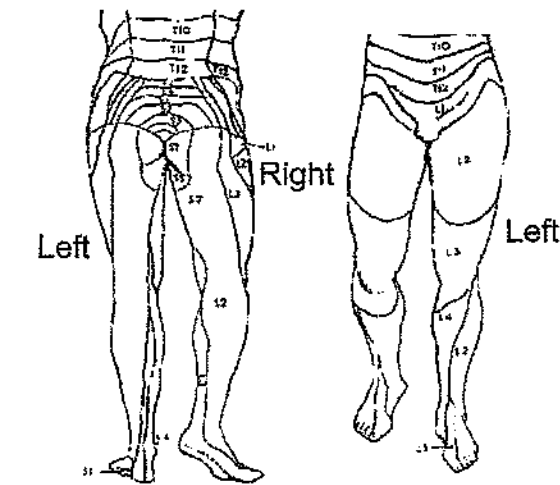
Patient MARIA CRUZ Today's Date 5-12-19 Date of Injury 2/1/19

Please shade in all areas on this picture where you have **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION** (I.E. PINS/NEEDLES, NUMB, TINGLING) in the past 7 days



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☒ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days

Describe how LOW BACK PAIN is affecting your normal daily activities A LITTLE SORE BUT ALMOST 100% BETTER

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt more)

- ☐ Laying in Bed
 ☐ Sitting
 ☐ Bending
 ☐ Twisting
 ☐ Lifting
 ☐ Pushing/Pulling
☐ Computer at Work
☐ Computer at Home
☐ Working
☐ Sports
☐ Driving
☐ Others (please list other things that make your LOW BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

- ☒ In-Office Treatments Helps for 1 Hours Days Weeks Months
☐ Medications Helps for _____ Hours Days Weeks Months
☒ Home Exercises Helps for 24 Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months
 _____ Helps for _____ Hours Days Weeks Months

DIAGNOSIS (Initial Encounter)

Patient MARIA CRUZ Today's Date 2/5/19 Date of Injury: 2/1/19

Neck

- ☒ Occipitocervical Segmental Dysf. (M99.00)
- ☒ Cervical Segmental Dysf. (M99.01)
- ☒ Cervical Sprain (S13.4XXA)
- ☒ Cervical Torn Ligament(s) w/ Laxity (M24.28)
- ☒ Cervical Motion Segment Hypermobility (M35.7)
- ☐ Cervical Tendon Injury (M46.03)
- ☒ Cervical Pain (M54.2)
- ☒ Cervical Muscle Pain (M79.1)
- ☒ Loss of Cervical Lordosis (M40.40)
- ☐ Traumatic Cervical Kyphosis (M40.299)
- ☐ Acquired Cervical Deformity (M95.3)
- ☐ Cervical Nerve Root Injury (S14.2XXA)
- ☐ Cervicobrachial Syndrome (M53.1)
- ☐ High Cervical Disc Displacement (M50.21)
- ☐ C4-5 Disc (M50.221) ☐ C5-6 Disc (M50.222)
- ☐ C6-7 Disc (M50.223) ☐ C7-T1 Disc (M50.23)
- ☐ High Cervical Disc w/ Radiculopathy (M50.11)
- ☐ C4-5 Disc w/ Rad (M50.121)
- ☐ C5-6 Disc w/ Radiculopathy (M50.122)
- ☐ C6-7 Disc w/ Radiculopathy (M50.123)
- ☐ C7-T1 Disc w/ Radiculopathy (M50.13)
- ☐ High Cervical Disc Degeneration (M50.31)
- ☐ C4-5 DJD (M50.321) ☐ C5-6 DJD (M50.322)
- ☐ C6-7 DJD (M50.323) ☐ C7-T1 DJD (M50.33)

Lumbar, Lumbosacral, SI & Pelvis

- ☒ Lumbar Segmental Dysfunction (M99.03)
- ☒ Lumbar Sprain (S33.5XXA)
- ☐ Lumbar Torn Ligaments w/ Laxity (M24.28)
- ☐ Lumbar Motion Segment Hypermobility (M35.7)
- ☐ Lumbar Tendon Enthesopathy (M46.06)
- ☒ Lumbago (M54.5) ☒ Lumbar Myalgia (M79.1)
- ☐ Lumb.Herniation.(M51.26) ☐ Lumb.DJD (M51.36)
- ☐ Lumbar Nerve Root Injury (S34.21XA)
- ☐ Lumbar Radiculopathy (M54.16)
- ☐ Spondylolisthesis (Congenital) (Q76.2)
- ☐ Spondylolisthesis (Acquired-Traumatic) (M43.10)
- ☒ SI Sprain (S33.9XXA) ☐ Coccyx Sprain (S33.8XXA)
- ☒ L5/S1 Seg.Dysf.(M99.03) ☒ SI Seg. Dysf.(M99.04)
- ☐ L5/S1 Herniation (M51.27) ☐ L5/S1 DJD (M51.37)
- ☐ Lumb/Sac Radicululopathy (M54.17)
- ☐ Sciatica ☐ Left (M54.32) ☐ Right (M54.31)

Brain & Miscellaneous

- ☒ Concussion w/out LOC (S06.0X0A)
- ☐ Concussion w/ LOC <30 minutes (S06.0X9A)
- ☒ Headache Post-Trauma-Intractable (G44.301)
- ☐ Headache Post-Trauma-Not Intractable (G44.309)
- ☒ Headache Cervicogenic (R51)
- ☐ Migraine, no Aura, not Intractable (G43.009)
- ☐ Migraine, no Aura, Intractable (G43.019)
- ☐ Migraine, Aura, not Intractable (G43.101)
- ☐ Migraine, Aura, Intractable (G43.119)
- ☐ Disruption of Sleep Patterns (G47.9)
- ☐ Dizzy (R42) ☒ Anxiety (F43.0) ☒ PTSD (F43.11)
- ☒ Depression ☒ Mild (F32.0) ☐ Mod (F32.1)
- ☒ Jaw Sprain ☒ Left(S03.41XA) ☐ Right(S03.42XA)

Upper Back & Torso

- ☒ Thoracic Segmental Dysf. (M99.02)
- ☒ Thoracolumbar Segmental Dysf. (M99.02)
- ☐ Costochondral Segmental Dysf. (M99.08)
- ☐ Costovertebral Segmental Dysf. (M99.08)
- ☒ Sternochondral Segmental Dysf. (M99.08)
- ☐ Sternoclavicular Segmental Dysf. (M99.07)
- ☒ Rib Cage Segmental Dysf. (M99.08)
- ☒ Thoracic Sprain (S23.3XXA)
- ☐ Thoracic Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor/Lumb Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor. Motion Segment Hypermobility (M35.7)
- ☐ Thor. Tendon Injury/Enthesopathy (M46.04)
- ☐ Thoracic Pain (M54.6)
- ☐ Thoracic Muscle Pain (M79.1)
- ☒ Ribs Sprain (S23.41XA)
- ☐ Sternoclavicular Sprain.(S23.420A)
- ☒ Chest/Sternum Pain (R07.2)
- ☐ Thoracic Disc Displacement (M51.24)
- ☐ Thoracolumbar Disc Displacement (M51.25)
- ☐ Thoracic. Disc w/ Radiculopathy (M51.14)
- ☐ Thoracolumbar Disc w/ Radiculopathy (M51.15)
- ☐ Brachial Plexopathy (S14.3XXA)
- ☐ Thoracic DJD/DDD (M51.34)
- ☐ Thoracolumbar DJD/DDD (M51.35)

Upper & Lower Extremity

- Chiropractic Segm. Dysfunctions
- ☒ Upper Extremity (M99.07)
 - ☐ A/C Joint (M99.07)
 - ☒ Lower Extremity (M99.06)
 - ☒ Hip (M99.05)
- Sprains
- | | |
|---|---|
| <input checked="" type="checkbox"/> Right Shoulder (S43.401A) | <input checked="" type="checkbox"/> Left (S43.402A) |
| <input checked="" type="checkbox"/> Right Elbow (S53.401A) | <input type="checkbox"/> Left (S53.402A) |
| <input checked="" type="checkbox"/> Right Wrist (S63.501A) | <input checked="" type="checkbox"/> Left (S63.502A) |
| <input checked="" type="checkbox"/> Right Hip (S73.101A) | <input type="checkbox"/> Left (S73.102A) |
| <input checked="" type="checkbox"/> Right Knee (S83.91XA) | <input checked="" type="checkbox"/> Left (S83.92XA) |
| <input type="checkbox"/> Right Ankle (S93.401A) | <input checked="" type="checkbox"/> Left (S93.402A) |
| <input type="checkbox"/> Right Foot (S93.601A) | <input type="checkbox"/> Left (S93.602A) |
| <input type="checkbox"/> Right Great Toe (S93.501A) | <input type="checkbox"/> Left (S93.502A) |
- Finger Joint Sprains
- | | |
|--|--|
| <input type="checkbox"/> Right Thumb (S63.601A) | <input type="checkbox"/> Left (S63.601A) |
| <input type="checkbox"/> Right Index (S63.610A) | <input type="checkbox"/> Left (S63.611A) |
| <input type="checkbox"/> Right Middle (S63.612A) | <input type="checkbox"/> Left (S63.613A) |
| <input type="checkbox"/> Right Ring (S63.614A) | <input type="checkbox"/> Left (S63.615A) |
| <input type="checkbox"/> Right Little (S63.616A) | <input type="checkbox"/> Left (S63.617A) |

Strain of Muscle, Fascia & Tendon (MFT)

- ☒ Head Strain of Muscle & Tendon (S09.11XA)
- ☒ Neck Strain of MFT (S16.1XXA)
- ☒ Low Back Strain of MFT (S39.012A)
- ☐ Pelvis Strain of MFT (S39.013A)
- ☒ Front Wall of Thorax Strain of MFT (S29.011A)
- ☒ Back Wall of Thorax Strain of MFT (S29.012A)



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DIAGNOSIS (Initial Encounter)

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury: 2/1/19

Neck

- ☒ Occipitocervical Segmental Dysf. (M99.00)
- ☒ Cervical Segmental Dysf. (M99.01)
- ☐ Cervical Sprain (S13.4XXA)
- ☒ Cervical Torn Ligament(s) w/ Laxity (M24.28)
- ☒ Cervical Motion Segment Hypermobility (M35.7)
- ☐ Cervical Tendon Injury (M46.03)
- ☒ Cervical Pain (M54.2)
- ☐ Cervical Muscle Pain (M79.1)
- ☒ Loss of Cervical Lordosis (M40.40)
- ☐ Traumatic Cervical Kyphosis (M40.299)
- ☐ Acquired Cervical Deformity (M95.3)
- ☐ Cervical Nerve Root Injury (S14.2XXA)
- ☐ Cervicobrachial Syndrome (M53.1)
- ☐ High Cervical Disc Displacement (M50.21)
- ☐ C4-5 Disc (M50.221) ☐ C5-6 Disc (M50.222)
- ☐ C6-7 Disc (M50.223) ☐ C7-T1 Disc (M50.23)
- ☐ High Cervical Disc w/ Radiculopathy (M50.11)
- ☐ C4-5 Disc w/ Rad (M50.121)
- ☐ C5-6 Disc w/ Radiculopathy (M50.122)
- ☐ C6-7 Disc w/ Radiculopathy (M50.123)
- ☐ C7-T1 Disc w/ Radiculopathy (M50.13)
- ☐ High Cervical Disc Degeneration (M50.31)
- ☐ C4-5 DJD (M50.321) ☐ C5-6 DJD (M50.322)
- ☐ C6-7 DJD (M50.323) ☐ C7-T1 DJD (M50.33)

Upper Back & Torso

- ☒ Thoracic Segmental Dysf. (M99.02)
- ☒ Thoracolumbar Segmental Dysf. (M99.02)
- ☐ Costochondral Segmental Dysf. (M99.08)
- ☐ Costovertebral Segmental Dysf. (M99.08)
- ☐ Sternochondral Segmental Dysf. (M99.08)
- ☐ Sternoclavicular Segmental Dysf. (M99.07)
- ☒ Rib Cage Segmental Dysf. (M99.08)
- ☐ Thoracic Sprain (S23.3XXA)
- ☐ Thoracic Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor/Lumb Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor. Motion Segment Hypermobility (M35.7)
- ☐ Thor. Tendon Injury/Enthesopathy (M46.04)
- ☒ Thoracic Pain (M54.6)
- ☐ Thoracic Muscle Pain (M79.1)
- ☐ Ribs Sprain (S23.41XA)
- ☐ Sternoclavicular Sprain (S23.420A)
- ☐ Chest/Sternum Pain (R07.2)
- ☐ Thoracic Disc Displacement (M51.24)
- ☐ Thoracolumbar Disc Displacement (M51.25)
- ☐ Thoracic Disc w/ Radiculopathy (M51.14)
- ☐ Thoracolumbar Disc w/ Radiculopathy (M51.15)
- ☐ Brachial Plexopathy (S14.3XXA)
- ☐ Thoracic DJD/DDD (M51.34)
- ☐ Thoracolumbar DJD/DDD (M51.35)

Lumbar, Lumbosacral, SI & Pelvis

- ☒ Lumbar Segmental Dysfunction (M99.03)
- ☐ Lumbar Sprain (S33.5XXA)
- ☐ Lumbar Torn Ligaments w/ Laxity (M24.28)
- ☐ Lumbar Motion Segment Hypermobility (M35.7)
- ☐ Lumbar Tendon Enthesopathy (M46.06)
- ☒ Lumbago (M54.5) ☐ Lumbar Myalgia (M79.1)
- ☐ Lumb.Herniation.(M51.26) ☐ Lumb.DJD (M51.36)
- ☐ Lumbar Nerve Root Injury (S34.21XA)
- ☐ Lumbar Radiculopathy (M54.16)
- ☐ Spondylolisthesis (Congenital) (Q76.2)
- ☐ Spondylolisthesis (Acquired-Traumatic) (M43.10)
- ☐ SI Sprain (S33.9XXA) ☐ Coccyx Sprain (S33.8XXA)
- ☒ L5/S1 Seg.Dysf.(M99.03) ☒ SI Seg. Dysf.(M99.04)
- ☐ L5/S1 Herniation (M51.27) ☐ L5/S1 DJD (M51.37)
- ☐ Lumb/Sac Radiculopathy (M54.17)
- ☐ Sciatica ☐ Left (M54.32) ☐ Right (M54.31)

Upper & Lower Extremity

Chiropractic Segm. Dysfunctions

- ☒ Upper Extremity (M99.07)
- ☐ A/C Joint (M99.07)
- ☒ Lower Extremity (M99.06)
- ☒ Hip (M99.05)

Sprains

- | | |
|---|---|
| <input checked="" type="checkbox"/> Right Shoulder (S43.401A) | <input type="checkbox"/> Left (S43.402A) |
| <input checked="" type="checkbox"/> Right Elbow (S53.401A) | <input type="checkbox"/> Left (S53.402A) |
| <input checked="" type="checkbox"/> Right Wrist (S63.501A) | <input checked="" type="checkbox"/> Left (S63.502A) |
| <input checked="" type="checkbox"/> Right Hip (S73.101A) | <input type="checkbox"/> Left (S73.102A) |
| <input checked="" type="checkbox"/> Right Knee (S83.91XA) | <input type="checkbox"/> Left (S83.92XA) |
| <input type="checkbox"/> Right Ankle (S93.401A) | <input type="checkbox"/> Left (S93.402A) |
| <input type="checkbox"/> Right Foot (S93.601A) | <input type="checkbox"/> Left (S93.602A) |
| <input type="checkbox"/> Right Great Toe (S93.501A) | <input type="checkbox"/> Left (S93.502A) |

Finger Joint Sprains

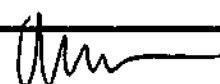
- | | |
|--|--|
| <input type="checkbox"/> Right Thumb (S63.601A) | <input type="checkbox"/> Left (S63.601A) |
| <input type="checkbox"/> Right Index (S63.610A) | <input type="checkbox"/> Left (S63.611A) |
| <input type="checkbox"/> Right Middle (S63.612A) | <input type="checkbox"/> Left (S63.613A) |
| <input type="checkbox"/> Right Ring (S63.614A) | <input type="checkbox"/> Left (S63.615A) |
| <input type="checkbox"/> Right Little (S63.616A) | <input type="checkbox"/> Left (S63.617A) |

Strain of Muscle, Fascia & Tendon (MFT)

- ☐ Head Strain of Muscle & Tendon (S09.11XA)
- ☐ Neck Strain of MFT (S16.1XXA)
- ☐ Low Back Strain of MFT (S39.012A)
- ☐ Pelvis Strain of MFT (S39.013A)
- ☐ Front Wall of Thorax Strain of MFT (S29.011A)
- ☐ Back Wall of Thorax Strain of MFT (S29.012A)

Brain & Miscellaneous

- ☒ Concussion w/out LOC (S06.0X0A)
- ☐ Concussion w/ LOC <30 minutes (S06.0X9A)
- ☐ Headache Post-Trauma-Intractable (G44.301)
- ☐ Headache Post-Trauma-Not Intractable (G44.309)
- ☒ Headache Cervicogenic (R51)
- ☐ Migraine, no Aura, not Intractable (G43.009)
- ☐ Migraine, no Aura, Intractable (G43.019)
- ☐ Migraine, Aura, not Intractable (G43.101)
- ☐ Migraine, Aura, Intractable (G43.119)
- ☐ Disruption of Sleep Patterns (G47.9)
- ☐ Dizzy (R42) ☒ Anxiety (F43.0) ☒ PTSD (F43.11)
- ☒ Depression ☒ Mild (F32.0) ☐ Mod (F32.1)
- ☒ Jaw Sprain ☒ Left(S03.41XA) ☐ Right(S03.42XA)



DIAGNOSIS (Initial Encounter)

Patient

MARIA CRUZ

Today's Date

4/8/19

Date of Injury:

2/1/19**Neck**

- ☒ Occipitocervical Segmental Dysf. (M99.00)
☒ Cervical Segmental Dysf. (M99.01)
☐ Cervical Sprain (S13.4XXA)
☒ Cervical Torn Ligament(s) w/ Laxity (M24.28)
☒ Cervical Motion Segment Hypermobility (M35.7)
☐ Cervical Tendon Injury (M46.03)
☒ Cervical Pain (M54.2)
☐ Cervical Muscle Pain (M79.1)
☒ Loss of Cervical Lordosis (M40.40)
☐ Traumatic Cervical Kyphosis (M40.299)
☐ Acquired Cervical Deformity (M95.3)
☐ Cervical Nerve Root Injury (S14.2XXA)
☐ Cervicobrachial Syndrome (M53.1)
☐ High Cervical Disc Displacement (M50.21)
☐ C4-5 Disc (M50.221) ☐ C5-6 Disc (M50.222)
☐ C6-7 Disc (M50.223) ☐ C7-T1 Disc (M50.23)
☐ High Cervical Disc w/ Radiculopathy (M50.11)
☐ C4-5 Disc w/ Rad (M50.121)
☐ C5-6 Disc w/ Radiculopathy (M50.122)
☐ C6-7 Disc w/ Radiculopathy (M50.123)
☐ C7-T1 Disc w/ Radiculopathy (M50.13)
☐ High Cervical Disc Degeneration (M50.31)
☐ C4-5 DJD (M50.321) ☐ C5-6 DJD (M50.322)
☐ C6-7 DJD (M50.323) ☐ C7-T1 DJD (M50.33)

Upper Back & Torso

- ☒ Thoracic Segmental Dysf. (M99.02)
☒ Thoracolumbar Segmental Dysf. (M99.02)
☐ Costochondral Segmental Dysf. (M99.08)
☐ Costovertebral Segmental Dysf. (M99.08)
☐ Sternochondral Segmental Dysf. (M99.08)
☐ Sternoclavicular Segmental Dysf. (M99.07)
☐ Rib Cage Segmental Dysf. (M99.08)
☐ Thoracic Sprain (S23.3XXA)
☐ Thoracic Torn Ligaments w/ Laxity (M24.28)
☐ Thor/Lumb Torn Ligaments w/ Laxity (M24.28)
☐ Thor. Motion Segment Hypermobility (M35.7)
☐ Thor. Tendon Injury/Enthesopathy (M46.04)
☒ Thoracic Pain (M54.6)
☐ Thoracic Muscle Pain (M79.1)
☐ Ribs Sprain (S23.41XA)
☐ Sternoclavicular Sprain (S23.420A)
☐ Chest/Sternum Pain (R07.2)
☐ Thoracic Disc Displacement (M51.24)
☐ Thoracolumbar Disc Displacement (M51.25)
☐ Thoracic Disc w/ Radiculopathy (M51.14)
☐ Thoracolumbar Disc w/ Radiculopathy (M51.15)
☐ Brachial Plexopathy (S14.3XXA)
☐ Thoracic DJD/DDD (M51.34)
☐ Thoracolumbar DJD/DDD (M51.35)

Lumbar, Lumbosacral, SI & Pelvis

- ☒ Lumbar Segmental Dysfunction (M99.03)
☐ Lumbar Sprain (S33.5XXA)
☐ Lumbar Torn Ligaments w/ Laxity (M24.28)
☐ Lumbar Motion Segment Hypermobility (M35.7)
☐ Lumbar Tendon Enthesopathy (M46.06)
☐ Lumbago (M54.5) ☐ Lumbar Myalgia (M79.1)
☐ Lumb.Herniation.(M51.26) ☐ Lumb.DJD (M51.36)
☐ Lumbar Nerve Root Injury (S34.21XA)
☐ Lumbar Radiculopathy (M54.16)
☐ Spondylolisthesis (Congenital) (Q76.2)
☐ Spondylolisthesis (Acquired-Traumatic) (M43.10)
☐ SI Sprain (S33.9XXA) ☐ Coccyx Sprain (S33.8XXA)
☒ L5/S1 Seg.Dysf.(M99.03) ☒ SI Seg. Dysf.(M99.04)
☐ L5/S1 Herniation (M51.27) ☐ L5/S1 DJD (M51.37)
☐ Lumb/Sac Radiculopathy (M54.17)
☐ Sciatica ☐ Left (M54.32) ☐ Right (M54.31)

Upper & Lower ExtremityChiropractic Segm. Dysfunctions

- ☒ Upper Extremity (M99.07)
☐ A/C Joint (M99.07)
☒ Lower Extremity (M99.06)
☒ Hip (M99.05)

Sprains

- | | |
|---|---|
| <input checked="" type="checkbox"/> Right Shoulder (S43.401A) | <input type="checkbox"/> Left (S43.402A) |
| <input checked="" type="checkbox"/> Right Elbow (S53.401A) | <input type="checkbox"/> Left (S53.402A) |
| <input type="checkbox"/> Right Wrist (S63.501A) | <input checked="" type="checkbox"/> Left (S63.502A) |
| <input checked="" type="checkbox"/> Right Hip (S73.101A) | <input type="checkbox"/> Left (S73.102A) |
| <input checked="" type="checkbox"/> Right Knee (S83.91XA) | <input type="checkbox"/> Left (S83.92XA) |
| <input type="checkbox"/> Right Ankle (S93.401A) | <input type="checkbox"/> Left (S93.402A) |
| <input type="checkbox"/> Right Foot (S93.601A) | <input type="checkbox"/> Left (S93.602A) |
| <input type="checkbox"/> Right Great Toe (S93.501A) | <input type="checkbox"/> Left (S93.502A) |

Finger Joint Sprains

- | | |
|--|--|
| <input type="checkbox"/> Right Thumb (S63.601A) | <input type="checkbox"/> Left (S63.601A) |
| <input type="checkbox"/> Right Index (S63.610A) | <input type="checkbox"/> Left (S63.611A) |
| <input type="checkbox"/> Right Middle (S63.612A) | <input type="checkbox"/> Left (S63.613A) |
| <input type="checkbox"/> Right Ring (S63.614A) | <input type="checkbox"/> Left (S63.615A) |
| <input type="checkbox"/> Right Little (S63.616A) | <input type="checkbox"/> Left (S63.617A) |

Strain of Muscle, Fascia & Tendon (MFT)

- ☐ Head Strain of Muscle & Tendon (S09.11XA)
☐ Neck Strain of MFT (S16.1XXA)
☐ Low Back Strain of MFT (S39.012A)
☐ Pelvis Strain of MFT (S39.013A)
☐ Front Wall of Thorax Strain of MFT (S29.011A)
☐ Back Wall of Thorax Strain of MFT (S29.012A)

Brain & Miscellaneous

- ☒ Concussion w/out LOC (S06.0X0A)
☐ Concussion w/ LOC <30 minutes (S06.0X9A)
☐ Headache Post-Trauma-Intractable (G44.301)
☐ Headache Post-Trauma-Not Intractable (G44.309)
☐ Headache Cervicogenic (R51)
☐ Migraine, no Aura, not Intractable (G43.009)
☐ Migraine, no Aura, Intractable (G43.019)
☐ Migraine, Aura, not Intractable (G43.101)
☐ Migraine, Aura, Intractable (G43.119)
☒ Disruption of Sleep Patterns (G47.9)
☐ Dizzy (R42) ☒ Anxiety (F43.0) ☒ PTSD (F43.11)
☒ Depression ☒ Mild (F32.0) ☐ Mod (F32.1)
☒ Jaw Sprain ☒ Left(S03.41XA) ☐ Right(S03.42XA)



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DIAGNOSIS (Initial Encounter)

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury: 2/11/19

Neck

- ☐ Occipitocervical Segmental Dysf. (M99.00)
- ☒ Cervical Segmental Dysf. (M99.01)
- ☐ Cervical Sprain (S13.4XXA)
- ☒ Cervical Torn Ligament(s) w/ Laxity (M24.28)
- ☒ Cervical Motion Segment Hypermobility (M35.7)
- ☐ Cervical Tendon Injury (M46.03)
- ☒ Cervical Pain (M54.2)
- ☐ Cervical Muscle Pain (M79.1)
- ☒ Loss of Cervical Lordosis (M40.40)
- ☐ Traumatic Cervical Kyphosis (M40.299)
- ☐ Acquired Cervical Deformity (M95.3)
- ☐ Cervical Nerve Root Injury (S14.2XXA)
- ☐ Cervicobrachial Syndrome (M53.1)
- ☐ High Cervical Disc Displacement (M50.21)
- ☐ C4-5 Disc (M50.221) ☐ C5-6 Disc (M50.222)
- ☐ C6-7 Disc (M50.223) ☐ C7-T1 Disc (M50.23)
- ☐ High Cervical Disc w/ Radiculopathy (M50.11)
- ☐ C4-5 Disc w/ Rad (M50.121)
- ☐ C5-6 Disc w/ Radiculopathy (M50.122)
- ☐ C6-7 Disc w/ Radiculopathy (M50.123)
- ☐ C7-T1 Disc w/ Radiculopathy (M50.13)
- ☐ High Cervical Disc Degeneration (M50.31)
- ☐ C4-5 DJD (M50.321) ☐ C5-6 DJD (M50.322)
- ☐ C6-7 DJD (M50.323) ☐ C7-T1 DJD (M50.33)

Lumbar, Lumbosacral, SI & Pelvis

- ☐ Lumbar Segmental Dysfunction (M99.03)
- ☐ Lumbar Sprain (S33.5XXA)
- ☐ Lumbar Torn Ligaments w/ Laxity (M24.28)
- ☐ Lumbar Motion Segment Hypermobility (M35.7)
- ☐ Lumbar Tendon Enthesopathy (M46.06)
- ☐ Lumbago (M54.5) ☐ Lumbar Myalgia (M79.1)
- ☐ Lumb. Herniation (M51.26) ☐ Lumb. DJD (M51.36)
- ☐ Lumbar Nerve Root Injury (S34.21XA)
- ☐ Lumbar Radiculopathy (M54.16)
- ☐ Spondylolisthesis (Congenital) (Q76.2)
- ☐ Spondylolisthesis (Acquired-Traumatic) (M43.10)
- ☐ SI Sprain (S33.9XXA) ☐ Coccyx Sprain (S33.8XXA)
- ☐ L5/S1 Seg. Dysf. (M99.03) ☐ SI Seg. Dysf. (M99.04)
- ☐ L5/S1 Herniation (M51.27) ☐ L5/S1 DJD (M51.37)
- ☐ Lumb/Sac Radiculopathy (M54.17)
- ☐ Sciatica ☐ Left (M54.32) ☐ Right (M54.31)

Brain & Miscellaneous

- ☒ Concussion w/out LOC (S06.0X0A)
- ☐ Concussion w/ LOC <30 minutes (S06.0X9A)
- ☐ Headache Post-Trauma-Intractable (G44.301)
- ☐ Headache Post-Trauma-Not Intractable (G44.309)
- ☐ Headache Cervicogenic (R51)
- ☐ Migraine, no Aura, not Intractable (G43.009)
- ☐ Migraine, no Aura, Intractable (G43.019)
- ☐ Migraine, Aura, not Intractable (G43.101)
- ☐ Migraine, Aura, Intractable (G43.119)
- ☒ Disruption of Sleep Patterns (G47.9)
- ☐ Dizzy (R42) ☒ Anxiety (F43.0) ☐ PTSD (F43.11)
- ☒ Depression ☒ Mild (F32.0) ☐ Mod (F32.1)
- ☒ Jaw Sprain ☒ Left (S03.41XA) ☐ Right (S03.42XA)

Upper Back & Torso

- ☐ Thoracic Segmental Dysf. (M99.02)
- ☐ Thoracolumbar Segmental Dysf. (M99.02)
- ☐ Costochondral Segmental Dysf. (M99.08)
- ☐ Costovertebral Segmental Dysf. (M99.08)
- ☐ Sternochondral Segmental Dysf. (M99.08)
- ☐ Sternoclavicular Segmental Dysf. (M99.07)
- ☐ Rib Cage Segmental Dysf. (M99.08)
- ☐ Thoracic Sprain (S23.3XXA)
- ☐ Thoracic Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor/Lumb Torn Ligaments w/ Laxity (M24.28)
- ☐ Thor. Motion Segment Hypermobility (M35.7)
- ☐ Thor. Tendon Injury/Enthesopathy (M46.04)
- ☐ Thoracic Pain (M54.6)
- ☐ Thoracic Muscle Pain (M79.1)
- ☐ Ribs Sprain (S23.41XA)
- ☐ Sternoclavicular Sprain (S23.420A)
- ☐ Chest/Sternum Pain (R07.2)
- ☐ Thoracic Disc Displacement (M51.24)
- ☐ Thoracolumbar Disc Displacement (M51.25)
- ☐ Thoracic Disc w/ Radiculopathy (M51.14)
- ☐ Thoracolumbar Disc w/ Radiculopathy (M51.15)
- ☐ Brachial Plexopathy (S14.3XXA)
- ☐ Thoracic DJD/DDD (M51.34)
- ☐ Thoracolumbar DJD/DDD (M51.35)

Upper & Lower Extremity

Chiropractic Segm. Dysfunctions

- ☐ Upper Extremity (M99.07)
- ☐ A/C Joint (M99.07)
- ☐ Lower Extremity (M99.06)
- ☐ Hip (M99.05)

Sprains

- | | |
|---|--|
| <input type="checkbox"/> Right Shoulder (S43.401A) | <input type="checkbox"/> Left (S43.402A) |
| <input type="checkbox"/> Right Elbow (S53.401A) | <input type="checkbox"/> Left (S53.402A) |
| <input type="checkbox"/> Right Wrist (S63.501A) | <input type="checkbox"/> Left (S63.502A) |
| <input type="checkbox"/> Right Hip (S73.101A) | <input type="checkbox"/> Left (S73.102A) |
| <input type="checkbox"/> Right Knee (S83.91XA) | <input type="checkbox"/> Left (S83.92XA) |
| <input type="checkbox"/> Right Ankle (S93.401A) | <input type="checkbox"/> Left (S93.402A) |
| <input type="checkbox"/> Right Foot (S93.601A) | <input type="checkbox"/> Left (S93.602A) |
| <input type="checkbox"/> Right Great Toe (S93.501A) | <input type="checkbox"/> Left (S93.502A) |

Finger Joint Sprains

- | | |
|--|--|
| <input type="checkbox"/> Right Thumb (S63.601A) | <input type="checkbox"/> Left (S63.601A) |
| <input type="checkbox"/> Right Index (S63.610A) | <input type="checkbox"/> Left (S63.611A) |
| <input type="checkbox"/> Right Middle (S63.612A) | <input type="checkbox"/> Left (S63.613A) |
| <input type="checkbox"/> Right Ring (S63.614A) | <input type="checkbox"/> Left (S63.615A) |
| <input type="checkbox"/> Right Little (S63.616A) | <input type="checkbox"/> Left (S63.617A) |

Strain of Muscle, Fascia & Tendon (MFT)

- ☐ Head Strain of Muscle & Tendon (S09.11XA)
- ☐ Neck Strain of MFT (S16.1XXA)
- ☐ Low Back Strain of MFT (S39.012A)
- ☐ Pelvis Strain of MFT (S39.013A)
- ☐ Front Wall of Thorax Strain of MFT (S29.011A)
- ☐ Back Wall of Thorax Strain of MFT (S29.012A)

Maria Cruz

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TREATMENT PLAN

Patient MARIA CRUZ Today's Date 2/5/19 DOI 2/1/19

The following recommended treatments are to be done through 3/5/19

Cervical Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB1XBZ Non-Manual CMT
- ☒ 9WB1XGZ Long Lever CMT
- ☐ 9WB1XHZ Short Lever CMT
- ☐ 9WB1XLZ Other Type CMT
- ☒ 97124 Massage 10 minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☐ Home Exercises ☐ Gym
- ☒ Home Stabilization ☒ Traction
- ☒ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Thoracic Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB2XBZ Non-Manual CMT
- ☐ 9WB2XGZ Long Lever CMT
- ☐ 9WB2XHZ Short Lever CMT
- ☒ 9WB2XLZ Other Type CMT
- ☒ 97124 Massage 10 minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lumbar Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB3XBZ Non-Manual CMT
- ☒ 9WB3XGZ Long Lever CMT
- ☐ 9WB3XHZ Short Lever CMT
- ☐ 9WB3XLZ Other Type CMT
- ☒ 97124 Massage 10 minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Upper Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB7XBZ Non-Manual CMT
- ☒ 9WB7XGZ Long Lever CMT
- ☐ 9WB7XHZ Short Lever CMT
- ☐ 9WB7XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lower Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB6XBZ Non-Manual CMT
- ☐ 9WB6XGZ Long Lever CMT
- ☒ 9WB6XHZ Short Lever CMT
- ☐ 9WB6XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☒ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Pelvis/Hip/Sacrum Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB5XBZ Non-Manual CMT
- ☒ 9WB5XGZ Long Lever CMT
- ☐ 9WB5XHZ Short Lever CMT
- ☐ 9WB5XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Brain Injury Plan

- ☒ 90791 Cognitive Consultation
- ☒ 96118 Cognitive Screening
- ☐ 90791 Hypersomnolence Consultation
- ☒ 97127 Cognitive Training In Office 15 min.
- ☒ 97039 Attended FDA cleared IR Laser
- ☒ Home Meditation
- ☐ Home Cognitive Rehabilitation Exercises
- ☐ MD Referral
- ☐ Neuropsychologist Referral
- ☐ Counseling
- ☐ Polysomnogram
- ☒ Avoid Stressful Activities
- ☒ Bed Rest
- ☐ Other _____

Depression/Anxiety Plan

- ☐ Exercise
- ☒ Meditation
- ☒ Avoid Stressful Activities
- ☒ Natural Anti-Depressants
- ☒ Natural Anti-Anxiety
- ☒ Bed Rest
- ☐ MD Referral
- ☐ Cardiologist Referral

TMJ Plan

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Splint for Home Use
- ☒ Home TMJ Exercises
- ☒ Restricted TMJ Activity
- ☒ Relaxation Exercises
- ☒ Soft Food/Liquid Diet
- ☐ DDS Referral

Misc Plans

- 3 Office Treatments per WEEK
- 7 Home Treatments per WEEK
- ☐ Home TENS
- ☐ Cane/Crutches/Orthotics
- ☒ Natural Pain Relievers
- ☐ Order Impairment Rating
- ☒ Natural Anti-Inflammatories
- Re-evaluate in 30 days

TREATMENT PLAN

Patient MARIA CRUZ Today's Date 3/5/19 DOI 2/1/19

The following recommended treatments are to be done through 4/5/19

Cervical Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB1XBZ Non-Manual CMT
- ☐ 9WB1XGZ Long Lever CMT
- ☒ 9WB1XHZ Short Lever CMT
- ☐ 9WB1XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☒ 97110 Ther.Exer. 1on1 15 min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☒ DMX

Thoracic Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB2XBZ Non-Manual CMT
- ☐ 9WB2XGZ Long Lever CMT
- ☒ 9WB2XHZ Short Lever CMT
- ☐ 9WB2XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lumbar Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB3XBZ Non-Manual CMT
- ☐ 9WB3XGZ Long Lever CMT
- ☒ 9WB3XHZ Short Lever CMT
- ☐ 9WB3XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Upper Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB7XBZ Non-Manual CMT
- ☒ 9WB7XGZ Long Lever CMT
- ☐ 9WB7XHZ Short Lever CMT
- ☐ 9WB7XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☒ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lower Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB6XBZ Non-Manual CMT
- ☒ 9WB6XGZ Long Lever CMT
- ☐ 9WB6XHZ Short Lever CMT
- ☐ 9WB6XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☒ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Pelvis/Hip/Sacrum Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB5XBZ Non-Manual CMT
- ☐ 9WB5XGZ Long Lever CMT
- ☒ 9WB5XHZ Short Lever CMT
- ☐ 9WB5XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Brain Injury Plan

- ☒ 90791 Cognitive Consultation
- ☒ 96118 Cognitive Screening
- ☐ 90791 Hypersomnolence Consultation
- ☒ 97127 Cognitive Training In Office 15 min.
- ☒ 97039 Attended FDA cleared IR Laser
- ☒ Home Meditation
- ☒ Home Cognitive Rehabilitation Exercises
- ☐ MD Referral
- ☐ Neuropsychologist Referral
- ☒ Counseling FOR ANXIETY, DEPRESSION, PTSD AND CONCUSSION
- ☐ Polysomnogram
- ☒ Avoid Stressful Activities
- ☒ Bed Rest
- ☐ Other _____

Depression/Anxiety Plan

- ☒ Exercise Gentle
- ☒ Meditation
- ☒ Avoid Stressful Activities
- ☒ Natural Anti-Depressants
- ☒ Natural Anti-Anxiety
- ☒ Bed Rest
- ☐ MD Referral
- ☐ Cardiologist Referral

TMJ Plan

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Splint for Home Use
- ☒ Home TMJ Exercises
- ☒ Restricted TMJ Activity
- ☒ Relaxation Exercises
- ☒ Soft Food/Liquid Diet
- ☒ DDS Referral

Misc Plans

- 2 Office Treatments per Week
- 7 Home Treatments per Week
- ☐ Home TENS
- ☐ Cane/Crutches/Orthotics
- ☒ Natural Pain Relievers
- ☐ Order Impairment Rating
- ☒ Natural Anti-Inflammatories
- Re-evaluate in 30 days

TREATMENT PLAN

Patient MARIA CRUZ Today's Date 4/8/19 DOI 2/1/19

The following recommended treatments are to be done through 5/8/19

Cervical Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB1XBZ Non-Manual CMT
- ☐ 9WB1XGZ Long Lever CMT
- ☒ 9WB1XHZ Short Lever CMT
- ☐ 9WB1XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Thoracic Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB2XBZ Non-Manual CMT
- ☐ 9WB2XGZ Long Lever CMT
- ☒ 9WB2XHZ Short Lever CMT
- ☐ 9WB2XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lumbar Spine Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB3XBZ Non-Manual CMT
- ☐ 9WB3XGZ Long Lever CMT
- ☐ 9WB3XHZ Short Lever CMT
- ☐ 9WB3XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Upper Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB7XBZ Non-Manual CMT
- ☒ 9WB7XGZ Long Lever CMT
- ☐ 9WB7XHZ Short Lever CMT
- ☐ 9WB7XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lower Extremity Tx

- ☒ 98943 Chiropractic Manip.
- ☐ 9WB6XBZ Non-Manual CMT
- ☐ 9WB6XGZ Long Lever CMT
- ☒ 9WB6XHZ Short Lever CMT
- ☐ 9WB6XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Pelvis/Hip/Sacrum Tx

- ☒ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB5XBZ Non-Manual CMT
- ☒ 9WB5XGZ Long Lever CMT
- ☐ 9WB5XHZ Short Lever CMT
- ☐ 9WB5XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☐ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Brain Injury Plan

- ☒ 90791 Cognitive Consultation
- ☒ 96118 Cognitive Screening
- ☒ 90791 Hypersomnolence Consultation
- ☒ 97127 Cognitive Training In Office 15 min.
- ☒ 97039 Attended FDA cleared IR Laser
- ☒ Home Meditation
- ☒ Home Cognitive Rehabilitation Exercises
- ☒ MD Referral PSYCHIATRIST
- ☐ Neuropsychologist Referral
- ☐ Counseling
- ☒ Polysomnogram SLEEP SPECIALIST
- ☒ Avoid Stressful Activities
- ☒ Bed Rest
- ☐ Other _____

Depression/Anxiety Plan

- ☒ Exercise
- ☒ Meditation
- ☒ Avoid Stressful Activities
- ☒ Natural Anti-Depressants
- ☒ Natural Anti-Anxiety
- ☒ Bed Rest
- ☒ MD Referral
- ☐ Cardiologist Referral

TMJ Plan

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☒ Splint for Home Use FROM
- ☒ Home TMJ Exercises Dr. H
- ☒ Restricted TMJ Activity
- ☒ Relaxation Exercises
- ☒ Soft Food/Liquid Diet
- ☒ DDS Referral

Misc Plans

- ☐ Home TENS
- ☐ Cane/Crutches/Orthotics
- ☒ Natural Anti-Inflammatories
- ☐ Office Treatments per 1 Week
- ☐ Home Treatments per 7 Week
- ☒ Natural Pain Relievers
- ☐ Order Impairment Rating
- Re-evaluate in 30 days

TREATMENT PLAN

Patient MARIA CRUZ Today's Date 5/12/19 DOI 2/1/19

The following recommended treatments are to be done through _____

Cervical Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB1XBZ Non-Manual CMT
- ☐ 9WB1XGZ Long Lever CMT
- ☐ 9WB1XHZ Short Lever CMT
- ☐ 9WB1XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Thoracic Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB2XBZ Non-Manual CMT
- ☐ 9WB2XGZ Long Lever CMT
- ☐ 9WB2XHZ Short Lever CMT
- ☐ 9WB2XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lumbar Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB3XBZ Non-Manual CMT
- ☐ 9WB3XGZ Long Lever CMT
- ☐ 9WB3XHZ Short Lever CMT
- ☐ 9WB3XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Office Other _____
- ☒ Home Exercises ☐ Gym
- ☐ Home Stabilization ☒ Traction
- ☐ Home Ice Pack ☒ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Upper Extremity Tx

- ☐ 98943 Chiropractic Manip.
- ☐ 9WB7XBZ Non-Manual CMT
- ☐ 9WB7XGZ Long Lever CMT
- ☐ 9WB7XHZ Short Lever CMT
- ☐ 9WB7XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☐ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Lower Extremity Tx

- ☐ 98943 Chiropractic Manip.
- ☐ 9WB6XBZ Non-Manual CMT
- ☐ 9WB6XGZ Long Lever CMT
- ☐ 9WB6XHZ Short Lever CMT
- ☐ 9WB6XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☐ Rest
- ☒ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Pelvis/Hip/Sacrum Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 9WB5XBZ Non-Manual CMT
- ☐ 9WB5XGZ Long Lever CMT
- ☐ 9WB5XHZ Short Lever CMT
- ☐ 9WB5XLZ Other Type CMT
- ☐ 97124 Massage _____ minutes
- ☐ 97035 Ultrasound _____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97039 Attended FDA IR Laser
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 _____ min
- ☐ 97150 Ther.Exer.Group _____ min
- ☐ Home Exercises ☐ Gym
- ☐ Home Stabilization ☐ Traction
- ☐ Home Ice Pack ☐ Rest
- ☐ MD ☐ Exam ☐ CT ☐ MRI ☐ DMX

Brain Injury Plan

- ☒ 90791 Cognitive Consultation
- ☒ 96118 Cognitive Screening
- ☒ 90791 Hypersomnolence Consultation
- ☐ 97127 Cognitive Training In Office _____ min.
- ☐ 97039 Attended FDA cleared IR Laser
- ☒ Home Meditation
- ☒ Home Cognitive Rehabilitation Exercises
- ☒ MD Referral SEEING PSYCHIATRIST
- ☒ Neuropsychologist Referral
- ☐ Counseling
- ☒ Polysomnogram UNDER MD'S CARE
- ☒ Avoid Stressful Activities
- ☒ Bed Rest
- ☐ Other _____

Depression/Anxiety Plan

- ☒ Exercise
- ☒ Meditation
- ☒ Avoid Stressful Activities
- ☐ Natural Anti-Depressants
- ☐ Natural Anti-Anxiety
- ☒ Bed Rest
- ☒ MD Referral
- ☐ Cardiologist Referral

TMJ Plan

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☒ Splint for Home Use
- ☐ Home TMJ Exercises
- ☐ Restricted TMJ Activity
- ☐ Relaxation Exercises
- ☐ Soft Food/Liquid Diet
- ☒ DDS Referral SEEING DENTIST

Misc Plans

- ☐ Home TENS
- ☐ Cane/Crutches/Orthotics
- ☐ Natural Anti-Inflammatories
- ☐ Office Treatments per MONTH
- ☐ Home Treatments per DAY
- ☐ Natural Pain Relievers
- ☐ Order Impairment Rating
- ☐ Re-evaluate in 30 days

[Handwritten signature]

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Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 2/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☐ Left ☒ Right.

Describe how your knee injury is affecting your job performance MY KNEE HURTS TO WALK SO I'M LIMPING

Describe how your knee injury is affecting your personal life CAN'T EXERCISE

What alleviates (relieves) your knee symptoms or function? PAIN MEDS, LAYING DOWN

What aggravates (worsens) your knee symptoms or function? WALKING. THE KNEE IS ESPECIALLY PAINFUL AFTER SITTING MORE THAN AN HOUR

How Severe are your knee symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☒ Unstable (Limp)

During the past 30 days, are your knee symptoms ☐ Improving ☐ Same ☒ Worse FROM CAR ACCIDENT ON 2/1/19

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in MC, LCL, INFRAPATELLAR BURSA
No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

EXQUISITE TENDERNESS AND SWELLING OF INFRAPATELLAR BURSA AREA. (P) KNEE HIT DASHBOARD

Doctor's Opinions

Knee injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Knee area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes


Signature of Doctor

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Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☐ Left ☒ Right.

Describe how your knee injury is affecting your job performance KNEE HURTS WHEN I GET UP FROM MY DESK AT WORK AFTER SITTING MORE THAN 30 MIN

Describe how your knee injury is affecting your personal life CAN'T GO TO GYM, PAIN WALKING UP OR DOWN STAIRS (DOWN WORSE)

What alleviates (relieves) your knee symptoms or function? PAIN MEDS, REST

What aggravates (worsens) your knee symptoms or function? IT STIFFENS UP AFTER SITTING FOR A WHILE THEN I LIMP FOR 20 STEPS

How Severe are your knee symptoms? (None) 0 ① 2 3 4 ⑤ 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your knee symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in MCL, INFRAPATELLA TENDON

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

SEND TO ORTHO FOR EVALUATION OF LIGAMENTS &

MENISCUS.

Doctor's Opinions		Knee injury caused by <u>2/1/19 MVC</u>		Apportionment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of other injury _____	
Inconsistencies? <input checked="" type="checkbox"/> None <input type="checkbox"/> Previous records/exam today		<input type="checkbox"/> Subjective & Objective today		<input type="checkbox"/> My Observations/History/Exam		<input type="checkbox"/> Symptoms/Studies	
Reliability of Exam Findings Today <u>100</u> %		Knee area is MMI today? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Other Areas Examined Today? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		<u>45</u> Minutes	

Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☐ Left ☒ Right.

Describe how your knee injury is affecting your job performance I HAD A CORTISONE SHOT AND IT IS LESS STIFF, LESS PAIN

Describe how your knee injury is affecting your personal life CAN'T GO TO GYM, SHARP PAIN WALKING DOWN STAIRS.

What alleviates (relieves) your knee symptoms or function? PAIN MEDS, REST

What aggravates (worsens) your knee symptoms or function? WALKING DOWN STAIRS IS THE WORST

How Severe are your knee symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your knee symptoms ☐ Improving ☐ Same ☒ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in MCL, INFRAPATELLA TENDON
 No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

ORTHO SAID MRI SHOWED TORN MENISCUS. CORTISONE SHOT ON 3/26/19 DIDN'T HELP MUCH

Doctor's Opinions
 Knee injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Knee area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☐ Left ☒ Right.

Describe how your knee injury is affecting your job performance MY KNEE STIFFENS UP AFTER SITTING AT MY DESK, CAN'T SQUAT TO LOW DRAWER

Describe how your knee injury is affecting your personal life CAN'T GO TO GYM

What alleviates (relieves) your knee symptoms or function? PAIN MEDS, CORTISONE SHOT (A LITTLE), AVOID STAIRS.

What aggravates (worsens) your knee symptoms or function? WALKING UP OR DOWN STAIRS, SITTING

How Severe are your knee symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☒ Unstable

During the past 30 days, are your knee symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in MCL, INFRAPATELA TENDON

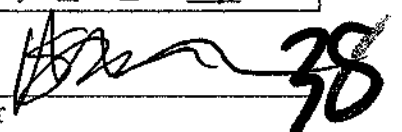
No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

PATIENT AWAITING (R) KNEE SURGERY FOR TORN MENISCUS.

I WILL STOP ATTENDING TO THIS KNEE.

Doctor's Opinions
 Knee injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Knee area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

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Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 2/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☒ Left ☐ Right.

Describe how your knee injury is affecting your job performance IT IS SORE

Describe how your knee injury is affecting your personal life SORE

What alleviates (relieves) your knee symptoms or function? PAIN MEDS

What aggravates (worsens) your knee symptoms or function? WALKING

How Severe are your knee symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your knee symptoms ☐ Improving ☐ Same ☒ Worse FROM 2/1/19 ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☒ Soft Tissues of PES ANSERINE, SARTORIUS, GRACILIS

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in PES ANSERINE BURSA, SARTORIUS, GRACILIS
No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions

Knee injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Knee area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Knee Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Knee is defined as the region from the mid femur to the mid tibia and including all the bone, joint, ligamentous and soft-tissue structures encompassing the joint. This form applies to ☒ Left ☐ Right.

Describe how your knee injury is affecting your job performance IT IS NOT.

Describe how your knee injury is affecting your personal life I'M OK NOW.

What alleviates (relieves) your knee symptoms or function? N/A

What aggravates (worsens) your knee symptoms or function? NOTHING

How Severe are your knee symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your knee symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which knee symptoms do you have? ☐ Numb ☐ Tingle ☐ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your knee symptoms ☐ Improving ☐ Same ☐ Worse HEALED

(For Doctor Use Only)

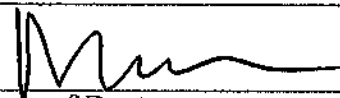
Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Femoral (L2-3) ☐ Obturator (L3-4) ☐ Saphenous (L3-4)
☐ Lat. Sural Cutaneous (L4-S1) ☐ Post. Femoral Cutaneous (S1,S3) ☐ Lat. Femoral Cutaneous (L2-3)

Patient's pain is ☐ Vague/non-localized ☐ Specifically in _____

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
 Knee injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Knee area is MMI today? ☒ Yes ☐ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

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Hip Consultation & Examination

Patient MARIA CRUZ Today's Date 2/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Hip is defined as the region from the articular cartilage of the acetabulum to the mid shaft of the femur, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☐ Left ☒ Right.

Describe how your hip injury is affecting your job performance IT ISN'T

Describe how your hip injury is affecting your personal life IT JUST HURTS

What alleviates (relieves) your hip symptoms or function? PAIN MEDS

What aggravates (worsens) your hip symptoms or function? WALKING

How Severe are your hip symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your hip symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which hip symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your hip symptoms ☐ Improving ☐ Same ☒ Worse FROM 2/1/19 ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Lat. Femoral Cutaneous (L2-3) ☐ Genitofemoral (L1-2)
☐ Inf. Cluneal (S1,S3) ☐ Femoral (L2-3) ☐ Perforating Cutaneous (S2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in THE OF FEMORAL LEG

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(R) FOOT WAS ON BRAKE, THEN (R) KNEE HIT DASHBOARD
WITH LINE OF DRIVE UP FEMUR TO HIP JOINT

Doctor's Opinions

Hip injury caused by MVC 2/1/19 Apportionment? ☒ Yes ☐ No Date of other injury 7/4/18
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Hip area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Maria Cruz 41

Hip Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Hip is defined as the region from the articular cartilage of the acetabulum to the mid shaft of the femur, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☐ Left ☒ Right.

Describe how your hip injury is affecting your job performance IT STIFFENS UP AFTER I SIT AT MY DESK A WHILE

Describe how your hip injury is affecting your personal life WHEN I GET UP IN THE MORNING IT IS STIFF

What alleviates (relieves) your hip symptoms or function? STRETCHING, ADUILL

What aggravates (worsens) your hip symptoms or function? GOING UP STAIRS

How Severe are your hip symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your hip symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which hip symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your hip symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Lat. Femoral Cutaneous (L2-3) ☐ Genitofemoral (L1-2)
☐ Inf. Cluneal (S1,S3) ☐ Femoral (L2-3) ☐ Perforating Cutaneous (S2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ILEO FEMORAL LIGT.

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
Hip injury caused by MVC 2/1/19 Apportionment? ☒ Yes ☐ No Date of other injury 7/4/18
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Hip area is MIM today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Hip Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Hip is defined as the region from the articular cartilage of the acetabulum to the mid shaft of the femur, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☐ Left ☒ Right.

Describe how your hip injury is affecting your job performance IT IS STIFF AFTER I SIT A WHILE. THEN I LIMP FOR 3-4 MINUTES

Describe how your hip injury is affecting your personal life HARD TO GET OUT OF BED IN THE MORNING.

What alleviates (relieves) your hip symptoms or function? NOTHING- ADVIL HELPS A FEW HOURS

What aggravates (worsens) your hip symptoms or function? STAIRS

How Severe are your hip symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your hip symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which hip symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your hip symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Lat. Femoral Cutaneous (L2-3) ☐ Genitofemoral (L1-2)
☐ Inf. Cluneal (S1,S3) ☐ Femoral (L2-3) ☐ Perforating Cutaneous (S2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ILIOFEMORAL LIGAMENT AND POSTERIOR JOINT CAPSULE
No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

I TOLD PATIENT TO TELL THE PAIN MANAGEMENT DOCTOR ABOUT THIS.

Doctor's Opinions
Hip injury caused by MVC 2/1/19 Apportionment? ☒ Yes ☐ No Date of other injury 7/4/18
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Hip area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Signature of Doctor

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Hip Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Hip is defined as the region from the articular cartilage of the acetabulum to the mid shaft of the femur, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☐ Left ☒ Right.

Describe how your hip injury is affecting your job performance IT IS SLOWING ME DOWN

Describe how your hip injury is affecting your personal life IT HURTS

What alleviates (relieves) your hip symptoms or function? ADVL

What aggravates (worsens) your hip symptoms or function? WALKING, STAIRS, SQUATTING

How Severe are your hip symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your hip symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which hip symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your hip symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Lat. Femoral Cutaneous (L2-3) ☐ Genitofemoral (L1-2)
☐ Inf. Cluneal (S1,S3) ☐ Femoral (L2-3) ☐ Perforating Cutaneous (S2-3)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in LEO FEMORAL LGT & JOINT CAPSULE (POST)
 No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

I AM SPECIFICALLY REFERRING MARIA TO PAIN MGMT FOR PROLOTHERAPY, PRP OR STEM CELL INJECTION.

Doctor's Opinions
 Hip injury caused by MVC 2/1/19 Apportionment? ☒ Yes ☐ No Date of other injury 7/14/18
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Hip area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Signature of Doctor

Foot-Ankle Consultation & Examination

Patient MARIA CRUZ Today's Date 2/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Foot-Ankle is defined as the region from below the mid-tibia to the toes, including all the bone, joint, ligamentous and soft-tissue structures encompassing the joints. This form applies to ☒ Left ☐ Right.

Describe how your foot-ankle injury is affecting your job performance IT ISN'T

Describe how your foot-ankle injury is affecting your personal life LEFT ANKLE BRACE HELPS ME WALK

What alleviates (relieves) your foot-ankle symptoms or function? LEFT ANKLE BRACE

What aggravates (worsens) your foot-ankle symptoms or function? WALKING

How Severe are your foot-ankle symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your foot-ankle symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which foot-ankle symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your foot-ankle symptoms ☐ Improving ☐ Same ☒ Worse FROM 2/1/19 ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ L4 ☐ L5 ☐ S1 ☐ Saphenous (L4-5) ☐ Sural (S1-2) ☐ Lat. Plantar (L4-5) ☐ Medial Plantar (L4-5) ☐ Deep Peroneal (L4-5) ☐ Superficial Peroneal (L4-S1) ☐ Lat. Sural (L4-S2)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ATEL (ANT. TALOFIBULAR LIG) CFL
No Symptoms Symptoms Objective Signs Loss of Function LOM Instability
CAVCANOFIBULAR LIG.

Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/> SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

LEFT FOOT HIT DASHBOARD

Doctor's Opinions
Foot-ankle injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Foot-ankle area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Foot-Ankle Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Foot-Ankle is defined as the region from below the mid-tibia to the toes, including all the bone, joint, ligamentous and soft-tissue structures encompassing the joints. This form applies to ☒ Left ☐ Right.

Describe how your foot-ankle injury is affecting your job performance IT DOESN'T INTERFERE WITH MY WORK

Describe how your foot-ankle injury is affecting your personal life IT IS STILL A LITTLE SORE TO WALK BUT MUCH BETTER

What alleviates (relieves) your foot-ankle symptoms or function? REST, ADVIL

What aggravates (worsens) your foot-ankle symptoms or function? WALKING

How Severe are your foot-ankle symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your foot-ankle symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which foot-ankle symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your foot-ankle symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ L4 ☐ L5 ☐ S1 ☐ Sappenous (L4-5) ☐ Sural (S1-2) ☐ Lat. Plantar (L4-5) ☐ Medial Plantar (L4-5) ☐ Deep Peroneal (L4-5) ☐ Superficial Peroneal (L4-S1) ☐ Lat. Sural (L4-S2)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ATFL & CFL

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
Foot-ankle injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Foot-ankle area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Foot-Ankle Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Foot-Ankle is defined as the region from below the mid-tibia to the toes, including all the bone, joint, ligamentous and soft-tissue structures encompassing the joints. This form applies to ☒ Left ☐ Right.

Describe how your foot-ankle injury is affecting your job performance IT'S FINE NOW

Describe how your foot-ankle injury is affecting your personal life _____

What alleviates (relieves) your foot-ankle symptoms or function? _____

What aggravates (worsens) your foot-ankle symptoms or function? _____

How Severe are your foot-ankle symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your foot-ankle symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which foot-ankle symptoms do you have? ☐ Numb ☐ Tingle ☐ Pain ☐ Weak ☐ Unstable

During the past 30 days, are your foot-ankle symptoms ☐ Improving ☐ Same ☐ Worse All Better

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ L4 ☐ L5 ☐ S1 ☐ Sappenous (L4-5) ☐ Sural (S1-2) ☐ Lat. Plantar (L4-5)
☐ Medial Plantar (L4-5) ☐ Deep Peroneal (L4-5) ☐ Superficial Peroneal (L4-S1) ☐ Lat.Sural (L4-S2)

Patient's pain is ☐ Vague/non-localized ☐ Specifically in _____

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions

Foot-ankle injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Foot-ankle area is MMI today? ☒ Yes ☐ No Other Areas Examined Today? ☐ No ☒ Yes 45 Minutes

Thumb - Finger - Hand Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Thumb-Finger-Hand is defined as the region from the carpalmatacarpal joints to the fingers, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☒ Left ☐ Right.

Describe how your thumb-finger-hand injury is affecting your job performance PALM HURTS

TO GRASP THINGS, HURTS TO TYPE

Describe how your thumb-finger-hand injury is affecting your personal life DIFFICULT TO

GRASP THINGS

What alleviates (relieves) your thumb-finger-hand symptoms or function? NOTHING

What aggravates (worsens) your thumb-finger-hand symptoms or function? GRASPING,

MOVEMENTS

How Severe are your thumb-finger-hand symptoms?(None) 0 1 2 (3) 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your thumb-finger-hand symptoms? ☐ 0-25% ☐ 26-50% ☒ 51-75% ☐ 76-100%

Which thumb-finger-hand symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your thumb-finger-hand symptoms ☐ Improving ☐ Same ☒ Worse AFTE
2/1/19 MVC

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ C6 ☐ C7 ☐ C8 ☐ Radial (C5-8) ☐ Median (C6-T1) ☐ Ulnar (C8-T1)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in FLEXOR TENDONS IN PALM

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
Thumb-finger-hand injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Thumb-finger-hand Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Thumb - Finger - Hand Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Thumb-Finger-Hand is defined as the region from the carpometacarpal joints to the fingers, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☒ Left ☐ Right.

Describe how your thumb-finger-hand injury is affecting your job performance MY PALM & FINGERS ARE STIFF

Describe how your thumb-finger-hand injury is affecting your personal life STIFF

What alleviates (relieves) your thumb-finger-hand symptoms or function? N/A

What aggravates (worsens) your thumb-finger-hand symptoms or function? COOKING, HOLDING A FRYING PAN

How Severe are your thumb-finger-hand symptoms?(None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your thumb-finger-hand symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which thumb-finger-hand symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your thumb-finger-hand symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ C6 ☐ C7 ☐ C8 ☐ Radial (C5-8) ☐ Median (C6-T1) ☐ Ulnar (C8-T1)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in PALM FLEXOR TENDONS

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TENDERNESS OVER PALM IN THE FLEXOR TENDONS OF FINGERS 2-4

Doctor's Opinions
 Thumb-finger-hand injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Thumb-finger-hand Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

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Thumb - Finger - Hand Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Thumb-Finger-Hand is defined as the region from the carpal/metacarpal joints to the fingers, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☒ Left ☐ Right.

Describe how your thumb-finger-hand injury is affecting your job performance HAND IS STIFF

Describe how your thumb-finger-hand injury is affecting your personal life STIFF

What alleviates (relieves) your thumb-finger-hand symptoms or function? _____

What aggravates (worsens) your thumb-finger-hand symptoms or function? _____

How Severe are your thumb-finger-hand symptoms?(None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your thumb-finger-hand symptoms? ☐ 0-25% ☐ 26-50% ☒ 51-75% ☐ 76-100%

Which thumb-finger-hand symptoms do you have? ☐ Numb ☐ Tingle ☐ Pain ☐ Weak STIFF

During the past 30 days, are your thumb-finger-hand symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ C6 ☐ C7 ☐ C8 ☐ Radial (C5-8) ☐ Median (C6-T1) ☐ Ulnar (C8-T1)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in PALM TENDONS

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
 Thumb-finger-hand injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Thumb-finger-hand Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Thumb - Finger - Hand Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Thumb-Finger-Hand is defined as the region from the carpometacarpal joints to the fingers, including all the bone, joint, ligamentous and soft-tissue structures. This form applies to ☒ Left ☐ Right.

Describe how your thumb-finger-hand injury is affecting your job performance PAIN GONE, JUST STIFF FINGERS NOW

Describe how your thumb-finger-hand injury is affecting your personal life STIFF

What alleviates (relieves) your thumb-finger-hand symptoms or function? _____

What aggravates (worsens) your thumb-finger-hand symptoms or function? _____

How Severe are your thumb-finger-hand symptoms?(None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your thumb-finger-hand symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which thumb-finger-hand symptoms do you have? ☐ Numb ☐ Tingle ☐ Pain ☐ Weak STIFF

During the past 30 days, are your thumb-finger-hand symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ C6 ☐ C7 ☐ C8 ☐ Radial (C5-8) ☐ Median (C6-T1) ☐ Ulnar (C8-T1)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in PALM TENDONS 2-4

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TO DAY I OBSERVED AND PALPATED SCAR TISSUE IN PALM TENDONS 2-4 CONSISTENT W/ ONSET OF DUPUYTREN'S CONTRACTURE

Doctor's Opinions

Thumb-finger-hand injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Thumb-finger-hand Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpalmetacarpal joints to the midforearm, including all, the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☐ Left ☒ Right.

Describe how your wrist injury is affecting your job performance IT IS SORE AT WORK

Describe how your wrist injury is affecting your personal life CAN'T LIFT WEIGHTS
SO MY EXERCISE ROUTINE IS IMPOSSIBLE

What alleviates (relieves) your wrist symptoms or function? PAIN MEDS

What aggravates (worsens) your wrist symptoms or function? USING IT HURTS.

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☐ Same ☒ Worse FROM ACCIDENT
2/1/19

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in LIGAMENTS OF WRIST

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RIGHT OUTSTRETCHED HAND/WRIST HIT DASHBOARD

Doctor's Opinions
Wrist injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpal/metacarpal joints to the midforearm, including all, the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☐ Left ☒ Right.

Describe how your wrist injury is affecting your job performance HURTS TO TYPE - MUCH BETTER THOUGHT

Describe how your wrist injury is affecting your personal life HURTS TO HOLD TRASH CAN TO DUMP IT IN THE TRASH BIN

What alleviates (relieves) your wrist symptoms or function? REST, ADVIL

What aggravates (worsens) your wrist symptoms or function? LIFTING

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your wrist symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in RADIAL COLLATERAL LIGT.

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TENDER OVER (R) RCL (RADIAL COLLAT. LIGT).

Doctor's Opinions

Wrist injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100 % Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpal/metacarpal joints to the midforearm, including all the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☐ Left ☒ Right.

Describe how your wrist injury is affecting your job performance IT DOESN'T PREVENT

ANY WORK ACTIVITIES NOW

Describe how your wrist injury is affecting your personal life MILD PAIN BUT NOT

STOPPING ME FROM DOING ANYTHING

What alleviates (relieves) your wrist symptoms or function? ADJL

What aggravates (worsens) your wrist symptoms or function? LIFTING

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your wrist symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in RCL

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MILD TENDERNESS (R) RCL

Doctor's Opinions
 Wrist injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☐ None ☒ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpometacarpal joints to the midforearm, including all the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☐ Left ☒ Right.

Describe how your wrist injury is affecting your job performance NOTHING - IT IS

ALL WELL

Describe how your wrist injury is affecting your personal life _____

What alleviates (relieves) your wrist symptoms or function? _____

What aggravates (worsens) your wrist symptoms or function? _____

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☐ Pain ☐ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☐ Same ☐ Worse ALL WELL

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☐ Specifically in _____

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NO TENDERNESS OF RCL TODAY

Doctor's Opinions
 Wrist injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100 % Wrist Area is MMt today? ☒ Yes ☐ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpalmetacarpal joints to the midforearm, including all, the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☒ Left ☐ Right.

Describe how your wrist injury is affecting your job performance DIFFICULT TO TYPE
WITH MY LEFT HAND DUE TO WRIST PAIN

Describe how your wrist injury is affecting your personal life I CAN'T HOLD A PAN
WHEN COOKING BECAUSE OF WRIST PAIN, WORKING OUT IMPOSSIBLE

What alleviates (relieves) your wrist symptoms or function? PAIN MEDS, WRIST
BRACE

What aggravates (worsens) your wrist symptoms or function? USING IT. REALLY,
THOUGH, IT HURTS ALL THE TIME

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☐ Same ☒ Worse FROM ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in FLEXOR TENDONS AND WRIST LIGAMENT

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

LEFT HAND / WRIST INJURED HOLDING STEERING WHEEL DURING
MVC ON 2/1/19

Doctor's Opinions

Wrist injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpalmetacarpal joints to the midforearm, including all, the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☒ Left ☐ Right.

Describe how your wrist injury is affecting your job performance CAN'T TYPE NORMALLY

B/c of Pain

Describe how your wrist injury is affecting your personal life HARD TO LIFT THINGS

What alleviates (relieves) your wrist symptoms or function? WRIST BRACE, ADVIL

What aggravates (worsens) your wrist symptoms or function? ACHES CONSTANTLY, SHARP, STABBING PAIN WHEN HOLDING, LIFTING OR GRASPING

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☒ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☐ Same ☒ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthasias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in Flexor tendons, STL (scaphotrapezium ligament)

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXQUISITE TENDERNESS OVER STL

REFERRED TO WRIST ORTHOPEDIC SURGEON

Doctor's Opinions	
Wrist injury caused by <u>2/1/19 MVC</u>	Apportionment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date of other injury _____
Inconsistencies? <input checked="" type="checkbox"/> None <input type="checkbox"/> Previous records/exam today <input type="checkbox"/> Subjective & Objective today <input type="checkbox"/> My Observations/History/Exam <input type="checkbox"/> Symptoms/Studies	Reliability of Exam Findings Today <u>100</u> % Wrist Area is MMI today? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Other Areas Examined Today? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

Wrist Consultation & Examination

Patient Maria Cruz Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpal/metacarpal joints to the midforearm, including all the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☒ Left ☐ Right.

Describe how your wrist injury is affecting your job performance (L) HAND ALMOST

USELESS AT WORK. CAN'T TYPE, LIFT, OR CARRY THINGS

Describe how your wrist injury is affecting your personal life I HAVE TO WEAR THE

WRIST BRACE ALL THE TIME (EVEN SLEEPING)

What alleviates (relieves) your wrist symptoms or function? WRIST BRACE, ADVIL

What aggravates (worsens) your wrist symptoms or function? USING MY LEFT HAND

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☒ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in STL

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

HAND SURGEON SAID ST LIGT IS TORN. CORTISONE

SHOT DIDN'T HELP MUCH

Doctor's Opinions
Wrist injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Wrist Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Wrist is defined as the region from carpometacarpal joints to the midforearm, including all, the bones (trapezoid, trapezium, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform), joints, ligamentous and soft-tissue structures encompassing the wrist joint. This form applies to ☒ Left ☐ Right.

Describe how your wrist injury is affecting your job performance HAND SURGEON PUT ME ON TEMPORARY DISABILITY - NOW ON LIGHT DUTY

Describe how your wrist injury is affecting your personal life I CAN'T USE MY LEFT HAND

What alleviates (relieves) your wrist symptoms or function? WRIST BRACE

What aggravates (worsens) your wrist symptoms or function? ANY MOVEMENT

How Severe are your wrist symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your wrist symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which wrist symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☒ Weak

During the past 30 days, are your wrist symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Antebrachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in Scaphotrapezium Lig

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

WRIST SURGERY SCHEDULED 5/17/19

Doctor's Opinions

Wrist injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100 % Wrist Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☒ Left ☐ Right

Describe how your shoulder injury is affecting your job performance IT ISN'T BUT IT IS SORE AT WORK (ALL THE TIME)

Describe how your shoulder injury is affecting your personal life JUST SORE ALL THE TIME

What alleviates (relieves) your shoulder symptoms or function? PAIN MEDS HELP FOR A FEW HOURS BUT JUST COMES BACK

What aggravates (worsens) your shoulder symptoms or function? NOTHING. IT ACHES ALL THE TIME

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☐ Improving ☐ Same ☒ Worse AFTER 2/1/19 ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☒ Soft Tissues of LEFT TRAPEZIUS

Patient has paresthesias of ☐ Subraclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☒ Vague/non-localized ☐ Specifically in _____

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions

Shoulder injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100 % Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☒ Left ☐ Right

Describe how your shoulder injury is affecting your job performance I CAN'T REACH OVERHEAD TO GET PAPER OUT OF THE SUPPLY ROOM

Describe how your shoulder injury is affecting your personal life IT HURTS WHEN I ROLL ONTO IT AT NIGHT AND WAKES ME UP.

What alleviates (relieves) your shoulder symptoms or function? REST, ADVIL

What aggravates (worsens) your shoulder symptoms or function? OVERHEAD USE OF SHOULDER

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak ACHE

During the past 30 days, are your shoulder symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☒ Soft Tissues of LEFT TRAPEZIUS

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☒ Vague/non-localized ☐ Specifically in _____

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I BELIEVE HER (L) "SHOULDER" PAIN IS ACTUALLY SCLEROGENIC REFERRED PAIN FROM TORN (R) C5-6 FACET LIGAMENT.

Doctor's Opinions		Shoulder injury caused by <u>2/1/19 MVC - C5-6 Facet Injury</u>		Apportionment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of other injury _____	
Inconsistencies? <input checked="" type="checkbox"/> None <input type="checkbox"/> Previous records/exam today		<input type="checkbox"/> Subjective & Objective today		<input type="checkbox"/> My Observations/History/Exam		<input type="checkbox"/> Symptoms/Studies	
Reliability of Exam Findings Today <u>100</u> %		Shoulder Area is MMI today? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Other Areas Examined Today? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			

Shoulder Consultation & Examination

Patient Maria Cruz Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☒ Left ☐ Right

Describe how your shoulder injury is affecting your job performance ACHES ALL DAY

Describe how your shoulder injury is affecting your personal life ACHES ALL DAY

What alleviates (relieves) your shoulder symptoms or function? ADNIL

What aggravates (worsens) your shoulder symptoms or function? NOTHING. IT JUST ACHES ALL THE TIME.

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☒ Soft Tissues of L TRAPS

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☒ Vague/non-localized ☐ Specifically in L MIDDLE TRAPEZIUS

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Tender <u>L</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C5-6 Facet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lgt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOT IN TRAPS - IN NECK

REFERRAL FOR FACET INJECTION

Doctor's Opinions
 Shoulder injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient Maria Cruz Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☒ Left ☐ Right

Describe how your shoulder injury is affecting your job performance THE SHOT IN MY NECK MADE MOST OF THE ~~SHOULDER~~ SHOULDER PAIN GO AWAY

Describe how your shoulder injury is affecting your personal life _____

What alleviates (relieves) your shoulder symptoms or function? _____

What aggravates (worsens) your shoulder symptoms or function? _____

How Severe are your shoulder symptoms? (None) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☒ 51-75% ☐ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☒ Improving ☐ Same ☐ Worse AFTER SHOT IN NECK

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☒ Soft Tissues of (L) TRAPEZIUS

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☒ Vague/non-localized Specifically in (L) MIDDLE TRAPS

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRP SHOT IN (L) C5/6 FACET LIGT/CAPSULE RELIEVED
(L) SHOULDER (TRAPS) ACHE BY 80%. M.D. WILL TAKE IT FROM HERE.

Doctor's Opinions

Shoulder injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☐ Left ☒ Right

Describe how your shoulder injury is affecting your job performance I CAN'T CARRY ANYTHING OVER 5 POUNDS, CAN'T LIFT/REACH OVERHEAD

Describe how your shoulder injury is affecting your personal life I CAN'T GET MY CLOTHES OUT OF MY CLOSET'S TOP SHELVES & RACKS

What alleviates (relieves) your shoulder symptoms or function? NOT MOVING MY ARM

What aggravates (worsens) your shoulder symptoms or function? SHOULDER MOVEMENTS ESPECIALLY OVERHEAD

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☐ Improving ☐ Same ☒ Worse AFTER 2/1/19 ACCIDENT

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☒ Soft Tissues of DELTOID, INFLAOPINA, SUBSCAPULARIS

Patient has paresthesias of ☐ Subraclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ANT/POST JOINT CAPSULE, ROT. CUFF

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(R) OUTSTRETCHED ARM HIT DASHBOARD

Doctor's Opinions

Shoulder injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100 % Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient Maria Cruz Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☐ Left ☒ Right

Describe how your shoulder injury is affecting your job performance I CAN'T REACH OVERHEAD TO GET PAPER FROM THE SUPPLY ROOM

Describe how your shoulder injury is affecting your personal life IT HURTS TO WASH MY HAIR, COMB & DRY MY HAIR.

What alleviates (relieves) your shoulder symptoms or function? NOT MOVING MY ARM

What aggravates (worsens) your shoulder symptoms or function? MOVING MY ARM

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☐ Improving ☐ Same ☒ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ROTATOR CUFF, JOINT CAPSULE

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lig/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Opinions
 Shoulder injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Shoulder Consultation & Examination

Patient Maria Cruz Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☐ Left ☒ Right

Describe how your shoulder injury is affecting your job performance ORTHO SAID I HAVE A TORN ROTATOR CUFF AND NEED SURGERY ON 4/21/19

Describe how your shoulder injury is affecting your personal life _____

What alleviates (relieves) your shoulder symptoms or function? _____

What aggravates (worsens) your shoulder symptoms or function? _____

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☐ Improving ☒ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ROTATOR CUFF

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SURGERY FOR TORN SUPRASPINATUS TENDON FULL THICKNESS TEAR WILL BE 4/21/19

Doctor's Opinions
 Shoulder injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Signature of Doctor [Signature]

Shoulder Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Shoulder is defined as the region from the midhumerus to the scapulothoracic region, including all the bone, joint, ligamentous and soft-tissue structures encompassing the shoulder joint. This form applies to ☐ Left ☒ Right

Describe how your shoulder injury is affecting your job performance I HAD SURGERY 4/21/19.
IT STILL HURTS ALOT BUT DOCTOR SAID IT WAS SUCCESSFUL

Describe how your shoulder injury is affecting your personal life _____

What alleviates (relieves) your shoulder symptoms or function? _____

What aggravates (worsens) your shoulder symptoms or function? _____

How Severe are your shoulder symptoms? (None) 0 1 2 3 4 5 (7 8) 10 (Intolerable)

How Frequent are your shoulder symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which shoulder symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your shoulder symptoms ☒ Improving ☐ Same ☐ Worse

AFTER SURGERY

(For Doctor Use Only)

Patient has tenderness of ☐ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of ☐ Subacromioclavicular Nerve (C3-4) ☐ Axillary Nerve (C5-6)

Patient's pain is ☐ Vague/non-localized ☐ Specifically in _____

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I COULD NOT EXAMINE THE (R) SHOULDER DUE TO
SURGERY. I WILL LET THE ORTHO HANDLE IT FROM NOW ON.

Doctor's Opinions

Shoulder injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Shoulder Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Elbow Consultation & Examination

Patient MARIA CRUZ Today's Date 2/4/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Elbow is defined as the region midforearm to midhumerus, including all the bone, joint, ligamentous and soft-tissue structures encompassing the elbow joint. This form applies to ☒ Left ☐ Right.

Describe how your elbow injury is affecting your job performance CAN'T CARRY HEAVY
(REAMS OF PAPER) BECAUSE ELBOW HURTS TOO MUCH

Describe how your elbow injury is affecting your personal life CAN'T EXERCISE

What alleviates (relieves) your elbow symptoms or function? NOTHING

What aggravates (worsens) your elbow symptoms or function? MOVEMENT

How Severe are your elbow symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your elbow symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☒ 76-100%

Which elbow symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your elbow symptoms ☐ Improving ☐ Same ☒ Worse FROM ACCIDENT
ON 2/1/19

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Brachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior ☐ Inferior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in ANNULAR LIG, RADIAL COLLATERAL
LIG

No Symptoms Symptoms Objective Signs Loss of Function LOM Instability

Soft Tissues	<input type="checkbox"/>	<input checked="" type="checkbox"/> swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(R) OUT STRETCHED ARM HIT DASHBOARD

Doctor's Opinions

Elbow injury caused by MVC 2/1/19 Apportionment? ☐ Yes ☒ No Date of other injury N/A
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Elbow Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Maria Cruz 68

Elbow Consultation & Examination

Patient MARIA CRUZ Today's Date 3/5/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Elbow is defined as the region midforearm to midhumerus, including all the bone, joint, ligamentous and soft-tissue structures encompassing the elbow joint. This form applies to ☐ Left ☒ Right.

Describe how your elbow injury is affecting your job performance IT IS GETTING BETTER

Describe how your elbow injury is affecting your personal life GETTING BETTER

What alleviates (relieves) your elbow symptoms or function? TREATMENTS HELPING ME

What aggravates (worsens) your elbow symptoms or function? MOVEMENT, LIFTING

How Severe are your elbow symptoms? (None) 0 1 (2) 3 4 (5) 6 7 8 9 10 (Intolerable)

How Frequent are your elbow symptoms? ☐ 0-25% ☒ 26-50% ☐ 51-75% ☐ 76-100%

Which elbow symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your elbow symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☒ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Brachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior ☐ Inferior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in RCL, ANNULAR LIGT.

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TENDERNESS OVER RCL, ANNULAR LIGT'S

Doctor's Opinions

Elbow injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
Reliability of Exam Findings Today 100% Elbow Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Elbow Consultation & Examination

Patient MARIA CRUZ Today's Date 4/8/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Elbow is defined as the region midforearm to midhumerus, including all the bone, joint, ligamentous and soft-tissue structures encompassing the elbow joint. This form applies to ☐ Left ☒ Right.

Describe how your elbow injury is affecting your job performance IT DOESN'T AFFECT ME AT WORK.

Describe how your elbow injury is affecting your personal life WALKING MY DOG AND HOLDING LEASH HURTS

What alleviates (relieves) your elbow symptoms or function? TREATMENTS, REST, ADULT

What aggravates (worsens) your elbow symptoms or function? WHEN ARM IS OUTSTRETCHED WALKING MY BIG DOG.

How Severe are your elbow symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your elbow symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which elbow symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your elbow symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Brachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior ☐ Inferior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in RCL

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligt/Bone/Joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RCL Tenderness - mild

Doctor's Opinions

Elbow injury caused by 2/1/19 MVE Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Elbow Area is MMI today? ☐ Yes ☒ No Other Areas Examined Today? ☐ No ☒ Yes

Elbow Consultation & Examination

Patient MARIA CRUZ Today's Date 5/12/19 Date of Injury 2/1/19

NOTE: Per AMA Guides 6th Ed., Elbow is defined as the region midforearm to midhumerus, including all the bone, joint, ligamentous and soft-tissue structures encompassing the elbow joint. This form applies to ☐ Left ☒ Right.

Describe how your elbow injury is affecting your job performance Mild Soreness - No
Big Deal

Describe how your elbow injury is affecting your personal life _____

What alleviates (relieves) your elbow symptoms or function? _____

What aggravates (worsens) your elbow symptoms or function? _____

How Severe are your elbow symptoms? (None) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

How Frequent are your elbow symptoms? ☒ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Which elbow symptoms do you have? ☐ Numb ☐ Tingle ☒ Pain ☐ Weak

During the past 30 days, are your elbow symptoms ☒ Improving ☐ Same ☐ Worse

(For Doctor Use Only)

Patient has tenderness of ☒ Ligament ☐ Tendon ☐ Bone ☐ Soft Tissues of _____

Patient has paresthesias of Brachial Cutaneous Nerve ☐ Medial ☐ Lateral ☐ Posterior ☐ Inferior

Patient's pain is ☐ Vague/non-localized ☒ Specifically in RCL - very mild

	No Symptoms	Symptoms	Objective Signs	Loss of Function	LOM	Instability
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lig/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ELBOW IS 98% HEALED

Doctor's Opinions

Elbow injury caused by 2/1/19 MVC Apportionment? ☐ Yes ☒ No Date of other injury _____
 Inconsistencies? ☒ None ☐ Previous records/exam today ☐ Subjective & Objective today ☐ My Observations/History/Exam ☐ Symptoms/Studies
 Reliability of Exam Findings Today 100% Elbow Area is MMI today? ☒ Yes ☐ No Other Areas Examined Today? ☐ No ☒ Yes

ACUTE CONCUSSION EVALUATION (ACE)

Physician/Clinician Office Version

Gerard Gioia, PhD¹ & Micky Collins, PhD²

¹Children's National Medical Center
²University of Pittsburgh Medical Center

Patient Name MARIA TERESA CRUZ

DOB: 7/4/80 Age: 38

Date: 2/4/19 ID/MR#

A. Injury Characteristics Date/Time of Injury 2/1/19 Reporter: ☒ Patient ☐ Parent ☐ Spouse ☐ Other

1. Injury Description REAR ENDED, HEAD HIT HEAD RESTRAINT

- 1a. Is there evidence of a forcible blow to the head (direct or indirect)? ☒ Yes ☐ No ☐ Unknown
 1b. Is there evidence of intracranial injury or skull fracture? ☐ Yes ☒ No ☐ Unknown
 1c. Location of Impact: ☐ Frontal ☐ Lt Temporal ☐ Rt Temporal ☐ Lt Parietal ☐ Rt Parietal ☒ Occipital ☒ Neck ☐ Indirect Force
 2. Cause: ☒ MVC ☐ Pedestrian-MVC ☐ Fall ☐ Assault ☐ Sports (specify) ☐ Other
 3. **Amnesia Before (Retrograde)** Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? ☐ Yes ☒ No Duration
 4. **Amnesia After (Anterograde)** Are there any events just AFTER the injury that you/ person has no memory of (even brief)? ☒ Yes ☐ No Duration 2 Hours
 5. **Loss of Consciousness:** Did you/ person lose consciousness? ☐ Yes ☒ No Duration
 6. **EARLY SIGNS:** ☒ Appears dazed or stunned ☒ Is confused about events ☒ Answers questions slowly ☒ Repeats Questions ☒ Forgetful (recent info)
 7. **Seizures:** Were seizures observed? No ☒ Yes ☐ Detail

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes).

*Lovell & Collins, 1998 JHTR

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 <u>1</u>	Feeling mentally foggy	0 <u>1</u>	Drowsiness	0 <u>1</u>
Nausea	0 <u>1</u>	Feeling slowed down	0 <u>1</u>	Sleeping less than usual	<u>0</u> 1 N/A
Vomiting	<u>0</u> 1	Difficulty concentrating	0 <u>1</u>	Sleeping more than usual	<u>0</u> <u>1</u> N/A
Balance problems	<u>0</u> 1	Difficulty remembering	0 <u>1</u>	Trouble falling asleep	<u>0</u> 1 N/A
Dizziness	0 <u>1</u>	COGNITIVE Total (0-4) <u>4</u>		SLEEP Total (0-4) <u>2</u>	
Visual problems	0 <u>1</u>	EMOTIONAL (4)		Exertion: Do these symptoms <u>worsen</u> with: Physical Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A <u>DON'T KNOW</u> Cognitive Activity <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Overall Rating: How <u>different</u> is the person acting compared to his/her usual self? (circle) Normal 0 1 2 3 4 <u>5</u> 6 Very Different	
Fatigue	0 <u>1</u>	Irritability	0 <u>1</u>		
Sensitivity to light	0 <u>1</u>	Sadness	0 <u>1</u>		
Sensitivity to noise	0 <u>1</u>	More emotional	0 <u>1</u>		
Numbness/Tingling	0 <u>1</u>	Nervousness	0 <u>1</u>		
PHYSICAL Total (0-10) <u>8</u>		EMOTIONAL Total (0-4) <u>4</u>			
(Add Physical, Cognitive, Emotion, Sleep totals)		Total Symptom Score (0-22) <u>18</u>			

C. Risk Factors for Prolonged Recovery (check all that apply)

Concussion History? Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	✓	Headache History? Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	✓	Developmental History	✓	Psychiatric History
Previous # 1 2 3 4 5		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days <u> </u> Weeks <u> </u> Months <u> </u> Years <u> </u>		History of migraine headache Personal <u> </u> Family <u> </u>		Attention-Deficit/ Hyperactivity Disorder		Depression
If multiple concussions, less force caused reinjury? Yes <input type="checkbox"/> No <input type="checkbox"/>				Other developmental disorder <u> </u>		Sleep disorder
						Other psychiatric disorder

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures) NONE

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

- * Headaches that worsen
- * Looks very drowsy/ can't be awakened
- * Can't recognize people or places
- * Neck pain
- * Seizures
- * Repeated vomiting
- * Increasing confusion or irritability
- * Unusual behavioral change
- * Focal neurologic signs
- * Slurred speech
- * Weakness or numbness in arms/legs
- * Change in state of consciousness

E. Diagnosis (ICD-10): ☒ Concussion w/o LOC S06.0X0A ☐ Concussion w/ LOC S06.0X1A ☐ Concussion (Unspecified) S06.0X9A ☐ Other (854)
No diagnosis

F. Follow-Up Action Plan Complete ACE Care Plan and provide copy to patient/family.

- No Follow-Up Needed
☒ Physician/ Clinician Office Monitoring: Date of next follow-up 3/5/19
 Referral:
☐ Neuropsychological Testing
☐ Physician: Neurosurgery ☐ Neurology ☐ Sports Medicine ☐ Psychiatrist ☐ Other
☐ Emergency Department

ACE Completed by: [Signature] MD RN NP PhD ATC

A concussion (or mild traumatic brain injury (MTBI)) is a complex pathophysiologic process affecting the brain, induced by traumatic biomechanical forces secondary to direct or indirect forces to the head. Disturbance of brain function is related to neurometabolic dysfunction, rather than structural injury, and is typically associated with normal structural neuroimaging findings (i.e., CT scan, MRI). Concussion may or may not involve a loss of consciousness (LOC). Concussion results in a constellation of physical, cognitive, emotional and sleep-related symptoms. Symptoms may last from several minutes to days, weeks, months or even longer in some cases.

ACE Instructions

The ACE is intended to provide an evidence-based clinical protocol to conduct an initial evaluation and diagnosis of patients (both children and adults) with known or suspected MTBI. The research evidence documenting the importance of these components in the evaluation of an MTBI is provided in the reference list.

A. Injury Characteristics:

1. Obtain **description of the injury** - how injury occurred, type of force, location on the head or body if force transmitted to head. Different biomechanics of injury may result in differential symptom patterns (e.g., occipital blow may result in visual changes, balance difficulties).
2. Indicate the **cause of injury**. Greater forces associated with the trauma are likely to result in more severe presentation of symptoms.
- 3/ 4. **Amnesia**: Amnesia is defined as the failure to form new memories. Determine whether amnesia has occurred and attempt to determine length of time of memory dysfunction – **before** (retrograde) and **after** (anterograde) injury. Even seconds to minutes of memory loss can be predictive of outcome. Recent research has indicated that amnesia may be up to 4-10 times more predictive of symptoms and cognitive deficits following concussion than is LOC (less than 1 minute).¹
5. **Loss of consciousness (LOC)** - If occurs, determine length of LOC.
6. **Early signs**. If present, ask the individuals who know the patient (parent, spouse, friend, etc) about specific signs of the concussion/ MTBI that may have been observed. These signs are typically observed early after the injury.
7. Inquire whether **seizures** were observed or not.

B. Symptom Checklist:²

1. Ask patient (and/ or parent, if child) to report presence of the four categories of symptoms since injury. It is important to assess all listed symptoms as different parts of the brain control different functions. One or all symptoms may be present depending upon mechanisms of injury.³ Record 1 for Yes or 0 for No for their presence or absence, respectively.
2. For all symptoms, indicate presence of symptoms as experienced within the past 24 hours. Since symptoms can be present pre-morbidly/at baseline (e.g., inattention, headaches, sleep, sadness), it is important to assess **change** from their typical presentation.
3. **Scoring**: Sum total **number** of symptoms present per area, and sum all four areas into Total Symptom Score (score range 0-22). (Note: most sleep symptoms are only applicable after a night has passed since the injury. Drowsiness may be present on the day of injury.) If symptoms are new and present, there is no lower limit symptom score. Any **score > 0** indicates **positive symptom** history.
4. **Exertion**: Inquire whether any symptoms worsen with physical (e.g., running, climbing stairs, bike riding) and/or cognitive (e.g., academic studies, multi-tasking at work, reading or other tasks requiring focused concentration) exertion. Clinicians should be aware that symptoms will typically worsen or re-emerge with exertion, indicating incomplete recovery. Over-exertion may protract recovery.
5. **Overall Rating**: Determine how different the person is acting from their usual self. Circle 0 (Normal) to 6 (Very Different).

C. Risk Factors for Protracted Recovery: Assess the following risk factors as possible complicating factors in the recovery process.

1. **Concussion history**: Assess the number and date(s) of prior concussions, the duration of symptoms for each injury, and whether less biomechanical force resulted in re-injury. Recent research indicates that cognitive and symptom effects of concussion may be cumulative, especially if there is minimal duration of time between injuries and less biomechanical force results in subsequent concussion (which may indicate incomplete recovery from initial trauma).⁴⁻⁸
2. **Headache history**: Assess personal and/or family history of diagnosis/treatment for headaches. Recent research indicates headache (migraine in particular) can result in protracted recovery from concussion.⁹⁻¹¹
3. **Developmental history**: Assess history of learning disabilities, Attention-Deficit/Hyperactivity Disorder or other developmental disorders. Recent studies indicate the possibility of a longer period of recovery with these conditions.¹²
4. **Psychiatric history**: Assess for history of depression/mood disorder, anxiety, and/or sleep disorder.¹³⁻¹⁵

D. Red Flags: The patient should be carefully observed over the first 24-48 hours for these serious signs. Red flags are to be assessed as **possible signs of deteriorating neurological functioning**. Any positive report should prompt strong consideration of referral for emergency medical evaluation (e.g. CT Scan to rule out intracranial bleed or other structural pathology).¹⁷

E. Diagnosis: The following ICD-10 diagnostic codes may be applicable.

S06.0X0A (Concussion, with no loss of consciousness) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); no evidence of LOC (A5), skull fracture or intracranial injury (A1b).

S06.0X1A (Concussion, with brief loss of consciousness < 30 minutes) - Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); positive evidence of LOC (A5), skull fracture or intracranial injury (A1b).

S06.0X9A (Concussion, unspecified) - Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); unclear/unknown injury details; unclear evidence of LOC (A5), no skull fracture or intracranial injury.

Other Diagnoses – If the patient presents with a positive injury description and associated symptoms, but additional evidence of intracranial injury (A 1b) such as from neuroimaging, a moderate TBI and the diagnostic category of **S06.890A (Intracranial Injury)** should be considered.

F. Follow-Up Action Plan: Develop a follow-up plan of action for symptomatic patients. The physician/clinician may decide to (1) monitor the patient in the office or (2) refer them to a specialist. Serial evaluation of the concussion is critical as symptoms may resolve, worsen, or ebb and flow depending upon many factors (e.g., cognitive/ physical exertion, comorbidities). Referral to a specialist can be particularly valuable to help manage certain aspects of the patient's condition. (Physician/clinician should also complete the ACE Care Plan included in this tool kit.)

1. **Physician/clinician serial monitoring**- Particularly appropriate if number and severity of symptoms are steadily decreasing over time and/or fully resolve within 3-5 days. If steady reduction is not evident, referral to a specialist is warranted.
2. **Referral to a specialist** – Appropriate if symptom reduction is not evident in 3-5 days, or sooner if symptom profile is concerning in type/severity.
 - **Neuropsychological Testing** can provide valuable information to help assess a patient's brain function and impairment and assist with treatment planning, such as return to play decisions.
 - **Physician Evaluation** is particularly relevant for medical evaluation and management of concussion. It is also critical for evaluating and managing focal neurologic, sensory, vestibular, and motor concerns. It may be useful for medication management (e.g., headaches, sleep disturbance, depression) if post-concussive problems persist.

RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE (RPQ)

Patient MARIA CRUZ DOI 2/1/19 Today's Date 2/4/19

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms listed below. Compare yourself now with how you were before the accident and circle the number closest to your answer.

- 0 = Not experienced at all before or after the accident
 1 = No more of a problem now than before the accident
 2 = A mild problem for me now
 3 = A moderate problem for me now
 4 = A severe problem for me now

0	1	2	<u>3</u>	4	Headaches
0	1	2	<u>3</u>	4	Dizzy feelings
0	1	<u>2</u>	3	4	Nausea, upset stomach or vomiting
0	1	2	3	<u>4</u>	Noise sensitivity, or easily upset by loud noises
0	1	2	3	<u>4</u>	Sleep disturbance or disruption of sleep patterns
0	1	2	3	<u>4</u>	Fatigue, tiring more easily
0	1	<u>2</u>	3	4	Being irritable, easily annoyed or angered
0	1	2	<u>3</u>	4	Feeling depressed, tearful, crying easily or more emotional
0	1	<u>2</u>	3	4	Getting frustrated easily or being less patient with others
0	1	2	<u>3</u>	4	Poor memory or forgetting things
0	1	<u>2</u>	3	4	Difficulty concentrating
0	1	<u>2</u>	3	4	Taking longer to think
0	1	<u>2</u>	3	4	Blurry vision
0	1	<u>2</u>	3	4	Bright lights irritate or upset me, sensitive to bright lights
<u>0</u>	1	2	3	4	Double vision
<u>0</u>	1	2	3	4	Restlessness, have to move around, can't sit still
0	1	2	3	4	Other _____

Patient Signature Maria Cruz Doctor Signature [Signature] **74**

RPQ was originally published in the Journal of Neurology, Neurosurgery and Psychiatry in 1995 by King, Crawford et al from the Oxford Head Injury Service, Rivermead Rehabilitation Centre, Abingdon Road, Oxford, OX1 4XD, United Kingdom

EPWORTH SLEEPINESS SCALE (ESS)

Patient MARIA CRUZ DOI 2/1/19 Today's Date 3/4/19

How likely are you to doze off in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to answer how you believe they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Chance of Dozing	Situation
0 1 2 (3)	Sitting and reading
0 1 2 (3)	Watching TV
0 1 (2) 3	Sitting inactive in a public place (theater, church or meeting)
0 1 (2) 3	As a passenger in a car for an hour without a break
0 1 2 (3)	Lying down to rest in the afternoon when circumstances permit
(0) 1 2 3	Sitting and talking to someone
0 1 2 (3)	Sitting quietly after a lunch where you did not drink alcohol
(0) 1 2 3	In a car while stopped for a few minutes in traffic
16	Total Score

Patient Signature

Maria Cruz

Doctor Signature

[Signature]

ESS was developed by Dr. Murray W. Johns as Director of the Sleep Disorders Unit at Epworth Hospital in Melbourne, Australia. The ESS was first published in 1991 (Murray W. Johns. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale, Sleep, 1991; 14 (6): 540-545).

75

Assessment of Reactions to a Stressful Car Accident

Name MARIA CRUZ Date of Injury 2/1/19 Date Today 2/4/19

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	(2)	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past?	1	(2)	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	1	2	(3)	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	(4)	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	(4)	5
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?	1	(2)	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	(5)
8. Trouble remembering important parts of a stressful experience from the past?	1	2	(3)	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	(4)	5
10. Feeling distant or cut off from other people?	1	(2)	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	(3)	4	5
12. Feeling as if your future will somehow be cut short?	1	2	(3)	4	5
13. Trouble falling or staying asleep?	1	2	3	4	(5)
14. Feeling irritable or having angry outbursts?	1	2	(3)	4	5
15. Having difficulty concentrating?	1	(2)	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	(4)	5
17. Feeling jumpy or easily startled?	1	2	3	4	(5)

Folstein Mini Mental State Examination

Patient MARIA CRUZ DOI 2/1/19 Today's Date 2/4/19

Task Instructions

Scoring

Date Orientation: "Tell me the date?" Ask for omitted items.

One point each for year, season, date, day of week, and month (5 total points)

5/₅

Place Orientation: "Where are you?" Ask for omitted items.

One point each for state, county, town, building, and floor or room. (5 total points)

5/₅

Register 3 Objects: Name three objects slowly and clearly. Ask the patient to repeat them.

One point for each item correctly repeated. (3 total points)

3/₃

Serial Sevens: Ask the patient to count backwards from 100 by 7. Stop after five answers. (Or ask them to spell "world" backwards.)

One point for each correct answer (or letter.) (5 total points)

4/₅

Recall 3 Objects: Ask the patient to recall the objects mentioned above.

One point for each item correctly remembered. (3 total points)

2/₃

Naming: Point to your watch and ask the patient "what is this?" Repeat with a pencil. One point for each correct answer. (2 total points)

2/₂

Repeating a Phrase: Ask the patient to say "no ifs, ands, or buts." One point if successful on first try (1 total point)

0/₁

Verbal Commands: Give the patient a plain piece of paper and say "Take this paper in your right hand, fold it in half, and put it on the floor."

One point for each correct action (3 total points)

3/₃

Written Commands: Show the patient a piece of paper with "CLOSE YOUR EYES" printed on it. One point if the patient's eyes close. (1 total point)

1/₁

Writing: Ask the patient to write a sentence.

One point if sentence has a subject, a verb, and makes sense. (1 total point)

1/₁

Drawing: Ask the patient to copy a pair of intersecting pentagons onto a piece of paper.

One point if the figure has ten corners and two intersecting lines (1 total point)

0/₁

Total

26/₃₀

Scoring: A score of 24 or above is considered normal. 23 or below is indicative of abnormal cognition.

Adapted from Folstein et al, Mini Mental State, J PSYCH RES 12:196-198 (1975).

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HEAD INJURY FOLLOW UP QUESTIONNAIRE (HIF)

Patient MARIA CRUZ Date of Injury 2/1/19 Today's Date 3/5/19

We would like to know if your brain concussion symptoms are improving, staying the same or getting worse. Please mark the box for each symptom to tell us how you are doing.

Symptom	Getting Worse	Staying Same	Getting Better	100% Well	Never Had
Anxiety, nervousness or worry	X				
Depression, crying or more emotional	X				
Irritable or getting angry easily	X				
Difficulty finding simple words when talking	X				
Difficulty concentrating or thinking slowly	X				
Memory problems or forgetting things	X				
Understanding what people say to me	X				
Sleep disturbance or disruption of sleep patterns	X				
Fatigue, tiring more easily or low energy	X	X ^{NO}			
The overall level of my physical pain(s)		X			
Feeling behind, never caught up or overwhelmed		X			
Relationship with my partner or family	X				
Ability to enjoy my hobbies or leisure activities	X				
Ability to exercise or play sports I enjoy	X				
The quality or quantity of how much work I can do	X				
How much I enjoy life	X				
Loud noises, noisy rooms or crowds bother me	X				
Bright lights bother me or I have to wear sunglasses		X			
Feeling like I want to socialize with friends or family	X				
Other					

Would you like a referral to a specialist for mental or emotional issues? ☒ Yes ☐ No

Would you like a referral to a specialist for help with physical pain? ☒ Yes ☐ No

Patient Signature Maria Cruz Doctor Signature [Signature] 78

HEAD INJURY FOLLOW UP QUESTIONNAIRE (HIF)

Patient MARIA CRUZ Date of Injury 2/1/19 Today's Date 4/8/19

We would like to know if your brain concussion symptoms are improving, staying the same or getting worse. Please mark the box for each symptom to tell us how you are doing.

Symptom	Getting Worse	Staying Same	Getting Better	100% Well	Never Had
Anxiety, nervousness or worry		X			
Depression, crying or more emotional		X			
Irritable or getting angry easily		X			
Difficulty finding simple words when talking	X				
Difficulty concentrating or thinking slowly		X			
Memory problems or forgetting things		X			
Understanding what people say to me	X				
Sleep disturbance or disruption of sleep patterns		X			
Fatigue, tiring more easily or low energy			X		
The overall level of my physical pain(s)		X			
Feeling behind, never caught up or overwhelmed	X				
Relationship with my partner or family			X		
Ability to enjoy my hobbies or leisure activities		X			
Ability to exercise or play sports I enjoy	X				
The quality or quantity of how much work I can do	X				
How much I enjoy life	X				
Loud noises, noisy rooms or crowds bother me	X				
Bright lights bother me or I have to wear sunglasses		X			
Feeling like I want to socialize with friends or family		X			
Other					

Would you like a referral to a specialist for mental or emotional issues? ☒ Yes ☐ No

Would you like a referral to a specialist for help with physical pain? ☒ Yes ☐ No

Patient Signature Maria Cruz Doctor Signature [Signature] 79

HEAD INJURY FOLLOW UP QUESTIONNAIRE (HIF)

Patient MARIA CRUZ Date of Injury 2/1/19 Today's Date 5/12/19

We would like to know if your brain concussion symptoms are improving, staying the same or getting worse. Please mark the box for each symptom to tell us how you are doing.

Symptom	Getting Worse	Staying Same	Getting Better	100% Well	Never Had
Anxiety, nervousness or worry		X			
Depression, crying or more emotional		X			
Irritable or getting angry easily			X		
Difficulty finding simple words when talking		X			
Difficulty concentrating or thinking slowly		X			
Memory problems or forgetting things		X			
Understanding what people say to me		X			
Sleep disturbance or disruption of sleep patterns	X				
Fatigue, tiring more easily or low energy	X				
The overall level of my physical pain(s)		X			
Feeling behind, never caught up or overwhelmed	X				
Relationship with my partner or family			X		
Ability to enjoy my hobbies or leisure activities		X			
Ability to exercise or play sports I enjoy		X			
The quality or quantity of how much work I can do		X			
How much I enjoy life	X				
Loud noises, noisy rooms or crowds bother me		X			
Bright lights bother me or I have to wear sunglasses		X			
Feeling like I want to socialize with friends or family		X			
Other					

Would you like a referral to a specialist for mental or emotional issues? ☒ Yes ☐ No

Would you like a referral to a specialist for help with physical pain? ☒ Yes ☐ No

Patient Signature Maria Cruz Doctor Signature MM 80

RIVERMEAD HEAD INJURY SERVICE FOLLOW UP QUESTIONNAIRE (RHFUQ)

Outcome Assessment (Every 3 months after injury)

Patient MARIA CRUZ DOI 2/1/19 Today's Date 5/12/19

After a head injury or accident some people experience problems which can cause worry or nuisance. We would like to know if you have difficulties with any of the activities listed below. We would like you to compare yourself now with before the accident/injury. For each one please circle the number closest to your answer.

- 0 = No change - I'm that same as before the injury
 1 = No recent change but still more difficult than before injury
 2 = A mild change in my ability compared to before injury
 3 = A moderate change in my ability compared to before injury
 4 = A very marked change in my ability compared to before injury

Compared with before the accident/injury, has there been a change in your...?

0	1	②	3	4	Ability to participate in conversation with one person
0	1	③	3	4	Ability to participate in conversation with 2 or more people
0	1	③	3	4	Performance of routine domestic activities
0	1	2	④	4	Ability to participate in previous social activities
0	1	2	④	4	Ability to enjoy previous leisure activities
0	1	2	④	4	Ability to maintain your previous work load or quality of work
0	1	2	④	4	Finding work more tiring
0	1	③	3	4	Relationship with previous friends
0	1	③	3	4	Relationship with your partner
0	1	2	④	4	Ability to cope with or handle family demands
0	1	2	3	4	Other difficulties _____
0	1	2	3	4	Other difficulties _____
0	1	2	3	4	Other difficulties _____
0	1	2	3	4	Other difficulties _____
Would you like a follow up appointment for further advice? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

Patient Signature Maria Cruz Doctor Signature [Signature] 81

RHFUQ was published in 1996 in the Journal of Neurology, Neurosurgery and Psychiatry by Crawford et al from the Oxford Head Injury Service, Rivermead Rehabilitation Centre, Abingdon Road, Oxford, OX1 4XD, United Kingdom. The conclusion of this study stated, "The RHFUQ is a short, simple, adequately reliable, and valid measure of outcome, across the entire range of severity, but particularly after mild to moderate head injury."

HEAD INJURY OUTCOME ASSESSMENT (HIO)

Patient MARIA CRUZ DOI 2/1/19 Today's Date 5/12/19

Patients can experience post-concussion symptoms for days, weeks, months or even years. Now that a number of months have passed since your brain concussion, we would like to know which symptoms you are still experiencing and how much they have changed your life. Please circle below the number closest to your answer.

- 1 = I am exactly the same as before my injury
 2 = I still have mild symptoms or this makes my life a little different than before
 3 = I still have moderate symptoms or this makes my life a lot different than before
 4 = I still have severe symptoms or this makes my life completely different than before

1	2	(3)	4	Anxiety, nervousness, tightness in my chest or sweaty palms
1	2	(3)	4	Depression, crying, more emotional or don't want to get out of bed
1	(2)	3	4	Wishing my life was over or not optimistic about my future
1	2	(3)	4	Irritability or anger that causes relationship problems for me
1	2	(3)	4	Difficulty finding simple words when I am talking
1	2	(3)	4	Difficulty concentrating, thinking slowly or thinking makes me tired
1	2	3	(4)	Memory problems, forgetting things or I have to write things down
1	2	3	(4)	I don't understand what people say to me unless I concentrate
1	2	3	(4)	I don't understand what I read unless I really concentrate
1	2	3	(4)	Loud noise, noisy rooms or many voices make me uncomfortable
1	2	3	(4)	I feel behind all the time, never catch up or get overwhelmed easily
1	2	3	(4)	I get no joy or happiness from my hobbies or sports activities
1	2	3	(4)	My sleep is different than before my injury
1	2	(3)	4	I am tired, have no energy or don't feel like doing anything
1	2	3	(4)	I have physical pain so bad that it is depressing to me
1	2	3	(4)	My life now is not as good as the life I had before my injury
1	2	(3)	4	Difficulty participating in conversations with 2 or more people

Would you like a referral to a specialist for help with your life? ☒ Yes ☐ No

Patient Signature Maria Cruz Doctor Signature [Signature] **82**

The HIO is based on the book, Whiplash & Motor Vehicle Collisions by Steven C Eggleston. (1st Ed. 2010, 2nd Ed. 2014). It was designed to be used by clinicians beginning 2 months after a head injury and every 2 months until the patient is well.

Duties Performed Under Duress at Work and Home

Patient MARIA CRUZ Date 3/5/19 Date of Injury 2/1/19

☒ Initial ☐ Update

Please check all that apply to your WORK because of the accident.

- | | |
|---|---|
| <input checked="" type="checkbox"/> I go to work but work in pain | <input checked="" type="checkbox"/> I work in pain because I have bills to pay |
| <input checked="" type="checkbox"/> I limit my work activities | <input checked="" type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input checked="" type="checkbox"/> Sitting at work hurts | <input checked="" type="checkbox"/> I believe in working even when I'm in pain |
| <input checked="" type="checkbox"/> Using the Computer at work hurts | <input checked="" type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input checked="" type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input checked="" type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input checked="" type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input checked="" type="checkbox"/> I don't enjoy work as much as before | <input checked="" type="checkbox"/> I cannot do the same work/job as before accident |
| <input checked="" type="checkbox"/> I doze off at work | <input checked="" type="checkbox"/> I can't concentrate as well at work |
| <input checked="" type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input checked="" type="checkbox"/> I make mistakes at work I didn't used to |
| <input checked="" type="checkbox"/> I feel tired at work | <input checked="" type="checkbox"/> I hide my poor work performance from my boss |
| <input checked="" type="checkbox"/> I need medication to be able to work. I take <u>400</u> mg of <u>ADVICE</u> at <u>7:30am</u> when my pain level gets to <u>8</u> /10 and/or again at <u>1:00</u> pm when my pain gets to <u>8</u> /10 | |

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> My house is not as clean now | <input checked="" type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input checked="" type="checkbox"/> I have <u>3</u> children ages <u>3, 7, 9</u> |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input checked="" type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input checked="" type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input checked="" type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input checked="" type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input checked="" type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input checked="" type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input type="checkbox"/> I cannot cook now | <input checked="" type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Maria Cruz
Signature

3/5/19
Date

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Duties Performed Under Duress at Work and Home

Patient MARIA CRUZ Date 4/8/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all that apply to your WORK because of the accident.

- | | |
|--|---|
| <input checked="" type="checkbox"/> I go to work but work in pain LIGHT DUTY
<input checked="" type="checkbox"/> I limit my work activities
<input type="checkbox"/> Bending at work hurts
<input type="checkbox"/> Stooping at work hurts
<input checked="" type="checkbox"/> Sitting at work hurts
<input checked="" type="checkbox"/> Using the Computer at work hurts
<input type="checkbox"/> Pushing at work hurts
<input type="checkbox"/> Pulling at work hurts
<input type="checkbox"/> Kneeling at work hurts
<input type="checkbox"/> I have lost status in my company
<input checked="" type="checkbox"/> I have lost job security
<input type="checkbox"/> I didn't get a promotion
<input checked="" type="checkbox"/> I don't enjoy work as much as before
<input checked="" type="checkbox"/> I doze off at work
<input checked="" type="checkbox"/> I take unpaid time off work to go to Dr.
<input type="checkbox"/> I daydream at work more than before
<input checked="" type="checkbox"/> I feel tired at work
<input checked="" type="checkbox"/> I need medication to be able to work. I take <u>800</u> mg of <u>Advil</u> at <u>11</u> am when my pain level gets to <u>8</u> /10 and/or again at <u>3</u> pm when my pain gets to <u>8</u> /10 | <input type="checkbox"/> I work in pain because I have bills to pay
<input type="checkbox"/> I can't take time off because I would lose my job
<input type="checkbox"/> I keep working so I don't lose status at company
<input type="checkbox"/> My business would fail if I took time off
<input type="checkbox"/> I believe in working even when I'm in pain
<input type="checkbox"/> I feel obligated to work even though I'm in pain
<input type="checkbox"/> My business would lose money if I took time off
<input type="checkbox"/> My work is not as good as it was before accident
<input type="checkbox"/> My boss reprimanded me for poor performance
<input type="checkbox"/> I got a different job within the same company
<input type="checkbox"/> I got a different job in another company
<input checked="" type="checkbox"/> I make less money than before the accident NONE
<input type="checkbox"/> I cannot do the same work/job as before accident
<input type="checkbox"/> I can't concentrate as well at work
<input type="checkbox"/> I take paid time off to go to Dr.
<input type="checkbox"/> I make mistakes at work I didn't used to
<input type="checkbox"/> I hide my poor work performance from my boss |
|--|---|

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|---|---|
| <input checked="" type="checkbox"/> My house is not as clean now
<input type="checkbox"/> My yard is not as neat now
<input type="checkbox"/> My garden is not as productive now
<input type="checkbox"/> I do yard work, but do it in pain
<input type="checkbox"/> I cannot do my normal yard work
<input type="checkbox"/> I do house work, but do it in pain
<input checked="" type="checkbox"/> I cannot do my normal house work
<input checked="" type="checkbox"/> Doing laundry hurts me
<input type="checkbox"/> I cannot do laundry now
<input checked="" type="checkbox"/> Washing dishes hurts me
<input type="checkbox"/> I cannot wash dishes now
<input type="checkbox"/> Vacuuming hurts me
<input checked="" type="checkbox"/> I cannot vacuum now
<input type="checkbox"/> Cooking hurts me
<input checked="" type="checkbox"/> I cannot cook now
<input type="checkbox"/> Washing the car hurts me
<input type="checkbox"/> I cannot wash my car
<input type="checkbox"/> _____
<input type="checkbox"/> _____ | <input type="checkbox"/> I cannot take time off because I care for children
<input checked="" type="checkbox"/> I have <u>3</u> children ages <u>3, 7, 9</u>
<input type="checkbox"/> I had to hire a paid housekeeper
<input checked="" type="checkbox"/> I asked someone for unpaid housekeeping help
<input type="checkbox"/> I had to hire a paid gardener
<input type="checkbox"/> I asked someone for unpaid yard work help
<input type="checkbox"/> Mowing the lawn hurts me
<input type="checkbox"/> I cannot mow the lawn
<input type="checkbox"/> Taking out the trash hurts me
<input type="checkbox"/> I cannot take out the trash
<input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to
<input type="checkbox"/> I do not enjoy my housework like I used to
<input type="checkbox"/> Gardening hurts me
<input type="checkbox"/> I cannot do my gardening at all since the accident
<input checked="" type="checkbox"/> Others living with me do my share of the work now
<input type="checkbox"/> Others living with me do my share of the yard work
<input type="checkbox"/> Others living with me do my share of the gardening
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|---|---|

Maria Cruz
Signature

4/8/19
Date

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Duties Performed Under Duress at Work and Home

Patient MARIA CRUZ Date 5/12/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all that apply to your WORK because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> I go to work but work in pain | <input type="checkbox"/> I work in pain because I have bills to pay |
| <input checked="" type="checkbox"/> I limit my work activities | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input type="checkbox"/> Sitting at work hurts | <input type="checkbox"/> I believe in working even when I'm in pain |
| <input type="checkbox"/> Using the Computer at work hurts | <input type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input checked="" type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input checked="" type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input checked="" type="checkbox"/> I don't enjoy work as much as before | <input type="checkbox"/> I cannot do the same work/job as before accident |
| <input checked="" type="checkbox"/> I doze off at work | <input type="checkbox"/> I can't concentrate as well at work |
| <input checked="" type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input type="checkbox"/> I make mistakes at work I didn't used to |
| <input checked="" type="checkbox"/> I feel tired at work | <input type="checkbox"/> I hide my poor work performance from my boss |
| <input checked="" type="checkbox"/> I need medication to be able to work. I take <u>600</u> mg of <u>Advil</u> at <u>11</u> am | |
| when my pain level gets to <u>8</u> /10 and/or again at <u>4</u> pm when my pain gets to <u>8</u> /10 | |

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|--|---|
| <input checked="" type="checkbox"/> My house is not as clean now | <input type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input checked="" type="checkbox"/> I have <u>3</u> children ages <u>3, 7, 9</u> |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input checked="" type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input checked="" type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input checked="" type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input checked="" type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input checked="" type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input checked="" type="checkbox"/> I cannot cook now | <input checked="" type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Maria Cruz
Signature

5/12/19
Date

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Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient MARIA CRUZ Date 3/5/19 Date of Injury 2/1/19

☒ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> My exercise was affected by this crash | <input checked="" type="checkbox"/> I have gained <u>5</u> pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input checked="" type="checkbox"/> I had to quit my <u>Tennis</u> team after the accident |
| <input checked="" type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input checked="" type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input checked="" type="checkbox"/> I don't enjoy the sport of <u>Tennis</u> anymore |
| <input checked="" type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|--|---|
| <input checked="" type="checkbox"/> My hobbies were affected by accident | <input checked="" type="checkbox"/> Hobby #3 <u>EMBROIDERY</u> |
| <input checked="" type="checkbox"/> Hobby #1 <u>PLAYING PIANO</u> | <input checked="" type="checkbox"/> I can't do hobby #3 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input checked="" type="checkbox"/> Hobby #4 <u>BAKING</u> |
| <input checked="" type="checkbox"/> Hobby #2 <u>Rock Climbing</u> | <input checked="" type="checkbox"/> I can't do hobby #4 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

Please check all that apply to your TRAVEL Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> Business travel was affected by crash | <input checked="" type="checkbox"/> Travel Plan #1 <u>WEEKEND TO LAS VEGAS w/ HUSBAND</u> |
| <input checked="" type="checkbox"/> Pleasure travel was affected by crash | <input checked="" type="checkbox"/> I did not go on travel plan #1 |
| <input checked="" type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input checked="" type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input checked="" type="checkbox"/> I have anxiety when I'm in a car - <u>BAD</u> | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

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Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient MARIA CRUZ Date 3/5/19 Date of Injury 2/1/19

☒ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Dressing | <input checked="" type="checkbox"/> Riding in a car |
| <input checked="" type="checkbox"/> Putting on pants | <input checked="" type="checkbox"/> Opening a jar |
| <input checked="" type="checkbox"/> Putting on shoes | <input checked="" type="checkbox"/> Lifting a pan when cooking |
| <input type="checkbox"/> Tying my shoes | <input checked="" type="checkbox"/> Closing the trunk on my car |
| <input checked="" type="checkbox"/> Putting on shirt | <input type="checkbox"/> Opening the garage door |
| <input checked="" type="checkbox"/> Drying my hair | <input checked="" type="checkbox"/> Using my home computer |
| <input type="checkbox"/> Combing my hair | <input checked="" type="checkbox"/> Climbing stairs |
| <input checked="" type="checkbox"/> Washing my hair | <input checked="" type="checkbox"/> Going down stairs |
| <input type="checkbox"/> Taking a shower | <input checked="" type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Taking a bath | <input checked="" type="checkbox"/> Turning my head to left or right |
| <input checked="" type="checkbox"/> Leaning forward | <input type="checkbox"/> Holding my head up all day |
| <input checked="" type="checkbox"/> Laying in bed | <input checked="" type="checkbox"/> Watching TV |
| <input checked="" type="checkbox"/> Sitting in my favorite chair | <input checked="" type="checkbox"/> I have pain sitting & doing nothing |
| <input checked="" type="checkbox"/> Sleeping | <input checked="" type="checkbox"/> Talking on the phone |
| <input type="checkbox"/> Going out with my friends <i>-I DO NOT GO</i> | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sitting in a restaurant | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Opening doors |
| <input checked="" type="checkbox"/> Driving to/from work | <input type="checkbox"/> Drying with a towel after a bath or shower |
| <input checked="" type="checkbox"/> Sitting in Church | <input checked="" type="checkbox"/> Life has become a chore just to do normal things |
| <input checked="" type="checkbox"/> Playing with my children | <input checked="" type="checkbox"/> It is depressing to live like this |
| <input checked="" type="checkbox"/> Caring for my children | <input type="checkbox"/> |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting in a movie theater | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> Exercise | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> Eating | <input type="checkbox"/> |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> |
| <input type="checkbox"/> Squatting down | <input type="checkbox"/> |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> |
| <input type="checkbox"/> Brushing my teeth | <input type="checkbox"/> |

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> School was affected by the accident | <input type="checkbox"/> I have pain carrying my school books |
| <input type="checkbox"/> I am a student at _____ | <input type="checkbox"/> I hurt sitting in class more than _____ minutes |
| <input type="checkbox"/> I am in the _____ year/grade | <input type="checkbox"/> My neck hurts when I look down to read |
| <input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn as quickly as before the crash |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash | <input type="checkbox"/> I have difficulty concentrating in class |
| <input type="checkbox"/> I missed _____ days of school | <input type="checkbox"/> It takes much longer to study/do my homework |
| <input type="checkbox"/> I had to drop out of school b/c of crash | <input type="checkbox"/> |
| <input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> |

Maria Denis Cruz
Signature of Patient

Date

3/5/19

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Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient MARIA CRUZ Date 4/8/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|--|---|
| <input checked="" type="checkbox"/> My exercise was affected by this crash | <input checked="" type="checkbox"/> I have gained <u>15</u> pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input checked="" type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input checked="" type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby #3 _____ |
| <input type="checkbox"/> Hobby #1 <u>ROCK CLIMBING</u> | <input type="checkbox"/> I can't do hobby #3 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input type="checkbox"/> Hobby #4 _____ |
| <input checked="" type="checkbox"/> Hobby #2 <u>EMBROIDERY</u> | <input type="checkbox"/> I can't do hobby #4 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input checked="" type="checkbox"/> <u>I DON IT FEEL LIKE DOING ANYTHING</u> |

Please check all that apply to your TRAVEL Activities because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> Business travel was affected by crash | <input checked="" type="checkbox"/> Travel Plan #1 <u>EASTER WITH PARENTS</u> |
| <input checked="" type="checkbox"/> Pleasure travel was affected by crash | <input type="checkbox"/> I did not go on travel plan #1 |
| <input checked="" type="checkbox"/> I hurt driving in my own car | <input checked="" type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input checked="" type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input checked="" type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

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Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient MARIA CRUZ Date 4/8/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all the DAILY LIVING Activities that cause you pain because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Dressing | <input checked="" type="checkbox"/> Riding in a car |
| <input checked="" type="checkbox"/> Putting on pants | <input type="checkbox"/> Opening a jar |
| <input checked="" type="checkbox"/> Putting on shoes | <input checked="" type="checkbox"/> Lifting a pan when cooking |
| <input type="checkbox"/> Tying my shoes | <input type="checkbox"/> Closing the trunk on my car |
| <input type="checkbox"/> Putting on shirt | <input type="checkbox"/> Opening the garage door |
| <input checked="" type="checkbox"/> Drying my hair | <input type="checkbox"/> Using my home computer |
| <input checked="" type="checkbox"/> Combing my hair | <input type="checkbox"/> Climbing stairs |
| <input checked="" type="checkbox"/> Washing my hair | <input checked="" type="checkbox"/> Going down stairs |
| <input checked="" type="checkbox"/> Taking a shower | <input checked="" type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Taking a bath | <input type="checkbox"/> Turning my head to left or right |
| <input type="checkbox"/> Leaning forward | <input type="checkbox"/> Holding my head up all day |
| <input checked="" type="checkbox"/> Laying in bed | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Sitting in my favorite chair | <input type="checkbox"/> I have pain sitting & doing nothing |
| <input checked="" type="checkbox"/> Sleeping | <input type="checkbox"/> Talking on the phone |
| <input type="checkbox"/> Going out with my friends | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sitting in a restaurant | <input type="checkbox"/> Writing |
| <input checked="" type="checkbox"/> Shopping | <input type="checkbox"/> Opening doors |
| <input type="checkbox"/> Driving to/from work | <input checked="" type="checkbox"/> Drying with a towel after a bath or shower |
| <input checked="" type="checkbox"/> Sitting in Church | <input checked="" type="checkbox"/> Life has become a chore just to do normal things |
| <input type="checkbox"/> Playing with my children | <input checked="" type="checkbox"/> It is depressing to live like this |
| <input checked="" type="checkbox"/> Caring for my children | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting in a movie theater | <input type="checkbox"/> _____ |
| <input checked="" type="checkbox"/> Exercise <u>CAN'T - DON'T FEEL LIKE IT</u> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Squatting down | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Brushing my teeth | <input type="checkbox"/> _____ |

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> School was affected by the accident | <input type="checkbox"/> I have pain carrying my school books |
| <input type="checkbox"/> I am a student at _____ | <input type="checkbox"/> I hurt sitting in class more than _____ minutes |
| <input type="checkbox"/> I am in the _____ year/grade | <input type="checkbox"/> My neck hurts when I look down to read |
| <input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn as quickly as before the crash |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash | <input type="checkbox"/> I have difficulty concentrating in class |
| <input type="checkbox"/> I missed _____ days of school | <input type="checkbox"/> It takes much longer to study/do my homework |
| <input type="checkbox"/> I had to drop out of school b/c of crash | <input type="checkbox"/> _____ |
| <input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> _____ |

Maria Cruz
Signature of Patient

Date 4/8/19

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Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient MARIA CRUZ Date 5/12/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|--|--|
| <input checked="" type="checkbox"/> My exercise was affected by this crash | <input checked="" type="checkbox"/> I have gained <u>20</u> pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input checked="" type="checkbox"/> I had to quit my <u>tennis</u> team after the accident |
| <input checked="" type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input checked="" type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input checked="" type="checkbox"/> I don't enjoy the sport of <u>Tennis</u> anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|--|---|
| <input checked="" type="checkbox"/> My hobbies were affected by accident | <input checked="" type="checkbox"/> Hobby #3 <u>EMBROIDERY</u> |
| <input type="checkbox"/> Hobby #1 <u>PIANO</u> | <input checked="" type="checkbox"/> I can't do hobby #3 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input checked="" type="checkbox"/> Hobby #4 <u>BAKING</u> |
| <input checked="" type="checkbox"/> Hobby #2 <u>Rock Climbing</u> | <input checked="" type="checkbox"/> I can't do hobby #4 anymore |
| <input checked="" type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

Please check all that apply to your TRAVEL Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> Business travel was affected by crash | <input checked="" type="checkbox"/> Travel Plan #1 <u>FAMILY REUNION IN BALTIMORE</u> |
| <input checked="" type="checkbox"/> Pleasure travel was affected by crash | <input checked="" type="checkbox"/> I did not go on travel plan #1 |
| <input checked="" type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input checked="" type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input checked="" type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient MARIA CRUZ Date 5/12/19 Date of Injury 2/1/19

☐ Initial ☒ Update

Please check all the DAILY LIVING Activities that cause you pain because of the accident.

- | | |
|---|--|
| <input checked="" type="checkbox"/> Dressing | <input checked="" type="checkbox"/> Riding in a car |
| <input checked="" type="checkbox"/> Putting on pants | <input checked="" type="checkbox"/> Opening a jar |
| <input checked="" type="checkbox"/> Putting on shoes | <input checked="" type="checkbox"/> Lifting a pan when cooking |
| <input checked="" type="checkbox"/> Tying my shoes | <input type="checkbox"/> Closing the trunk on my car |
| <input checked="" type="checkbox"/> Putting on shirt | <input type="checkbox"/> Opening the garage door |
| <input checked="" type="checkbox"/> Drying my hair | <input checked="" type="checkbox"/> Using my home computer |
| <input checked="" type="checkbox"/> Combing my hair | <input checked="" type="checkbox"/> Climbing stairs |
| <input checked="" type="checkbox"/> Washing my hair | <input checked="" type="checkbox"/> Going down stairs |
| <input checked="" type="checkbox"/> Taking a shower | <input checked="" type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Taking a bath | <input type="checkbox"/> Turning my head to left or right |
| <input type="checkbox"/> Leaning forward | <input type="checkbox"/> Holding my head up all day |
| <input type="checkbox"/> Laying in bed | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Sitting in my favorite chair | <input checked="" type="checkbox"/> I have pain sitting & doing nothing |
| <input checked="" type="checkbox"/> Sleeping | <input checked="" type="checkbox"/> Talking on the phone |
| <input checked="" type="checkbox"/> Going out with my friends | <input checked="" type="checkbox"/> Reading |
| <input checked="" type="checkbox"/> Sitting in a restaurant | <input checked="" type="checkbox"/> Writing |
| <input checked="" type="checkbox"/> Shopping | <input checked="" type="checkbox"/> Opening doors |
| <input checked="" type="checkbox"/> Driving to/from work | <input checked="" type="checkbox"/> Drying with a towel after a bath or shower |
| <input checked="" type="checkbox"/> Sitting in Church | <input checked="" type="checkbox"/> Life has become a chore just to do normal things |
| <input checked="" type="checkbox"/> Playing with my children | <input checked="" type="checkbox"/> It is depressing to live like this |
| <input checked="" type="checkbox"/> Caring for my children | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting in a movie theater | <input type="checkbox"/> _____ |
| <input checked="" type="checkbox"/> Exercise <u>CAN'T</u> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Squatting down | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> _____ |
| <input checked="" type="checkbox"/> Brushing my teeth | <input type="checkbox"/> _____ |

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> School was affected by the accident | <input type="checkbox"/> I have pain carrying my school books |
| <input type="checkbox"/> I am a student at _____ | <input type="checkbox"/> I hurt sitting in class more than _____ minutes |
| <input type="checkbox"/> I am in the _____ year/grade | <input type="checkbox"/> My neck hurts when I look down to read |
| <input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn as quickly as before the crash |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash | <input type="checkbox"/> I have difficulty concentrating in class |
| <input type="checkbox"/> I missed _____ days of school | <input type="checkbox"/> It takes much longer to study/do my homework |
| <input type="checkbox"/> I had to drop out of school b/c of crash | <input type="checkbox"/> _____ |
| <input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> _____ |

Signature of Patient

Date

5/12/19

91

XRAY Initial Report

Patient MARIA CRUZ

Date of X-Ray Films 2/4/19

Date of Injury 2/1/19

Films Reviews of Cervical Thoracic Lumbar (R) Knee, (R) shoulder

Number of Films Reviewed 7VC, 2VT, 2VL AND (L) wrist, (R) wrist

Date Films Taken 2/4/19

Location Where Films Taken ABC chiropractic

☒ I Will Send These Films for Radiologist Overread? ☒ Yes ☐ No

☒ These films are good diagnostic quality EXCEPT

☒ The following films should be re-taken to obtain good diagnostic quality

APOM IN (R) LAT-FLEXION

☒ These films show abnormal joint curvature at

C/S LOSS OF LORDOSIS, STAIR STEP C5-6 GEORGE'S EXTENSION

☒ These films demonstrate newly torn ligaments at

C5-6 ALL POSSIBLE FACET C5-6

☒ Video Fluoroscopy to evaluate all the ligaments in this body area is required
☐ immediately ☒ after swelling is reduced

☒ These films demonstrate findings that require prolotherapy referral to

C/S Prolo, (R) shoulder, (R) knee, (L) wrist


☒ Prolotherapy referral will be made

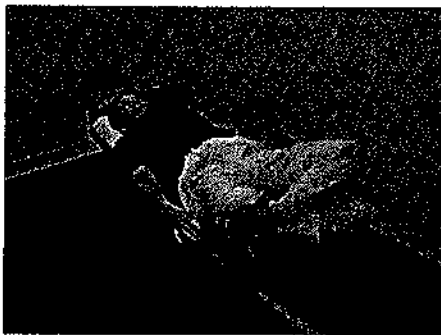
☐ immediately ☒ 90-120 days after injury when swelling reduced

☒ These films demonstrate findings requiring consultation with spine surgeon

☐ immediately ☒ in approximately 30-60 DAYS days

☒ I am aware of torn ligaments in this body area and am planning to deliver low force adjustments and treatments to this patient


Signature of Doctor



1

Leg Lift
can be
done 2
different
ways.

With legs
crossed
as shown
to the left
here.



Do 30 leg lifts
a day of either
type



Or with
legs
straight
as shown
here.



2 Piriformis
Stretch
Pull leg 5
seconds then
pull again for
5 seconds.
Repeat 5X



3 Gluteus Lift
10 each Leg



4 Side Leg Lift
10 each Leg



5 Hamstring
Stretch

Push leg into
floor 5 seconds
then relax and
stretch it for 5
seconds.
Repeat 5X



3 Stretches for the Neck and Shoulders

Neck Rotation Exercise

Turn head firmly to left 5X, then
repeat to the right 5X



Neck Tilt Exercise

Tilt head firmly to left 5X, then
repeat to the right 5X



Shoulder Rotation Exercise

Push shoulders forward, then up,
then backward. Repeat 5X



TMJ Instructions

Conservative Instructions for Jaw Trauma & Joint Pain

Soft Diet: By eating a soft diet you will allow the TMJ including the chewing muscles an opportunity to rest and heal. This is a partial list of soft foods that you can eat:

Soup	Cottage Cheese
Jell-O	Scrambled Eggs
Fish	Mashed Potatoes
Pudding	Steamed Vegetables
Milkshakes	Yogurt

Avoid foods such as steak, bagels, caramel candy, or any foods that require excessive chewing. **DO NOT CHEW GUM OR ICE.**

It is recommended to chew your food on both sides at the same time (or alternate sides, 5 chews on left, then 5 chews on right) to reduce strain on one side.

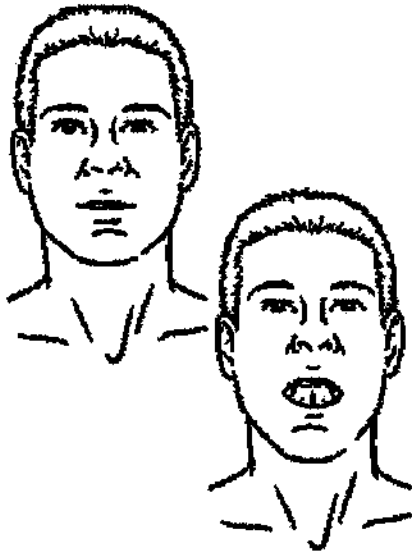
Some people's symptoms go away after two or three weeks on a soft-food diet. Others will need to follow it for a longer time.

Moist Heat and Exercise: you will find moist heat to the side of the face will help relax tight and spasming muscles that may be causing pain. Use a warm washcloth to the side of the face over the TMJ for 5 minutes per side. Follow this with gentle massaging of the TMJ with fingertips for 1 minute per side. This should be done in the morning and evening before bedtime. A simple stretching exercise should also be included, following these simple steps.

1. Put your left thumb under your upper front teeth.
2. Put your right index and middle fingers on top of your lower teeth.
3. Gently pull the jaw apart using your hands, not your jaw muscles
4. Hold for 5 seconds, repeat 5 times.

Tips for Pain Relief: Yawn and chew as little as possible and avoid extreme jaws movements. Prolonged dental treatments should also be avoided until the pain has been reduced. Don't rest your chin on your hand or hold the telephone between your shoulder and ear. Try to remember to keep your teeth slightly apart as often as you can (don't clinch). It is natural for your jaw to open a little if your lips are closed.

TMJ Therapeutic Exercises Program

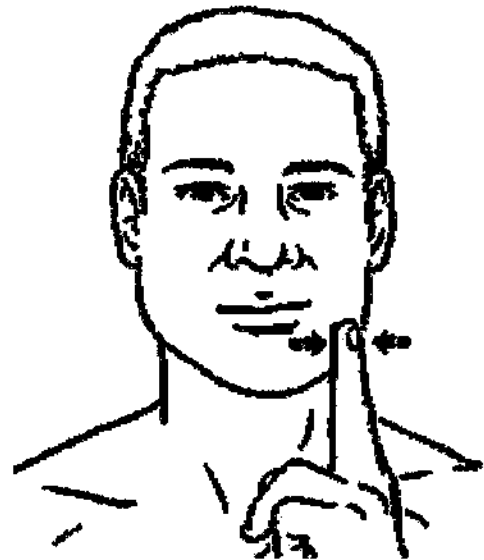


Joint/Muscle Relaxation

Place tongue on roof of mouth as far back as possible. Slowly open mouth, keeping tongue up.

Repeat 10 times per set

1 set per day



Lateral Glide (Isometric)

Place 2 fingers on side of jaw. Resist movement of jaw to same side. Relax, repeat on opposite side.

Hold 5 seconds each time

Repeat 10 times per set, 1 set per day

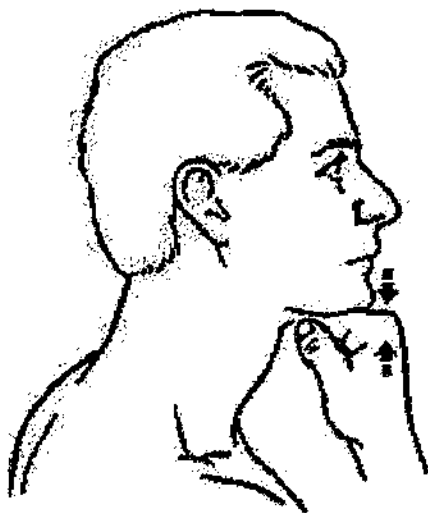
Opening (Isometric)

Place your fist under your chin. Resist downward movement of chin..

Relax, repeat 10 times per set

Hold 5 seconds each time

1 set per day



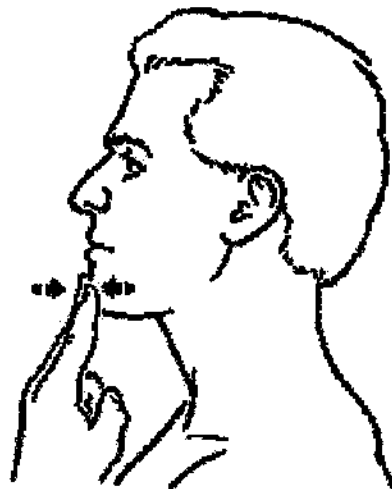
Chin Protrusion (Isometric)

Place 2 fingers your chin. Resist forward movement of chin..

Relax, repeat 10 times per set

Hold 5 seconds each time

1 set per day



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