**Patient Name**

**Date of Birth: 00/00/0000**

**Summary of Injuries/Treatment rendered**

**XXXX Medical Center:**

On **00/00/0000**, Mr. XXXX presented to ER for upper extremity injury. He was evaluated by YYY, M.D. He had finger injury, just PTA sustained laceration to volar right thumb on serrated edge of aluminum foil container. On exam, he was noted with laceration, 3cm to volar mid right thumb. He was able to flex/extend with strength at MCP and IP joint. He was assessed with laceration right thumb. He underwent laceration repair with 6 interrupted sutures for 3.0 cm volar mid right thumb. He was improved in the ER. His thumb and hand remained neurovascularly intact. All digits were pink warm with immediate capillary refill. He was discharged to home with wound care instructions. *(Ref: 2449-2452)*

**AAAA XXXX Health Services:**

 On **00/00/0000,** Mr. XXXX returned 10-days post injury for suture removal. His right thumb was swollen, tender to touch and with slight erythema. His sutures were removed without difficulty. He was prescribed with Keflex 500mg every 12 hours x 10 days and to return after completion of antibiotics and expect discharge at next appointment. He would return to regular duty. *(Ref: 2422-2424)*

**XXXX Medical Services:**

On **00/00/0000,** Mr. XXXX was involved in a motor vehicle traffic accident. He stated that he was riding his motorcycle when an oncoming car came into his lane, and he was struck head-on. He was driving approximate 15-20 mph at the point of impact. He was thrown onto the car and struck the windshield with his right shoulder and rolled back onto the hood. He did try to stand up but laid down when he felt the pain in his back. The patient stated that he had back surgery and that he was dealing with chronic back pain. He did have one alcoholic drink prior to leaving work approximately 1 hour ago. He complained of lower back pain with back spasms. On assessment, small lacerations were noted in left inner forearm, minimal bleeding noted, lower back abrasion, complained of spasms in lower right back area. Cervical collar and full spine board were placed. **He was on cardiac monitor, IV started and 250ml 0.9% NS infused, Fentanyl 50mcg given at 2342 hrs., 2350 hrs. & 0005 hrs., bleeding control device applied. Patient showed good movement in all extremities, no neuro deficits. He denied any loss of consciousness. He complained of lower back pain with spasms on the right side which run down through his buttocks** and into his leg. He had good PMS in all extremities. He did not want to be transported to XXXX but advised about the seriousness of the mechanism of injury and he agreed to be transported to XXXX. Secondary assessment revealed abrasions to left flank area. He stated decreased muscle spasms and intensity post pain medication. Patient was transferred to XXXX ER in a stable condition. *(Ref: 1491-1497)*

**XXXX Physical Medicine:**

On **00/00/2014 & 00/00/0000,** Mr. XXXX was seen by YYYY, D.O. for a follow-up visit. He was presented with neck pain, headaches, right shoulder pain, and back pain. He had an MRI of his cervical spine, right shoulder, and lumbar spine. He was on therapy. Physical examination revealed flexed neck posture, sat uncomfortably and stood with difficulty. He had decreased range of motion noted in the neck; right shoulder and the back; pain with range of motion in the neck; right shoulder; the back; paraspinal muscle spasms. He was assessed with neck sprain, lumbar sprain, joint pain, shoulder region, muscle spasm, cervical sprain, cervical disc displacement, myalgia, muscle spasms, neck pain, partial RTC tear, right shoulder pain, thoracic sprain, lumbar sprain, lumbar fusion, and back pain. He was prescribed with Zanaflex and Percocet (Norco not helping). He was advised to continue conservative care and was given a referral to see Dr. YYYY for possible cervical ESIs. *(Ref: 2211, 2202)*

From **00/00/0000 to 00/00/0000**, Mr. XXXX s had 22 sessions of chiropractic therapy. Treatment interventions included Chiropractic Manipulative Treatment (CMT) spinal three to four regions, electrical stimulation ultrasound, therapeutic exercises neuromuscular re-education of movement, balance, coordination, self-care management training and hot or cold packs. *(Ref: 2163-2169, 2179-2186, 2200-2201, 2203-2210, 2212-2217)*

**XXXX:**

On **00/00/0000**, MRI cervical spine without contrast showed multilevel degenerative changes.

MRI thoracic spine without contrast showed no severe canal stenosis and mild degenerative changes at T8-T9. *(Ref: 3010-3017)*

On **00/00/0000**, Mr. XXXX underwent a C5-C6 cervical epidural steroid injection performed by XXXX, M.D., *(Ref: 18)*

**XXXX YYYY:**

From **00/00/0000 to 00/00/0000**, Mr. XXXX was seen by YYYY MSPT, at XXXX Rehab. He received physical therapy sessions on 04/29/2019, 05/02/2019, 05/06/2019, 05/14/2019, 05/15/2019, 05/20/2019, 05/22/2019, 05/23/2019, 05/28/2019, 05/29/2019, 06/03/2019, 06/04/2019, 06/06/2019, 06/12/2019, 06/17/2019, 06/19/2019, 06/24/2019, 06/26/2019. Interventions included modalities as needed, soft tissue mobilization, joint mobilization, therapeutic exercises, body mechanics training/joint protection and mechanical decompression traction. *(Ref: 3144-3162)*

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