**NARRATIVE SUMMARY**

**PRIOR RECORDS**

From April 18, YYYY to June 6, YYYY, Ms. XXXX had multiple clinical visits at Wings XXXXX, 550 clinic and XXXXX Memorial Hospital for multiple problems such as left ear infection, left wrist ganglion cyst, HIV, left hand pain, headache, pharyngitis, rash on fingers, rash on left leg, hypertension, right ankle sprain, cough, upper respiratory tract infection, sub-acute tooth fracture, acute abdominal pain, gastroesophageal reflux disease, obesity, vitamin D deficiency, joint pain, urinary tract infection and polyuria.

**MOTOR VEHICLE COLLISION – MAY 28, YYYY**

On May 28, YYYY, Ms. XXXX was a restrained driver of her vehicle; she was struck on the right side by another vehicle. She sustained a blow to the head and was sustained injuries to her neck and back.

Following the collision, on the same day she presented to the Emergency Room of XXXXX Memorial Hospital and was evaluated by Dr. XXXXX for complaints of mild pain in her neck. She was the restrained driver of her vehicle when she was struck on the right (passenger) side by another vehicle. She sustained a blow to the head and was ambulatory at the scene. A physical examination revealed mild vertebral tenderness of the mid cervical spine. An X-ray of cervical spine was performed which revealed no acute fracture and straightening of the cervical spine, which might be from muscle spasm. She was diagnosed with neck strain. She was prescribed Acetaminophen and Ibuprofen. She was instructed to follow-up with her doctor as needed and was discharged home in a stable condition.

On June 3, YYYY, Ms. XXXXX was seen by XXXX, a registered nurse at KY XXXXX, PSC for complaints of headache, pain in the neck, mid back and low back. She described her headache as throbbing, dull and aching pain in forehead and relayed it to be 7/10 on the pain scale. She described her neck pain as constant, bilateral, dull, shooting, weakness, tight and stiff and relayed it to be 5-6/10. She described her mid back pain as bilateral, frequent, achy, tight and stiff pain with weakness and relayed as 5-6/10. She described her low back pain as bilateral, midline, constant, dull, shooting, tight and stiff and relayed to be 5-6/10 on the pain scale. Physical examination revealed moderately painful range of motion in the cervical, thoracic and lumbar spine. There was moderate bilateral tenderness throughout the cervical, thoracic and lumbar spine and their facet joints with mild to moderate increased hypertonicity. She was diagnosed with cervicalgia (neck pain), cervical sprain/strain, neck stiffness, thoracic spine pain, thoracic sprain/strain, lumbago (low back pain), lumbar sprain/strain, low back stiffness, headache and insomnia. She was recommended X-ray of cervical, thoracic and lumbar spine. She was also recommended chiropractic treatment that included Biofreeze, TENS unit, life-back lumbar support, stretches, patient education for 3 times per week. She was also recommended to follow-up an M.D. in 4-6 weeks.

On June 5, YYYY, Ms. XXXXX was seen by Dr. XXXXX at KY XXXXX, PSC for pain in the neck and low back. She described her neck pain as constant, most of day, sharp, achy with numbness and relayed to be 4-5/10. She described her low back pain as most of day, midline, constant, dull, and achy and relayed to be 2/10 on the pain scale. Physical examination revealed moderate tenderness in cervical spine with moderate hypertonicity and right segmental restriction 2-3, occiput to C7. There was mild to moderate tenderness and hypertonicity in thoracic spine with bilateral segmental restriction at T1-2. There was mild to moderate tenderness and hypertonicity with bilateral segmental restriction at L5. O’Donohue test was positive bilaterally. She had forehead numbness increased with cervical flexion. She was diagnosed with cervical, thoracic and lumbar subluxation, lumbalgia, cervical pain, pain in thoracic spine and headaches. She was recommended to continue treatment 3 times per week for the next 4 weeks.

From June 7 to June 14, YYYY, she underwent four visits of chiropractic treatment that included heat, electrical stimulation, ultrasound therapy, massage therapy and mechanical traction.

On June 12, YYYY, Ms. XXXXX was seen by Jeannie XXXXX, a registered nurse at XXXXX Family Care Center for complaints of neck and back pain. She was diagnosed with HIV during her pregnancy in 2000. She has been taking Norvir, Reyataz and Epzicom daily. She was involved in a motor vehicle accident on May 28, YYYY. Since then, she continued to have neck and low back pain. Physical examination revealed palpable tenderness in spine with positive straight leg raise test at 45 degrees. She was diagnosed with high blood pressure RF Metoprolol, symptomatic HIV infection, back pain and abnormal nevus. She was recommended dermatology and neurosurgeon consultation. She was prescribed Flexeril, Naproxen, Prenatal multivitamins, Metoprolol Tartrate, Epzicom, Norvir and Reyataz.

Ms. XXXXX presented for a final chiropractic visit on June 20, YYYY. She was seen by Dr. XXXXX at KY XXXXX, PSC for complaints of neck and low back pain. She described her neck pain as right, midline, most of day, constant and some tightness over left anterior cervical spine and relayed to be 4/10 on the pain scale. She described her low back pain as occasional, midline, variable and achy and relayed to be 2-3/10 on the pain scale. Physical examination revealed mild to moderate tenderness and hypertonicity in her cervical spine with left C7 segment restriction. There was mild to moderate tenderness and hypertonicity in thoracic spine with bilateral segment restriction at T1-2. There was mild to moderate tenderness and left L4 segment restriction. She had chiropractic treatment that included electrical stimulation, hot pack application, ultrasound therapy, massage therapy and mechanical traction.

On June 21, YYYY, X-rays of cervical, thoracic and lumbosacral spine were performed by Dr. XXXXX. The X-ray of cervical spine revealed disruption of George’s line at C4-5. The X-ray of thoracic spine revealed no osseous or periosteal injury. The normal curve was well maintained. The X-ray of lumbosacral spine revealed narrowed disc spacing at L4-5 level.

On June 27, YYYY, Ms. XXXXX presented to the XXXXX Family Care Center and was seen by Heather XXXXX, a physician assistant for neurosurgical evaluation of low back pain. She described her low back pain as sharp and relayed it to be 6/10 on the pain scale. The pain was constant and stable. She stated that the pain was aggravated by bending, carrying heavy objects, driving long distances, lifting, prolonged sitting, prolonged standing and staying in one position for extended periods. She also complained of posterior neck pain and mid back (T6-9 region). Physical examination revealed palpable tenderness over C5-7, T6-8 and L4-S1 diffusely. She was diagnosed with lumbago/low back pain, cervicalgia and thoracic pain. She was recommended to obtain X-ray of cervical, thoracic and lumbosacral spine.

On the same day, X-rays of cervical, thoracic and lumbar spine were performed at XXXXX Memorial Hospital. The X-ray of cervical spine revealed straightening or loss of the normal lordosis on the lateral view without soft tissue deformity, probably positional. It could be secondary to spasm. The X-ray of thoracic spine revealed no acute bony abnormality. The X-ray of lumbar spine revealed moderate to severe degenerative disk disease at L4-5 with associated hypertrophic spurring.

On July 5, YYYY, MRI scans of her lumbar spine and cervical spine were performed at XXXXX Memorial Hospital. The MRI of lumbar spine revealed disc desiccation at L4-5. There was a moderate impression on the thecal sac that looked like it was due to a combination of osseous spurring superimposed on bulging of the annulus of the disc. The MRI of cervical spine revealed signal within the nasopharyngeal that could relate to underlying thornwaldt cyst. There was some lymphadenopathy within the neck bilaterally of uncertain significance. This might be reactive.

On July 11, YYYY, Ms. XXXXX presented for a follow-up at XXXXX Family Care Center. Her cervical and lumbar MRI’s were reviewed. She was diagnosed with degeneration of lumbosacral intervertebral disc, lumbago/low back pain, lumbar disc herniation, lumbosacral radiculopathy, lumbar spondylosis, cervicalgia and thoracic pain. She was recommended physical therapy three times a week for four weeks.

On July 12, YYYY, Ms. XXXXX presented to XXXXX Family Care Center for complaints of occasional difficulty swallowing. On physical examination she was noted to have lymphadenopathy in her neck. She was diagnosed with cervical lymphadenopathy and back pain. She was prescribed Norco, Tramadol and Prenatal oral tablet.

On November 19, YYYY, she was seen by Dr. XXXXX for pain in her neck, shoulder and back. She complained of pain in lower lumbar region which radiated to lower extremities. She reported that she had tingling in her lower extremities. She also complained of neck pain that radiated to right and left arm. She underwent physical therapy for 10 weeks without improvement in symptoms. She established care with neurosurgery and they had recommendation for non surgical treatment. Her past medical history was significant for allergy, cervicalgia, degeneration of lumbosacral intervertebral disc, high blood pressure, symptomatic HIV infection, lumbago/low back pain, lumbar disc herniation L4-5, thoracic pain, lumbar spondylosis and tuberculosis or positive PPD test. She was diagnosed with hypertriglyceridemia, cervicalgia, human immunodeficiency virus disease, lumbago and lumbar disc herniation. She was recommended a neurosurgeon consultation.

On November 19, YYYY, an MRI of her right shoulder was performed at XXXXX Diagnostic Imaging. It revealed somewhat prominent right axillary lymph nodes measuring up to 2 cm in maximum dimension.

On November 22, YYYY, Ms. XXXXX presented for a follow-up with Dr. XXXXX. She was diagnosed with right shoulder pain and was recommended physical therapy two times a week for four weeks.

On December 2, YYYY, Ms. XXXXX was seen at XXXXX Memorial Hospital for complaints of choking sensation since motor vehicle accident dated May 28, YYYY. She underwent EGD with biopsy and was diagnosed with small hiatal hernia and L.A. class B reflux esophagitis. She was prescribed Omeprazole 40 mg.

On the same day, a surgical pathology of duodenum and distal esophagus was performed. The duodenum biopsy revealed no significant pathologic abnormality. The distal esophagus biopsy revealed mild to moderate reflux esophagitis with focal erosion and gastric cardia with mild chronic inflammation. Ms. XXXXX tolerated the procedure well.

On December 4, YYYY, she was seen by Dr. XXXXX at XXXXX Pain Relief, PLLC for pain in the shoulder, neck and back. She described her pain as constant, intermittent, burning, splitting, cramping, shooting, dull, sore, throbbing, stabbing, tingling, numbness and pins and needles. She relayed her pain as 9/10 on the pain scale. She stated that medicine made her pain better. Her review of systems was positive for frequent headaches, neck pain, neck lumps, heart burn, indigestion, arthritis, muscular pain, chronic back pain, shoulder pain, morning stiffness, loss of strength and sleeping difficulty. She had chronic low back pain after MVA in May YYYY. Subsequently she had developed severe low back pain radiating down to bilateral lower extremity. She described her pain as 90% on back and 10% in her legs with prolonged sitting. Physical examination revealed abnormality in cervical spine. There was palpable tenderness in her cervical spine (C7). There was palpable pain over lumbar intervertebral spaces (discs). Palpation of greater trochanteric bursa revealed tenderness on the left side. Anterior flexion, left lateral flexion and right lateral flexion of the back caused pain. Patrick’s test was positive for left hip pain. She was recommended lumbar epidural steroid injection using fluoroscopy. She was prescribed Gralise and Norco and was instructed to follow-up after 2 months as needed.

On February 12, YYYY, Ms. XXXXX underwent lumbar epidural steroid injection that was performed by Dr. XXXXX at XXXXX Pain Relief, PLLC. She was postoperatively diagnosed with lumbar radiculopathy and lumbar degenerative disc disease and was prescribed Norco, Gralise and Cyclobenzaprine.

On February 17, YYYY, Ms. XXXXX presented to XXXXX Family Care Center for right buttock pain and bruise after fall. She stated that she slipped on ice and fell on her buttocks down the stairs. She had some pain in right buttock and hip. She also had large bruise to her right buttock. She was diagnosed with allergy, buttock contusion, pain in the low back, hip. She was recommended to undergo X-rays of lumbar spine, coccyx and right hip.

On the same day, X-rays of lumbar spine, pelvis and sacrum/coccyx were performed. The X-ray of lumbar spine revealed degenerative change. The X-ray of pelvis and sacrum/coccyx were negative.

On February 24, YYYY, Ms. XXXXX presented for a follow-up at XXXXX Family Care Center for persistent lumbago/low back pain, edema and hip pain. She reported that her bruise remained discolored. She was diagnosed with lumbago/low back pain, edema of lower extremity and hip pain. She was recommended to avoid sodium in diet and drink more water. She was advised to elevate lower extremity when indicated and support hose as needed.

On February 25, YYYY, Ms. XXXXX underwent lumbar epidural steroid injection that was performed by Dr. XXXXX at XXXXX Pain Relief, LLC. She was postoperatively diagnosed with lumbar radiculopathy and lumbar degenerative disc disease.

On May 2, YYYY, Ms. XXXXX underwent EGD with biopsy for history of distal esophageal ulcers at Surgical Center of XXXXX. It revealed ulcers at the Gastroesophageal junction with slight 1-2 mm nodule around it. The procedure was performed by Dr. XXXXX.