NEUROLOGY ASSOCIATES OF TEXAS

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NEUROLOGY

Patient Name: Isabella Jones
Patient DOB: 02-03-1944
Patient Sex: Female
Visit Date: 07-17-2015

Chief Complaints

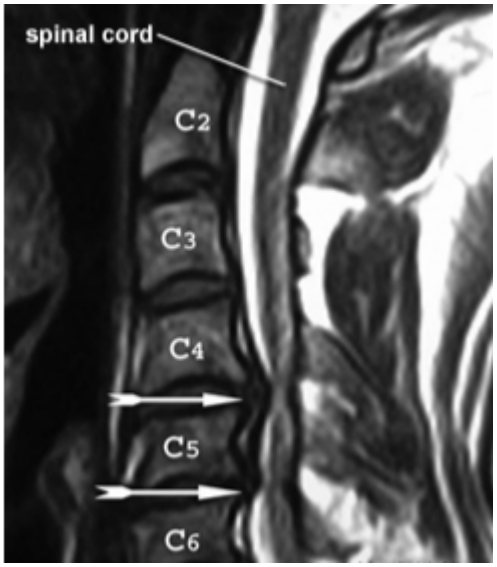
Patient presents with Neck Pain. It was suuden in onset. On a scale of 1 to 10, with 10 being the worst pain, the patient rates it at 7. It is sharp and stabbing in quality. Gets aggravated by bending and stretching. Get relieved by heat and analgesic medications. Associated symptoms include numbness in right hand and right arm and tingling in right hand and right arm.

HPI

The patient - Isabella Jones is a 71 year(s) old married, right-handed, smoker, female who states that she was involved in a motor vehicle accident. Date of accident is 03 March, 2016. She was the driver and was wearing seat belt. The patient states that she did sustain head trauma. The patient states that she had loss of consciousness. The patient was brought by ambulance to Harlem Hospital, where she was examined and discharged. In the ER the patient received physical examination, medications and x-ray. The X-ray result was negative for fracture.

Review of Medical Records

MRI: The patient had an MRI cervical spine on March 04, 2016 which revealed abnormal disc herniation at C4, C5 and C6



Daily Activities

Affected Activities of daily living includes difficulty doing small daily household chores, taking out the garbage, exercise or

going to gym, playing with kids, driving and brushing teeth.

Accident Details

Following information was revealed from the patient:
Driving conditions: dry
Patient location in vehicle: driver
Patient wearing a seat-belt: yes
Did airbags deploy: yes
Area of Impact: Rear
Did Patient see accident about to occur: no
Did patient brace for impact: yes
Was The Patient Car Moving: yes
How fast: 65 mph
Was the other vehicle moving: yes
Head position at time of impact: Looking straight
Did patient hit body parts on auto: Dont remember
How soon did pain begin: after 15 min
Did patient had a pre-existing complaint: no
Has patient been in accident before: no
Did patient go to the hospital or urgent care: yes
Did patient suffer any cuts, scrapes, or bruises: no
Were x-rays taken: yes
Fractures: no

Past Medical History

DM - Type II
HTN

Surgical History

No significant surgical history

Family History

No significant family history

Social History

Denies alcohol, drug and tobacco use.

Functional History

Marital Status: married.

Allergies

No Known Drug Allergies

Review of Systems

No c/o nausea, vomiting, diarrhea, constipation, sob, chest pain, abdominal pain, rashes, edema.

Vital Signs

The Systolic BP is 160.
The Diastolic BP is 100.
Sitting Pulse is 85.
Temperature is 98.6 F.
Height is 64 in.
Weight is 150 lbs.
BMI is 25.74.

Prior Studies
MRI-Cervical Spine: Revealed disc herniation at C4-5-6 levels.

Physical Exam
General Appearance
The patient appears well developed. - Slight distress due to neck pain
Gait: normal.

Head
Head: normocephalic and atraumatic.
Eyes: pupils were equal and reacted to light and accommodation and extraocular muscles were intact.

Neck
Neck: Trachea midline, No JVD, Thyroid normal, symmetrical, not enlarged, non-tender, no nodules, No masses, No scars and Pain, stiffness, masses, limitation of movement.

Chest
Chest:- no deformities.

Skin
Abrasion: no

Heart
The heart was in regular rhythm and rate: normal S1 and S2.

Lungs
Clear to auscultation & percussion bilaterally

Abdomen
Abdomen:- soft, normoactive bowel sounds and negative tenderness.

Muscle:
Bulk: Within normal limits
Spasm: C-spine
Tone: normal

Extremities
No edema

Neurological Examination:
Mental Status
The patient is oriented to person, place and time.
Cognitive function: Normal

Psychological assessment
Patient complains of: unusual fears of driving, traffic situations and difficulty in concentrating.
Patient has had psychological problems in past: no.
Patient was treated for psychological problem in past: no.
Patient was completely well before accident: yes.
Patient feels that accident exacerbated the previous problems: no.
Patient desires psychological Treatment: no.

Cranial Nerve Examination
CN II: Pupils are equal round regular reactive to light and accommodated directly and consensually Visual fields are full on direct and double simultaneous stimulation. Visual acuity is within normal limits. Extraocular muscles are intact. Orbicularis oculi are normal. CN VII-Muscular expression and movement of the face is within normal limits. Jaw opening is symmetrical. Facial sensation to light touch and pinprick is normal bilaterally at VI (forehead), V2(Cheek) and

V3 (lower lip). Fundi are unremarkable. CN VIII- Hearing is within normal limits. CN IX & X- Ability to swallow and movement of the palate is intact. The corneal reflex, gag reflex, and the remainder of the brainstem reflexes are normal and symmetrical bilaterally. Smell and taste were not tested.

Strength Testing of the Upper Extremities

Strength testing of the upper extremities is normal except:

Right Side	Left Side
Right deltoids: 3/5	Left deltoids: 3/5
Right biceps: 3/5	Left biceps: 3/5
Right triceps: 3/5	Left triceps: 3/5
Right wrist flexors: 3/5	Left wrist flexors: 3/5
Right wrist extensors: 3/5	Left wrist extensors: 3/5
Right finger flexors: 4/5	Left finger flexors: 4/5
Right finger extensors: 5/5	Left finger extensors: 5/5
Right hand intrinsics: 5/5	Left hand intrinsics: 5/5

Strength Testing of the Lower Extremities

Strength testing of the lower extremities is normal except:

Right Side	Left Side
Right Iliopsoas: 5/5	Left Iliopsoas: 5/5
Right knee flexors: 5/5	Left knee flexors: 5/5
Right knee extensors: 5/5	Left knee extensors: 5/5
Right ankle extensors: 5/5	Left ankle extensors: 5/5
Right ankle flexors: 5/5	Left ankle flexors: 5/5

Reflexes

Reflexes were all normal except:

Right Side	Left Side
Right biceps: 1+	Left biceps: 1+
Right triceps: 1+	Left triceps: 1+
Right brachioradialis: 1+	Left brachioradialis: 1+

Right patellar: 1+	Left patellar: 1+
Right achilles: 1+	Left achilles: 1+

Sensory Examination
Sensory Examination: Within normal limits

Cerebellar:
Finger-nose test is intact.
Rhomberg test was negative.

Cervical Spine Exam
Palpation
Multiple trigger points are noted along the cervical spine upon examination at Bilateral C4 C5 and C6
Tenderness over cervical paraspinal.
Patient has cervical paravertebral muscle spasm moderate
Trigger points present on the bilateral paraspinal muscles.
The Foraminal Compression test was positive on the bilateral sides.
Soto hall test is positive. If positive : Will hold physical therapy and r/o fracture..
Valsalva test (patient took a deep breath and held it while attempting to exhale for 2-3 seconds which resulted in positive findings radiating pain to bilateral shoulders.

Range of Motion: Cervical spine region (Performed with the aid of a goniometer)

Movement & Exam	% loss of ROM
Flexion (Normal: 60 degrees): At exam 30 degree which revealed	50% loss of ROM.
Extension (Normal: 40 degrees): At exam 20 degree which revealed	50% loss of ROM.
Lt. Lateral Flexion (Normal: 45 degrees): At exam 15 degree which revealed	67% loss of ROM.
Rt. Lateral Flexion (Normal: 45 degrees): At exam 20 degree which revealed	56% loss of ROM.
Left Rotation (Normal: 80 degrees): At exam 40 degree which revealed	50% loss of ROM.
Right Rotation (Normal: 80 degrees): At exam 40 degree which revealed	50% loss of ROM.

Thoracic Spine Exam
There was muscle spasm and tenderness at the thoracic paraspinal muscles
The range of motion is restricted in all directions secondary to pain

Lumbar Spine Exam
Examination of the lumbar spine was unremarkable.

Elbow
Elbow exam: Unremarkable

Wrist Exam
Wrist exam: Unremarkable

Hip Exam

Hip exam: Unremarkable

Knee Exam
Knee Exam: Unremarkable

Ankle Exam
Ankle exam: Unremarkable

Assessment
Cervicalgia (M54.2)
Spondylosis With Myelopathy, Cervical Region (M47.12)
Person Injured In Unsp Motor-Vehicle Accident, Traffic, Init (V89.2XXA)
Headache (R51)
Dizziness And Giddiness (R42)

Plan
Lab
CMP
MRI BRAIN

Today's Medication
Tramadol Hydrochloride 100mg Extended-Release Tablet is Prescribed, Take as needed

Follow Up
Patient is advised to follow up in 4 weeks.

Health Education
DIZZINESS
HERNIATED DISC

Recommendations
Continue Current Medications

Continue home exercise program

Patient advised if headaches worsen or become associated with blurred vision to report to the Emergency room

Physical therapy and future course of treatment based on diagnostic studies of EMG/NCV/MRI/CAT Scan

Further treatment options will depend upon his/her clinical course

Upon palpation, I have noted muscle spasm and trigger points along the C4, C5 and C6 level. Therefore, I will initially treat the generalized area with the trigger point and/or nerve block injection therapy as needed. If the pain persists, more diagnostic test would be needed to localize the exact area. Pain management injection is prescribed for symptomatic relief and management of post-traumatic pain. The goal being better compliance and participation in a comprehensive physical therapy program.

Referrals
Pain Management: consult

Discussion

In your opinion, was he incident that the patient described the competent medical cause of this injury/illness? Yes.
Are the patients complaints consistent with his/her history of the injury/illness? Yes.
What is the percentage (0-100%) of impairment? 30 %.
What is the degree of disability? Partial moderate.

The visit was electronically signed off by Joseph Tracy, MD on 03/08/2016 05:04:38 PM