Personal Injury Mid-Term Assignment
Spring 2008

199 Rosewood Drive
Danvers, MA 01923

December 31, 2003
ECrane@travelers.com

Kristine M. Eiro
Law Offices of Robert D. Armano
600 Andover St.
Lawrence, MA 01843

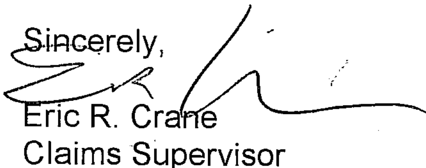
RE:
File #:
Our Insured: Martha
Claimant: Jonathan
Date of Loss: October 21, 2003

Dear Ms. Eiro:

Per your request for limits, our policyholder, Martha [redacted] holds a Massachusetts Automobile Policy with Compulsory Bodily Injury limits of $20,000 per person, $40,000 per accident and Optional Bodily Injury Limits of $100,000 per person, $300,000 per accident. Our disclosure of these limits should not be construed as confirmation that coverage is afforded to Martha Sevcik for this accident. As we develop this claim, we may determine that the policy's terms, conditions or provisions, as well as Massachusetts law, excludes coverage under either the Compulsory or Optional Coverage or both.

If you have any questions, please do not hesitate to contact me at (978) 750-3344.

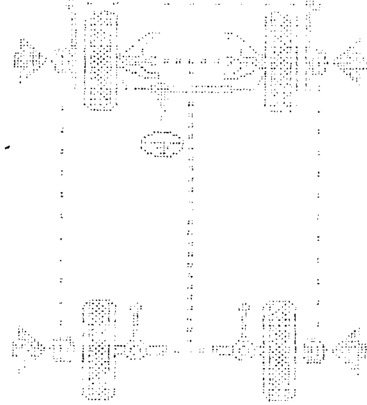
Sincerely,



Eric R. Crane
Claims Supervisor

Alignment Measurements

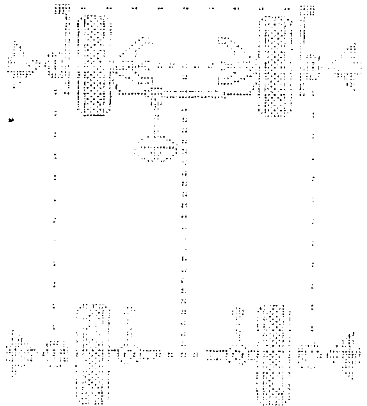
Front	Left		Right
Camber	-0.5°		-0.5°
Cross Camber		-0.3°	
Caster	3.7°		4.1°
Cross Caster		-0.4°	
SAI	......		......
Included Angle	......		......
Toe	[illegible]		[illegible]
Total Toe		-0.02"	
Set Back		-0.04°	
Turning Angle Diff.	......		......
Rear			
Camber	-1.6°		-1.3°
Toe	0.21"		0.04"
Total Toe		0.25"	
Thrust Angle		0.17°	



Adjust rear wheels.

Alignment Measurements

Front	Left		Right
Camber	-0.5°		-0.5°
Cross Camber		-0.4°	
Caster	3.7°		4.1°
Cross Caster		-0.4°	
SAI	......		......
Included Angle	......		......
Toe	0.00"		0.01"
Total Toe		0.01"	
Set Back		-0.28°	
Turning Angle Diff.	......		......
Rear			
Camber	-1.6°		-1.3°
Toe	0.20"		0.03"
Total Toe		0.24"	
Thrust Angle		0.17°	

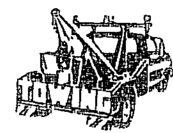


Adjust rear wheels.

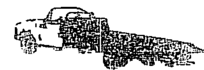
Key #13

TROMBLY BROS., INC.

T 005695



141-153 SUTTON STREET
NO. ANDOVER, MASS. 01845
978-683-1031 & FAX 978-683-9118
24 HOUR
ICC MC291389 - LOCAL & LONG DISTANCE TOWING



MA. INSP. STA. 5077

TOWING REPORT

Date 10-21 2003

Name Jonathan w/ Joseph

Address Ipswich

Make of Car: Volkswagen Model: GTI VR6 Yr:

Reg. No.: 414 XT State: Ma Color: Black

Vin. # 3VWD17 9JH4VM00 8422

Tow From: Main st. and Washington Boxford

Tow to: Trombly

P.O. #: Driver & Unit: Mark #5

TOW AUTH BY Box PD ODO. MILES

REMARKS

Remove vehicle from median island
Set up for Tow. Battery Disconnected
4F wheel flat, oil pan and Transmission cracked

REASON

- [ ] ABANDON / HAZARD
- [x] ACCIDENT
- [ ] SNOW
- [ ] UNLICENSED
- [ ] BREAKDOWN
- [ ] ARREST
- [ ] BURNED
- [ ] STOLEN CAR
- [ ] UNREG.-UNINS.
- [ ] OTHER

TYPE OF TOW: [x] FRONT [ ] Rear [ ] Ramp Trk.	75	00
[ ] Overturned [ ] Winching		
Storage: Days @ = N/C		
Time In: Mileage In:		
Time Out: Mileage Out:		
Total Time: Total Mileage:		
Other Charges:		
Mileage Charges: 4 Miles @ =	5	00
AUTHORIZATION TO RELEASE VEHICLE		
Signature: Ok To Release TOTAL $	80	00

NOT RESPONSIBLE FOR LOSS OR DAMAGE TO CARS OR ARTICLES LEFT IN CARS IN CASE OF FIRE, THEFT OR ANY OTHER CAUSE BEYOND OUR CONTROL.

SULLIVAN TIRE
AND AUTO SERVICE
www.sullivantire.com

FAMILY SPIRIT IS WHAT SULLIVAN IS ALL ABOUT.

CUSTOMER CODE NO.		FORM NO.	DATE

NAME	SHIP TO	SALESMAN
		WORK PHONE NO.
		HOME PHONE NO.

PURCHASE ORDER NO.	CREDIT CARD NO.	LICENSE NO. & STATE	MAKE & YEAR OF VEHICLE
VEHICLE NO.	VEHICLE SERIAL NO.	ODOMETER READING	OTHER INFORMATION

ITEM NO.	QTY.	SIZE	DESCRIPTION	PLY	C	UNIT PRICE	EX. PRICE	MECHANIC
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

COMMENTS:

TAXABLE AMOUNT		BILLING STATUS
SALES TAX		
NON-TAX AMOUNT		
TOTAL		

PARTS WARRANTY - TO THE EXTENT PERMITTED BY STATE OR LOCAL LAW, ANY WARRANTIES ON THE PRODUCTS SOLD HEREIN ARE THOSE MADE BY THE MANUFACTURER. THE SELLER HEREBY EXPRESSLY DISCLAIMS ALL WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE AND NEITHER ASSUMES NOR AUTHORIZES ANY OTHER PERSON TO ASSUME FOR IT ANY LIABILITY IN CONNECTION WITH THE SALE OF SAID PRODUCTS.

MERCHANDISE REC'D. BY

X

☐ I DO NOT WANT TO RETAIN MY OLD TIRES OR AUTO PARTS

☐ I HAVE RECEIVED MY OLD TIRES OR AUTO PARTS AS REQUESTED

X
(Signature)

I HEREBY AUTHORIZE THE ABOVE REPAIR WORK TO BE DONE ALONG WITH THE NECESSARY MATERIAL, AND HEREBY GRANT YOU AND/OR YOUR EMPLOYEES PERMISSION TO OPERATE THE VEHICLE DESCRIBED ON STREETS, HIGHWAYS OR ELSEWHERE FOR THE PURPOSE OF TESTING AND/OR INSPECTION. AN EXPRESS MECHANIC'S LIEN IS HEREBY ACKNOWLEDGED ON ABOVE VEHICLE TO SECURE THE AMOUNT OF REPAIRS THERETO WHICH I HAVE AUTHORIZED AND ARE NOT COVERED BY MY WARRANTY. YOU WILL NOT BE HELD RESPONSIBLE FOR LOSS OR DAMAGE TO VEHICLE OR ARTICLES LEFT IN VEHICLE IN CASE OF FIRE, THEFT, ACCIDENT OR ANY OTHER CAUSE BEYOND YOUR CONTROL.

X
(Signature)

NOTICE: In order to operate your vehicle safely; we may have changed your preferred settings for the mirror, seat, etc. We are sorry for any inconvenience caus

CUSTOMER COPY

Section C: You and Your Passengers

Please provide the full name, address, and DOB or Age for all passengers in your vehicle. Then write the corresponding code in each of the boxes for each occupant of the vehicle (yourself and all passengers). A list of the possible codes is provided at the bottom of this section.

		Date of Birth/Age	Sex (M/F)	A	B	C	D	E	F	G	H	Name of Medical Facility
Driver (See previous page)					0	4	4	0	0	4	2	LGH
Name of Passenger 1 (Last, First, Middle)	Address / City/Town State Zip											
Name of Passenger 2 (Last, First, Middle)	Address / City/Town State Zip											
Name of Passenger 3 (Last, First, Middle)	Address / City/Town State Zip											

A. Seating Position
1 Front seat - left side (or motorcycle driver)
2 Front seat - middle
3 Front seat - right side
4 Second seat - left side (or motorcycle passenger)
5 Second seat - middle
6 Second seat - right side
7 Third row - left side (or motorcycle passenger)
8 Third row - middle
9 Third row - right side
10 Sleeper section of cab
11 Enclosed passenger area
12 Unenclosed passenger area
13 Trailing unit
14 Riding on vehicle exterior
97 Other
99 Unknown

B. Safety System Used
0 None used
1 Shoulder and lap belt
2 Lap belt only
3 Shoulder belt only
4 Child safety seat
5 Helmet
99 Unknown

C. Air Bag Status
1 Deployed-front
2 Deployed-side
3 Deployed both front and side
4 Not deployed
5 Not applicable
99 Unknown

D. Air Bag Switch
1 Switch in ON position
2 Switch in OFF position
3 ON-OFF switch not present
4 Unknown if switch is present
99 Unknown

E. Ejected From Vehicle?
0 Not ejected
1 Totally ejected
2 Partially ejected
3 Not applicable
99 Unknown

F. Trapped?
0 Not trapped
1 Freed by mechanical means
2 Freed by non-mechanical means
99 Unknown

G. Injured?
1 Fatal injury
Non-fatal injury:
2 Incapacitating
3 Non-incapacitating
4 Possible
5 No injury
99 Unknown

H. Transported for Medical Care?
1 Not transported
2 EMS (emergency service)
3 Police
97 Other
99 Unknown

Section D: Other Vehicle(s) Involved in the Crash

Number of occupants in the Vehicle: 1 **Was vehicle Damage above $1000?** _ Yes _ No **Moped?** _ Yes X No **Hit and Run?** _ Yes _ No

Driver's License Number	License State	Date of Birth	Age	Sex	License Class	Commercial Driver's License Endorsements
196[illegible]43	MA	3-26-21		_ M X F	X D _ A _ B _ C _ M _ Unknown	H _ Hazardous N _ Tank vehicles P _ Passenger transport T _ Doubles/triples X _ Tank and Hazardous

Full Name of Vehicle Driver (Last, First, Middle)	Street Address	City/Town	State	Zip
[illegible], MARTA H	[illegible] MAIN St	Boxford	MA	[illegible]

Insurance Company	Vehicle Registration #	Reg. Type	Reg. State	Vehicle Year	Vehicle Make
The Premier Ins	180MXW	PAN	MA	1966	OLDS

Indicate type of vehicle
(1) Passenger car — circled
2 Light truck (van, mini-van, pick-up, sport utility)
3 Motorcycle
4 Bus (15 or more passengers)
5 Bus (7-15 passengers)
6 Single-unit truck (2 axles)
7 Single-unit truck (3 or more axles)
8 Truck/trailer
9 Truck tractor (bobtail)
10 Tractor/semi-trailer
11 Tractor/doubles
12 Tractor/triples
13 Unknown heavy truck
14 Motor home/recreational vehicle
97 Other
99 Unknown

Full Name of Vehicle Owner (Last, First, Middle)	Street Address	City/Town	State	Zip
Servcik, MARTA H	548 MAIN St	Boxford	MA	01921

Vehicle Travel Direction
_ N _ S _ E (X W) — circled

What Was The Vehicle Doing Prior to Crash?
1 Travelling straight ahead
2 Slowing or stopped
3 Turning right
(4 Turning left) — circled
5 Changing lanes
6 Entering traffic lane
7 Leaving traffic lane
8 Making U-turn
9 Overtaking/passing
10 Backing
11 Parked
97 Other
99 Unknown

Section E: Non-Motorist(s) Involved in the Crash

Indicate the type of non-motorist involved 1 Pedestrian 2 Cyclist 3 Skater 97 Other 99 Unknown

What was the non-motorist doing prior to the crash?
1 Entering or crossing location
2 Walking, running or cycling
3 Working
4 Pushing vehicle
5 Approaching or leaving vehicle
6 Working on vehicle
7 Standing
97 Other
99 Unknown

Where was the non-motorist prior to the crash?
1 Marked crosswalk at intersection
2 At intersection but no crosswalk
3 Non-intersection crosswalk
4 In roadway
5 Not in roadway
6 Median (but not on shoulder)
7 Island
8 Shoulder
9 Sidewalk
10 Shared-use path or trails
99 Unknown

Date of Birth/Age	Sex	Full Name of Non-Motorist (Last, First, Middle)	Street Address	City/Town	State	Zip
	_ M _ F					

Safety Equipment?
0 None used
6 Helmet
7 Protective pads (elbows, knees, etc.)
8 Reflective clothing
9 Lighting
10 Other
99 Unknown

Injured?
1 Fatal injury
Non-fatal injury:
2 Incapacitating
3 Non-incapacitating
4 Possible
5 No injury
99 Unknown

Transported for Medical Care?
1 Not transported
2 EMS (emergency service)
3 Police
97 Other
99 Unknown

If transported, please indicate Hospital/Medical Facility:

Section F: Crash Conditions

Light Conditions	Weather Conditions (up to two)	Traffic Control Device	Was the traffic control device functioning at the time of the crash?	Road Surface	Roadway Intersection Type
(1 Daylight) circled 2 Dawn 3 Dusk 4 Dark - lighted roadway 5 Dark - roadway not lighted 6 Dark - unknown roadway lighting 97 Other 99 Unknown	1 Clear (2 Cloudy) circled (3 Rain) circled 4 Snow 5 Sleet, hail, freezing rain 6 Fog, smog, smoke 7 Severe crosswinds 8 Blowing sand, snow 97 Other 99 Unknown	1 No controls 2 Stop signs 3 Traffic control signal 4 Flashing traffic control signal 5 Yield signs 6 School zone signs 7 Warning signs 8 Railroad crossing device 99 Unknown	1 __ Yes 2 __ No	1 Dry (2 Wet) circled 3 Snow 4 Ice 5 Sand, mud, dirt, oil, gravel 6 Water (standing, moving) 7 Slush 8 Other 99 Unknown	1 Not at intersection (2 Four-way intersection) circled 3 T-intersection 4 Y-intersection 5 On ramp 6 Off ramp 7 Traffic circle 8 Five-point or more 9 Driveway 10 Railway grade crossing 99 Unknown

Trafficway Description	School Bus Related?	Work Zone Related?	Manner of Collision
(1 Two-way) circled, not divided 2 Two-way, divided, unprotected median 3 Two-way divided, protected median 4 One-way, not divided 99 Unknown	1 __ Yes 2 X No	1 __ Yes 2 X No	1 Single vehicle crash 2 Rear-end (3 Angle) circled 4 Sideswipe, same direction 5 Sideswipe, opposite direction 6 Head on 7 Rear to rear 99 Unknown

Section G: Crash Diagram

133 133 MAIN St

Please draw a diagram of the roadway or streets where the crash occurred, indicating the vehicles involved and direction of travel using the following symbols:

→ = Direction
[1] = Vehicle 1 (Your Vehicle)
[2] = Vehicle 2
O = Pedestrian/Non-Motorist

Select one of the following if the crash did not occur on a public way:

- __ Off-street parking lot
- __ Garage
- __ Mall/shopping center
- __ Other private way

Section H: Witness Information

Witness Name (Last, First, Middle)	Address	Phone
, Bill		

Section I: Property Damage Information (Other than Vehicles)

Owner Name (Last, First, Middle)	Address	Phone	Property and Damage Description

Section J: Crash Narrative

I WAS TRAVELING IN A EASTERLY DIRECTION ALONG ROUTE 133 (WASHINGTON ST) IN BOXFORD WHEN MY VEHICLE WAS STRUCK BY V2. V2 WAS ATTEMPTING TO EXECUTE A LEFT HAND TURN ONTO MAIN ST FROM ROUTE 133. AS A RESULT OF THE COLLISION, MY VEHICLE WAS DIRECTED INTO THE MEDIAN LOCATED IN THE SE CORNER OF THE INTERSECTION AND SUSTAINED ADDITIONAL DAMAGE TO THE UNDERCARRIAGE.

Section K: Signature

________ Print JONATHAN _____ Date 10-28-03

"Signed under Pains and Penalties of Perjury"

Lawrence General Hospital
One General Street
Lawrence, MA 01842

EMERGENCY DEPARTMENT RECORD

, JONATHAN
MR#:190649 ACCT#: _
DOB:12/19/75 DATE OF SERVICE: 10/21/03
TIME SEEN:

CHIEF COMPLAINT: Pain in the neck and left lower back and shoulder.

MODE OF ARRIVAL: The patient came in by ambulance.

HISTORY OF PRESENT ILLNESS: The patient is a 27-year-old male who was an unrestrained driver of a car that was struck on the driver's side. There is no loss of consciousness, no nausea or vomiting or headache. He complained of pain in the back of his neck, shoulder and lumbosacral spine. He was brought here for evaluation.

PAST MEDICAL HISTORY: Past medical history includes asthma.

FAMILY HISTORY/SOCIAL HISTORY: He currently lives with his wife. He denied use of cigarettes, alcohol or drugs.

ALLERGIES: HE HAS NO KNOWN DRUG ALLERGY.

MEDICATIONS: Albuterol and Advair.

PERSONAL PHYSICIAN: Dr. Sobrado.

PHYSICAL EXAMINATION: General appearance: The patient is a well-developed, well-nourished adult male who is conscious, alert, no obvious distress. Vital Signs: Temperature 98.6, pulse 89, respirations 18, blood pressure 117/77, pulse oximetry 97%. Glasgow coma scale 15.

HEENT: Normocephalic. Throat is normal.
NECK: There is mild posterior neck tenderness without any step off. There is minimal pain in the back of his neck. He is able to flex and extend it without any increasing pain.
MUSCULOSKELETAL: There is also some slight pain on the left shoulder. There is also some pain in the lumbosacral area. There is minimal spasm noted. Straight leg raising is 70 degrees bilaterally. Reflexes are equal and normal bilaterally and no sensory or motor loss is noted.

INTERPRETATIONS:

C-SPINE/LS-SPINE/SHOULDER X-RAY: X-rays were obtained which are all negative.

Lawrence General Hospital
One General Street
Lawrence, MA 01842
EMERGENCY DEPARTMENT RECORD

_, JONATHAN
MR#:190649 ACCT#:
DOB:12/19/75 DATE OF SERVICE: 10/21/03
TIME SEEN:

IMPRESSION:
Multiple sprains following motor vehicle accident.

PLAN:
1. The patient is able to tolerate Motrin and is given Motrin 3x a day.
2. He is to follow with Dr. Sobrado.

DISPOSITION: Discharged home.
TIME OUT: 1500

Ricardo Gervasio, MD

DOD: 10/23/2003 1020 3515/157:4984960
DOT: 10/23/2003 2121

CC: 2171:Sobrado,MD,Alberto

LAWRENCE GENERAL HOSPITAL IMAGING SERVICES

Patient Name: ____ , JONATHAN
Physician: EMERGENCY MD
Medical Record Number:
12/19/1975 /27Y M
EMERGENCY DEPARTMENT
Date of Service: 10/21/2003

Document Status: **Archived**

Account Number: 3350586

03R44729
03R44730
03R44731

, JONATHAN

EXAMINATION: CERVICAL SPINE/LUMBAR SPINE/LEFT SHOULDER
HISTORY: PAIN/MVA
DATE: 10/21/03

CERVICAL SPINE:

There is loss of usual lordotic curvature. This may be positional or due to spasm. Vertebral body height as well as alignment is otherwise maintained. Facets are in normal alignment. Spinous process appear intact. Paraspinal soft tissues are unremarkable. The relationship of the lateral masses to C2 vertebral body is anatomic.

IMPRESSION: LOSS OF USUAL LORDOTIC CURVATURE. OTHERWISE UNREMARKABLE STUDY.

LEFT SHOULDER:

SHOULDER: AP view in external rotation and a Neer view show no bone, joint or soft tissue abnormality.

IMPRESSION: NORMAL LEFT SHOULDER.

LUMBAR SPINE:

There is minimal loss of usual lordotic curvature. Vertebral body alignment is maintained. Disc height is also maintained. Pedicles appear intact. There is slight anterior wedging of T12 and also of the L1 vertebral body, although no definite acute fracture is identified. Clinical correlation is warranted. There appears to be Schmorl's node involving the inferior end plate of the T12 vertebral body.

IMPRESSION: SLIGHT ANTERIOR WEDGING OF T12 AND L1 OF UNCERTAIN AGE. CLINICAL CORRELATION IS WARRANTED. SLIGHT LOSS OF USUAL LORDOTIC CURVATURE.

(Page 1 of 2. Continued on next page)

continued : ,JONATHAN

Susannah Kay,MD
Radiologist

DD: 10/22/03
DT: 10/22/03
SK/lw.
ES/SK.

Lawrence General Hospital
1 GENERAL ST. PO BOX 189
LAWRENCE, MA 01842-0389
(978) 683-4000 Ext. 2850

PATIENT ITEMIZED STATEMENT

TYPE OF BILL FINAL PAGE NO. 1

BILL DATE 10/30/03

PLEASE REFER TO THIS NUMBER ON ALL CORRESPONDENCE

TAX I.D. NO. 043-103-586

MAKE CHECKS PAYABLE TO: LAWRENCE GENERAL HOSPITAL

GUARANTOR	PATIENT NAME	ACCOUNT NO.
JONATHAN ROAD IPSWICH MA 01938	, JONATHAN	3350586

ADMISSION DATE	DISCHARGE DATE
10/21/03	10/21/03

NO.	INSURANCE COMPANY	POLICY NO.	PLAN	POLICY HOLDER
1	AUTO ACCIDENT		500-02	, JONATHAN
2	BC PPO SECONDARY		649-02	, JONATHAN

↑ PLEASE DETACH HERE AND RETURN ABOVE PORTION WITH YOUR PAYMENT ↑

DATE OF SERVICE	CHARGE CODE	SERVICE DESCRIPTION	QTY.	UNIT PRICE	AMOUNT
10/21/03	3710007	ER INTERMEDIATE	1	330.00	330.00
10/21/03	3710008	ER INTERMEDIATE PHY.FEE	1	177.00	177.00
10/21/03	4322078	CERV SPINE 2 OR 3 VIEWS	1	215.00	215.00
10/21/03	4322246	LUMBAR SPINE 2 OR 3 VIEWS	1	215.00	215.00
10/21/03	4322728	SHOULDER LEFT 2 OR > VIEW	1	170.00	170.00

FOR YOUR CONVENIENCE, THIS BILL MAY ALSO BE PAID BY VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER AT OUR OFFICE.

TOTAL 1107.00

PATIENT NAME	HOSPITAL	ACCOUNT NO.	BILL DATE
JONATHAN	LAWRENCE GENERAL HOSPITAL		10/30/03

L & M RADIOLOGY, INC.
BILLING OFFICE / A65
P.O. BOX 847235
BOSTON, MA 02284-7235
800-294-5696 OR 508-295-5556

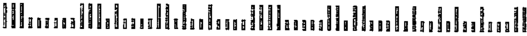
If you have an HMO please reply promptly

EIN 04-2499135

404000

*P0041I00209260***
[redacted] A65*018856

IPSWICH, MA 01938-1030



DATE OF SERVICE	LOCATION	PROCEDURE CODE	ICD9-CM CODE	DESCRIPTION OF SERVICE	AMOUNT	MSG
12/08/02	LAWRENCE GENERAL HOS	7363026	959.7	FOOT 3 VIEWS	27.00	053
10/21/03	LAWRENCE GENERAL HOS	7204026	959.09	CERVICAL SPINE LESS	33.00	053
10/21/03	LAWRENCE GENERAL HOS	7303026	959.2	SHOULDER 2 VIEWS	41.00	053
10/21/03	LAWRENCE GENERAL HOS	7210026	959.1	LUMBAR SPINE LESS TH	41.00	053

053 : IF CHARGES ARE RELATED TO AN AUTO ACCIDENT OR WORKER'S COMPENSATION, RETURN BILL WITH THE ACCIDENT INSURANCE.

COVERED BY INSURANCE - SEE REVERSE

Make sure the providers address shows in the window of enclosed return envelope.

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

PATIENT BALANCE	$142.00
AMOUNT ENCLOSED	$ ______

PRIMARY INSURANCE
MEDITROL INC
145 SPRINGFIELD ST
CHICOPEE MA 01013
030586569

SECONDARY INSURANCE
NONE

PATIENT'S NAME
[redacted]
ACCOUNT NO.
7
STATEMENT DATE
11/17/03

MAKE CHECKS PAYABLE TO:

L & M RADIOLOGY, INC.
BILLING OFFICE / A65
P.O. BOX 847235
BOSTON, MA 02284-7235

IF YOU HAVE CHANGED INSURANCE CARRIERS OR YOUR INSURANCE INFORMATION REQUIRES CORRECTION, COMPLETE THE INFORMATION BELOW AND RETURN THIS ENTIRE STATEMENT TO US IN THE ENVELOPE PROVIDED OR FAX IT TO US AT 508-273-1300

PATIENT'S NAME: JONATHAN ARMANO	ACCOUNT NO: 018856A65
MEDICARE REQUIRED INFORMATION	MEDICARE NUMBER: ______ PATIENT DATE OF BIRTH: ______ SUPPLEMENTAL INSURANCE NAME: ______ ADDRESS: ______ POLICY NO: ______ GROUP NO: ______ SUBSCRIBER'S NAME:
BLUE CROSS/ BLUE SHIELD REQUIRED INFORMATION	YOUR BC/BS IS PROVIDED BY WHICH STATE: ______ CERTIFICATE NUMBER: ______ SUBSCRIBER'S NAME: ______ PATIENT'S DATE OF BIRTH : ______ RELATIONSHIP TO SUBSCRIBER : SELF ☐ SPOUSE ☐ DEPENDENT ☐
COMMERCIAL HMO REQUIRED INFORMATION	INSURANCE COMPANY NAME: ______ INSURANCE COMPANY CLAIMS ADDRESS: ______ POLICY NUMBER : ______ SUBSCRIBER'S NAME: ______ RELATIONSHIP TO SUBSCRIBER : SELF ☐ SPOUSE ☐ DEPENDENT ☐
MOTOR VEHICLE INFORMATION	INSURANCE COMPANY NAME: ______ INSURANCE COMPANY CLAIMS ADDRESS: ______ FILE OR CLAIM NUMBER: ______ DATE OF INJURY :
WORKER'S COMP	INSURANCE COMPANY NAME: ______ INSURANCE COMPANY CLAIMS ADDRESS : ______ FILE OR CLAIM NUMBER: ______ DATE OF INJURY : ______ EMPLOYER NAME : ______ EMPLOYER ADDRESS:
STATE ASSISTANCE REQUIRED INFORMATION	YOUR MEDICAL ASSISTANCE IS PROVIDED BY WHICH STATE : ______ POLICY NUMBER : ______ SUBSCRIBER'S NAME: ______ PATIENT'S DATE OF BIRTH : ______ RELATIONSHIP TO SUBSCRIBER : SELF ☐ SPOUSE ☐ DEPENDENT ☐
MASS HEALTH ONLY	PATIENT'S PRIMARY CARE PHYSICIAN NAME: ______ PHYSICIAN ADDRESS: ______ PHYSICIAN PHONE:

PLEASE SUBMIT PHOTO COPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD(S).
YOUR INSURANCE COMPANY MAY HAVE A CLAIMS FILING TIME LIMIT SO RETURN INFORMATION PROMPTLY.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE CHANGES BELOW.

NAME: ______

STREET OR PO BOX: ______

CITY, STATE, ZIP: ______

PHONE : ______

SIGNATURE: ______ **DATE:** ______

MAGER CHIROPRACTIC OFFICE
139 ELLIOTT STREET
BEVERLY, MA 01915
Telephone 922-1605

RECEIPT FOR SERVICES

(21170) DOB:12191975 INS:PV BS AAY
ROAD IPSWICH, MA 01938 12/22/03
H:978- -0169 W:978-

	Date		Detail	Description	Amount
Px	102403	----->	99203	COMPREHEN HISTORY/EXAM	225.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px		----->	L0515	LUMBAR HYPEREXT CUSHIO	45.00
Px		----->	L0515	INDUSTRIAL LUMBAR BRAC	55.00
Px		----->	E0943	CERVICAL HYPEREXT ORTH	40.00
Px	102703	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	102903	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	103003	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	110303	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	110603	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	111103	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	111103	----->	72074	THORACIC XRAY WITH OBL	125.00
Px	111303	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	111803	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	112403	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	112603	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	120103	----->	98940	SPINAL MANIPULATION	65.00

MAGER CHIROPRACTIC OFFICE
139 ELLIOTT STREET
BEVERLY, MA 01915
Telephone 922-1605

RECEIPT FOR SERVICES

(21170) DOB:12191975 INS:PV BS AAY
ROAD IPSWICH, MA 01938 11/13/03
H:978- -0169 W:978- -5900

	Date		Detail	Description	Amount
Px	102403	----->	99203	COMPREHEN HISTORY/EXAM	225.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px		----->	L0515	LUMBAR HYPEREXT CUSHIO	45.00
Px		----->	L0515	INDUSTRIAL LUMBAR BRAC	55.00
Px		----->	E0943	CERVICAL HYPEREXT ORTH	40.00
Px	102703	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	102903	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	103003	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	110303	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	110603	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	111103	----->	98940	SPINAL MANIPULATION	65.00
Px		----->	97035	ULTRASONIC THERAPY	40.00
Px		----->	97014	ELECTRIC STIMULATION T	40.00
Px		----->	97140	MYOFASCIAL RELEASE TX	60.00
Px	111103	----->	72074	THORACIC XRAY WITH OBL	125.00
				Total for these Procedures:	1,820.00

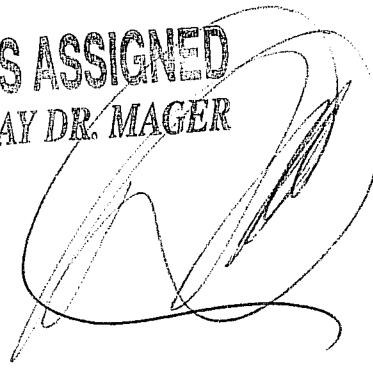
BENEFITS ASSIGNED
PLEASE PAY DR. MAGER

I hereby certify the the foregoing is a fair, reasonable and necessary bill for services rendered to this patient. This statement is signed under the pains and penalties of perjury this 13th day of November, 2003

Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
Px	120303	------>	98940	SPINAL MANIPULATION	65.00
Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
Px	120803	------>	98940	SPINAL MANIPULATION	65.00
Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
Px	121003	------>	98940	SPINAL MANIPULATION	65.00
Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
Px	121503	------>	98940	SPINAL MANIPULATION	65.00
Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px	121703	------>	98940	SPINAL MANIPULATION	65.00
Px		------>	97035	ULTRASONIC THERAPY	40.00
Px		------>	97014	ELECTRIC STIMULATION T	40.00
Px		------>	97140	MYOFASCIAL RELEASE TX	60.00
					===========
				Total for these Procedures:	3,870.00

BENEFITS ASSIGNED

PLEASE PAY DR. MAGER



I hereby certify the the foregoing is a fair, reasonable and necessary bill for services rendered to this patient. This statement is signed under the pains and penalties of perjury this 22nd day of December, 2003

DR. DEBORAH ANN MAGER
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology
Former Member of Mass. Board of Chiropractic Registration

October 24, 2003

RE: JONATHAN
DL: OCTOBER 21, 2003
INITIAL NARRATIVE

History:

As I sit today in consultation and evaluation with Mr. Jonathan , he details that he was involved in a motor vehicle accident. The date of this automobile collision accident was October 21, 2003. On that date, Mr. was the operator of his vehicle that was struck in the side aspect by another motor vehicle. This collision has caused hyperextension and hyperflexion spinal injuries. The force of this side-impact collision caused his head, neck and body to be flung side to side. Mr. suffered immediate pain in his left shoulder and lower back. Jonathan was taken by ambulance to the Lawrence General Hospital Emergency Room. There he was evaluated and appropriate radiographs were obtained. He was later discharged with medication and home care instructions. As his initial symptoms have worsened Mr. presents to my office in acute distress today, October 24, 2003 for initial evaluation.

Past History:

Jonathan denies any previous incident that could contribute to his current complaints. His present subjective symptoms and objective findings are therefore directly and causally related only to the injuries that he suffered in this road traffic accident of October 21, 2003.

Subjective Symptoms:

Jonathan was unable is sleep well last night, his left shoulder and scapula pain is intensifying today and he is aware of the nidus of most intense symptoms to be his neck base with cervical spine along the scapulothoracic articulation. Mr. further relates to me during the active care session today that he has deep central burning to the scapulothoracic articulation. There are guarded postures of his neck and left shoulder girdle in all active ranges of motion. He is unable to perform any quick or turning motions. Mr. notes that any extension of his left shoulder intensifies the level of symptomatology. He experiences the most severe pain with sudden elevation of the scapula, quick movement of the upper extremity. The pain is intense and radiates from the injured scapulothoracic articulation into the ipsilateral shoulder dome. he denies any paresthesias or radiating pains into the bilateral upper extremity.

137-9 Elliott Street, Beverly, Massachusetts 01915 Telephone (978) 922-1605 • (978) 922-1730
Fax (978) 922-9664

Mr. has the onset of low back pain ever since the motor vehicle accident of yesterday. This pain is central with bilateral muscular splinting. Simple tasks of arise from a reclined position or from a chair, donning a pair of shoes are difficult due to painful lower spinal symptoms. Jonathan is unable to perform every function of the usual work, duties and daily activities. This limited functional capacity is causally related to the trauma suffered in the accidental incident of October 21, 2003. Sleep is poor, all changes of position and posture requires slow compensation movements. Jonathan notes an inability to bend and twist at the waist; indeed all active motions of the lumbar spine are reduced.

Objective Findings:

Left sided glenohumeral joint ranges are markedly restricted, noted with today's examination. Abduction is 35 degrees, extension and external rotation cause wincing pain at only 45 degrees. This injured left shoulder joint is held with guarded posture. Rotator cuff weakness of grade 4/5 (normal maximum is 5/5) is noted with testing of the left side. Pain is noted with passive stretching and percussion of the left sided acromio-clavicular joint. The nidus of intense pain is the coalescence of proximal biceps brachii, distal pectoralis minor and coracobrachialis. Positive response to impingement sign testing is noted on the left glenohumeral joint. Maximums of protraction and retraction are accomplished with the left scapula, pains into the levator scapula, rhomboid major and minor, subscapularis and proximal latissimus are elicited. The cervical spine compression tests are positive when performed on the left with radiations to the vertebral border of the ipsilateral scapula.

Spurling's test is negative and George's test is negative. He presents with a symmetrical face, eye movements are symmetric. Cervical spine distraction testing is positive for alleviating the neck pains. The shoulder depressor test is positive when performed today on the right side. The shoulder depression testing is eliciting a positive response on the left side. There is considerable pain and contraction noted to the slightest of palpation to the right-sided cervical and trapezius soft tissues. There is marked, consistent splinting noted in the left the erector spinae cervicis along the splenius capitis, semispinalis cervicis, levator scapulae, superior and middle fibers of the trapezei from the short recti to the thoracocervical junction.

Complaints of pain are elicited when I percuss the spinous processes of the vertebrae of C2-T4. There is a reproduction of the posterior scalp headache pain with percussion of the greater occipital nerve with radiations to the vertex of the skull. There is pain produced with percussion of the auricular temporal nerve with radiations extending to the temporal and parietal regions. The complaints of posterior scalp headaches are re-produced with the passive stretching of the short recti of the suboccipital complex. Jonathan denies visual or auditory disturbances, he has not experienced difficulty with speech of swallowing. There is pain upon the slightest movement of the scapulothoracic articulation on the right. The scapulothoracic articulation on the left is splinted with the spasm of the parascapular musculature. All attempts of passive and active motion cause pain with minimal motion possible.

All of the active attempts at lumbar ranges of motion are restricted with Minor's sign is present, with pain in the lumbar spine, when arising from a seated position. I note with examination today that there is a positive response to the Adam's forward bending test at the beginnings of flexion of the torso, there noted also a positive response to Goldthwait's testing that reproduces the complaints of low back pain at the motion of lumbosacral joint. Kemp's testing is positive when testing the right side, with the patient assuming both a seated posture and positive with the patient in a standing position Kemp's testing is positive on the left for complaints of pain on that side of the lumbar spine. This positive response to testing is noted with the patient in the seated and in the standing positions.

Gaenslen's testing is positive on the right, the iliac compression test elicits a similar positive response to testing the right sacroiliac joint. Gaenslen's testing is positive on the left; the iliac compression test elicits a similar positive response to testing the left sacroiliac joint. Continued positive bilaterally, on the right and left sides, examination today remains a positive SLR testing on the right, for re-producing right lower back pain and no radiations. This test is positive at 45 degrees of elevation, checking due to hamstring limitations on that side. Straight-leg rising testing is performed on the left leg today. There is a moderately positive response for reproducing local lumbar pain without radiating pain into the left lower extremity, the test is positive today at 55 degrees of elevation.

Left straight leg-raising, SLR, is painful to accomplish with the left-sided lumbar spine injury screaming at only 35 degrees of elevation with radiations to the posterior gluteal and lateral trochanteric regions of the left. No reported complaints of bowel or bladder dysfunction. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL). There is good strength and mobility in the 4 limbs. Pinwheel response testing is negative for increasing or decreasing sensation in the 4 limbs. * Peripheral pulses are within normal limits.

Assessment:

Mr. Jonathan has sustained personal injuries as a result of the automobile collision accident of October 21, 2003. Diagnoses for his injuries include the following. There is a musculoligamentous injury to his left glenohumeral joint and scapulothoracic articulation. There is coupled an injury to the lumbosacral structure and sacroiliac joint. Dorsal spine musculoskeletal injury exists.

Plan:

I request his records with a signed consent authorization.

DR. DEBORAH ANN MAGER
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology
Former Member of Mass. Board of Chiropractic Registration

January 28, 2004

RE: JONATHAN
DL: OCTOBER 21, 2003
DISCHARGE SUMMARY

Subjective Symptoms:

As Mr. receives relief with recumbency and with home rehabilitation exercises, further treatment is not scheduled at this time, on an as-needed basis, if symptoms dictate. Jonathan does continue to experience stiffness and discomfort with repeated bending at the waist, excessive twisting of the torso and lifting, especially from the ground. The residual stiffness and discomfort of the lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction is does ease with home rehabilitation regimen of stretching reps first followed by strengthening exercises.

Objective Findings of Evaluation:

Lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction ranges of motion are within normal limits. Goldthwait's testing remains positive to a slight degree, Adam's forward bending testing is negative now with stiffness extant at the end of range.

Kemp's testing is mildly positive on the right in the seated position only, without radiations to the bilateral lower extremities. Kemp's maneuvers are negative when performed on the left in the seated and standing postures. Minor's sign is not present; antalgia is gone with this individual able to stand erect with the torso over the pelvis Gaenslen's maneuvers no longer spark pain when performed over the right and left joints of the sacro-iliac joints and Iliac Compression maneuvers do cause residual myofascial discomfort over the bilateral sacroiliac joints. Straight-leg raising, SLR, is negative response to testing on the right and on the left sides, no tenderness is elicited with sciatic notch deeper palpation and passive stretching.

Myofascial splinting is noted with trigger point acupressure to the erector spinae lumborum, bilateral quadratus, longissimus thoracis, dorsolumbar aponeurosis and the iliocostalis and the paraspinal lumbar muscles and the dorsolumbar aponeuosis. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL). There is good strength and mobility in the 4 limbs. Pinwheel response testing is negative for increasing or decreasing sensation in the 4 limbs.

137-9 Elliott Street, Beverly, Massachusetts 01915 Telephone (978) 922-1605 • (978) 922-1730
Fax (978) 922-9664

Assessment:

Mr. is released from the active care of this office for his well healed traumatic injuries suffered in the motor vehicle incident of October 21, 2003.

Plan:

Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and paracervical muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease paracervical muscular pain and further open the symptomatic facet joints. No cervical spine manipulation is performed on this date of service.

Mr. receives the following chiropractic and physiotherapy care during today's office visit. Ultrasound is used in both the pulsed and continuous mode, over the area of injury to facilitate healing with thermal and mechanical changes to the inflamed and symptomatic soft tissues. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Trigger point therapy and deep myofascial release are used for the therapeutic effect of improved muscular flexibility. Treatment includes very gentle passive stretching of the collateral ligaments and mobilization of the injured knee, with stamina training. For the relief of acute pain over inflamed injuries, ice is used to tolerance and as indicated. No cervical spine manipulation is performed on this date of service.

Total Disability

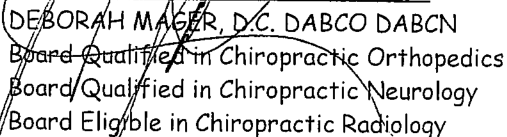
Jonathan has suffered a total disability due to the personal injury sustained in this traumatic motor vehicle accident. This period of temporary and total disability began on the date of the automobile collision accident, October 21, 2003, and continued until on or about November 1, 2003. This period of total disability is directly caused by the personal injury to which this individual was victim in this road traffic accident occurring on the 21st of October 2003.

Partial Disability

Mr. has suffered a period of temporary and partial disability that began on or about November 1, 2003 and continued until January 28, 2004. This period of partial disability is causally related to the injuries suffered in this motor vehicle accident of October 21, 2003.

Jonathan is released from active care at this time. At this time, with continued home care and rehab exercises, chiropractic care is ended. If pain dictates, further treatment may be reasonable and necessary.

I AM A DULY AUTHORIZED AGENT AND HEREBY CERTIFY THAT THE FOREGOING MEDICAL/CHIROPRACTIC RECORDS/REPORTS REFLECT A TRUE AND ACCURATE RECORD OF THE TREATMENT. THESE DOCUMENTS ARE SWORN AND SUBSCRIBED TO UNDER THE PAINS AND PENALTIES OF PERJURY ACCORDING TO THE MGL 233, CH 79G. I FURTHER CERTIFY THAT THIS REPORT IS HELD TO A REASONABLE DEGREE OF MEDICAL CERTAINTY.



DEBORAH MAGER, D.C. DABCO DABCN
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology

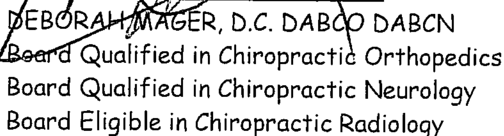
I prescribe cervical pillow for Jonathan. This support will aid in decreasing the painful ranges of motion and diminish pain; he should be able to sleep better. I prescribe and fit a lumbar brace to him. This support will aid in decreasing the painful ranges of motion and diminish pain during the day. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage. I prescribe the simpler version of the William's lower back stretching repetitions and for later, the more involved strengthening exercises.

Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and paracervical muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease paracervical muscular pain and further open the symptomatic facet joints. No cervical spine manipulation is performed on this date of service.

Mr. receives the following chiropractic and physiotherapy care during today's office visit. I utilize a drop thoracic spinal manipulative technique with a double pisiform contact to correct the thoracic subluxations. I now use side posture spinal manipulative techniques to correct subluxations of the lumbar spine. Treatment for this date includes the use of supportive procedure ultrasound and EMS to promote soft tissue healing. In addition, the use of muscular massage and trigger point therapy optimizes healing and reduces active care treatment time.

Recall is for four-office visits per week, to quiet the desperately painful signs and symptoms.

I AM A DULY AUTHORIZED AGENT AND HEREBY CERTIFY THAT THE FOREGOING MEDICAL/CHIROPRACTIC RECORDS/REPORTS REFLECT A TRUE AND ACCURATE RECORD OF THE TREATMENT. THESE DOCUMENTS ARE SWORN AND SUBSCRIBED TO UNDER THE PAINS AND PENALTIES OF PERJURY ACCORDING TO THE MGL 233, CH 79G. I FURTHER CERTIFY THAT THIS REPORT IS HELD TO A REASONABLE DEGREE OF MEDICAL CERTAINTY.



DEBORAH MAGER, D.C. DABCO DABCN
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology

Office Note: RE: JONATHAN
DL: OCTOBER 21, 2003

- -

Dr. Mager, DC

1-21-2004 - office note continued

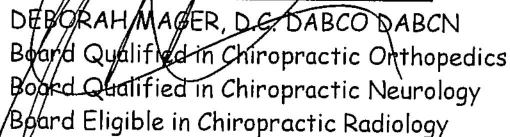
RATIONALE FOR FINAL CARE IN THIS RESOLVING PARTIALLY HEALED INJURIES AND JOINT DAMAGE OF THIS INJURED LUMBAR SPINE:

Remodeling Stage: The fourth stage, the remodeling stage, occurs when the repaired soft tissues undergo reorganization and reorientation along the lines of stress. Recent clinical reviews conclude that process will peak at 3-4 weeks and continues up to approximately one year. Within this stage two activities take place, the first being realignment of the collagen source to increase the functional capacity of the collagen as it is stressed in normal usage. The tensile strength of collagen is dependent on the force imposed on it during the remodeling stage. The second activity is the replacement of type III collagen with the re-injury type I collage. The type III collagen is deficient in the number of cross-linkages with the tropocollagen subunits. Clinical studies have determined that even after 40 weeks the normal ligament substance may not have been reproduced by the remodeling process.

McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

1-28-2004- Please refer to the enclosed discharge summary.

Jon has been compliant with home rehabilitation and with appointment scheduling. Active chiropractic care is suspended. Further treatment is not scheduled at this time, on an as-needed basis, if symptoms dictate.



DEBORAH MAGER, D.C. DABCO DABCN
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology

Office Note: RE: JONATHAN
DL: OCTOBER 21, 2003

- -

Dr. Mager, DC

1-21-2004-Subjective Symptoms: Mr. admits to me that with the home rehabilitation exercises that have been prescribed, that there is relief with consistent performance of these repetitions. Jonathan also tells me today that the burning radiations to the scapula are easing. Sleep is still difficult through the night, turning from side to side is intermittently painful. Jonathan is pleased to state that only stiffness and dull discomfort lingers.

Objective Findings of Evaluation: Mr. presents with a symmetrical face, eye movements are symmetric, and 6 positions of gaze are normal. The pupils are equal and reactive to light and accommodation. Cranial nerve testing 3-12 is normal (taste is not tested). George's test is negative. Stretching passively of the occipital musculature and the short recti of the proximal cervical soft tissues continues to cause discomfort and to spark a dull pain that no longer radiates to the bilateral frontal region. There remains moderate pain at the suboccipital region to percussion and passive stretching of the posterior scalp soft tissues.

Lumbar motions continue to increase with evaluation revealing 55 degrees of lumbar flexion, rotation with extension is 25 degrees side to side. Lateral flexion is within normal limits with stiffness and discomfort at end range. Adam's bending testing is positive now at end of forward flexion. Goldthwait's testing slightly positive with this healing lumbosacral damage. Kemp's testing is positive on the left for complaints of pain on that side of the lumbar spine. This positive response to testing is noted with Jonathan in the seated and in the standing positions. Gaenslen's testing is positive on the left, the iliac compression test elicits a similar positive response to testing the left sacroiliac joint.

Assessment: Functional capacity is improved with continued easing of injury condition and improvement in quality of life for Mr. today.

Plan: Jonathan is not able to tolerate thoracic spine manipulation, therefore only massaging and deep myofascial releases are performed to the thoracic spine and paradorsal musculature. A spinal manipulation is performed on lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No thoracic spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the parathoracic and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and parathoracic muscles with trigger point treatment. I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis. No thoracic spine manipulation is performed on this date of service.

Mr. continues with the following thorough program of chiropractic therapy. Part of the treatment protocol of this office is to aid in edema correction and muscular spasms with passive modalities of ultrasonic and EM. My certified therapists then perform a prolonged session of myofascial release and lymphatic drainage. Chiropractic manipulation is performed gently over the lumbar misalignments; no thoracic spine and paradorsal musculature manipulation is done today.

Office Note: RE: JONATHAN
DL: OCTOBER 21, 2003

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Dr. Mager, DC

1-6-2003 - office note continued

DURATION AND FREQUENCY: chiropractic care is reasonable and necessary active care for in this case. Recent research published by the post-graduate faculty of National University reveals that chiropractic manipulation does indeed open the zygapophyseal joints. This opening or 'gapping' of the zygapophyseal joints removes the impingement to the synovial meniscal in-folding of the facet capsule. It is further indicated that fibrous adhesions could break up as the manipulation is opening the articular surfaces of the zygapophyseal joints. Further healing is thought to occur with manipulation in that it RE-establishes additional motion in hyper mobile facets.

RATIONALE FOR FINAL CARE IN THIS RESOLVING PARTIALLY HEALED INJURIES AND JOINT DAMAGE OF THIS INJURED LUMBAR SPINE:

Remodeling Stage: The fourth stage, the remodeling stage, occurs when the repaired soft tissues undergo reorganization and reorientation along the lines of stress. Recent clinical reviews conclude that process will peak at 3-4 weeks and continues up to approximately one year. Within this stage two activities take place, the first being realignment of the collagen source to increase the functional capacity of the collagen as it is stressed in normal usage. The tensile strength of collagen is dependent on the force imposed on it during the remodeling stage. The second activity is the replacement of type III collagen with the re-injury type I collage. The type III collagen is deficient in the number of cross-linkages with the tropocollagen subunits. Clinical studies have determined that even after 40 weeks the normal ligament substance may not have been reproduced by the remodeling process.

McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

Jon will continue conservative care on a reduced frequency. Recall is for 2 week follow-up care.

Partial Disability: This fellow continues to suffer with a partial disability at this time due to the resolving, yet still disabling trauma suffered in this accidental incident occurring on the 21st of October 2003.

Office Note: RE: JONATHAN
DL: OCTOBER 21, 2003

Dr. Mager, DC

1-6-2003-Subjective Symptoms: Mr. admits to me that with the home rehabilitation exercises that have been prescribed, that there is relief with consistent performance of these repetitions. Jonathan explains during the treatment session on this date that the lumbar spine pains are considerably improved with the last office visit.

Objective Findings of Evaluation: Moving in the six ranges of lumbar motion, there is a slight lag now only with left lateral bending and left rotation of the torso. Extant is continued myofascial pain at these extremes of leftward movement, although to a considerably lessened amount. Adam's bending testing is positive only at 55 degrees of flexion with myofascial stiffness of the paralumbar muscles and Goldthwait's testing slightly positive with this healing lumbosacral damage.

Kemp's testing of the healing left lumbar spine is positive with moderate pain. This maneuver and testing is performed in both the seated and standing patient positions. Gaenslen's testing is only mildly positive on the left side. Iliac compression testing on that side does spark residual discomfort in the left S/I joint. Straight leg raising is positive on the left at 60 degrees of elevation, producing the symptoms of localized lumbar mechanic pain. I am also able to demonstrate today the presence of continued moderate myofascial pain in the left paralumbar and gluteal musculature. Deep palpation and passive stretching reveals myofascial splinting of the paraspinal and erector spinae lumborum muscles.

Assessment: Jonathan has a favorable response to care in this office is favorable and with healing occurring over the injuries, the prognosis is improving. Additional healing can be expected with active care for Jon and his resolving, partially healed injuries and joint damage suffered in the traumatic road traffic accident of October 21, 2003.

Plan: Jon is not able to tolerate thoracic spine manipulation, therefore only massaging and deep myofascial releases are performed to the thoracic spine and paradorsal musculature. A spinal manipulation is performed on lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No thoracic spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the parathoracic and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and parathoracic muscles with trigger point treatment. I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis. No thoracic spine manipulation is performed on this date of service.

Mr. receives the following treatment. Pulsed and continuous mode of ultrasonic modality is utilized over the injured and symptomatic parathoracic and scapular musculature. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Deep myofascial releases are used today for the optimal healing of soft tissue edema and splinting. * I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis.

RE: JONATHAN
DL: OCTOBER 21, 2003

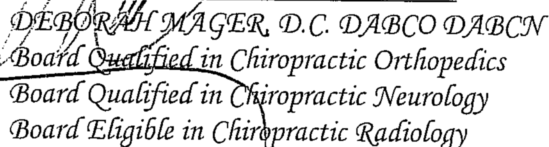
12-30-2003 - office note continued

Assessment: Jonathan is told to return on an as-needed basis at this time, if symptoms dictate. Active chiropractic care is suspended.

Plan: Mr. is not able to tolerate thoracic spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No thoracic spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the parathoracic and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and parathoracic muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease parathoracic muscular pain and further open the symptomatic facet joints. No thoracic spine manipulation is performed on this date of service.

Jon receives the following treatment. Pulsed and continuous mode of ultrasonic modality is utilized over the injured and symptomatic parathoracic and scapular musculature. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Deep myofascial releases are used today for the optimal healing of soft tissue edema and splinting. * I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis.

Jon has been compliant with home rehabilitation and with appointment scheduling. he is released from the active care of this office.



DEBORAH MAGER, D.C. DABCO DABCN
Board Qualified in Chiropractic Orthopedics
Board Qualified in Chiropractic Neurology
Board Eligible in Chiropractic Radiology

12-23-2003 - office note continued

Mr. receives modalities and massaging with limited mobilization of extra-spinal joints and restricted spinal manipulation as follows. Cost effective treatment is to fully address both the soft tissue injuries with modality regimen correctly set with the damage status of the region. The pain portion from locked facet joints is now addressed with manual techniques incorporating chiropractic adjustments. No cervical spine manipulation is performed on this date of service.

I instruct proper performance of ADL's to decrease pain with daily function. My physical therapy assistants actively demonstrate corrective stretching and strengthening exercises. Strengthening exercises are prescribed.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role he has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

12-30-2003-Subjective Symptoms: Mr. is feeling considerable improvement, he has stiffness and discomfort in his lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction that is alleviated with recumbency and rehab exercises.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

12-23-2003-Subjective Symptoms: Jonathan admits that the therapeutic exercises that were prescribed at the last visit are very helpful. I encourage Jonathan to gradually increase the repetitions. Mr. notices that with fatigue, the injured shoulder ranges of motion are quickly limited and pervasive fatigue is noted. He identifies today that sharp pains at the scull base are still frequent with cervical spine extension. Rare now, are the stabbing pains in the lower neck and the upper back. He admits to me that with the home rehabilitation exercises that have been prescribed, that there is relief with consistent performance of these repetitions. Mr. explains during the treatment session on this date that his lumbar spine pains is considerably improved with the last office visit.

Objective Findings of Evaluation: Moving in the six ranges of lumbar motion, there is a slight lag now only with left lateral bending and left rotation of the torso. Extant is continued myofascial pain at these extremes of leftward movement, although to a considerably lessened amount. Adam's bending testing is positive only at 55 degrees of flexion with myofascial stiffness of the paralumbar muscles and Goldthwait's testing slightly positive with this healing lumbosacral damage. Kemp's testing of the healing right and left lumbar spine is positive with moderate pain. This maneuver and testing is performed in both the seated and standing patient positions. Gaenslen's testing is only mildly positive on the left side. Iliac compression testing on that side does spark residual discomfort in the left S/I joint. Straight leg raising is positive on the left at 60 degrees of elevation, producing the symptoms of localized lumbar mechanic pain. Straight-leg raising, SLR, is negative on the right, there is no sciatic notch tenderness on the right or on the left. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL). There is good strength and mobility in the 4 limbs. Pinwheel response testing is negative for increasing or decreasing sensation in the 4 limbs.

Assessment: Mr. response to care in this office is favorable and with healing occurring over the injuries, the prognosis is improving. Additional healing can be expected with active care.

Plan: Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, As these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral paraspinal cervical muscles injury.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN

DL: OCTOBER 21, 2003

12-17-2003 - office note continued

Assessment: he has an injury status that is not as grave as earlier. Healing has been initiated with home care, resting to tolerance and active care. Continued active care is reasonable and necessary for his residual personal injury signs and symptoms from the traumatic injuries suffered in the motor vehicle incident of October 21, 2003.

Plan: he is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral paraspinal cervical muscles injury. No cervical spine manipulation is performed on this date of service.

Jonathan treats in this office today for continued active care of the personal injuries. I continue to prescribe and use with each treatment the use of passive healing modalities of hydrocollator and or ultrasound with EMS over the edematous soft tissue and adjacent muscular spasms. I then add prolonged massage and trigger point therapy. Correction of the painful misalignments is the focus of chiropractic care today. Spinal adjustive mobilization techniques are gently used to correct thoracic and lumbar subluxations only. There is no cervical spine manipulation performed today. Mobilization of the glenohumeral joint and scapulothoracic articulation are the focus of treatment today. Particular attention is paid to mobilization of all four bellies of rotator cuff continuing along to distal insertion to the humerus extending to the deltoid tuberosity and biceps brachii, brachialis and coracobrachialis. This active care treatment eases adhesive capsulitis and aids in restoration of normal scapulothoracic articulation to glenohumeral joint motion, the optimal ratio is 1:2.

Mr. will continue conservative care on a reduced frequency. Improvement in functional capacity and the increase in home rehab allow for only one office visit at this time for continued active care of these injuries.

Partial Disability: he is partially disabled at this time due to his continued restrictions due to the injuries from the accidental incident.

12-15-2003 - office note continued

Plan: Mr. is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, As these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral paraspinal cervical muscles injury. No cervical spine manipulation is performed on this date of service.

Jonathan continues under the active care of this office for further treatment of the personal injury. Treatment today continues with a demonstration of additional stretching exercises, continues with the healing thermal and mechanical qualities of ultrasound with EMS. Massaging and mobilization techniques are used over the axial and appendicular injuries Today care includes a full spinal manipulation conducted by myself. No cervical spine manipulation is performed on this date of service.

12-17-2003 –Subjective Symptoms: As I sit today in consultation and evaluation with the Jonathan I stress to him that there needs to be further attention to optimal healing of his right shoulder and upper spinal resolving, partially healed injuries and joint damage suffered in the traumatic road traffic accident of October 21, 2003.

Objective Findings of Evaluation: There is basically a full range of motion demonstrated in the cervical spine, residual complaints of pain elicited at the end movement of backward extension of the neck with rotation to the right and to the left. Compression testing is mildly positive on the right and on the left for cervical maximum and Jackson, Lateral Flexion manuvers, reproducing local cervical spine pain that migrates to the superior angle of the ipsilateral scapula. Depression testing on the right and on the left reveal is slowing a continued positive, albeit moderate response to the shoulder depression manuvers. Less than the initial dramatic response is noted.

With testing Jonathan today, his maximal protraction and retraction are accomplished with the right scapula, pains into the levator scapula, rhomboid major and minor, subscapularis and proximal latissimus are elicited. Muscular splinting is evident along the paraspinal thoracic and parascpular soft tissues. Digital palpation and deep percussion erupts continued myofascial splinting to a moderate degree.

Forward flexion is measured today at 95 degrees and backward extension was measured at 90 degrees, external rotation is full with stiffness and discomfort at end movement and internal rotation is within normal limits. Abduction is limited today with only a response of 75 degrees. Negative now is the testing of the drop arm and forearm drop testing when testing the right shoulder. His rotator cuff is no longer demonstrating any weakness, testing is now 5/5 to strength testing. Slight today is the right response to testing the impingement maneuver of the right shoulder. Still there is stiffness and

Office Notes

Patient:

discomfort with slight edema along the anterior shoulder soft tissues and an easing of pain to percussion.

Dr. Mager

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

12-10-2003 - office note continued

Myofascial splinting is noted with trigger point acupressure to the erector spinae lumborum, bilateral quadratus, longissimus thoracis, dorsolumbar aponeurosis and the iliocostalis and the paraspinal lumbar muscles and the dorsolumbar aponeuosis. Gaenslen's maneuvers no longer spark pain when performed over the right and left joints of the sacro-iliac joints and Iliac Compression maneuvers do cause residual myofascial discomfort over the bilateral sacroiliac joints.

Assessment: Jonathan is noting lessening of pain and Jonathan is attempting to increase daily activities. The healing of the injuries is at a gradual rate and further positive response to care is anticipated with reasonable and necessary chiropractic care for his injuries of October 21, 2003.

Plan: Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, As these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral paraspinal cervical muscles injury. No cervical spine manipulation is performed on this date of service.

Mr. continues under the active care of this office for further treatment of the personal injury. Treatment today continues with a demonstration of additional stretching exercises, continues with the healing thermal and mechanical qualities of ultrasound with EMS. Massaging and mobilization techniques are used over the axial and appendicular injuries Today care includes a full spinal manipulation conducted by myself. No cervical spine manipulation is performed on this date of service.

I now prescribe a more comprehensive home exercise regimen for this patient, more of the stretching repetitions and a beginning of resistance exercising. These will aide in more optimal healing of the injured soft tissues with improved strength.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role the patient has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Jon and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

12-15-2003 – Subjective Symptoms: Mr. is quite stiff today through out is right shoulder and scapular ranges of motion. With the exposed to dampness or chill, this injury is somewhat painful again, his sleep was difficult last night and he has been aware of the burning radiations have returned and are into his right scapula. Early in the day the scapular and shoulder discomfort is less, the symptoms worsen easily as the day progresses.

Objective Findings of Evaluation: Increasing ranges of motion are demonstrated today in the partially healed right glenohumeral joint. Noted is a smooth ratio of movement of 2:1 with respect to the scapula. Extension is now full as is flexion, although today there is moderate myofascial splinting is noted with trigger point acupressure to the middle and posterior fibers of the deltoid without weakness. Abduction numbers to 80. Drop arm testing is negative response to testing on the right and on the left sides. Right and left scapulo-thoracic articulations have increasing movement to adduction and protraction movements. Deep percussion and passive stretching of the anterior musculature of the anterior aspect of the right shoulder, namely the proximal biceps brachii and coracobrachialis and the distal pectoralis minor, is moderately painful today. Passive stretching at the base of the occiput does evoke tenderness along the bellies of the short recti. There are not any radiations to the forehead or temporal regions today. No pain is elicited with passive stretching of the suboccipital soft tissues. Although deeper palpation continues to cause tenderness at the ligamentum nuchae and the mastoids, this is now to a lesser degree.

Evaluation is accomplished with goniometric measures taken for the improving ranges of motion of the cervical vertebrae. Forward flexion is within normal limits, there is myofascial splinting is noted with trigger point acupressure to the left superior and middle fibers of the trapezius at end range. Backward extension coupled with left rotation has stiffness and discomfort at 35 degrees. Extant today with evaluation, the residual myofascial splinting of the superior and middle fibers of left trapezius, distal levator capitis, and full belly of SCM and paracervical muscles. Passive stretching and deeper myofascial palpation of the left sided thoracic, scapular and dorsal musculature reveals continued tenderness. Percussion to the thoracic vertebrae along T4-T10 spinous process is moderately painful still. Cervical compression testing is similarly negative on the left for causing pain to radiate into the left upper extremity, this maneuver does cause the signs and symptoms of left neck base pain with causalgia to the scapulothoracic articulation on the left side.

Passive stretching and deep palpation of the right cervico-thoracic soft tissues reveals myofascial splinting along trapezius, levator, and splenius and paracervical musculature. Myofascial splinting is noted with trigger point acupressure to the erector spinae lumborum, bilateral quadratus, longissimus thoracis, dorsolumbar aponeurosis and the iliocostalis and the paraspinal lumbar muscles and the dorsolumbar aponeuosis.

Assessment: Jonathan has suffered personal injury causally related to the trauma sustained in this motor vehicular accident of October 21, 2003. Jonathan is healing at a satisfactory rate.

12-8-2003 - office note continued

Plan: Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940; as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role he has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

12-10-2003 -- Subjective Symptoms: Mr. is noting that Jonathan is feeling about the same as since the last treatment, additional stretching and strengthening repetitions are taught along with an improvement in the seated and standing postures. Jonathan is slouched with respect to a lateral plumbline. The lumbar active ROM's are improved and Jonathan is able to perform more of the stretching exercises now. There is still limitation and pain, but the course of treatment in this office is easing the intense discomfort.

Objective Findings of Evaluation: Basically full torso movements are evinced with lumbar movements today, pain is at the end of extension and rotation still at this time, although much improved over the initial dramatic painful responses. Evaluation reveals that the Adam's forward bending test continues to be mildly positive for reproducing myofascial localized pain in the lumbar spine at 50 degrees of truncal flexion. Goldthwait's testing is now negative with today's examination.

Goldthwait's testing remains positive to a moderate degree, Adam's forward bending testing is negative now with stiffness extant at the end of range. Kemp's testing is mildly positive on the right in the seated position only, without radiations to the bilateral lower extremities. Kemp's maneuvers are negative when performed on the left in the seated and standing postures.

12-8-2003 - office note continued

Extant still is moderate stiffness and discomfort at passive stretching to maximal the bilateral shoulder blades and interscapular musculature. Compression testing of the injured cervical spine is positive when performed on the both sides with radiations to the vertebral border of the ipsilateral scapulae.

With testing Jonathan the grade 5/5 is the score with testing there is good strength and mobility in the 4 limbs. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL). There is moderate pain and contraction noted to the deeper palpation to the cervical and trapezius soft tissues. There is moderate myofascial splinting of the right scapulo-thoracic articulation and left scapulothoracic articulation when stretching of the rhomboid, subscapularis and trapezei musculature. Still positive are the responses to shoulder depressor test of both sides.

Distraction testing is positive still today with alleviation of the cervical spine injury. Deeper palpation and passive stretching of this injured region reveals persisting myofascial splinting is noted with trigger point acupressure to the erector spinae cervicis, to include the posterior scalp short recti of the suboccipital region extending through the paracervical muscles to the superior and middle fibers of the trapezei. Compression testing of the cervical spine reveals a continued positive, yet slight, response to this maneuver on the right side. Reproduction of this individual's localized pain along trapezius, paracervical, and splenius and levator scapula is accomplished. Compression testing is negative on the left. On motor examination there is no drift, no tremor, no flap, There is normal ambulating gait, there is a normal tandem walk and a negative Romberg today, and there are downgoing toes. Cerebellar function is within normal limits in the bilateral upper extremity and the bilateral lower extremity. Percussion of the occipital ridge and palpation of the short recti no longer sharp the radiating headaches along the auricular temporal nerve, although localized stiffness is still along the posterior scalp, suboccipital muscles. Passive stretching and deeper palpation no longer cause pain along the short recti of the suboccipital musculature.

Maximal motions are possible with scapulothoracic articulation, retraction and elevation are full and pain-free, and protraction continues to cause stiffness along the rhomboid, distal trapezei and proximal latissimus.

With testing Jonathan this evening, he has full ranges of motion with respect to his right shoulder and there is a negative drop arm testing and a mildly positive on the right impingement testing. Maximal motions are possible with scapulothoracic articulation, retraction and elevation are full and pain-free, and protraction continues to cause stiffness along the rhomboid, distal trapezei and proximal latissimus. Yergason's testing is negative response to testing on the right and on the left sides.

Assessment: Functional capacity is improved with continued easing of injury condition and improvement for the traumatic injuries suffered in the motor vehicle incident of October 21, 2003.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN

DL: OCTOBER 21, 2003

12-3-2003 - office note continued

Assessment: with respect to him, here is some improvement in the functional capacity is present with increasing ranges of movement and diminishing symptom complex. Clinically there is a slight diminution in signs and symptoms; active care continues to be reasonable and necessary.

Plan: he is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and paracervical muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease paracervical muscular pain and further open the symptomatic facet joints. No cervical spine manipulation is performed on this date of service.

Care is for the personal injury the treatment that is described as follows. Active care for this case today does continue to use muscle stimulation with ultrasonic treatment. The adjunct of massage and myofascial release over the regions of inflamed soft tissues completes the thorough clinical regimen. Shoulder mobilization is performed to improve all restricted ranges of motion. I conduct a spinal manipulation only with the prone drop thoracic and a side posture lumbar technique. No cervical spine manipulation is performed on this date of service.

Jonathan will continue conservative care on a reduced frequency. Improvement in functional capacity and the increase in home rehab allow for only one office visit at this time for continued active care of these injuries.

12-8-2003- Subjective Symptoms: Mr. admits that the therapeutic exercises that were prescribed at the last visit are very helpful. I encourage Jonathan to gradually increase the repetitions. Jonathan shares that head pain is gone in the morning; returning with fatigue, prolonged driving, and with reaching above chest level. This is good news as sleeping has improved to four hour intervals.

Objective Findings of Evaluation: With testing today, he presents with a symmetrical face, eye movements are symmetric, and 6 positions of gaze are normal. The pupils are equal and reactive to light and accommodation. Cranial nerve testing 3-12 is normal (taste is not tested). Evaluation is accomplished with goniometric measures taken for the improving ranges of motion of the cervical vertebrae. Flexion is limited to 40 degrees and extension elicits moderate myofascial splinting is noted with trigger point acupressure to the paracervical spinal musculature with only 20 degrees of backward motion. Rotation side to side is basically full with stiffness at the end of range.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN

DL: OCTOBER 21, 2003

12-3-2003 – Subjective Symptoms: Jonathan delineates that pain along the lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction has eased to a consistent degree now, a level of 4-5/10. Recently with being exposed to dampness or chill, the pain escalated last night to 6/10. He suffers with causalgia which is still extant with prolonged sitting and protracted standing, any exertional tasks. Jonathan receives relief with recumbency and with home rehabilitation exercises.

Objective Findings- a plethora of positive testing evinces today with the following orthopedic maneuvers positive. Positive response is an Adam's forward bending test at 45 degrees of flexion and a positive Goldthwait's maneuver. Kemp's maneuvers have moderate positive on his right and left sides in seated and standing positions, without radiating pains into his bilateral lower extremities. The deep causalgic pains involve pain the left lateral trochanteric and posterior gluteal soft tissues, without sciatica of 2 or 3. With evaluation, the passive and the active ROM of the lumbar spine are considerably improved with flexion still reduced to 55 degrees, backward extension is 25 degrees and right lateral flexion and left lateral bending are full with stiffness and discomfort at end movment. Right rotation and left rotation cause central lower back pain with end ranges achieved.

Antalgia is no longer extant, Mr. can stand erect, Right Straight-leg raising, SLR, continues to be painful to accomplish, to a moderate degree only now, with the right lumbar spine stiffness and discomfort evoked at 55 degrees of elevation with radiations to the posterior gluteal and lateral trochanteric regions of right lower extremity, this maneuver being limited by hamstring complex of musculature, the longitudinal fibers of semitendonosis, the barrel belly of semimembranosus, the biceps femoris, on the ipsilateral side. Left Straight-leg raising, SLR, is painful to accomplish with the left-sided lumbar spine injury screaming at only 35 degrees of elevation with radiations to the posterior gluteal and lateral trochanteric regions of the left.

Cervical spine ranges of motion are improved with testing today. Flexion with chin tucks is now to 55 degrees, extension is now full. Right rotation evokes stiffness and discomfort at end range. Compression testing of the cervical spine reveals a continued positive, yet moderate, response to this maneuver on the right side. Reproduction of this individual's localized pain along trapezius, paracervical, and splenius and levator scapula is accomplished. Left sided neck pain evaluation reveals a positive response to compression testing of cervical spine due to mildly splinted soft tissues.

Shoulder depression testing of the right side continue to evoke a positive response, now to a slight degree with myofascial splinting of the trapezius, scalenes, splenius are noted. Moderate now is the response to testing of the left shoulder depression testing. Similar response is noted with the cervical spine compression testing of the homolateral side. Suboccipital pain continues to be sparked with passive stretching of the short recti and there exist radiations along the auricular temporal and the greater occipital nerves bilaterally. Passive stretching of the bilateral scapulothoracic articulations on the right and on the left creates global pain about the supporting muscles. Rhomboids are flexible and moving though full ranges of motion with subscapularis no longer splinted. Protraction or retraction is within normal limits.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

12-1-2003 - office note continued

Continued positive bilaterally, on the bilateral and left sides, examination today remains a positive SLR testing on the right, for re-producing bilateral lower back pain and no radiations. This test is positive at 45 degrees of elevation, checking due to hamstring limitations on that side. Straight-leg rising testing is performed on the left leg today. There is a moderately positive response for reproducing local lumbar pain without radiating pain into the left lower extremity, the test is positive today at 55 degrees of elevation.

Evaluation today further reveals that piriformis syndrome exists today in a classic presentation on the left and on the bilateral sides. With myofascial splinting of the bilateral external hip rotators; piriformis and gemelli evinced with passive stretching and deeper percussion of these muscle bellies. Resistance testing and passive stretching cause global pain and rampant spasm in this posterior gluteal region, radiating to trochanters. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL).

Passive stretching of the paralumbar and erector spinae soft tissues, with deeper palpation reveals moderate pain and lessening of the muscular splinting, especially right-sided quadratus and aponeurosis. I am also able to demonstrate today the presence of continued moderate myofascial pain in the left paralumbar and gluteal musculature.

Assessment: Functional capacity is improved with continued easing of injury condition and improvement in quality of life for Jonathan with respect to his resolving, partially healed injuries and joint damage suffered in the traumatic road traffic accident of October 21, 2003.

Plan: Mr. receives the following treatment. I continue to prescribe and use with each treatment the use of passive healing modalities of hydrocollator and or ultrasound with EMS over the edematous soft tissue and adjacent muscular spasms. I then add prolonged massage and trigger point therapy. Manual distraction of the lumbar spine and pelvis are conducted today to ease paralumbar joint and soft tissue splinting. No lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction manipulation are performed due to the grade 3 sciatica.

Mr. will continue conservative care on a reduced frequency. Recall is for three office visits per week for the next 2-3 weeks and to be reducing after that as symptoms ease and disability diminishes.

11-26-2003 - office note continued

I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage.
I mobilize the injured glenohumeral joint and perform gentle distraction of the acromio-clavicular joint. Also care today includes mobilization of the scapulothoracic articulation on the injured side.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role he has with caring for the cervical spine injury.

LONG TERM GOALS-to educate Jonathan and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. Home rehabilitation regimens of stretching reps first followed by strengthening exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured cervical vertebrae and thoracic spine and paradorsal musculature.

Jonathan will continue conservative care on a reduced frequency.

12-1-2003 – Subjective Symptoms: Jonathan tells me that early morning pain is alleviated with recumbency and home stretching exercises. The lower back pain is no longer sharp; the dull discomfort continues to be constant however. Fatigue is noted by midday, intense pain returns with exertion. Reporting also is done today that the William's flexion exercises continue to afford relief to the injured lumbar spine. The resistance McKenzie exercise evokes pain and are therefore discontinued.

Objective Findings of Evaluation: Sciatic scoliosis is not present today as arises from a seated and reclined position Minor's sign is not present; antalgia is gone with Mr. able to stand erect with the torso over the pelvis. Attempts at lumbar movements are improved, testing with the aid of a goniometer, with 40 degrees of flexion and 20 degrees of side to side lateral bending. Extension checks at 20 degrees with splinting. With testing today, there is a positive response to lumbosacral damage with Adam's test and Goldthwait's testing. Continued positive response is elicited today with the performing of the Kemp's tests on the bilateral and on the left. Testing does reveal a moderate response bilaterally now as compared to earlier dramatic responses. The testing of Iliac Compression testing and the supine Gaenslen's manuvers are classically positive bilaterally for testing of the lumbar spine today.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN

DL: OCTOBER 21, 2003

11-26-2003 – Subjective Symptoms: Jon has moderate improvement with respect to his right shoulder injuries from the road traffic incident of 21st October 2003. he notes that his lower back pain, although moderately improved overall, will on occasion still have disabling episodes.

Objective Findings of Evaluation: Right gleno-humeral joint pain is reproduced with passive stretching of the long axis of the humerus, with circumduction and rotation. There are regions of myofascial splinting with passive attempts to adduct, retract the homolateral scapulothoracic articulation. Today the evaluation of the right shoulder does reveal pain to passive stretching of the anterior soft tissues arising from the coracoid process, namely the proximal biceps brachii, coracobrachialis and the distal pectoralis minor.

Compression testing of the cervical spine reveals a continued positive, yet moderate, response to this maneuver on the right side. Reproduction of this individual's localized pain along trapezius, paracervical, and splenius and levator scapula is accomplished. Compression testing is negative on the left. Depression testing of the right cervical thoracic junction and musculature is positive for reproducing pain from the paracervical soft tissues through the trapezei into the scalene complex, the levator scapulae with causalgia into the rhomboideus. Moderate now is the response to testing of the left shoulder depression testing. Similar response is noted with the cervical spine compression testing of the homolateral side. Rotator cuff testing is significant with shoulder joint complaints as cuff involvement is common pathology, especially with the potential for tearing. The drop arm testing is positive on the right upper extremity for rotator cuff involvement. Similarly positive is the forearm drop testing as well on the involved side.

Right rotation and left lateral bending continues to cause, at 35 degrees, myofascial pain along the right paracervical, splenius capitis, levator scapulae and scalenes. Flexion continues to flunk at 35 degrees and extension is 30. On motor examination there is no drift, no tremor, no flap, There is normal ambulating gait, has normal tandem walk and a negative Romberg today, there are downgoing toes. Cerebellar function is within normal limits in the bilateral upper extremity and the bilateral lower extremity. Reproduction of the posterior scalp headache pain with percussion of the greater occipital nerve with radiations to the vertex of the skull is extant with passive stretching of the short recti at the posterior scalp.

Assessment: There is some improvement in the functional capacity is present with increasing ranges of movement and diminishing symptom complex. Clinically there is a slight diminution in signs and symptoms; active care continues to be reasonable and necessary.

Plan: Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940; as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature.

11-18-2003 - office note continued

Plan: Mr. receives as active care for the personal injury the treatment that is described as follows. Passive modalities of ultrasonic therapy are used to further muscular healing by easing inflammatory damage. Passive treatment of EMS is used today to control spasm and ease painful muscular splinting. Passive massaging and deeper trigger point work are used for healing of deeper tissues. I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis.

A home exercising program is prescribed to begin with flexibility repetitions first and then graduated to resistance exercises. I suggest that for improved stamina that also aerobic, low impact work be done to tolerance.

LONG TERM GOALS-to further aid in optimal healing of the painful injuries and instruct in the proper postural mechanics.

SHORT TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Ranges of motion exercises for the lumbosacral structure are taught today. Home care is emphasized as a vital role in active care of the injured spinal lumbar structure. William's exercises are to be done at first to tolerance. The use of moist heat about the painful injury further optimizes healing, improves joint ranges of motion and diminishes disability.

I now prescribe a more comprehensive home exercise regimen for him, with more of the stretching repetitions and a beginning of resistance exercising. These will aide in more optimal healing of the injured soft tissues with improved strength.

11-24-2003 – Subjective Symptoms: Jonathan tells me that early morning pain is alleviated with recumbency and home stretching exercises. The lower back pain is no longer sharp; the dull discomfort continues to be constant however. Fatigue is noted by midday, intense pain returns with exertion. Reporting also is done today that the William's flexion exercises continue to afford relief to the injured lumbar spine. The resistance McKenzie exercise evokes pain and are therefore discontinued.

Objective Findings of Evaluation: Sciatic scoliosis is not present today as arises from a seated and reclined position Minor's sign is not present; antalgia is gone with Mr. able to stand erect with the torso over the pelvis. Attempts at lumbar movements are improved, testing with the aid of a goniometer, with 40 degrees of flexion and 20 degrees of side to side lateral bending. Extension checks at 20 degrees with splinting. With testing today, there is a positive response to lumbosacral damage with Adam's test and Goldthwait's testing. Continued positive response is elicited today with the performing of the Kemp's tests on the bilateral and on the left. Testing does reveal a moderate response bilaterally now as compared to earlier dramatic responses. The testing of Iliac Compression testing and the supine Gaensien's manuvers are classically positive bilaterally for testing of the lumbar spine today.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-24-2003 - office note continued

Continued positive bilaterally, on the bilateral and left sides, examination today remains a positive SLR testing on the right, for re-producing bilateral lower back pain and no radiations. This test is positive at 45 degrees of elevation, checking due to hamstring limitations on that side. Straight-leg rising testing is performed on the left leg today. There is a moderately positive response for reproducing local lumbar pain without radiating pain into the left lower extremity, the test is positive today at 55 degrees of elevation. Evaluation today further reveals that piriformis syndrome exists today in a classic presentation on the left and on the bilateral sides. With myofascial splinting of the bilateral external hip rotators; piriformis and gemelli evinced with passive stretching and deeper percussion of these muscle bellies. Resistance testing and passive stretching cause global pain and rampant spasm in this posterior gluteal region, radiating to trochanters. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL).

Passive stretching of the paralumbar and erector spinae soft tissues, with deeper palpation reveals moderate pain and lessening of the muscular splinting, especially right-sided quadratus and aponeurosis. I am also able to demonstrate today the presence of continued moderate myofascial pain in the left paralumbar and gluteal musculature.

Assessment: Functional capacity is improved with continued easing of injury condition and improvement in quality of life for Jonathan with respect to his motor vehicular accident traumatic injuries suffered on October 21, 2003.

Plan: Mr. receives the following treatment. I continue to prescribe and use with each treatment the use of passive healing modalities of hydrocollator and or ultrasound with EMS over the edematous soft tissue and adjacent muscular spasms. I then add prolonged massage and trigger point therapy. Manual distraction of the lumbar spine and pelvis are conducted today to ease paralumbar joint and soft tissue splinting. No lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction manipulation are performed due to the grade 3 sciatica.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role he has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN.
DL: OCTOBER 21, 2003

11-13-2003 – Subjective Symptoms: Jonathan describes that there is a deep causalgia in his right scapulo-thoracic articulation with radiating pains into the right shoulder dome. I obtain anterior-posterior views of the thoracic spine in this erect position.

Objective Findings of Evaluation: the tested active attempts at cervical spine ROM's are gravely limited with less than 10 degrees of backward extension, right rotation and lateral bending to the right and to the left. The cervical spine compression tests are positive for eliciting pain and re-producing the complaints of right sided neck pain with radiations to the vertebral border of the ipsilateral scapula. There is a reproduction of the posterior scalp headache pain with percussion of the greater occipital nerve with radiations to the vertex of the skull. There is pain produced with percussion of the auricular temporal nerve with radiations extending to the temporal and parietal regions. The complaints of Jennifer's posterior scalp headaches are re-produced with the passive stretching of the short recti of the suboccipital complex. There is pain upon the slightest movement of the scapulothoracic articulation on the right. Complaints of pain are elicited when I percuss the spinous processes of the vertebrae of C2-T4.

Cervical spine distraction testing is positive for alleviating the neck pains. Coughing and sneezing increase the complaints of neck and upper scapular pains. The drop arm testing is positive on the right upper extremity for rotator cuff. There is weakness to testing the rotator cuff musculature of the right glenohumeral joint and ipsilateral scapulothoracic articulation, this weakness tests to 4+/5 (5 of 5 is maximal normal strength). Right gleno-humeral joint movements, diminished are flexion to 50 degrees with pain extending from the anterior acromio-clavicular joint to the anterior joint and deltoid musculature. Extension is painful to 45 degrees and abduction checks at 60. Impingement testing of the right gleno-humeral joint is positive on the right side with pain at the coracoid process extending to the acromio-clavicular joint. The causalgia radiates to the anterior deltoid and proximal biceps brachii.

*Drop arm and forearm drop testing manuvers are both positive on the right shoulder. There is a brake away weakness to testing the injured right gleno-humeral joint. * Weakness is noted to testing of the right-sided rotator cuff and there is pinpoint pain at the distal supraspinatus tendon as it emerges from the subacromial space.*

Assessment: Cervical spine injury exists with musculoligamentous damage to the zygapophyseal joints and the paraspinal musculature. Dorsal spine musculoskeletal injury exists. Jon has a partially healing injury condition from the damage suffered in this motor vehicular incident of October 21, 2003.

Plan: he is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940; as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature.

11-13-2003 - office note continued

Jonathan expresses relief with the following care regimen. Still under active care, not maintenance care, he enjoys heating modalities of pulsed ultrasound, effleurage and petrissage. These physiotherapeutic measures support optimal healing along with mobilization of the injured spinal facet joints and mobilization of appendicular joints.

SHORT TERM GOALS-to ease the immediate pain and improve the daily functional capacity.

LONG TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured neck. I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage.

I prescribe home rehabilitation regimen of stretching reps first followed by strengthening exercises.

Resistance home exercises are augmented by strengthening repetitions. The home rehabilitation regimen is stressed as the key for optimal healing of these traumatic injuries.

11-18-2003 – Subjective Symptoms: Jonathan requires assistance with arising from a chair, walking across a room. Simple tasks of putting on a coat or donning a pair of shoes are difficult due to severe, acutely painful lower spinal symptoms. he cannot deep breath or cough without increasing agony of spasms in the paralumbar soft tissues of iliocostalis, quadratus and longissimus thoracics with erector spinae lumborum. He assumes the protective posture of sciatic scoliosis with radiations to the buttock and hip on the injured side. There exists an unleveling of the pelvis and a lateral flexion deformity of the spine due to severe pain and muscular splinting.

Assessment: Diagnoses include that there is a musculoskeletal injury to the lumbar spine, the adjacent paraspinal lumbar muscles and the dorsolumbar aponeurosis. This is coupled with sacroiliac joint involvement.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-11-2003-Subjective Symptoms: Jonathan illustrates an improved range of motion with slow pendulum swings of the injured arm and rotations of the damaged shoulder. Sudden movements are still out of the question; however, gentle and slow movement is possible. He paints the picture that deep pain is gone. Crepitation is still present with any motions beyond 25 degrees of extension, abduction with rotation. Although limited movements are possible, the injured shoulder remains adhesive. He states to me directly to me as we consult on his injury status today that he relates that the treatment has afforded steady and satisfying relief from lumbar injury. The home rehabilitation exercises are also affording much additional relief. Sleep is now improved each and every night with no interruption due to lumbar symptoms. Jonathan notes that chill and dampness are less aggravating to the continued intermittent lumbar discomfort. There are still symptoms of pain with exposure to prolonged cold or wet.

Objective Findings of Evaluation: Active and passive ratings of the lumbar vertebrae ranges of motions have slightly improved with the testing scores today at 40 degrees of flexion and 20 degrees of right lateral bending. Left lateral bending is still limited to 25 degrees. Extension checks at 25 degrees with splinting. With testing today, there is a positive response to lumbosacral damage with Adam's test and Goldthwait's testing. Continued positive response is elicited today with the performing of the Kemp's tests on the right and on the left. Testing does reveal a moderate response bilaterally now as compared to earlier dramatic responses.

Evaluation today shows lumbar signs and symptoms are positive on both sides with Gaenslen's testing and Iliac Compression tests. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL). There remains a positive response to SLR testing on the right, for re-producing right lower back pain and no radiations. This test is positive at 45 degrees of elevation, checking due to hamstring limitation on that side. Straight-leg raising testing is performed on the left leg today. There is a moderately positive response for reproducing local lumbar pain without radiating pain into the left lower extremity, the test is positive today at 55 degrees of elevation.

Hip testing on the right and on the left are as follows Ely and Patrick Fabere testing are negative on the right and left. Passive stretching of the paralumbar and erector spinae soft tissues, with deeper palpation reveals moderate pain and lessening of the muscular splinting, especially right-sided quadratus and aponeurosis. I am also able to demonstrate today the presence of continued moderate myofascial pain in the left paralumbar and gluteal musculature.

With testing Mr. his left glenohumeral joint ranges of motion are increasing with forward flexion to 75 degrees and abduction to 65 degrees, backward extension checks with 45 degrees, these ranges of motion are tested with the aid of a goniometer, reveals the persistently limited movements of the damaged left ball and socket joint. Evaluation of the left injured glenohumeral joint reveals a positive response with the impingement sign being present. Still inflamed, although now to a moderate degree are the anterior shoulder soft tissues and an easing of pain to percussion. Drop arm testing and forearm drop testing is positive when testing the left shoulder. This rotator cuff is still demonstrating actual or reflexive weakness of 4/5 to strength testing. Exquisite complaints of pain are elicited with all motions of the left sided scapula and the associated paradorsal, subscapularis and rhomboid major and minor musculature. No winging is evident to testing today.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-6-2003-Subjective Symptoms: Mr tells me that early morning pain is alleviated with recumbency and home stretching exercises. The lower back pain is no longer sharp; the dull discomfort continues to be constant however. Fatigue is noted by midday, intense pain returns with exertion. Reporting also is done today that the William's flexion exercises continue to afford relief to the injured lumbar spine. The resistance McKenzie exercise evokes pain and are therefore discontinued.

Jonathan demonstrates improvement with respect to his left shoulder ranges of motion. He cannot perform any over-reaching movements, no motions of above chest level work, no sudden rotating of the injured shoulder and scapula joints.

Objective Findings of Evaluation: Today the evaluation of left scapulothoracic articulation and glenohumeral joint does reveal diminishing stiffness and discomfort to passive stretching of the anterior soft tissues of arising from the coracoid process, namely the proximal biceps brachii and coracobrachialis and the distal pectoralis minor. There is a positive impingement sign when testing the left glenohumeral joint.

With testing Mr. , ranges of motion of the glenohumeral joint and scapulothoracic articulation are increasing on the left sided joint. Moderately restricted to 70 degrees is extension, 60 degrees of abduction with external rotation. Flexion is possible to 75 degrees before continued moderate anterior glenohumeral and posterior scapular pains check motion. The drop arm testing continues to be positive on the left upper extremity for rotator cuff.

Rotator cuff testing is positive on a continued basis, this being significant with shoulder joint complaints as cuff involvement is common pathology, especially with the potential for tearing. The drop arm testing is positive on the left upper extremity for rotator cuff involvement. Similarly positive is the forearm drop testing as well on the involved side.

Dawburn's testing is now negative response to testing on the left. Yegason's test is negative on the left; however, the maneuver on the left continues with positive findings and there is pain extant along the bicipital groove with stretching of the long bead of the biceps brachii, distal latissimus, distal pectoralis major and teres major. Apley's scratch testing is not possible due to myofascial splinting is noted with trigger point acupressure of the left glenohumeral joint.

Sciatic scoliosis is not present today as arises from a seated and reclined position Minor's sign is not present; antalgia is gone with Jonathan able to stand erect with the torso over the pelvis.

Attempts at lumbar movements are improved, testing with the aid of a goniometer, with 40 degrees of flexion and 20 degrees of side to side lateral bending. Extension checks at 20 degrees with splinting. With testing today, there is a positive response to lumbosacral damage with Adam's test and Goldthwait's testing. Continued positive response is elicited today with the performing of the Kemp's tests on the bilateral and on the left. Testing does reveal a moderate response bilaterally now as compared to earlier dramatic responses. The testing of Iliac Compression testing and the supine Gaenslen's manuvers are classically positive bilaterally for testing of the lumbar spine today.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-6-2003 - office note continued

Continued positive bilaterally, on the bilateral and left sides, examination today remains a positive SLR testing on the right, for re-producing bilateral lower back pain and no radiations. This test is positive at 45 degrees of elevation, checking due to hamstring limitations on that side. Straight-leg rising testing is performed on the left leg today. There is a moderately positive response for reproducing local lumbar pain without radiating pain into the left lower extremity, the test is positive today at 55 degrees of elevation.

Evaluation today further reveals that piriformis syndrome exists today in a classic presentation on the left and on the bilateral sides. With myofascial splinting of the bilateral external hip rotators; piriformis and gemelli evinced with passive stretching and deeper percussion of these muscle bellies. Resistance testing and passive stretching cause global pain and rampant spasm in this posterior gluteal region, radiating to trochanters. Toe walk and heel walk is within normal limits. The deep tendon reflexes are +2 of 2 (NORMAL).

Passive stretching of the paralumbar and erector spinae soft tissues, with deeper palpation reveals moderate pain and lessening of the muscular splinting, especially right-sided quadratus and aponeurosis. I am also able to demonstrate today the presence of continued moderate myofascial pain in the left paralumbar and gluteal musculature.

Bilateral hip ball and socket ranges of motion are limited today due to pain and contracture. Forward flexion is restricted to only 30 degrees from a neutral position and backward extension is painful with only 20 degrees of motion. External rotation is similarly flunking with a poor grade of only 35 degrees of movement. Adduction is painful at end range along the gracilis and adductor musculature and supporting soft tissues. The lateral movers of tensor fascia lata, proximal the iliotibial band are painful to deeper palpation and passive stretching of this injured region. Circumduction of the injured bilateral hip causes pain through the entire movements.

Assessment: Functional capacity is improved with continued easing of injury condition and improvement in quality of life. Mr. is partially healing injury condition from the damage suffered in this motor vehicular incident, occurring on the 21st of October 2003.

Plan: Jonathan receives the following treatment. I continue to prescribe and use with each treatment the use of passive healing modalities of hydrocollator and or ultrasound with EMS over the edematous soft tissue and adjacent muscular spasms. I then add prolonged massage and trigger point therapy. Manual distraction of the lumbar spine and pelvis are conducted today to ease paralumbar joint and soft tissue splinting. No lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction manipulation are performed due to the grade 3 sciatica.

11-6-2003 - office note continued

Jon is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and paracervical muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease paracervical muscular pain and further open the symptomatic facet joints. No cervical spine manipulation is performed on this date of service.

I mobilize gently the injured glenohumeral joint and scapulothoracic articulation. This is to promote flexibility, circulation, decrease pain and ease potential of adhesive capsulitis.

I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage.

Jonathan will continue conservative care on a reduced frequency. Recall is for three office visits per week for the next 2-3 weeks and to be reducing after that as symptoms ease and disability diminishes.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role Jonathan has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Jonathan and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

11-11-2003 - office note continued

Assessment: Jonathan's injury status is not as grave as earlier. His healing has been initiated with home care, resting to tolerance and active care. He has resolving, partially healed injuries and joint damage suffered in the traumatic road traffic accident of October 21, 2003.

Plan: Mr. is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940; as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature.

Mr. asks for and receives the long modalities for soft tissue healing of the erector spinae lumborum, bilateral quadratus, longissimus thoracis, dorsolumbar aponeurosis and the iliocostalis. Today's treatment includes the sedating nature of the chiropractic care. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Mobilization is also rendered to the pelvis and bilateral sacroiliac joint. I mobilize gently the injured glenohumeral joint and scapulothoracic articulation. This is to promote flexibility, circulation, decrease pain and ease potential of adhesive capsulitis.

Healing thermal and mechanical qualities of ultrasound with E.M.S. are performed over the region of injured paraspinal lumbar muscles and the dorsolumbar aponeuosis and posterior gluteal and lateral trochanteric regions. Massaging and mobilization techniques are used over the axial and appendicular injuries To further promote joint flexibility, to further promote healing, I utilize shoulder mobilization and upper dorsal spine manipulation with scapular adjusting. Trigger point treatment is used over the posterior rib and scapular musculature. Then passive traction of the thoracic vertebrae is performed. Then care is followed up with a drop thoracic spinal maneuver to correct the subluxation complex. No cervical spine manipulation is performed on this date of service.

McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure. Exercises and home care as well are prescribed. First stretching attempts are performed twice daily for improved flexibility. Then resistance repetitions are encouraged for optimal strengthening of this injury.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role Jonathan has with caring for the lumbar spine injury.

LONG TERM GOALS-to educate Jonathan and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. McKensie hyperextension exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured lumbopelvic structure.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-3-2003 - office note continued

LONG TERM GOALS-to educate Mr. and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured spine and improve posture. Home rehabilitation regimens of stretching reps first followed by strengthening exercises are to be started easily and cautiously. These exercises are to be performed at home to tolerance, for optimal healing of the injured cervical vertebrae and thoracic spine and paradorsal musculature.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN I
DL: OCTOBER 21, 2003

11-3-2003 - Subjective Symptoms: Jonathan tells me today that the posterior scalp headaches have eased in both intensity and frequency. Early morning time is more comfortable now; by noon each day the symptoms worsen and there is a resumption of the wryneck. She illustrates an improved range of motion with slow pendulum swings of the injured arm and rotations of the damaged shoulder. Sudden movements are still out of the question; however, gentle and slow movement is possible.

Mr. and I have a detailed consultation and evaluation this morning. Jon has difficulty and resultant disability with climbing upstairs and downstairs, going up an incline as well, prolonged sitting and protracted standing, any exertional tasks. Jonathan continues to be limited from bending at the waist, twisting of the torso and lifting, especially from the ground. With any exertion or awkward positioning, his lower back pain flares easily and then there is grade 2 sciatica with referred pain along the posterior lateral thigh.

Objective Findings of Evaluation: Mr. presents with a symmetrical face, eye movements are symmetric, and 6 positions of gaze are normal. The pupils are equal and reactive to light and accommodation. Cranial nerve testing 3-12 is normal (taste is not tested). Four limb strength testing is grade 5/5, normal maximal response, except for the right shoulder weakness of 4/5 to rotator cuff testing.

Range of motion testing with the aid of a goniometer, reveals the persistently limited movements of the damaged left ball and socket joint. Drop arm testing and forearm drop testing is positive when testing the left shoulder. This rotator cuff is still demonstrating actual or reflexive weakness of 4/5 to strength testing. Evaluation of the left injured glenohumeral joint reveals a positive response with the impingement sign being present. Still inflamed, although now to a moderate degree are the anterior shoulder soft tissues and an easing of pain to percussion.

On motor examination there is no drift, no tremor, no flap, There is normal ambulating gait, there is a normal tandem walk and a negative Romberg today, there are downgoing toes. Cerebellar function is within normal limits in the bilateral upper extremity and the bilateral lower extremity. There is a reproduction of the posterior scalp headache pain with percussion of the greater occipital nerve with radiations to the vertex of the skull. There is pain produced with percussion of the auricular temporal nerve with radiations extending to the temporal and parietal regions. The complaints of posterior scalp headaches are re-produced with the passive stretching of the short recti of the suboccipital complex.

Maximums of protraction and retraction are accomplished with the left scapula, pains into the levator scapula, rhomboid major and minor, subscapularis and proximal latissimus are elicited. Evaluation of the left sided cervical complaints reveals a painfully positive response to compression testing of neck on the right. Diminishing pains and improving flexibility is noted in the soft tissues of left suboccipital along the paraspinal cervical into the superior and middle fibers of trapezius and rhomboids. Shoulder depression testing of the left side continue to evoke a positive response, now to a moderate degree with myofascial splinting of the trapezius, scalenes, splenius are noted.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

11-3-2003 - office note continued

Improved are the active attempts at lumbar ranges of motion are moderate improved with forward flexion to 50 degrees and backward extension to 25 degrees with pain at the end range. Left rotation and left lateral bending is restricted due to myofascial splinting of erector spinae lumborum, bilateral quadratus, longissimus thoracis, dorsolumbar aponeurosis and the iliocostalis.

I note with examination today that there is a positive response to the Adam's forward bending test at the beginnings of flexion of the torso, there noted also a positive response to Goldthwait's testing that reproduces the complaints of low back pain at the motion of lumbosacral joint. The manuvers of Kemp's testing is moderately positive on left sides of this lumbar spine in both the seated and standing postures. This testing is positive for reproducing the localized lumbar symptoms without radiations to the lower extremities. The testing of Iliac Compression testing and the supine Gaenslen's manuvers are classically positive on the left for testing of the lumbar spine today.

No reported complaints of bowel or bladder dysfunction. Peripheral pulses are within normal limits.

Assessment: Jonathan 's progress is continuing and his injury status is not as poor.

Plan: Mr. is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, As these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral paraspinal cervical muscles injury. No cervical spine manipulation is performed on this date of service.

Jonathan continues with the following thorough program of chiropractic therapy. Part of the treatment protocol of this office is to aid in edema correction and muscular spasms with passive modalities of ultrasonic and EM. My certified therapists then perform a prolonged session of myofascial release and lymphatic drainage. Chiropractic manipulation is performed gently over the lumbar misalignments; thoracic subluxations are corrected with mobilization. No cervical spine manipulation is performed today.

I now prescribe a more comprehensive home exercise regimen for Jonathan, more of the stretching repetitions and a beginning of resistance exercising. These will aide in more optimal healing of the injured soft tissues with improved strength.

SHORT TERM GOALS-to further prescribe the home rehabilitation regimen of stretching reps first followed by strengthening exercises, this will further optimal healing time and increase the active role Jonathan has with caring for the cervical spine injury.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

10-30-2003 - Subjective Symptoms: Mr. requires assistance with arising from a chair, walking across a room. Simple tasks of putting on a coat or donning a pair of shoes are difficult due to severe, acutely painful lower spinal symptoms. Jonathan cannot deep breath or cough without increasing agony of spasms in the paralumbar soft tissues of iliocostalis, quadratus and longissimus thoracics with erector spinae lumborum. He assumes the protective posture of sciatic scoliosis with radiations to the buttock and hip on the injured side. There exists an unleveling of the pelvis and a lateral flexion deformity of the spine due to severe pain and muscular splinting.

Assessment: Diagnoses include that there is a musculoskeletal injury to the lumbar spine, the adjacent paraspinal lumbar muscles and the dorsolumbar aponeurosis. This is coupled with sacroiliac joint involvement.

Plan: Jonathan receives as active care for the personal injury the treatment that is described as follows. Passive modalities of ultrasonic therapy are used to further muscular healing by easing inflammatory damage. Passive treatment of EMS is used today to control spasm and ease painful muscular splinting. Passive massaging and deeper trigger point work are used for healing of deeper tissues. I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis.

A home exercising program is prescribed to begin with flexibility repetitions first and then graduated to resistance exercises. I suggest that for improved stamina that also aerobic, low impact work be done to tolerance.

LONG TERM GOALS-to further aid in optimal healing of the painful injuries and instruct in the proper postural mechanics.

SHORT TERM GOALS-to educate Jonathan and demonstrate proper postural mechanics. Ranges of motion exercises for the lumbosacral structure are taught today. Home care is emphasized as a vital role in active care of the injured spinal lumbar structure. William's exercises are to be done at first to tolerance. The use of moist heat about the painful injury further optimizes healing, improves joint ranges of motion and diminishes disability.

I now prescribe a more comprehensive home exercise regimen for Jonathan, more of the stretching repetitions and a beginning of resistance exercising. These will aide in more optimal healing of the injured soft tissues with improved strength.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

10-29-2003 - Subjective Symptoms: Mr. relates to me during the active care session today that the injury discomfort is less at night, sleep is therefore minimally improved. Increasing flexibility is noted with more stretching exercises. The strengthening exercises do elicit sharp pain, these resistance exercises are stopped. Also reported is that stretching exercises do ease the pain in the early morning, however, the cervical spine pain continues to easily worsen by midmorning and remains constant for the day. Jonathan's left shoulder is slightly improved with home rehabilitation regimen of stretching reps and chiropractic care. He illustrates that with respect to the severity of lower back pain, it is such that all torso movement is greatly restricted, all motions of the trunk are labored and slow. He narrates that the spasms are present with distressful intense waves of pain. The motions most afflicted are attempts at backward extension of the cervical spine and lateral bending of the head. Scapular protraction causes increased suffering with causalgia. He cannot simply sit for a few minutes or stand for a short time. Intense central lumbar distress radiates into the posterior gluteal region creating a lateral list of this torso, this splinted antalgic posture reflecting paralumbar spasm.

Objective Findings of Evaluation: Antalgia is present and Minor's sign is present when attempting to arise from a seated or reclined position. This sciatic scoliosis is due to the twisted torso deformity, there are rampant spasms in the paralumbar soft tissues, especially along the erector spinae, quadratus, and iliocostalis and longissimus thoracis, on the left.

Evaluation today reveals a diminished active ROM of the lumbopelvic structure with forward flexion flunking at only 40 degrees, backward extension also is limited considerably at only 15 degrees. Rotation side to side checks at a dismal 20 degrees, while lateral bending is poor on the right at only 15 degrees. Adam's forward bending testing is positive at 40 degrees for lumbo-sacral involvement. Goldtwait's is positive at movement of the lumbosacral joint. Kemp's testing is positive on the right and on the left, in both the seated and reclined positions, for reproducing the lumbar distress in the center lower back.

SLR testing reproduces the left-localized LBP at 40 degrees of elevation with radiation, and SLR is positive on the right at 50 degrees limited by paralumbar contraction and antalgia, with radiations to the posterior gluteal and lateral trochanteric regions. Toe and Heel walk is within normal limits. Deep tendon reflexes are +2 bilaterally without clonus. There are no complaints of bowel or bladder complaints. Peripheral pulses are adequate with testing the bilateral lower extremities. Myofascial splinting is evident to the lightest of passive stretching and deeper palpation the paralumbar soft tissues, especially along the erector spinae, quadratus, iliocostalis and longissimus thoracis on the left extending to the posterior gluteal and lateral trochanteric regions.

Assessment: Signs and symptoms reveal a diagnosis for today's complaints to include acute lumbar spasms with lumbosacral and sacroiliac injury. Antalgia with sciatic scoliosis, there is clinical concern for neuralgia. There is clinical concern for injury to the glenohumeral joint and adjacent scapulothoracic articulation.

Plan: Bracing of the lumbar spine with a durable brace, this will aid in optimal healing when used to tolerance. Home exercises are stressed as well as proper ADL's being hammered home.

10-29-2003 - office note continued

Jon is not able to tolerate thoracic spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No thoracic spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the parathoracic and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and parathoracic muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease parathoracic muscular pain and further open the symptomatic facet joints. No thoracic spine manipulation is performed on this date of service.

Active, aggressive treatment schedule is reasonable and necessary now to ease this painful distress. Ultrasound is prescribed and used over the paralumbar soft tissues, especially along the erector spinae, quadratus, and iliocostalis and longissimus thoracis. This is used in both the pulsed and continuous modes to ease pain and promote flexibility with the thermal nature of this modality and the micromassage effect of the sonic waves into the soft tissues. EMS is used to ease pain and promote an actual isometric contraction of the injured musculature. Passive, manual flexion distraction is performed on the lumbar structure. Massaging is then utilized over the inflamed and contracted the paralumbar soft tissues, especially along the erector spinae, quadratus, and iliocostalis and longissimus thoracis. First gentle effleuage is used and then a deeper myofascial release to tolerance. Ice is for home use for the acute phase. No lumbosacral vertebrae and supporting musculature, especially at the lumbosacral junction manipulation are performed due to the grade 3 sciatica.

Recall is for tomorrow to ease the crisis of pain and disability, this injury is effectively incapacitating from all functions of the usual work, duties and daily activities.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN
DL: OCTOBER 21, 2003

10-27-2003 - Subjective Symptoms: Mr. . says that sitting for even 30 minutes and standing, even for 20 minutes, causes an immediate aggravation and flaring of paracervical spasm. Jonathan tells me today that gradual decrease in pain has allowed slow improvement in ranges of motion. Stabbing pains still rip through the injured shoulder with any movements beyond 40 degrees in any direction. He reiterates that worst pain is that in the center lumbar spine, of a sharp nature. The slightest of exertion, indeed deep breathing, causes waves of crippling spasms. He explains that limited functional capacity is present for all aspects of daily work, duties and activities.

Objective Findings of Evaluation: Left gleno-humeral joint pain is reproduced with passive stretching of the long axis of the humerus, with circumduction and rotation. There are regions of myofascial splinting with passive attempts to adduct, retract the homolateral scapulothoracic articulation. Today the evaluation of the left shoulder does reveal pain to passive stretching of the anterior soft tissues arising from the coracoid process, namely the proximal biceps brachii, coracobrachialis and the distal pectoralis minor.

Compression testing of the cervical spine reveals a continued positive, yet moderate, response to this maneuver on the left side. Reproduction of Mr. localized pain along trapezius, paracervical, and splenius and levator scapula is accomplished. Depression testing of the left cervical thoracic junction and musculature is positive for reproducing pain from the paracervical soft tissues through the trapezei into the scalene complex, the levator scapulae with causalgia into the rhomboideus. Moderate now is the response to testing of the left shoulder depression testing. Similar response is noted with the cervical spine compression testing of the homolateral side. Rotator cuff testing is significant with shoulder joint complaints as cuff involvement is common pathology, especially with the potential for tearing. The drop arm testing is positive on the right upper extremity for rotator cuff involvement. Similarly positive is the forearm drop testing as well on the involved side.

Right rotation and left lateral bending continues to cause, at 35 degrees, myofascial pain along the right paracervical, splenius capitis, levator scapulae and scalenes. Flexion continues to flunk at 35 degrees and extension is 30. On motor examination there is no drift, no tremor, no flap, There is normal ambulating gait, has normal tandem walk and a negative Romberg today, there are downgoing toes. Cerebellar function is within normal limits in the bilateral upper extremity and the bilateral lower extremity. Reproduction of the posterior scalp headache pain with percussion of the greater occipital nerve with radiations to the vertex of the skull is extant with passive stretching of the short recti at the posterior scalp. Active ranges of motion of the lumbar spine and sacral regions have improved with respect to the initial findings. Lumbar movements continue; however, to be limited with flexion checking at 30 degrees and extension restricted at 20 degrees. Duo testing with a positive response to testing for lumbosacral damage, there is a positive Adam's forward bending test at 40 degrees of flexion and a positive Goldthwait's maneuver. Jonathan notes that the intense lower back pain is reproduced and Kemp's testing is positive on the right for complaints of pain on that side of the lumbar spine. This positive response to testing is noted with Jonathan in the seated and in the standing positions. Kemp's testing is positive when testing the left side as well, with assuming both a seated posture and positive with Jonathan in a standing position.

10-27-2003 - office note continued

Gaenslen's testing elicits a positive response bilaterally to movement of the right sacroiliac joint and the left counterpart. Right Straight-leg raising, SLR, continues to be painful to accomplish, to a moderate degree only now, with the right lumbar spine stiffness and discomfort evoked at 55 degrees of elevation with radiations to the posterior gluteal and lateral trochanteric regions of right lower extremity, this maneuver being limited by hamstring complex of musculature, the longitudinal fibers of semitendonosis, the barrel belly of semimembranosus, the biceps femoris, on the ipsilateral side Left Straight-leg raising, SLR, continues to be painful to accomplish, to a moderate degree only now, with the left-sided lumbar spine stiffness and discomfort evoked at 55 degrees of elevation with radiations to the posterior gluteal and lateral trochanteric regions of the left.

Contraction and exquisite pain are extant along the bellies of the piriformis and external hip rotators on both sides. Passive stretching and attempts at resisted external hip rotation are painfully limited.

Assessment: Jonathan has suffered personal injury as a causally related to the trauma suffered in the accidental incident of October 21, 2003. Diagnoses for this fellow's injury status include the following. There is clinical concern for injury to the glenohumeral joint and adjacent scapulothoracic articulation. Diagnoses include that there is a musculoskeletal injury to the lumbar spine, the adjacent paraspinal lumbar muscles and the dorsolumbar aponeurosis. This is coupled with sacroiliac joint involvement.

Plan: Mr. is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940; as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature.

Jon receives the following chiropractic and physiotherapy care during today's office visit. Ultrasound is used in both the pulsed and continuous mode, over the area of injury to facilitate healing with thermal and mechanical changes to the inflamed and symptomatic soft tissues. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Trigger point therapy and deep myofascial release are used for the therapeutic effect of improved muscular flexibility. I also correct with spinal manipulation the subluxation complex of left posterior rotation of the L4 and the L5 vertebral bodies with a left anterior pelvis.

I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage. I mobilize gently the injured glenohumeral joint and scapulothoracic articulation. This is to promote flexibility, circulation, decrease pain and ease potential of adhesive capsulitis.

10-27-2003 - office note continued

I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage.

LONG TERM GOALS-to ease the immediate pain and improve the daily functional capacity.

SHORT TERM GOALS-to educate Jonathan and demonstrate proper postural mechanics. Gentle range of motion exercises are prescribed with attention to graduated repetitions. Upper spinal repetitions are also demonstrated to improve the spinal posture and enrich the home care regimen for the injured neck. I prescribe the pendulum exercises, with emphasis on scapular retraction, corner presses and backward shrugging exercising. I prescribe range of motion stretching exercises for the cervical spine to include chin tucks, flexion repetitions and gentle turns with lateral bends. I prescribe exercises for the shoulder girdle, scapula region and upper dorsal musculature. I emphasize shoulder shrugging, scapula retractions, corner presses and cat/camel repetitions. I further instruct in proper posture, to prevent forward carriage.

I prescribe home rehabilitation regimen of stretching reps first followed by strengthening exercises.

Recall is for three-office visits per week.

Office Notes

Patient:

Dr. Mager

RE: JONATHAN

DL: OCTOBER 21, 2003

10-24-2003 - Please refer to the initial intake narrative for SOAP notes and examination findings and treatment plans for today. His pertinent records are requested, with a signed consent.

Jonathan is not able to tolerate cervical spine manipulation, therefore only massaging and deep myofascial releases are performed to the neck. A spinal manipulation is performed on the thoracic and lumbar vertebrae. CPT-4 allows payment on 97140 and 98940, as these two procedures are done to distinctly separate spinal regions. No cervical spine manipulation is performed on this date of service. Ultrasound is used in the continuous and pulsed mode to ease edema and reduce pain and spasm in the paracervical and trapezei musculature. The therapeutic appointment for today's care involves a prolonged session of deep myofascial release for the bilateral superior fibers of the trapezei and paracervical muscles with trigger point treatment on the suboccipital and sternocleidomastoid, levator scapula soft tissues. I perform manual traction of the neck to ease paracervical muscular pain and further open the symptomatic facet joints. No cervical spine manipulation is performed on this date of service.

Mr. receives the following chiropractic and physiotherapy care during today's office visit. Ultrasound is used in both the pulsed and continuous mode, over the area of injury to facilitate healing with thermal and mechanical changes to the inflamed and symptomatic soft tissues. Electric muscle stimulation is used to decrease spasm and promote healing over painful muscle tissue. Trigger point therapy and deep myofascial release are used for the therapeutic effect of improved muscular flexibility.

Recall is for four-office visits per week, to quiet the desperately painful signs and symptoms.