Brief Summary/Flow of Events

02/29/YYYY- Motor vehicle concussion

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A1 Center

02/29/YYYY-Patient complains of neck pain and taken to emergency department**.** CT head was normal and X-ray of spine-cervical showed slight straightening of the cervical lordosis and no fracture. On 03/01/YYYY, patient went to emergency department due to MVA/neck pain, upper back pain, headache and right shoulder pain. Due to persistence of these problems patient had multiple follow-ups. *Police report is not available*

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03/27/YYYY**- A2 Ophthalmology Associates**- consultation for left side headache
04/03/YYYY- **A3 Orthopedic surgery** - consultation for neck and lower back pain after MVA
04/05/YYYY- **A4 Neurology** – consultation for neurological symptoms and diagnosed with Post concussive syndrome
04/12/YYYY- **A5 Center** - consultation for neck pain, Right greater than left shoulder pain, Low back pain particularly on the right side of her lower back, Right and left knee pain
04/13/YYYY- **Consultation with Dr. xxxx**- Patient has pain in left and right shoulders, right wrist, hand and ankle, right and left knee. She has vision changes, headache, dizziness, decreased concentration, fatigue and decreased sleep. The pain radiates to left and right buttock, right knee, fingers, arms and elbows
04/17/YYYY-04/24/YYYY- **A6 Rehabilitation** –physical therapy
05/23/YYYY-07/18/YYYY- **A7**- physical therapy-no improvement in condition

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A8 Diagnostic Imaging

09/18/YYYY- Arthrogram and MRI of joint space done and showed Acromioclavicular joint degenerative change with impingement and bursitis. Supraspinatus and infraspinatus tendinosis with partial-thickness undersurface tears.
12/17/YYYY-**Consultation- neurophysiology** for persistent symptoms involving headaches, shoulder pain, memory and concentration problems
01/22/YYYY- 04/25/YYYY- **A7** - Physical therapy-no improvement in condition
01/24/YYYY-03/21/YYYY- **A7 -** Acupuncture treatment- no improvement in condition

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A9 Surgical center

04/26/YYYY- Right shoulder arthroscopy done. Patient advised to continue physical therapy. Patient will require left shoulder surgical intervention in the future for a more permanent solution for her left shoulder condition

Patient History

Past Medical History: Hypotensive, Anxiety (53, 2)

Surgical History: Has no history of surgery (2)

Family History: Father-hypertensive, type 2 Diabetes (2)

Social History: The patient works as a right handed receptionist at xxxx office, she is a nonalcoholic, non smoker and no history of drug abuse (230)

Allergy: No known drug allergies (2)

Detailed Chronology

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
02/29/YYYY	A1 Center EMS-BLS	**EMS/Ambulance Report** Crew 1: Drive: Mitchell xxxx Crew 2: Primary caregiver- Retaia xxxx Dispatched as: MVC Moved from: stretcher Position: supine Receiving hospital: A Center, emergency department **Chief Complaint**: MVC/ Neck Pain **Description**: Patient was sitting in the driver seat of vehicle 1. Vehicle 2 hit her at about 35-40 mph. Noticeable mechanism of injury on both motor vehicles. No air bag deployment. Patient was wearing her seat belt. **History** : Patient was the driver of the vehicle that got hit from the driver-side rear. On impact the patient reported to BLS that the car spun and ended going slightly off road up the curb. During the spin she slammed her head against the side of the car(internal B Post of the vehicle). She was complaining of neck pain that radiated to both shoulders and a throbbing sensation to her head (left temple above her ear). **Neurological examination:** No loss of consciousness Mental: normal Glasgow coma scale: EVM-456, Total-15 Pupils: normal Motor and sensory comments: appropriate **Injury Details** **Assessment** Head findings: HEENT unremarkable. Patient complaining of throbbing pain from impact. Neck findings: Unremarkable stiff and throbbing sensation that radiated to shoulders Chest findings: Chest wall intact, symmetrical expansion	53-55

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Abdominal appearance: Normal
Abdominal palpation: Soft, non-tender, no masses
Pelvis findings: Stable to flexion/compression
Back findings: No abnormalities
Extremity findings: Moves all extremities well
Skin findings: Warm, dry, normal in color
Activity
Time: 1439
Heart Rate: 50
BP: 90/60
Respiration: 16
Crew: 2
BLS assessment after patient was boarded and collared due to complaint of neck pain. BLS assessment indicated no signs of injury or trauma. BLS found negative signs of swelling, bruising, crepitus etc around the area of impact on her head. Assessment of vitals indicated that the patient was hypertensive. Patient informed BLS that she has a history of low blood pressure and has seen a doctor for it many times because it causes her to pass out. Once transport was underway the patient started complaining of being light headed. BLS placed patient on oxygen via nasal catheter at 4 liters per minute which she stated made her feel better within 3 minutes. After placing patient on oxygen for more than 5 minute there was noticeable increase in patient condition and vitals. Patient stated she was feeling much better. BLS transported patient to A1- center ED room 14. Patient care was transferred to staff RN.</td><td></td></tr>
<tr><td>02/29/YYYY</td><td>A1 Center

Michael xxxx, M.D.</td><td>ER Record
Admit time: 1637
Admit type: emergency
Mode of arrival: ambulance
Accident type: auto accident/N
Accident Date/Time: 02/29/YYYY 1500
ED prior/ongoing treatment: O2, C-collar, backboard
Discharge Date/Time: 02/29/YYYY 1758 discharged to home
<table><tr><td>Height</td><td>182cms</td></tr><tr><td>Weight</td><td>72.60kgs</td></tr></table>Gait: normal
Mental status: oriented to own ability
Vitals @1612
<table><tr><td>Temperature</td><td>96.2F</td></tr><tr><td>Pulse</td><td>55</td></tr><tr><td>Respiratory rate</td><td>20</td></tr><tr><td>BMI</td><td>22</td></tr><tr><td>BP</td><td>113/63</td></tr><tr><td>O2 saturation</td><td>100</td></tr><tr><td>Pain scale</td><td>4</td></tr></table>ED teaching and education: Patient educated with printed materials and advised to follow up</td><td>40-48</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Chief complaint: MVA, patient complains of neck pain, positive shortness of breath
History of present illness: Pain in head and neck is sudden in onset, throbbing and tightness in nature, precipitated by movements
Physical assessment done and within defined limits except musculoskeletal assessment
Pain interventions: cold, rest
ED Triage : triage level 3 @ 1516
Medications : Tylenol tablets</td><td></td></tr>
<tr><td>02/29/YYYY</td><td>A1 Center

Dr. Lane xxxx M.D.</td><td>CT head without IV contrast
Impression: Normal study.
Discussion: CT reveals the ventricles and sulci to be normal in size and position for the patient's stated age. There is no intracranial hemorrhage, mass effect or shift. There is no extra-axial collection. The gray/white differentiation is within normal limits. The osseous structures are unremarkable</td><td>49</td></tr>
<tr><td>02/29/YYYY</td><td>A1 Center

Dr. Schwarz xxxx, M.D.</td><td>Radiology/X-ray of spine-cervical, complete
Impression: Slight straightening of the cervical lordosis and no fracture is seen.
Comment: Five views of the cervical spine were obtained including oblique views. There is slight straightening of the spinal lordosis. There is good preservation of vertebral bodies and disc spaces. No fracture is seen. The odontoid process is intact. If pain persists, further evaluation is advised.</td><td>50-51</td></tr>
<tr><td>02/29/YYYY</td><td>A1 Center</td><td>Consent for medical treatment , release of medical records and admission, Authorization and acknowledgement of the same taken from patient</td><td>57-63</td></tr>
<tr><td>03/01/YYYY</td><td>A1 Center

David xxxx, M.D.</td><td>ER Record
Admit time: 1818
Admit type: emergency
Reason for admit: MVA/neck pain, upper back , headache, right shoulder pain
Discharge date/time: 03/01/YYYY at 2142
Vitals @ 2050
<table>
<tr><td>Pulse</td><td>63</td></tr>
<tr><td>Respiratory rate</td><td>20</td></tr>
<tr><td>BP</td><td>101/59</td></tr>
<tr><td>O2</td><td>98</td></tr>
</table>
Pain scale
<table>
<tr><td>@1721</td><td>@1736</td><td>@1928</td><td>@2000</td><td>@2020</td><td>@2024</td><td>@2050</td><td>@2057</td></tr>
<tr><td>9</td><td>9</td><td>7</td><td>7</td><td>9</td><td>9</td><td>2</td><td>2</td></tr>
</table>
@1826- patient parent refused CT scan of head
@2057- discharge instructions given. Treatment explained, informed no drinking alcohol and no driving while on Percocet. Informed to follow up with primary medical doctor and to go back to ER for any worsening condition.
Physical assessment:
Cardiovascular, gastrointestinal and musculoskeletal assessment: not within defined limits
Site of treatment: back, neck, shoulder right side. Focal headache present
Pretreatment neurovascular status: neurovascular intact distal to injury, Pulses distal to injury palpable, Skin distal to injury warm and pink</td><td>76-91</td></tr>
</table>

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<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Pain location: right side neck, right shoulder, chest pain, left side parietal ha
Pain is acute, constant, throbbing, aching in nature, no precipitating factors. Chest pain is sudden in onset, located at sternum and aching type
Alertness: alert
Mental status: oriented to own ability
GI symptoms: nausea
Triage: triage level 4 at 1702
Discharged : home and ambulatory</td><td></td></tr>
<tr><td>03/01/YYYY</td><td>A1 Center</td><td>Consent for medical treatment , release of medical records and admission, Authorization and acknowledgement for the same taken from patient</td><td>92-97</td></tr>
<tr><td>03/01/YYYY</td><td>A1 Center

David xxxx, M.D.</td><td>Consultation Report for neck pain and body soreness
Chief complaint: Auto Collision
History Of Present illness: Patient reports of being the driver involved in MVC 1 day ago. She states that her sedan was struck by an SUV to the front driver's side on a local road and struck her head on the windshield, which did not shatter. (+) seatbelt, (-) airbag deployment. Patient had mild neck soreness but today her neck pain worsened and now also has entire body soreness. Patient states she feels a headache. Otherwise: (+) head trauma, (-) LOC, (-) blunt trauma to trunk, (-) headache, (+) neck pain, (-) Chest pain, (-) abdominal pain, (-)extremity pain.
Review Of Systems: Other than the symptoms associated with the present events nothing negative.
Physical Examination:
Generalized Appearance: Patient is alert, awake and in mild distress. Arrived in the Emergency Department walking
Vital Signs:
<table><tr><td>Temperature</td><td>97.8F</td></tr><tr><td>Pulse</td><td>81</td></tr><tr><td>Respiratory rate</td><td>18</td></tr><tr><td>BP</td><td>105/57</td></tr></table>Skin: Warm, dry, (-) cyanosis.
Head: (-) scalp swelling, (-) scalp tenderness
Eyes: (-) conjunctival pallor.
ENMT: Mucous membranes moist.
Airway patent: (-) stridor.
Neck: (-) paravertebral tenderness, (-) midline tenderness, (-) crepitus, (-) step-off
chest and respiratory: (-) tenderness and crepitus
Lungs: (-) rales, rhonchi and wheezes. Breath sounds equal bilaterally
Heart and cardiovascular: (-) irregularity, murmur, gallop
Abdomen and GI: (-) ecchymosis, abrasion, distention, tenderness, guarding, rebound and rigidity.
Back: (+) bilateral cervical paravertebral tenderness, (-) sacroiliac
Extremities, neurology and psychology: within normal limits.
Diagnostics: Pulse Ox: 100% on RA indicating adequate oxygenation.
X-ray Neck from 02/09/YYYY reviewed.
Emergency Department Course And Treatment: Patient's condition remained stable during Emergency Department evaluation with no evidence of serious head</td><td>104-106</td></tr>
</table>

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		injury, neurologic injury, chest or abdominal injury. Previous medical records requested and reviewed. Patient was seen 1 day ago and was discharged, diagnosed with MVC evaluation. Patient given Valium 5, Tylenol and Percocet. Patient states pain still persists. On re-evaluation, patient given Dilaudid and Zofran. Patient states her pain improved and agrees to discharge. After the evaluation in the Emergency Department, my clinical impression is MVC-cervical strain, head injury. Patient received written and verbal instructions regarding this condition. To follow up with Dr. Baron xxxx in 1 day for further evaluation.	
03/06/YYYY	A1 Center Nadisha xxxx, P.A.	**Follow up visit for headache, neck pain/ spasm on right side** **History:** Patient was involved in car accident last wednesday and has been having on and off headaches since then. Valium and Percocet given at ER, she said she had bad dreams with medication so stopped taking. Woke up confused, forgetting typical schedule since then, headache daily, takes Tylenol and Motrin throughout the day. Patient also complaining of nausea in the mornings, she complains of acid reflux. Denies any blurry vision. Patient states that she was taken to A1 Center ER and had a CT scan of head and x-ray of neck which were both negative. Patient states that she has also been suffering from neck pain/spasm on the right side. **Review of systems:** all systems reviewed and negative **Physical examination:** **Musculoskeletal:** digits/nails- no clubbing, cyanosis or evidence of ischemia or infection. Normal gait. Range of motion: pain with neck forward flexion and lateral flexion. Psychiatric: mental statue-alert and oriented x3, appropriate affect and demeanor. Other systems examined and within normal limits. **Assessment**: Headache **Plan:** Medication: Indocin Recommendations: increase oral fluid intake. Referrals: To a neurologist and a psychiatrist. Follow-up: Instructed to call if she develops new or worsening symptoms, including worsening intensity, vomiting and fever. Schedule a follow-up appointment in 2 weeks	2-3
03/06/YYYY	A10 Group Lisa xxxx, M.D.	**Work status report** Patient under follow up for MVA and would be able to return to work on 03/10/YYYY **reviewer's comment- date of return to work is overwritten*	217
03/23/YYYY	A1 Center Nadisha xxxx,	**Follow up visit for headache** **History:** Patient complains of headache. She is without symptoms currently but is seeking evaluation. The location is primarily frontal. It does not radiate. She characterizes it as throbbing and pain behind the eyes. The headache is exacerbated with looking at computer for long periods of time and quick sudden eye movements to the left. Diagnosed with generalized anxiety disorder several weeks ago. Her symptom complex includes apprehension and palpitations. Apparent triggers include driving - since recent car accident. Current treatment includes counseling. Neck pain details: the location of discomfort is on the left side. There is no radiation. The pain is characterized as cramping and pulling. Initial onset was several	4-6

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		weeks ago. The precipitating event seems to have been motor vehicle accident. Associated symptoms include neck stiffness. Additionally, she presents with history of allergies that started 1 to 2 weeks ago. The allergy pattern seems to be seasonal. Her symptom complex includes sneezing and runny nose. Medications previously used include antihistamines. **Review of system:** Musculoskeletal: Negative for arthralgias, back pain, and myalgias Psychiatric: Negative for anxiety, depression, and sleep disturbances Other systems reviewed and negative **Physical examination:** Musculoskeletal: digits/nails- no clubbing, cyanosis or evidence of ischemia or infection. Normal gait. Range of motion- pain with neck left lateral flexion. Neurologic: cranial nerves II-XII grossly intact. Psychiatric: mental status- alert and oriented x 3, appropriate affect and demeanor. Other systems reviewed and within normal limits **Assessment**: Headache, generalized anxiety disorder, neck pain and allergies **Plan:** Medications: Fexofenadine, over the contour medications recommended like ibuprofen, naproxen and oral antihistamines **Headache** Recommendations given include increased oral fluid intake. Referral initiated to a neurologist and a psychiatrist. Follow-up: Instructed to call if she develops new or worsening symptoms including worsening intensity, vomiting and fever. Schedule a follow-up appointment in 2 weeks. **Generalized anxiety disorder-**Recommendations given include stress reduction and continue follow up with counselor. Follow-up: Schedule a follow-up visit in 1 month. **Neck pain-** Recommendations given include: range-of motion exercises for the neck, moist heat and massage. Follow-up: Schedule a follow-up visit in 1 month. Follow-up: Schedule follow-up appointments as and when needed. **reviewer's comment: consultation report for anxiety disorder is missing*	