**2504 Monroe St.**
**LaPorte, IN 46350-5241**
**Phone: (219) 326-5100**
**Fax: (219) 326-0180**

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|---|---|---|---|
| **Patient:** | **Doe, John E** | **DOB:** | **1/1/1973** |
| **Ins Co** | | **Pol #** | **Insured** |

**Date** 01/14/2016

**Provider** Matthew C. Kirkham, DC, CCSP

**Subjective:**

**HEALTH HISTORY:** In addition to this note, refer to the attached Confidential Patient Case History form for additional review of Mr. John Doe's history of present illness. John completed the patient intake questionnaire which was reviewed by the consulting provider, and is in the patient's permanent digital file available for review.

**PRIMARY COMPLAINT - Low Back Pain With Right Sciatica:** Mr. John Doe reported a complaint in the lower back region that he described as moderate to severe (6-8 on VAS scale) constant dull achy pain with frequent sharp shooting episodes. He indicated radiating symptoms originating from the lower back and right buttock region into the back of the right lower extremity to the calf and heel of the foot. He also reported associated frequent bilateral lower back stiffness and muscle spasms. On a scale of 0 to 10, with 10 being severe, he rated the discomfort intensity of this complaint as being as high as 7 and is constantly occurring between 75-100% of the time. He reported that this complaint began with a gradual onset that has been at its worst the past 3 weeks; and has been noticeable overall since beginning 2 years ago. He also said this symptom was most recently aggravated from bending wrong and carrying heavy items and has been getting worse over time. John reported aggravating factors which include primarily arising from a seated position and sitting for long periods; and relieving factors of primarily lying down. The pain does intensify during physical exertion and with sudden movements involving the upper body, such as coughing, sneezing, or laughing.

**SECONDARY COMPLAINT - Neck Pain Without Radiating Symptoms:** John also reported neck pain that he described as mild to moderate (3-4 on VAS scale). On a scale of 0 to 10, with 10 being severe, he rated the intensity of the discomfort as being as high as **4/10** and is frequently occurring between 50-75% of the time. He reported that this complaint began with a gradual onset that has been at its worst the past 6 months and has been noticeable overall since beginning many years ago.

**PAST HISTORY:** Mr. Doe's general health was reported as good. In addition to the consultation, the patient also completed a questionnaire in regards to past medical, family and social history which was reviewed by me in its entirety. He reported having a prior similar episode(s) of this primary complaint 5 years ago.

**ALLERGIES:** The patient reported having an allergy history related to hay fever.

**HOSPITALIZATIONS/SURGERIES:** Prior hospitalizations and/or surgeries include nothing remarkable.

**MEDICATIONS:** The patient's current medication intake includes muscle relaxers and pain relievers.

**PAST TREATMENT:** John reported having other recent treatment for his primary complaint. He reported that it has been within the last year since his last physical examination by his medical doctor. In addition to the consultation, the patient also completed a questionnaire in regards to past treatment which was reviewed by me in its entirety. He says he consulted and was evaluated by a general practitioner for this condition 1 week ago and the resulting diagnosis according to the patient was herniated disc. He said that the doctor performed MRI and treatment included prescription medications which he admitted has not changed his symptoms.

**REVIEW OF SYSTEMS:** A complete review of systems was completed and revealed the following findings. John was quizzed on general health symptoms of weakness, fatigue, fever, chills, night sweats or fainting and he reported experiencing on occasion none of these. In addition to the

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consultation, the patient also completed a questionnaire in regards to review of systems which was reviewed by me in its entirety. Gastrointestinal System was reviewed and indicated heartburn and constipation. A review of the remaining organ systems were negative.

**PSYCHO-SOCIAL HISTORY:** John is married. He reports no relevant pshycho-social history as it relates to stress aggravation of the primary complaint from factors such as mental and physical work, exercise, smoking, alcohol and caffeine consumption.

**SMOKING HABITS:** John is a non-smoker both past and present.

**FAMILY HEALTH HISTORY:** John reported no hereditary factors or other relevant family medical history related to his current illness.

**RECREATIONAL/JOB HISTORY:** His occupation is a chiropractic assistant. The patient noted that his current working conditions are a factor in aggravating or prolonging his condition.

**PATIENT GOALS FOR CARE:** John stated that his goals for care are to reduce pain, increase range of motion, decrease muscle tightness, pain management and relieve symptoms in the short-term and improve muscle tone, improve strength, increase flexibility and increase overall wellness in the long-term.

**RED FLAGS SCREENING:** Certain and specific questions were asked of Mr. Doe in order to investigate and rule out the potential of a serious non-musculoskeletal cause for his current complaints as well as detect possible potential pathologies that may otherwise be asymptomatic. This screening included inquiries about major trauma, tumor, infection, cancer, epidural hematoma, cauda equina syndrome, myelopathy, and cerebrovascular dysfunction. John denied potential indicators with all of the above.

**Objective:**

A new patient initial examination was performed today on Mr. John Doe. The patient, a 43 year old Caucasian Male, is right-handed and his demeanor indicated he was in moderate pain. He appears generally to be well-nourished, well-groomed and his build is slightly overweight.

**JUDGEMENT, ORIENTATION & MOOD/AFFECT:** The patient exhibits sound judgement. John's responses during consultation indicated his general cognition was normal in regards to person, place and time, and his current mental status was found to be normal. His mood/affect seemed to indicate he is positive.

**VITALS:** His vital signs are as follows: Height: 6 feet, 1 inches; Weight: 225 pounds. Blood Pressure (left sitting): 125/88. Pulse Rate: 72 bpm.

**GAIT & STATION:** His carriage and gait showed normal pattern and his movements were restricted. A standing postural examination using the plumb-bob gravity assessment was performed which revealed forward head translation, rounded shoulders, high right shoulder and high right iliac crest. The lateral spinal curves were visualized and appeared to be as cervical hypolordosis, thoracic normal kyphosis and lumbar hypolordosis. Feet position was pronation and flared outward bilaterally. Prone leg length displayed shortness on the right with a difference of 1/4" (6 mm) Antalgia was evident. Radiographs are recommended to confirm or rule out the presence of a congenital anomaly as well as to further investigate the patient's spinal condition.

**ANTALGIC GAIT:** Based on the abnormal antalgic standing and walking presentation of RIGHT ANTALGIA WITH ASSOCIATED RIGHT LEG PAIN, this would suggest a lateral lumbar and sacral disc protrusion on the right that is medial to the nerve root. The patient is leaning to the right to favor a biomechanical position to decrease pressure on the nerve root from the right laterally HERNIATED DISC material. Significant paraspinal muscle spasms are the consequential result of the underlying

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structural instability.

**RANGE OF MOTION:** Active range of motion of the spine was evaluated visually. No gross instability was noted in the neck, back or extreme ties. This finding does not rule out more subtle ligament instability in the spine; however, ligament instability must be ruled out on imaging studies. Lumbar active range of motion was severely restricted with pain in forward flexion, extension and left lateral flexion and the rhythm was abnormal. CREPITATION was not present in the lumbar spine.

**INSPECTION, PERCUSSION, PALPATION:** Mild to moderate digital palpation was performed on Mr. Doe to selectively evaluate tissue consistency and response to pressure, especially in regards to misalignment. His entire spine was inspected, percussed and palpated for any misalignment as well as to assess pain, tenderness, muscle actions, tissue tone, edema (swelling), and induration (abnormal hardening). This evaluation revealed point tenderness due to inflammation and edema at the C7, T1, T6, T7, L5 and sacrum spinal levels.

**SUBLUXATIONS/MISALIGNMENTS:** Subluxations and segmental dysfunctions were assessed and are evident by misalignment, joint restriction and temperature differential at the C7, T6 and L5 spinal levels.

**MUSCLE STRENGTH AND TONE:** Paravertebral muscle hypertonicity and tightness were also noted bilaterally at these levels. Active trigger points were elicited in right lumbar paraspinals, right piriformis and right hamstring. Muscle strength and joint instability was assessed bilaterally at the shoulder and hip joints. Left deltoid strength was graded 5/5 (Normal). Right deltoid strength was graded 5/5 (Normal). Left psoas strength was graded 5/5 (Normal). Right psoas strength was graded 4/5 (Good).

**EXAMINATION OF JOINTS, BONES, MUSCLES:** Orthopedic testing was utilized in the examination of joints, bones and muscles in the neck, back and proximal upper and lower extremities. Cervical Compression Test was positive for local pain indicating joint damage or facet lock bilaterally. Shoulder Depression Test was positive bilaterally for dural sleeve adhesion. Latent trigger points in the upper trapezius and deltoid were present bilaterally. Palpable tenderness over the anterior bursa was evident in the bilateral shoulder. Shoulder joint crepitis was not noticeable upon movement. Kemp's Test was positive bilaterally with right greater than left for lower back with leg pain. Straight Leg Raise (SLR) was positive at 30 degrees on the right for lower back with leg pain and positive on the left at 60 degrees for lower back without leg pain. Fabere Patrick's test was negative bilaterally for hip joint pain. Milgram's Test was positive for lower back pain caused from herniated intervertebral disc. Minor's Sign was positive for pathologic condition of lumbosacral origin. Dejerine's Sign was positive for a space-occupying lesion creating neurological compression.

**DEEP TENDON REFLEXES (DTRs):** Deep tendon reflexes were tested at the biceps (C5), brachioradialis (C6), triceps (C7), patellar (L4) and Achilles (S1) and were all normal (2+) and symmetric.

**EVALUATION & MANAGEMENT SERVICE:** A Detailed evaluation and management was performed today which included an extended history, a detailed examination, and low complexity clinical decision making. About 35 minutes of doctor time was spent with the patient today.

**Treatment:**
No treatment was administered today.

**Assessment:**
**PRELIMINARY WORKING DIAGNOSIS:** A more accurate and detailed diagnosis will be determined before the patient's next visit after a thorough review of the patient's history, diagnostic test results

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and examination findings has been completed. An initial working diagnosis at this time includes neck pain and low back pain with leg pain.

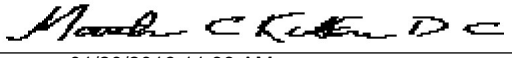
**PROGNOSIS:** The patient's preliminary prognosis at this time, in my opinion, is EXCELLENT. This may be changed or updated upon further review of his condition.

**X-RAY EVALUATION:** A initial analysis radiographic examination was ordered and performed today by Dr. Matthew Kirkham, D.C. to determine the patient's current structural status as is relates to treatment needs. Based upon the patient's history and examination, radiographs were ordered. As routine procedure the patient confirmed that there were no contraindications to taking radiographs, including but not limited to pregnancy, trying to become pregnant, receiving active radiation therapy, or other contraindication for X-ray exposure. The rationale was due to need of structural integrity assessment. ARTIFACT NOTICE: The patient was instructed to remove any and all items and/or piercings that may be identified on the x-ray. Any artifacts, if present, on the x-rays obtained today are due to the patient's refusal or inability to remove the item in question. The examination consisted of the following: LUMBAR SPINE: Weight-bearing x-rays of the lumbosacral spine (anteroposterior and lateral) were obtained today to assess the patient's current condition and determine probable structural cause for the objective and subjective findings. A radiology report and Gonstead line analysis was completed.

**Plan:**

I have informed Mr. Doe that I will need some time to review his case findings and advised him to return as soon as tomorrow or at his earliest convenience to review the results of the findings as well as go over treatment options. The patient was given specific home care instructions which consisted of applying ice pack to region of pain for 20 minutes, avoiding a reclining posture, avoiding applications of heat to region of pain and avoiding standing for long periods to be observed especially over the next 2 weeks. I informed John that I am recommending he have additional testing in order to further evaluate his health condition which includes MRI for potential herniated disc.

**Diagnosis**
M54.41: Lumbago w/ sciatica, RT side
M51.27: Other IVD displacement, lumbosacral region
M54.2: Cervicalgia
M62.830: Muscle spasm of back
R26.2: Difficulty in walking, NEC
M62.49: Contracture of muscle, multiple sites
M62.59: Muscle wasting/atrophy, NEC, multiple sites
M79.1: Myalgia
R29.3: Abnormal posture
M99.01: Cervical segmental/somatic dysfunction
M99.02: Thoracic segmental/somatic dysfunction
M99.03: Lumbar segmental/somatic dysfunction

Provider Signature X 
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