2504 Monroe St.
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Patient:	**Doe, John E**	**DOB:**	**01/01/1973**
Ins Co		**Pol #**	**Insured**

Date **02/20/2017**

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

Subjective:

ACCIDENT HISTORY: Mr. John Doe was seen in our office today for the purpose of consultation, examination and treatment for injuries he sustained in an automobile accident that occurred on 2/13/2017. He explained that he was the driver of a mid-size car when he was struck by another vehicle from behind. Mr. Doe said his vehicle was stopped and the other vehicle was moving. The road conditions, according to the patient, was dry and the visibility was good with bright sunlight. He said he did have a seat belt on, and he was looking forward at the time of the collision. He said he was surprised and not braced for impact. He reported the impact caused his left clavicular, left chest and posterior head to hit the seat belt and the headrest. Immediately after the accident, Mr. Doe said he was stunned. The patient said he did go immediately to the emergency room following the accident and departed the accident location via ambulance.

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 digital file available for review.

NECK REGION COMPLAINT - Neck Pain Without Radiating Symptoms into Upper Extremity: Mr. John Doe reported a complaint in the neck region that he described as moderate (4-6 on VAS scale) dull achy pain with occasional sharp episodes. On a scale of 0 to 10, with 10 being severe, he rated the intensity of the discomfort as being as high as **6**/**10** and is frequently occurring between 50-75% of the time. He reported that this complaint began with a sudden onset that has been at its worst the past one week and has been noticeable overall since beginning 1 week ago. He also said this symptom started from an auto accident, has been noticeable off and on throughout the day; and has been getting worse over time. John reported aggravating factors which include primarily looking down, looking up, tilting head and turning head; and relieving factors of primarily lying down. He denies radiating symptoms into his upper extremities bilaterally. The pain does not seem to intensify during physical exertion or with sudden movements involving the upper body, such as coughing, sneezing, or laughing.

SPRAIN and STRAIN of CERVICAL REGION: John reported that this recent onset of symptoms began with a mode consistent with both a sprain and strain type of injury. He describes symptoms indicating a sprain such as pain, inflammation, joint instability, and possible ligament tear. Strain is also indicated by pain, inflammation, muscle spasm, muscle weakness that has been accumulating over time until it's peak most recently.

LOW BACK REGION COMPLAINT - Low Back Pain Without Radiating Symptoms: John also reported low back pain that he described as moderate (4-6 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 one week and has been noticeable overall since beginning 1 week ago. He said this symptom was most recently aggravated from an auto accident.

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 not having a prior similar episode(s) of this primary complaint never previously before.

ALLERGIES: The patient reported having an allergy history related to penicillin.

HOSPITALIZATIONS/SURGERIES: Prior hospitalizations and/or surgeries include knee

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arthroscopic surgery.

PRIOR ILLNESS: diabetes.

MEDICATIONS: The patient's current medication intake includes (See Medication List Attached).

PAST TREATMENT: John reported having other recent treatment for his primary complaint. He reported that it has been 3 weeks since his last physical examination by his medical doctor. In addition to the consultation, the patient also completed a written questionnaire in regards to past treatment which was reviewed. He says he consulted and was evaluated by an emergency room physician for this condition 3 weeks ago and the resulting diagnosis according to the patient was sprain/strain injury. He said that CT scan and X-ray was performed and treatment included muscle relaxers and pain 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 consultation, the patient also completed a questionnaire in regards to review of systems which was reviewed by me in its entirety. Cardiovascular System was reviewed and indicated unremarkable. Gastrointestinal System was reviewed and indicated heartburn and indigestion. A review of the remaining organ systems were negative.

PSYCHOSOCIAL HISTORY: John is married. Physical work is heavy for about 8 hours per day.

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 factory worker. The patient noted that his current working conditions are a factor in aggravating or prolonging his condition.

TIME LOSS: Due to the severity of Mr. Doe's symptoms and acute condition, he reported he has had to be on time loss from work for one week.

GUIDELINES FOR THE TREATMENT OF CAD (CERVICAL ACCELERATION DECELERATION) INJURIES: In order to determine a guideline for the number and duration of treatment for Mr. John Doe, the Croft Guidelines for treatment of CAD injuries was utilized. **At the initial examination of Mr. Doe, he was found to have x-ray abnormalities detailed in the x-ray report. According to the Croft Guidelines above, John's injuries would fall into a Grade 3. Treatment guidelines for this grade will be followed accordingly.** The Croft Guidelines have been considered the standard in the industry since it's inception in 1993 by Arthur Croft, DC, MS, MPH, FACO, FACFE. No competing guidelines relative to CAD treatment have been published during that time, with the exception of the Quebec task force guidelines on WAD, but these are only applicable for patients who remain on disability. Several American State Chiropractic organizations and associations, as well as at least one Canadian province, have now adopted the Croft Guidelines.

The following is a summary of the Croft Guidelines for the treatment of the five grades of CAD injuries:

Grade 1 Severity of Injury: *Criteria: Minimal; No Limitation of Motion; No Ligamentous Injury; No Neurological Findings. Treatment Recommendation Guideline: Daily for 1 week, 3 times weekly for 1-2 weeks, 2 times weekly for 2-3 weeks, 1 time weekly up to 4 weeks, possible follow up at one month (Total duration up to 11 weeks and up to 21 treatments).*

Grade 2 Severity of Injury: *Criteria: Slight; Limitation of Motion; No Ligamentous Injury; No Neurological Findings. Treatment Recommendation Guideline: Daily for 1 week, 3 times weekly up to 4 weeks, 2 times weekly up to 4 weeks, 1 time weekly up to 4 weeks, 1 time monthly up to 4 months (Total duration up to 29 weeks and up to 33 treatments).*

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Grade 3 Severity of Injury: *Criteria: Moderate; Limitation of Motion; Some Ligamentous Injury; Neurological Findings May Be Present. Treatment Recommendation Guideline: Daily for 1-2 weeks, 3 times weekly up to 10 weeks, 2 times weekly up to 10 weeks, 1 time weekly up to 10 weeks, 1 time monthly up to 6 months (Total duration up to 56 weeks and up to 76 treatments).*

Grade 4 Severity of Injury: *Criteria: Moderate to Severe; Limitation of Motion; Ligamentous Instability; Neurological Findings Present; Fracture or Disc Derangement May Be Present. Treatment Recommendation Guideline: Daily for 2-3 weeks, 3 times weekly up to 16 weeks, 2 times weekly up to 12 weeks, 1 time weekly up to 20 weeks, may require permanent monthly or PRN treatment.*

Grade 5 Severity of Injury: *Criteria: Severe; Requires Surgical Management/Stabilization. Treatment Recommendation Guideline: Surgical stabilization is necessary, chiropractic care is post surgical.*

DUTIES UNDER DURESS: Despite the pain and severity of Mr. Doe's symptoms caused by the incident, he reported that he has had to continue the following activities of daily living even though the symptoms give him duress while doing them:

Work Duties: He reports he has had to continue to work while under duress because he would lose job if took time off and couldn't support family otherwise. Mr. Doe reports that he has experienced changes in ability to perform at work due to difficulty with postural positions as a result of the injuries sustained in the incident.

Household Duties: Mr. Doe reports he has experienced problems with the following activities and chores *outside* of the home: mowing the grass and gardening.

The duration of these symptoms causing duties under duress are ongoing. It is anticipated that the inability to perform normal pre-injury work activities without pain is not a permanent condition.

Objective:

A new patient initial examination was performed today on Mr. John Doe. The patient, a 44 year old Caucasian Male, is right-handed and his demeanor indicated he was in marked pain. He appears generally to be well-nourished, well-groomed and his build is well proportioned.

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: 5 feet, 10 inches; Weight: 195 pounds. Blood Pressure (left sitting): 130/82. Pulse Rate: 78 bpm.

ASYMMETRY/MISALIGNMENT OF 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 and head tilt to the right. The lateral spinal curves were visualized and appeared to be as cervical hypolordosis, thoracic normal kyphosis and lumbar hypolordosis. Feet position was pronation on the right. 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 SIGN: The patient demonstrates antalgic positioning in the cervical spine towards the right and anterior due to severe pain and muscle spasm. Significant paraspinal muscle spasms are the consequential result of the underlying structural instability.

RANGE OF MOTION: Active range of motion of the spine was evaluated using a dual inclinometer and the results were as follows:

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CERVICAL SPINE ROM (Normal Degrees): [Patient Degrees]: Flexion (50): [23] with pain; Extension (60): [22] with pain; Right Lateral Flexion (45): [25] with pain; Left Lateral Flexion (45): [23] with pain; Right Rotation (80): [65] with pain; Left Rotation (80): [70] with pain. CREPITATION was not present in the cervical spine.

SPECIAL TESTING - COMPUTERIZED RANGE OF MOTION: According to the AMA, dual inclinometry is the preferred method for measuring the compound motions of the spine. Using dual inclinometry protocols from the AMA Guides, the patient's range of motion of the cervical spine was objectively assessed today. Today, for extreme accuracy, a computerized dual inclinometry was utilized. (See the attached report for the results of Mr. Doe's computerized dual inclinometer range of motion study performed today.)

PAIN AND TENDERNESS: 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 at the occiput, C1, C2, C6, C7, T1, T2, T6, T7, T8, L5 and sacrum spinal and paraspinal levels.

SUBLUXATIONS/SEGMENTAL DYSFUNCTIONS/MISALIGNMENTS: Segmental dysfunctions (subluxations) were assessed and are evident by misalignment, joint restriction and temperature differential at the C6, C7, T6, T7, L5 and sacrum spinal levels.

MUSCLE STRENGTH AND TONE: Paraspinal muscle hypertonicity and tightness were also noted bilaterally at these levels. Active trigger points were elicited in bilateral paracervicals, bilateral scalenes, bilateral trapezius and bilateral levator scapula. Muscle strength and joint instability was assessed bilaterally at the shoulder and hip joints. Left deltoid strength was graded 4/5 (Good). Right deltoid strength was graded 5/5 (Normal). Left psoas strength was graded 5/5 (Normal). Right psoas strength was graded 5/5 (Normal).

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 with right greater than left. 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 for lower back without leg pain. Straight Leg Raise (SLR) was negative at 70 degrees on the right for lower back and leg pain and positive on the left at 70 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 negative for pathologic condition of lumbosacral origin. Dejerine's Sign was negative for a space-occupying lesion creating neurological compression.

EXTRASPINAL EXAMINATION OF SHOULDER JOINT: A initial examination of the patient's left shoulder revealed moderate limited range of motion upon flexion, abduction and internal rotation. Palpable tenderness over the anterior bursa was pronounced. Active trigger points in the upper trapezius and deltoid were present. Shoulder joint crepitis was not noticeable upon movement.

Shoulder Orthopedic Tests: Wright's test was negative for hyperabduction thoracic outlet compression syndrome, Dugas's test was negative for shoulder dislocation, Apprehension test was negative for shoulder dislocation, Yergason's test was positive for bicipital tenosynovitis, Apley's Superior Scratch test was positive for tendinitis of the supraspinatus tendon, Apley's Inferior Scratch

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test was positive for tendinitis of the supraspinatus tendon, Codman's Arm Drop test was negative for tear in the rotator cuff complex, and Shoulder Depression test was negative for dural sleeve adhesion at C5. This exam provides a diagnosis which includes: **left shoulder joint pain (M25.512),**

LYMPHATIC SYSTEM: Gentle palpation of the lymphatic system throughout the head, neck, axillae and groin was performed. Lympatic chains with tender and swollen nodes was noticeable in no regions on the right and left.

SKIN INSPECTION: Inspection of the patient's skin over the head and neck, posterior trunk, right upper extremity and left upper extremity regions revealed a bruise at left chest region.

SEATBELT SIGN: "Seatbelt sign" indicating abrasions and contusions across the patient's chest and shoulder from the impact of the seatbelt during an automobile accident impact was noted on Mr. Doe and has been photographed in the patient file.

DEEP TENDON REFLEXES (DTRs): Deep tendon reflexes were tested at the biceps (C5), brachioradialis (C6), triceps (C7), patellar (L4) and Achilles (S1) and graded using Wexler's scale. DTRs were normal (2+) except for the left biceps graded 1+ (hypoactive). Reinforcement was not needed to elicit the strongest response.

SENSORY EVALUATION OF UPPER EXTREMITIES: Cervical and thoracic nerve dermatomes (C4-T3) were tested for sensory deficits in the upper extremities using light touch. All were normal except the C6 and C7 which showed a decreased sensitivity.

COORDINATION: John was able to touch his finger to his nose and heel to shin without difficulty as well as perform rapid alternating movements which all indicated normal coordination.

GRIP STRENGTH EVALUATION: Grip strength testing using a hand-held Dynomometer resulted in the following measurements in pounds: Right Hand was 65 pounds, and Left Hand was 50 pounds.

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 and treatment was performed distinctly separate from the exam.

Treatment:

Based upon presenting symptoms, objective findings, and clinical assessment, today's treatment consisted of the following:

CHIROPRACTIC ADJUSTMENTS (CMTs) 3-4 REGIONS [98941]: A 3-4 spinal region adjustment was performed today for active treatment on areas of segmental dysfunction (subluxation) using a manual Gonstead technique. A lumbo-sacral region CMT was performed at the L5 and sacrum level(s) with a Sacrum BP listing using the side posture pelvic bench. A thoracic region CMT was performed at the T7 level(s) with a PL-T listing with the patient prone. A cervical region CMT was performed at the C7 level(s) with a P listing using the cervical chair.

EXTRASPINAL ADJUSTMENT CMT [98943]: An extraspinal region CMT was performed on the LEFT SHOULDER (glenohumeral joint). Joint dysfunction was indicated by objective findings which included point tenderness over the anterior bursa and restricted range of motion especially in flexion and abduction planes. The range of motion was immediately improved following the adjustment.

THERAPEUTIC MODALITIES: In order to promote healing, reduce inflammation and relax muscle spasm/tension, the following modalities were utilized on today's visit. This therapy had doctor supervision with clinical assistance. Electrical Muscle Stimulation (EMS) [97014] was administered to the neck and upper back muscle regions using Interferential Current (IFC) at 80-120hz sweep for about 10 minutes with the intensity set to patient's mildest sensation and comfort level. The goal of this treatment is for pain relief, muscle stimulation, increased blood flow, and reduction of edema

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through the muscle pumping action. Cryotherapy using an insulated ice gel pack was administered to the neck and upper back region for 10 minutes for vasoconstriction, analgesia and to reduce joint and nerve inflammation.

Assessment:

CURRENT DIAGNOSIS: After review of the patient's history, diagnostic tests and examination findings, the following is a list of diagnostic impressions for Mr. Doe's current condition: (M50.23) Other cervical disc displacement, cervicothoracic region, (M62.49) Contracture of muscle, multiple sites, (M54.5) Low back pain, (M62.81) Muscle Weakness, (M79.1) Myalgia, (M25.512) Pain in LT shoulder, (M99.07) Upper Extremity segmental/somatic dysfunction, (M99.01) Cervical segmental/somatic dysfunction, (M99.02) Thoracic segmental/somatic dysfunction, (M99.03) Lumbar segmental/somatic dysfunction, (M99.04) Sacral segmental/somatic dysfunction.

PROGNOSIS: The patient's initial prognosis at this time, in my opinion, is GUARDED with compliance and completion of the established treatment plan. If the patient does not respond in a reasonable amount of time, additional testing will be recommended. If the patient follows the outlined treatment plan and complies with all of the home care instructions, a 40% to 60% improvement is expected within the first 4 weeks.

POST TREATMENT CHANGE: Today's treatment was performed without incident and John reported that he felt slight relief and increased range of motion following the treatment. Post treatment motion palpation of the involved dysfunctional joints revealed an immediate increase in joint motion as well as a decrease in point tenderness.

COMPLICATING CONDITIONS: John's current condition is complicated by severe pain and muscle spasm. Complicating factors may require an increase in treatment frequency and duration, if present, and result in a delay or inability for his condition to fully recover and stabilize. Full recovery without residuals is anticipated and treatment time is likely to exceed expected norms. An overall positive functional outcome is, however, greatly anticipated.

CONTRAINDICATIONS: Known contraindications to chiropractic treatment based on past and present history were assessed for the following:

Absolute Contraindications: no contraindications noted. (Examples of Absolute Contraindications include: upper cervical spine hypermobility, acute fracture, unstable os odontoidium, avascular necrosis, bone malignancy, bone infection, acute myelopathy or acute cauda equina syndrome.)

Relative Contraindications: no contraindications noted. (Examples of Relative Contraindications include: spondylosis, spondylolisthesis, bone demineralization condition, osteoporosis, vertebrobasilar insufficiency, abdominal aneurysm, pregnancy, cardiac pace maker/defibrillator, anticoagulant therapy, rheumatoid arthritis, or spine surgery.)

X-RAY EVALUATION: A initial analysis radiographic examination was ordered and performed today by myself 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. Clinical rationale for radiographs was due to need of structural integrity assessment and history of significant trauma. 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: CERVICAL SPINE: X-rays of the cervical spine [72040] (anteroposterior, lateral and odontoid A-P open mouth views) 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

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chiropractic line analysis was completed.

X-RAY/IMAGING FINDINGS: An imaging review was performed of X-rays obtained in this office on Mr. Doe's cervical spine. (See the attached report for the detailed written report included in this patient's digital file.) The following pertinent findings and clinical impressions are apparent based on this study:

SPINAL KYPHOSIS: Postural and other kyphosis of the cervical spine region (M40.292).

IMAGING REVIEW: A review and imaging report was performed today of CT scans obtained 2/13/2017 at the hospital on Mr. Doe's cervical spine and thoracic spine. See the attached report.

Plan:

REPORT OF FINDINGS - Consent to Treatment: A report of findings was presented today. Mr. Doe was counseled regarding the following: diagnostic results, the importance of compliance with the prescribed treatment plan, the importance of not missing scheduled visits and risk factor reductions to preclude additional injury and promote healing. Mr. Doe was informed of the relative benefits, substantial risks and alternatives to chiropractic and physical therapeutic care and he gave consent to begin treatment. He said he understood the results of the findings and I let him know that if any questions or concerns regarding any aspect of his care arise to let me or my staff know immediately. I also let the patient know that it is often common to expect to feel some soreness at the beginning of treatment but that normally soreness will ease within a couple weeks. All questions were addressed and there was an expression of understanding and willingness to begin treatment.

HOME CARE INSTRUCTIONS: John 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, avoiding standing for long periods and sleeping on a firm mattress. These are to be followed for at least the next 2 weeks then assessed for continuation if necessary.

TREATMENT PLAN: The following initial treatment plan, initiated today, is prescribed for John after review of his case history, examination findings, and any diagnostic test results. His condition is acute and is severe in nature.

TREATMENT FREQUENCY: The frequency of treatment during this acute relief phase of care will be 3 times per week for 4 weeks at which time a progress examination will be performed and further care needs determined. The patient will likely need an additional 30-60 days of gradual reduction of treatment following this initial treatment plan.

TREATMENT THERAPIES: Procedures and modalities to be used during this phase of treatment include chiropractic spinal adjustments (CMTs) [98940-2], electrical muscle stimulation [97014], mechanical traction [97012] and cold packs [97010] as necessary.

REHABILITATIVE THERAPIES: Specific active care in-office and/or at-home rehabilitative procedures will also be incorporated in the cervical spine region using therapeutic exercises [97110], neuromuscular reeducation [97112], and ADL instruction [97535] including lifestyle modifications. The patient will progress through progressive exercises consisting of range of motion, isometrics, stretching and resistive tubing. The patient will also demonstrate the ability to perform an at-home exercise program during and at the completion of his care program.

TREATMENT GOALS: SHORT-TERM GOALS: in general are to decrease pain, inflammation, muscle tightness and increase range of motion. Specifically, decrease average pain level to a 3-4 out of 10 on the QVAS and reduce segmental dysfunctions 30-50% as well as increase restricted range of motion segments by 50%. These short-term goals are expected to be reached within 3-5 weeks.

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LONG-TERM GOALS: in general are to improve muscle tone, function, stability, coordination and to increase strength and flexibility. Specifically, reduce average pain level to a 1-2 out of 10 on the QVAS as well as improve function, stability and strength 80-100% and increase restricted range of motion segments by 75-95%. These long-term goals are expected to be met in 2-3 months. Functional goals are to increase his ability to sit and stand for more than one hour without pain. Progress of John's ADLs will be monitored using outcomes assessment questionnaires as well as periodic examinations.

Diagnosis
M50.23: Other cervical disc displacement, cervicothoracic region
M40.292: Other kyphosis, cervical region (reduced cervical curve)
M54.5: Low back pain
S13.4XXA: Sprain of ligaments of cervical spine, initial encounter
S16.1XXA: Strain of muscle, fascia and tendon at neck level, init
M62.49: Contracture of muscle, multiple sites
M62.81: Muscle Weakness
M25.512: Pain in LT shoulder
M99.07: Upper Extremity segmental/somatic dysfunction
M99.01: Cervical segmental/somatic dysfunction
M99.02: Thoracic segmental/somatic dysfunction
M99.03: Lumbar segmental/somatic dysfunction
M99.04: Sacral segmental/somatic dysfunction

Electronically Signed Matthew C Kirkham DC
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