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INTERIM EXAMINATION

8/17/2004

Patient: John Q Public
Date of Loss/Onset: 2/2/2005
Date of Exam: 2/2/2005

TO WHOM IT MAY CONCERN:

This is an interim report following the S.O.A.P. note format. This report is based upon scientific peer-reviewed literature and gold standard functional/structural outcome assessments. The examination procedures and report are in compliance with The Guidelines for Evaluation and Management Services published by the Health Care Financing Administration (HCFA) of the United States Federal Government (May 1997).

PRESENT SYMPTOMATOLOGY:

Self-Reporting Measures of Pain and Disability and Measures of Health and Lifestyle were completed by the patient to assess the degree of impairment (and improvement upon re-evaluation) the patient is experiencing and how the patient copes with these circumstances. The index score for each questionnaire is noted below.

	Normal	7/13/2004	8/16/2004	%Imp
Neck Pain Disability	0%	86%	32%	63%
Oswestry Chronic Lower Back Pain	0%	38%	26%	32%

Mr. Public reports the present symptoms are:

Symptoms	Intensity (0-10, 10 worse)	Frequency of Awake Time
Headaches - left side	4	2xs daily
Neck Pain -	4	constant
Middle Back -	3	end of day
Low Back -	4	constant

What makes pain worse:

Symptoms/Description	Pain Quality	Time of Day
Headaches - stress	Throbbing	P.M.
Neck Pain - sleeping	Dull	A.M.
Middle Back - lifting	Achy	P.M.
Low Back - driving	Sharp	P.M.

What makes pain better:

Symptoms/Description
Headaches - massage and rest
Neck Pain - massage
Middle Back - massage and hot tub
Low Back - massage and hot tub

ACTIVITIES OF DAILY LIVING:

Self-Reporting Measures of Lifestyle changes were completed by the patient to assess the degree of impairment (and activity

changes upon re-evaluation) the patient is experiencing and the ways the patient copes with these circumstances. The index score is noted below.

	Normal	7/13/2004	8/17/2004	%Imp
RAND 36 Item Health Survey	100%	58%	71%	18%

RAND 36 Item Health Survey Summary for 8/17/2004
Physical Functioning - 65%
Role Limitations Due to Emotional Health - 100%
Role Limitations Due to Physical Health - 100%
Energy/Fatigue - 50%
Emotional Well Being - 68%
Social Functioning - 75%
Pain - 68%
General Health - 65%
Composite - 71%

NEUROLOGICAL EXAMINATION:

Cranial nerves II-IX are grossly intact. Romberg is physiologic. Cerebellum functioning is grossly within normal limits. Mr. Public is alert and oriented to time, place and person. Reflexes are equal and reactive bilaterally in both upper and lower extremities and are +2. He can heel and toe walk without difficulty. Toes are downgoing and there are no pathological reflexes present.

ORTHOPEDIC EXAMINATION:

Cervical Distraction Test was positive on the left side. While seated, the patient actively rotates the head and neck until radicular pain is produced. The examiner then rotates the head to the same extent but with strong upward traction added to the motion. If this action performed by the examiner gives relief or significantly reduces the patient's cervical and/or radicular pain, this test is considered positive, indicating nerve root compression. If the patient can't actively rotate the head or neck because of pain, the examiner can still do this test by adding traction with or without rotation.

Ely's Heel to Buttock Test was positive on the left side. This test is a two stage test done with the patient in a prone position. First the knee is flexed to the opposite buttock. Then the thigh is hyperextended. If this action cannot be performed normally, then the test is positive, indicating one of the following: a hip lesion, irritation of the Iliopsoas muscle or its sheath, inflammation of the lumbar nerve roots, or the presence of lumbar nerve root adhesions.

Lasegue's Straight Leg Raise Test was positive bilaterally. This test is done with the patient supine and with the knee in extension. The examiner, actively flexes each thigh slowly while holding the other hand on the knee to prevent its flexion. The leg is lifted 90 degrees or until pain prevents further motion. The final angle of flexion at which pain occurs, as well as the location and intensity of the pain are noted by the examiner. This test is considered positive when the straight leg cannot be raised to 90 degrees without pain.

Maximum Cervical Compression Test was positive on the left side. In this test, the patient, sitting upright, attempts to laterally flex the neck and head toward the affected shoulder. Then the examiner directs the patient to bring the chin as close as possible to the shoulder. The test may be repeated passively if there is no response when the patient does the action actively. The test is positive when the action causes radicular pain on the side of the flexion and rotation. A positive test reveals cervical nerve root compression in that the action narrows the diameters of the intervertebral foramina as much as anatomically possible.

Shoulder Depression Test was positive bilaterally. This test is done with the patient supine. The examiner standing at the head of the patient, flexes the neck to the side opposite to the shoulder being tested while pushing the shoulder caudad. Then, while maintaining the depression of the shoulder, the head is rotated, again to the side opposite to the shoulder being tested. If radicular pain is either produced or aggravated the first action and then confirmed by the second, the test is considered positive. A positive test indicates adhesions of the dural sleeves, the spinal roots, or the adjacent structures of the joint capsule on the side of the shoulder being depressed.

SPINAL EXAMINATION:

A thorough Spinal examination was done on Mr. Public. Spinal examination consisted of static and motion palpation of the

cervical, thoracic, lumbar spine and pelvis. It included intervertebral joint play analysis. Comparative leg length analysis. Range of motion evaluation. The examination revealed dysfunctions/vertebral subluxations at the following levels: C3, T4, L3.

These articular dysfunctions are associated and accompanied by joint edema. Joint capsulitis. Deep and superfical myospasms. There is muscle splinting and tenderness upon digital palpation at the levels of the articular dysfunctions. There is pain on percussion of the spinous processes at these levels as well. There are myofascial trigger points located in the following musculature: C3, T4, L3.

FUNCTIONAL AND STRUCTURAL ASSESSMENTS:

Individual physical test measurements and their calculated values are listed below. The first examination serves as a starting point or baseline for comparison with subsequent test measurements and subsequently documenting change over time. In this manner, test scores and functional assessments are used as outcome measures.

Range of Motion (ROM) Testing - Restriction and/or asymmetry in spinal motion was noted in the physical examination. Active range of motion testing was performed to document the extent of those spinal restrictions and asymmetries using the Zero-Neutral, Gravity-Based SFTR (Sagittal Frontal Transverse Rotation) Method developed by John J. Gerhardt, M.D.

	7/13/2004		% Limitation		8/16/2004		% Limitation		Improvement		% Improved	
Cervical Extension/Flexion	40°	38°	33%	24%	50°	53°	17%	0%	+10°	+15°	25%	39%
Cervical Lateral Flexion (Left/Right)	30°	26°	33%	42%	38°	33°	16%	27%	+8°	+7°	27%	27%
Cervical Rotation (Left/Right)	60°	45°	25%	44%	72°	60°	10%	25%	+12°	+15°	20%	33%
Lumbar Extension/Flexion	15°	40°	40%	33%	22°	51°	12%	15%	+7°	+11°	47%	28%
Lumbar Lateral Flexion (Left/Right)	20°	16°	20%	36%	25°	24°	0%	4%	+5°	+8°	25%	50%

Manual, Subjectively Rated Strength Tests were performed on selected major muscle groups of the upper and/or lower extremities. A rating scale of five to zero is used, five being normal.

	7/13/2004			8/16/204		
Subjective Muscle Strength	Left	Right	%Diff	Left	Right	%Diff
Shoulder Abductors	5	4	20%	4	4	0%
Shoulder Extensors	4	4	0%			
Shoulder Flexors				4	4	0%
Shoulder Lateral Rotators				4	5	20%
Hip Flexors				4	4	0%
Hip Abductors				4	4	0%

A Computerized Comparative Muscle Strength Test (CCMT) procedure was performed in order to determine asymmetry in muscle strength and to quantify muscle strength loss as noted on the subjective muscle strength test. These muscle strength losses of the upper and/or lower extremities indicate neurological facilitation resulting from trauma to the cervical and/or lumbar spine.

	7/13/2004			8/16/2004			%Imp	
Isometric Muscle Strength	Left	Right	%Diff	Left	Right	%Diff	Left	Right
Shoulder Abductors	15	19	27%	29	31	6%	93%	63%
Shoulder Flexors	16.5	18.5	12%	30	31	3%	82%	68%
Shoulder Lateral Rotators	14	18	29%	32.5	33	2%	132%	83%
Hip Flexors	35	40.5	16%	54	60	10%	54%	48%
Hip Abductors	38	42	11%	59	65	9%	55%	55%

According to Bohannon et al (Bohannon, R. and Andrews, A. W.; Perpetual and Motor Skills, 1999, 89, 878-880), with the possible exception of wrist extension, differences in strength between sides is typically less than 6%.

Mr. Public underwent a Regional Muscular Sensitivity/Pressure Pain Threshold (RMS/PPT) Test examination to assess muscular tenderness on the indicated date(s) below. A computerized algometer was used to determine their Pressure Pain Threshold (PPT) at each site.

RMS/PPT (lbs)	7/13/2004			8/16/2004			%Imp	
	Left	Right	%Diff	Left	Right	%Diff	Left	Right
Cervical Spine								
Cervical Paraspinals (C1 level)	6.1	4.6	25%	13.8	12.1	12%	126%	163%
Cervical Paraspinals (C4 level)	8.4	7.4	12%	8.4	7.4	12%	0%	0%
Cervical Paraspinals (C6 level)	5.8	5.6	3%	14.9	13.6	9%	157%	143%
Upper Trapezius	7.9	10	21%	7.9	10	21%	0%	0%
Supraspinatus	8.3	4.8	42%	7.3	10.3	29%	-12%	115%
Infraspinatus	4.6	4.4	4%	9.2	8	13%	100%	82%
Rhomboids	4.9	7	30%	8.2	7.3	11%	67%	4%

Grip Strength Test

	7/13/2004	8/16/2004	%Imp
Grip Strength - Left	10.3 lbs	21 lbs	104%
Grip Strength - Right	18.3 lbs	31 lbs	69%

VITAL LUNG CAPACITY:

	7/13/2004	8/4/2004	%Imp
Spirometry Measurement	3200 cc	4100 cc	28%

RADIOLOGY:

	Normal	7/13/2004	8/16/2004	
Cervical Jackson's Angle	39.9	20	N/A	Degrees
C2 MSI Angular Variation	< 7	N/A	11.9	Degrees
C5 MSI Angular Variation	< 7	N/A	13.1	Degrees
C5 MSI Translation Variation	< 1	4.5	N/A	Millimeters

ASSESSMENT/DIAGNOSIS:

	7/13/2004	N/A	%Imp
Prognosis Value	135		
Prognosis Group	5		

The Prognosis is considered clinically unstable. The probability of future surgery, persistent neurological deficit and a surgical consultation is indicated.
Norris and Watt, Journal of Bone and Joint Surgery, 1983.
Foreman and Croft, Acceleration-Deceleration/Injuries of the Cervical Spine, 1990.

Mr. Public presented with the above described complaints. His current chiropractic, orthopedic and neurological examination is as described above.

The following is a working diagnosis:

E812.0 Driver of an automobile involved in a motor vehicle collision
839.08 Multiple Cervical Spine Subluxations (closed)
839.20 Multiple Lumbar Spine Subluxations (closed)

TREATMENT PLAN/RECOMMENDATIONS:

The patient will be seen 2 times a week, based on the progress shown visit to visit. The patient will be re-evaluated in 13 visits using the same functional assessments. Treatment plan will be re-evaluated or modified based on the test results. Follow-up progress reports will be sent. Care will continue until the patient's condition is stabilized.

If you have any questions regarding this report please contact my office.