MEDICAL CHRONOLOGY - INSTRUCTIONS TO FOLLOW

General Instructions:

I: Accident report: *These will be left blank if the records are not available/applicable*

II. Injury report: *This comprises of an abstract of the patient's related damages, surgical details, disability, ADLs details, etc*

III. Patient History:
Details related to the patient's past history (medical, surgical, social, occupational, family history and allergy details.) present in the medical records

Verbatim Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information capture (all details/zoom-out model and relevant details/zoom-in model) is as per the demands of the case which will be elaborated under the 'Specific Instructions'

Reviewer's Comments:
*Comments on contradictory information and misinterpretations in the medical records, illegible handwritten notes, missing records, clarifications needed etc. are given in italics and red font color and will appear as * Reviewer's Comment*

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular consultation/report.*

Specific Instructions:

1. *Police report is not available for review*
2. *The injury records post-accident have been summarized in detail.*
3. *Multiple physical therapy records had been combined and elaborated in a single row. However, we have summarized initial and final physical therapy visits separately*
4. *Multiple chiropractic therapy records had been combined and elaborated in a single row. However, we have summarized initial and final chiropractic therapy records in detail.*

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I. Accident Report

Page Reference to Police Report/Accident Scene Investigation Report: *Not available*

PARAMETER	DETAILS		PDF REF
Date and Time of Accident			
Location			
Direction of Travel			
Speed			
Scene of Accident			
No of Vehicles Involved			
Party Details			
Vehicle Details Unit 1	**Model**		
	Year		
	Color		
	Insurance/Policy Number		
Vehicle Details Unit 2	**Model**		
	Year		
	Color		
	Insurance/Policy Number		
Description of Accident			
Did Airbag Deploy?			
Seat Belt Applied?			
Seating Position			
Vehicle Damages/ Vehicle Towed			
Property loss			
Violation Code/Reason for Accident/ Sobriety and Distraction Factors			
Parties Cited/At Fault Party			
Was 911 Called?			
Who Arrived at the scene First?			
Other Details			

II. Injury Report

PARAMETER	DETAILS	PDF REF
Related Injuries and Medical Condition Before incident	*Not available*	
Damages Developed/Sustained as a	• Neck pain • Low back pain	3-8, 11-13, 44, 32-42, 87-89,

PARAMETER	DETAILS	PDF REF
result of incident	• Pain in leg • Bilateral knee pain • Right arm tingling/Right hand numb • Mid low back pain • Focal weakness • Loss of sensation in entire right hand • Apparent function dependent weakness through right arm • Paraspinal pain • Right shoulder pain • Lumbar strain • Right shoulder sprain • Bilateral knee sprain/contusions • Difficulty sleeping • Irritability • Fatigue • Dizziness, shock immediately after accident • Neck pain • Mid back pain • Cervical sprain • Thoracic sprain • Lumbar sprain • Muscle spasms	90-92, 95-98, 119-120
Surgeries or procedures underwent as a result of incident	*Not available*	
Postsurgical complications	*Not applicable*	
Aggravation of pre-existing conditions	*Not available*	
Did patient return to work	**06/04/20XX:** Patient was seen in the emergency department on 06/04/20XX and is excused from work for 2 days. She can return to work in 3 days without restrictions. **06/07/20XX:** Patient is a safety worker and has been off of work for a few days. Missed work since 06/04/20XX to 06/07/20XX. **07/23/20XX: Work Excuse:** The patient has an appointment at this office for back, knee pain on 07/23/20XX. Please excuse this absence. **07/30/20XX: Work Excuse:** The patient has an appointment at this office for back and knee pain on 07/30/20XX. Please excuse this absence/late arrival. **08/13/20XX: Work Excuse:** The patient has an appointment at this office for back pain on 08/13/20XX. Please excuse this absence.	81, 87-89, 95-98, 108, 111, 113
Impact of Injury on ADLs/Quality of Life	**06/07/20XX**: Knee Pain - Unspeakable pain and unable to get out of the bed and possibly delirious. Aggravating Factors – Movement and standing. Right Shoulder pain aggravated by movement and lifting. Back pain	87-89, 90-92, 95-98, 99, 100, 101, 103, 104,

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PARAMETER	DETAILS	PDF REF
	aggravated by movement. Severe pain that dominates sense and significantly limits the ability to perform daily activities. Bilateral knee pain – achy with bending and squatting overall stiffness. Patient's current symptoms are pain, numbness, swollen and stiff. These symptoms affect the following activities of daily living: walk, stairs, sit, stand and sleep. I cannot work, can't stand very long, the pain at night, cannot sleep. **Degree of Difficulty on a scale of 1-5**: Lying on Back, Lying on Side, Walking, Stretching: 4. Lying on Stomach and Sitting: 2. Lovemaking, Running, Sports, Working, Lifting, Bending, Kneeling, Pulling, and Reaching: 5. These deficits limit patient from performing transfers, walking, standing, stair negotiation, raising arm OH and gross use of RUE. **06/12/20XX-06/14/20XX**: Patient reports pain is distressing. The moderately strong pain interferes with normal daily activities and can be hard to concentrate. **06/19/20XX**: Limited sleep secondary to pain. **06/28/20XX-07/05/20XX: Pain Level at Arrival**: Patient reports pain is distressing. The moderately strong pain interferes with normal daily activities and can be hard to concentrate. **07/23/20XX:** Her pain interferes with work, her daily routine, driving, standing, bending, sleeping, sitting, and walking. She also reported symptoms of present difficulty in sitting. This patient also reported present difficulty in standing. Present difficulty in bending and present difficulty in walking. **07/25/20XX:** Patient stated she was unable to go to work yesterday due to the pain in her knees and back. Present difficulty in sitting and present difficulty in standing. Present difficulty in bending and present difficulty in walking. **07/30/20XX**: The patient also complained of present difficulty in sitting, present difficulty in standing, present difficulty in bending and Present difficulty in walking. Patient is released to return to work on 07/27/20XX under the following instructions: Restriction on lifting, pushing or pulling; restriction on stooping, bending and climbing. Other – Not able to breakup lights, unable to walk, rounds. **Duration and Specification of restrictions**: Thursday, 08/31/20XX. **08/01/20XX**: Present difficulty in sitting. Present difficulty in standing, Present difficulty in bending and present difficulty in walking **08/09/20XX**: Present difficulty in sitting and present difficulty in standing. difficulty in bending. **08/13/20XX**: Present difficulty in sitting. Present difficulty in standing and present difficulty in bending.	119-120, 115-118, 119-120, 120-121, 121, 121-122, 122-123

PARAMETER	DETAILS	PDF REF
Disability (if any)	**07/25/20XX: Disability Certificate**: Has been under my professional care and was totally incapacitated from 07/24/20XX to 07/25/20XX. **Remarks**: Due to back and knee pain. **07/30/20XX: Disability Certificate**: Has been under my professional care and was totally incapacitated from 07/28/20XX to 07/28/20XX. **Remarks**: Due to back and knee pain. **08/01/20XX: Disability Certificate**: Has been under my professional care and was totally incapacitated from 08/04/20XX to 08/11/20XX. **Remarks**: Due to acute related injuries.	109, 110, 112

III. Patient History

Past Medical History: No past medical history on file *(PDF Ref: 32-42)*

Past Surgical History: No past medical history on file *(PDF Ref: 32-42)*

Occupational History: Safety worker *(PDF Ref: 87-89)*

Family History: No family history on file *(PDF Ref: 32-42)*

Social History: Smoking Status – never smoker. No alcohol use. No drug use. *(PDF Ref: 32-42)*

Allergy: Iodine causes throat swelling *(PDF Ref: 32-42)*

Detailed Chronology

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		Motor Vehicle Accident (MVA) on 06/04/20XX	
06/04/20XX @1520 hours	Milwaukee Fire Department TripTix EMS Patient Care Record	**Milwaukee Fire Department-TripTix EMS Patient Care Record:** **Pick Up**: Scene of accident. **Location**: Roadway (Street or Highway). **Trip Information: Patient Disposition**: Patient treated, transferred care to another EMS unit. **Response Type**: 911 Response (Scene). **Response Mode**: Emergent (Immediate Response). **Unit Type**: ALS-Paramedic. **Dispatched As**: Traumatic Injury. **Destination**: Froedtert Memorial Lutheran Hospital-Peds. **Location Type**: Emergency Department-Hospital. **Destination Reason**: Patient's choice. **Conveyed By**: Paratech. **Incident Date/Times:** Dispatch notified @1524 hours, arrived on scene @1524 hours, arrived at patient @ 1527 hours, unit back in service @ 1546 hours.	3-8

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		Cause of Injury: MVA, traffic-car. **Injury Mechanism**: Blunt. **Risk Factors**: EMS Provider Judgment. **Type of Injury**: Back pain without swelling/bruising. **Chief Complaint**: MVA (neck and back pain). **Primary Sign and Symptom**: Back pain. **Allergies**: No known drug allergies. **@1528 hours**: Cervical collar applied for stabilization. **Physical Examination**: **@1529 hours: Vitals**: **Glasgow Coma Score (GCS)**: 15. **Heart Rate**: 84. **SpO2**: 100%. **Pain Score**: 6. **Narrative**: Engine (ENG) 22 arrived on the scene to find a 28-year-old female with complains of MVA x10 minutes. Patient was found walking around outside of the vehicle ambulatory. The vehicle that she was the passenger in was struck on the driver's side (no airbag deployment). Patient that she was having neck and back pain upon arrival on the scene. Patient had good Circulation, Motion and Sensory (CMS) in all extremities. Patient was Alert and Oriented (AxO) x4. Patient was placed in her vehicle by ENG 22. Patient was given C-spine precaution by Paratech upon their arrival to the scene. Patient had two children travelling in the back seat of the car with no apparent injuries as stated by the two children. The children were removed from the scene by the grandmother. Patient was transported to the hospital for further treatment and care. **Primary Impression**: Injury of lower back.	
06/04/20XX	Paratech Ambulance Service	**EMS Ambulance Report:** **Service Type**: 911 Response (Scene). **Response Mode**: Emergent (immediate response). **Transport Mode**: Non-emergent. **Sending Type**: Street and/or highway. **Sending**: West Capitol Drive and West Appleton Avenue, Milwaukee, WI 53216. **Dispatch Complaints**: Traffic/Transportation incident. **Disposition**: Treated, transported by EMS unit. **Receiving Type**: Hospital-Emergency Department. **Receiving**: Froedtert Memorial Lutheran Hospital, 9200 West Wisconsin Avenue, Milwaukee, WI 53226. **Destination Determination**: Patient's protocol. **Times and Mileage**: Assigned and Departed: 06/04/20XX @1517 hours. Arrived-Sending Location: 06/04/20XX @1520 hours. Arrived-Patient: 06/04/20XX @1521 hours. Depart-Sending: 06/04/20XX @1536 hours. Arrival-Receiving: 06/04/20XX @1553 hours. **Chief Complaint**: Lower back pain.	11-13

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		Primary Symptom: Back pain. **Other Symptoms**: Pain in leg. **Patient Transport/Positioning**: **Patient Moved To**: Assisted/Walk, Stretcher. **Patient's Position in Transport**: Fowlers (semi-upright sitting). **Past Medical History**: None reported. **Allergies**: No known drug allergies. **Physical Examination:** **@1550 hours: Vitals**: **Blood Pressure (BP)**: 140/90. **Pulse**: 84. **Respirations**:18. **SpO2**: 98%. **Narrative**: Squad 103 was dispatched emergent to the above location for an MVA. Upon arrival Milwaukee Fire Department (MFD) engine 22 was on scene with Milwaukee Police Department (MPD) unit 7262. PAS was directed to a blue SUV in the middle of all three vehicles involved. Patient is sitting with her legs out of the vehicle on the driver's side, A/Ox4, able to answer all questions appropriately, ambulatory on scene prior to our arrival, patent airway. No obvious bleeding or trauma. Patient stated that she was in the passenger seat when they were hit on the driver's side rear and then their car hit another car. Patient was not wearing her seatbelt. No airbags were deployed. No Loss of Consciousness (LOC). no spidering of the windshield. Patient said that after the accident happened someone came over and helped her out of the car and that's how she ended up on the driver's side. Patient was complaining of back pain and was put into a C-Collar. Patient was able to stand and pivot to the cot for us, buckled x5, and wheeled to the ambulance. Patient was complaining of lower back pain, pain in both knees, and right arm tingling. Vitals were taken and all vitals were stable. Patient denied any head or neck pain. Patient was transported to Froedtert, care was transferred, signatures and paperwork were obtained. PAS cleared. **Primary Impression**: Injury of lower back.	
06/04/20XX @1601 hours	FF Hospital Fallon Kowalkowski, RN	**Triage Record Status Post MVA**: Patient arrived via Paratech, 3 car MVA, positive low back pain and knee, right hand numb. Patient was passenger. Hit from driver side rear and then her car rear ended the vehicle in front of her. Patient ambulatory on scene. Patient walked to driver's side. Travelling approximately 25 mph, no airbags, no seatbelt. No LOC.	44
06/04/20XX @1608 hours	FF and Medical College of Wisconsin	**ER Visit Status Post Motor Vehicle Crash (MVC)**: **Arrival Date/Time**: 06/04/20XX @1559 hours. **Admission Date/Time**: 06/04/20XX @1601 hours.	32-42, 18-19, 21-22, 28, 47, 49-53

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
	Amy E. Zosel, M.D. Justine E. Wergin, M.D. Cody Bonk, M.D.	**Chief Complaint**: Motor vehicle crash. **History of Present Illness**: 28-year-old female with no Past Medical History (PMH) to ED via EMS following MVC. Patient was unrestrained passenger, no airbag deployment, no spidering of windshield, no LOC. Patient's vehicle was rear-ended on driver's side, struck at intersection, pushed into another vehicle on vehicle's front. Patient was extricated by bystanders, was able to stand at scene, but had to lean on vehicle due to bilateral knee pain. Patient was in vehicle with two children and children's father. Patient very concerned about location of purse, reported that she has "lots of cash" in there. She also expressed concern of location of children. In ED, patient expressing loss of sensation in right hand, and inability to move right arm up to shoulder. She also expressed mid-low back pain, and bilateral anterior knee pain. No headache (H/A), vision changes, posterior neck pain, other neurological symptoms, no recent colds/coughs/fevers/chills, no current Nausea/Vomiting (N/V), no belly pain. **Past Medical History**: No past medical history on file. **Past Surgical History**: No past surgical history on file. **Social History**: Smoking Status – never smoker. No alcohol use. No drug use. **Family History**: No family history on file. **Allergies**: Iodine causes throat swelling. **Medications**: No medication comments found. **Review of Systems:** **Neurological**: Positive for sensory change and focal weakness. Negative for dizziness, loss of consciousness, weakness and headaches. **Physical Examination**: **@1605 hours: Temperature**: 99-degree Fahrenheit. **Pulse**: 85. **Respirations**: 16. **BP**: 142/78. **SpO2**: 99%. **@1801 hours: Temperature:** 98.9-degree Fahrenheit. **Pulse**: 81. **Respirations**: 18. **BP**: 140/68. **SpO2**: 99%. **@1904 hours**: **Temperature**; 98.4-degree Fahrenheit. **Pulse**: 84. **Respirations**: 18. **BP**: 122/63. **SpO2**: 99%. **Neck:** C-spine in place, no posterior spine tenderness. **Musculoskeletal:** Range of Motion (ROM) limited in bilateral knee due to pain in anterior knee, no external evidence of trauma. Full Passive Range of Motion (PROM) in bilateral hip, with mild tenderness in low back with hip flexion. No external evidence noted on skin and musculoskeletal exam. Patient with lumbar spinal tenderness, no step off. ROM severely limited in Right Upper Extremity (RUE) at shoulder, elbow, wrist and hand throughout. Full PROM without tenderness in RUE. 2+ pulses throughout in all extremities. **Neurological**: Reported loss of sensation in entire right hand, dorsal and palmar aspect up to wrist. 1/5 muscle strength in right shoulder, 0/5 in remaining muscle groups throughout right arm. Appears effort dependent. **@1611 hours: Pain Location**: Back radiation to right arm. **Pain Score**: 8 at rest, 8 at activity.	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		@1801 hours: **Pain Location**: Back radiation to right arm. **Pain Score**: 6 at rest and 6 at activity. **Prescience of Pain**: Complains of pain/discomfort. **Frequency**: Constant. **@1653 hours: Stephen W. Goth, M.D., Joshua P. Jarman, M.D.**: **X-Ray of Lumbar Spine, Left Knee and Right Knee 2 Views**: **Clinical Information**: Motor vehicle crash, lumbar pain and tenderness, bilateral knee pain. **Impression**: Normal exam of the lumbar spine and bilateral knees. **@1725 hours: Stephen W. Goth, M.D.**: **Chest X-Ray 1 View**: **Clinical Information**: Status post motor vehicle crash. **Impression**: No radiographic evidence of acute cardiopulmonary disease. **@1853 hours: David V. Smullen, M.D.**: **CT Cervical Spine without Contrast: Clinical Information**: Trauma. **Impression:** Negative cervical exam following neck trauma for fracture. Flexion-extension radiographs, or MRI with STIR sequence, may be considered to evaluate for occult ligamentous injury if symptoms warrant. **Medical Decision Making**: 28-year-old female, unrestrained passenger involved in MVC, struck on driver rear then forced into another vehicle, no airbag, no LOC, who presented to ED in No Acute Distress (NAD), normal vital signs with reports of low back pain, bilateral knee pain and reported loss of sensation in entire right hand and apparent function dependent weakness throughout right arm. Brachial plexus injury possible, but symptoms would correlate with C4-C8 injury. CT – C-spine, X-ray L-spine, bilateral knee, Cervical x-ray ordered to evaluate for injury. Patient refused Per Oral (p.o.) medications. Peripheral IV placed, given 25 mcg fentanyl for pain control. Care of patient signed out to doctors Sharpless and Wergin with pending results of imaging, clearance of C-spine, and final disposition. **@1925 hours**: Imaging without abnormalities. C-collar removed at bedside in ED. Neuro exam non-focal with Cranial Nerves (CN) II-XII grossly intact, bilateral Upper Extremity (UE)/Lower Extremity (LE) motor strength 5/5, gross sensation intact. No midline C-spine tenderness to palpation. Full ROM of neck with no pain. Strength in all muscle groups intact in RUE limited by effort. Now complaining of paraspinal pain. Given Toradol and bilateral Lidoderm patches. Patient is well appearing and appropriate for outpatient management. Diagnostic imaging, findings and pain discussed with the patient. Questions answered. Patient demonstrated verbal understanding and patient was discharged with return precautions. **Visit Diagnosis**: Motor vehicle collision. **Discharge Date/Time**: 06/04/20XX @2015 hours. **Discharge Disposition**: Home or Self-care. **Follow-Up**: With Primary care scheduling, call in 1 day, call today to establish with a primary care doctor.	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
06/04/20XX	FF and Medical College of Wisconsin Justine E. Wergin, M.D.	**Work Excuse Form:** Patient was seen in the emergency department on 06/04/20XX and is excused from work for 2 days. She can return to work in 3 days without restrictions.	81
06/04/20XX	FF and Medical College of Wisconsin	**ER Related Records:** Medical bills, face sheet. ED Care timeline, orders, flow sheets, consent.	16-17, 20, 23-27, 29-31, 43-46, 48, 54-80
06/07/20XX	WW Medical Group Haley Schultz, D.O.	**Office Visit for Knee Pain, Shoulder Pain and Back Pain:** **Chief Complaint**: Knee pain, shoulder pain and back pain. **History of Present Illness**: On 06/04/20XX, patient was the unrestrained passenger in a car that was hit by a car that T-boned at a high rate of speed on the driver's side. Other cars airbags deployed, but theirs did not. Patient denies LOC. Patient did hit the dashboard. Patient sustained low back pain, right shoulder pain and bilateral knee pain. Patient went to the ER where x-rays were done of the knees and lumbar spine that were Within Normal Limits (WNL). Patient is a safety worker and has been off of work for a few days. Patient denies these symptoms prior to this MVA. **Knee Pain**: Mechanism of injury – MVA. Direct blow to the knee – Dashboard. Location – Bilateral. Onset – Rapid. Constant, achy and stiff. **Severity** – Unspeakable pain and unable to get out of the bed and possibly delirious. **Aggravating Factors** – Movement and standing. **Alleviating Factors** – Rest. **Associated Symptoms** – No radiation. Effusion – yes. **Shoulder Pain**: Mechanism of injury – MVA. **Dominant Hand**: Right. Sudden, stiff, intense pain that severely limits physical activity. Conversation requires great effort. **Aggravating Factors** – Movement and lifting. **Alleviating Factors** – Rest. **Associated Symptoms** – No radiation. **Back Pain**: Location – Lumbar. Gradual, achy, severe pain that dominates sense and significantly limits the ability to perform daily activities. **Aggravating Factors** – Movement. **Alleviating Factors** – Rest. **Associated Symptoms** – No radiation. **Review of Systems**: **Musculoskeletal**: Reports knee pain bilateral, right shoulder pain, knees - stiffness, locking, catching, and popping. Swelling – knees and shoulder. Decreased ROM and low back pain. Denies hip pain. **Physical Examination:** **Musculoskeletal**: Tender paraspinal muscles/spine: Lumbar. Back ROM: decreased flexion/Extension/Rotation (F/E/Rot). Shoulder ROM: Decreased	87-89, 94

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		abduction due to pain in right. Elbow ROM: WNL. Knee ROM: Decreased Flexion/Extension bilateral. Muscle strength 5/5. **Knee**: Bruising, mild bilateral point tenderness. Patella ROM – flexion, extension decreased. Muscle strength 5/5. Valgus Stress Test: Normal. Varus Stress Test: Normal. **Assessment and Plan**: Knee pain, shoulder pain, back pain and lumbar strain. Patient likely has lumbar strain, right shoulder sprain, bilateral knee sprain/contusion. **Plan**: Physical therapy 2-3 per weeks. Over the Counter (OTC) for pain. Will hold on further imaging of the right shoulder for now. **Follow-Up**: 4 weeks.	
06/07/20XX	WW Medical Group Kristen Nett, DPT	**Initial Physical Therapy Visit for Low Back Pain, Bilateral Knee Pain, and Right Shoulder Pain:** Patient involved in MVA 06/04/20XX sustained Low back pain, Bilateral knee pain, and Right shoulder pain. Bilateral knee pain most prevalent at this time. Describes pain as achy with bending and squatting, overall stiffness. Right shoulder: Sharp pain with all motion, stiff Lumbar: pulling, tight. **Alleviating**: Ibuprofen. **Occupation:** Works for safety at MPS, currently without restrictions. **Personal Injury Intake Form: Occupation:** Safety worker. **Accident Information**: **Date**: 06/04/20XX @1500 hours. Reported to the police *(* Reviewer's Comment: Police Report is not available).* Traffic violation issued to the other driver. **Location of Accident**: Appleton and Capitol. **Number of passengers**: 4. **Were there other witnesses**: Yes. **Make/Model of care the patient was in** 2017 Nissan Rogue. **Accident Occurred**: We were heading East on Capitol going through the intersection when a car heading West made a left turn hit me. Direction headed to East. Approximate speed of vehicle is 25 mph. . Impact of vehicle came from front and left. During impact, facing forward. Surprised by the impact. Passenger in front seat, vehicle equipped with airbags and did not inflate. In relationship to the base of the skull, the headrest was at above. Vehicle impact another vehicle. Patient's knees were hit the dash. **Physical Therapy (PT) Eval Medical Condition/Medical History**: **Pain Level**: Patient reports pain is severe, and it significantly limits the ability to perform daily activities. Patient's current symptoms are pain, numbness, swollen and stiff. These symptoms affect the following activities of daily living: walk, stairs, sit, stand and sleep. **PT Eval Demographic Background**: Patient's Occupation is Safety- MPS. **Patient's Goals** are: Improve mobility, decrease pain. **Pt Eval Objective**: **Shoulder Active Range of Motion (AROM)**: Flexion: 80 degrees, Internal Rotation(IR)/External Rotation (ER): WNL, painful. Pain stays in Right	90-92, 95-98

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		shoulder. **Cervical AROM**: WNL. **Lumbar AROM**: Flexion: Moderate limit, pain. Extension: Mild limit, pain. bilateral pain with Side Bending (SB). Bilateral Upper Extremities (BUE) - support to sit to stand. Unable to complete standing march. **PT Eval Other Tests:** Palpation/Sensation Severe Tenderness to Palpation (TTP) over bilateral knee Right greater than left light touch. Unwilling to lie prone supine or side lying for objective measurements. **Pain Levels**: Right shoulder - Achy pain. Bilateral Knees – Achy pain. Low Back – Burning pain and sharp pain. **Pain Scale**: Knees – 10. Lower Back – 8. Right Shoulder – 8. **Taking Birth Control**: Yes. **Post-Injury Information**: Since the accident, Patient was seen other doctor immediately by ambulance to Froedtert. Treatment received - pain medications and scans. Missed work since 06/04/20XX to 06/07/20XX, work activities restricted as a result of injury. **Result of the Accident**: Difficulty sleeping, arm/shoulder pain, numb hands/fingers, irritability, fatigue, back pain and low back pain. **Other**: Knees. **Condition**: Worsened. **Condition Affecting Work**: I cannot work, can't stand very long, the pain at night, cannot sleep. **Degree of Difficulty on a scale of 1-5**: Lying on Back, Lying on Side, Walking, stretching: 4. Lying on Stomach and Sitting: 2. Standing, Lovemaking, Running, Sports, Working, Lifting, Bending, Kneeling, Pulling, and Reaching: 5. **Work Hours**: 8. **Job Duties**: Standing, twisting, sitting, walking, lifting, bending, and stopping. In work with minimum physical effort and for how long: Sitting. **PT Eval Assessment:** **Assessment/Clinical Judgment**: Patient is a pleasant 28-year-old female presenting to PT with Bilateral knee pain, low back pain, Right shoulder pain following MVA on 06/04/20XX. Patient presents with decreased strength, AROM, bed mobility, transfer ability, pain and soft tissue restrictions. These deficits limit patient from performing transfers, walking, standing, stair negotiation, raising arm Over Head (OH) and gross use of RUE. PT will address above stated deficits and address functional goals. **Treatment**: Electrical stimulation (E-Stim), Hot Pack/Cold Pack – Bilateral knees, Home Exercise Program (HEP), manual therapy.	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		Plan of Care: Frequency/Duration: 3 times a week for 8 weeks. **Prescription**: Physical therapy to evaluate and treat 2-3 weeks for 12 weeks.	
06/12/20XX-07/05/20XX	WW Medical Group Nicole Rietveld, PTA Milan Grbic, PT William Lois, DPT Danra Chang, PTA	**Multiple Physical Therapy Visit for Lumbar Pain, Right Shoulder Pain and Bilateral Knee Pain:** **Diagnosis:** Bilateral knee pain, low back pain, Right shoulder pain. **Treatment**: Electrical stimulation (E-Stim), Hot Pack/Cold Pack – Bilateral knees, HEP, manual therapy, therapeutic exercise. **06/12/20XX**: Patient reports no change. High levels of pain in lumbar spine, states that she is still sleeping in a recliner due to back pain, notes knee hurts too but is not as bad as the back. **Assessment**: Tolerance: Fair. **Assessment Note**: Improved after session. Today was only patient's second session therefore focus of session was on gentle ROM, pain control and light PRE's. Patient did have decreased pain and increased lumbar ROM secondary to treatment. **Pain Level After Treatment**: Patient reports pain is distressing. The moderately strong pain interferes with normal daily activities and can be hard to concentrate. **06/14/20XX**: Patient reports no change. Impossible to fulfill work duties as a recreation coordinator; pain is keeping me up at night and cannot sleep in a bed. Iontophoresis did help briefly. Pain Level at Arrival: Patient reports pain is intense and physical activities are severely limited. **Assessment**: Tolerance: Fair. **Assessment Note**: Improved after session. Issued TENS unit for home use and instructed in application; patient able to demo independence with use of unit. **Pain Level After Treatment**: The moderately strong pain interferes with normal daily activities and can be hard to concentrate. **06/19/20XX**: Patient reports no change. Limited sleep secondary to pain and stiffness. **Assessment**: Fair. **Assessment Note**: Improved after session. **06/26/20XX**: Patient reports no change. Patient offers complains of neck and knee pain as chief complaint (c/c) for today. **Pain Level at Arrival**: Patient reports pain is absent. States she fell getting out of bed two days ago because her knees gave out on her. **Assessment**: Tolerance: Fair. Continues with bilateral lower extremity weakness contributing to decreased tolerance to ambulation and decreased balance, increasing risk of falls, decreased tolerance to bed mobility. **Assessment Note**: Improved after session. **06/28/20XX**: Patient reports bilateral knee and low back pain this date. **Pain Level at Arrival**: Patient reports pain is distressing. The moderately strong pain interferes with normal daily activities and can be hard to concentrate. States she fell getting out of bed two days ago because her knees gave out on her. **Assessment**: Tolerance: Fair. Pain continues to limit patient's tolerance to ADLs. Limited tolerance to treatment this session due to complaint of pain. Progress made. **Assessment Note**: Improved after session.	93, 99, 100, 101, 102, 103, 104

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF/BATES REF
		07/05/20XX: Patient reports low back pain this date. back pain this date. **Pain Level at Arrival**: Patient reports pain is distressing. The moderately strong pain interferes with normal daily activities and can be hard to concentrate. States she fell getting out of bed two days ago because her knees gave out on her. **Assessment**: Tolerance: Fair. Pain and stiffness limit patient's tolerance to PRE's this date. Patient encouraged to continue HEP to restore functional strength and verbalized understanding. Patient is progressing. **Assessment Note**: Improved after session. **Reviewer's Comment: Multiple physical therapy visits had been combined and elaborated in a single row for ease of reference.*	
07/11/20XX	WW Medical Group Danra Chang, PTA	**Final Physical Therapy Visit for Low Back Pain and Right Knee Pain:** Patient reports minor improvement. Patient reports low back pain and right knee pain this date. States that right knee has painful clicking. Patient does state overall improvement with increased mobility. **Pain Level at Arrival**: Patient reports pain is moderate and when deeply involved in an activity, it can be ignored for a period of time, but it is still distracting. States she fell getting out of bed two days ago because her knees gave out on her. **Objective:** Crepitus with right patella. Increasing mobility. **Treatment**: Therapeutic exercises, manual therapy, and myofascial release. **Assessment**: Tolerance: Good. Patient demonstrates increasing mobility with increased tolerance to PRE's this date. Increased lumbar ROM/flexibility noted. Patient is progressing. **Assessment Note**: Improved after session. **Plan**: Continue plan of care. Increase PRE program.	105-106
07/23/20XX	KK Chiropractor Center Corinne A. Kennedy, DC	**Initial Chiropractic Therapy Visit for Neck pain, Mid Back Pain, Low Back Pain, and Bilateral Knee Pain:** Patient reported she was a front seat passenger in a Nissan Rogue traveling eastbound on Capitol Drive, when a car traveling westbound turned left in front of them, T-boning the driver's side of her car, pushing the passenger side of her car into another car. She was wearing her seatbelt, looking straight ahead, unaware of the impending impact. At the moment of impact, she was thrown to the left, then to the right, striking her knees on the lower dash. She stated her seat was broken and she believes the airbags deployed. Immediately following the accident, she was experiencing dizziness, shock, neck, mid back, low back pain and bilateral knee pain. She was transported by ambulance to Froedtert ER where they performed an examination and obtained x-rays. Dr. Schultz referred her to Physical Therapy where they have instructed her on exercises and provided her with a TENS unit. She states her symptoms have not changed since she has been attending PT. She describes her pain as sharp, throbbing, shooting and stiff. Her pain interferes with work, her daily routine, driving, standing, bending, sleeping, sitting, and walking. The patient reported indications of severe constant neck pain on both sides, severe constant mid back pain and	119-120, 115-118, 108, 124

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		severe constant low back pain. This patient also reported severe constant pain in both knees. She also reported symptoms of present difficulty in sitting. This patient also reported present difficulty in standing. Present difficulty in bending and present difficulty in walking. **Automobile Accident History Form: Date of Accident**: 06/04/20XX. **Time of Accident**: 1500 hours, daylight. Road condition –Dry. Patient was a front seat passenger. It was surprise. Initial symptoms were dizzy, shock, neck pain, back pain and other – knees. Same the next day. Police came to the accident scene. *(* Reviewer's Comment: Police Report is not available for review)*. Stride knees on gloves box. Patient was wearing a seatbelt. The seat adjustment altered during impact. Seat broken during the accident. Airbag did ? deploy. Head pointing at the time of impact – straight. Patient went to the hospital to Froedtert by ambulance. The hospital findings were exam and x-rays. **Patient's Car Details:** Make and model of the car: Year 2017, Nissan Rogue. The car was not stopped at the time of impact. The vehicle moving at the time of impact, at approximately 35 mph. **Other Car Details:** Make and model of other car: 2007, Toyota Sienna. The other car was moving at the time of impact, at approximately 35 mph. **Accident Description**: Head East on Capitol a car, head west making a left turn hit my car in the intersection which caused my car to hit another vehicle. She was T-boned and was pushed into car to her right, passenger side. **Confidential Health Questionnaire – Present History**: Reason for Visit: Auto accident pain. Describe Current Symptoms: Lower back and knee pain. Date Symptoms Began: 06/04/20XX related to auto accident. Experience of Symptoms: Constantly (76-100% of the day). Type of Pain Felt: Sharp, throbbing, shooting and stiffness. Pain interferes with work, daily routine, driving, standing, bending, sleep, sitting, and walking. Pain Score: 8/10. Neck pain, bilateral knee pain, mid back pain and low back pain. Symptoms Changing: Not changing. WI Medical Group – Dr. Schultz referred PT for past month, PT exercise and TENS unit. **Occupation**: Safety. **Social History:** Non smoke, no alcohol. **Physical Examination**: **Objective Findings**: To a reasonable degree of chiropractic certainty the above injuries are secondary to the MVA on 06/04/20XX. Muscle hypertonicity at the cervical region, the cervical trapezius musculature, the mid to upper thoracic region, and the lumbar region bilaterally. Tenderness was elicited in both knees. Reduced motion was evident to a degree affecting the cervical region and lumbar region bilaterally. A result of positive was acquired from the Maximum cervical compression of the cervical region bilaterally.	

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		Positive findings were obtained from the Extension Compression Test. Her Shoulder Depression Test and Cervical Compression Test elicited a response of positive bilaterally. Gaenslen's test, Ely's sign, Mennel's Test, Hibb's Test, and Yeomen's Test returned a result of positive bilaterally. **Palpation/Observation**: **Static/Motion**: Tenderness to anterior knees bilaterally. Hypertonicity C2-T9 paraspinals bilateral, trapezius bilateral, L1-S1 paraspinals bilateral. **Range of Motion (ROM)**: **Cervical Spine**: Flexion 20 degrees, moderate pain. **Extension and Right Rotation**: 25 degrees, severe pain. **Right Lateral Flexion and Left Lateral Flexion**: 15 degrees, severe pain. **Left Rotation**: 30 degrees, severe pain. **Lumbar Spine**: **Flexion**: 50 degrees, moderate pain. **Extension**: 10 degrees, severe pain. **Right Lateral Flexion, Left Lateral Flexion, and Right Rotation**: 15 degrees, moderate pain. **Left Rotation**: 20 degrees, moderate pain. **Grade System**: C2-T9, L1-S1: Left and Right: +3. **Neurological Evaluation**: **Deep Tendon Reflexes**: Biceps, Triceps, Brachioradialis, Patellar, Achilles: 2 in left and right. **Neurological Function**: **Heel Walk and Toe Walk**: Negative. **Orthopedic Tests/Signs:** **Cervical**: Distraction, rotation extension, Adson's, modified Adson, hyperabduction, costoclavicular, Allen, Soto Hall, Lhermitte: Left and Right: Negative. **Compensatory/Pain**: Minor S, Valsalva, Dejerine Triad: Negative. **Dorso-lumbar**: Bechterew, Tripod S, Straight Leg Raise (SLR), Braggard, Well Leg Raise, Lewin Supine, Linder, Farfan Torsion, Trendelenburg: Negative. Double SLR, leg lowering, Laquerre, Nachlas/Fem Stretch: Positive. **Knee**: Squat, Anterior Drawer, Posterior Drawer, McMurray, Collateral, Appley compression/distraction: Left and Right: Negative. Patellofemoral: Left and Right: Positive. **Upper Extremity**: Trapezius, Deltoideus, Biceps, Wrist Extensors, Triceps, Wrist Flexors, Finger Flexors, Finger Abductor: 5/5. **Lower Extremity**: Hip Flexors, Hip Extensors, Knee Extensors, Knee Flexors, Ankle Extensors, Ankle Flexors: 5/5. **Peripheral Sensitivity Testing**: C5, L2: Left and right: Negative. **Diagnoses**: Cervical sprain. Thoracic sprain. Lumbar sprain. Muscle spasms. Right knee pain. Left knee pain.	

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		Treatment: The treatment she received consisted of manipulation to the lower cervical region, the upper thoracic region, and the lower lumbar region. Ultrasound was administered to both knees. Percussion therapy was applied to the complete spinal region. Interferential therapy to the full spine was applied to the complete spinal region. The treatment she received included hot packs to the complete spinal region. **Plan of Action**: She will be following a treatment plan consisting of two visits per week. The patient may use hot packs at home. **Work Excuse:** The patient has an appointment at this office for back, knee pain on 07/23/20XX. Please excuse this absence.	
07/25/20XX-08/09/20XX	KK Chiropractor Center Corinne A. Kennedy, DC	**Multiple Chiropractic Therapy Visits for Neck pain, Mid Back Pain, Low Back Pain, and Bilateral Knee Pain:** **Diagnoses**: Cervical sprain. Thoracic sprain. Lumbar sprain. Muscle spasms. Right knee pain. Left knee pain. **Treatment**: Manipulation, Ultrasound, Percussion therapy, Interferential therapy, and hot packs. **07/25/20XX**: Patient stated she was unable to go to work yesterday due to the pain in her knees and back. She states her job requires her to stand for most of her shift. The patient reported severe constant neck pain on both sides and severe constant mid back pain. The neck pain on both sides is the same as the last visit and the mid back pain is the same as the last treatment. Patient also reported indications of severe constant low back pain, severe constant pain in both knees. Present difficulty in sitting and present difficulty in standing. The low back pain is unchanged from the last treatment and the pain in both knees is the same as the last visit. Patient also reported indications of present difficulty in bending and present difficulty in walking. **Assessment**: In my clinical opinion, patient is feeling approximately the same. **Disability Certificate**: Has been under my professional care and was totally incapacitated from 07/24/20XX to 07/25/20XX. **Remarks**: Due to back and knee pain. **07/30/20XX**: The patient complained of moderately severe constant neck pain on both sides, moderately severe constant mid back pain, moderately severe constant low back pain and moderately severe constant pain in both knees. The neck pain on both sides is slightly better since the last visit, the mid back pain is a little improved over the last treatment, the low back pain is mildly improved over her last visit, and the pain in both knees is slightly better since the last treatment. The patient also complained of present difficulty in sitting, present difficulty in standing, present difficulty in bending and Present difficulty in walking. **Assessment**: It is my clinical opinion that the patient is feeling a little better. **Work Excuse:** The patient has an appointment at this office for back and knee pain on 07/30/20XX. Please excuse this absence/late arrival. **Disability Certificate**: Has been under my professional care and was totally incapacitated	119-120, 109, 120-121, 110-111, 114, 121, 112, 121-122

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		from 07/28/20XX to 07/28/20XX. **Remarks**: Due to back and knee pain. **Disability Release Form**: Employer: MPS. The above-named employee is released to return to work on 07/27/20XX under the following instructions: Restriction on lifting, pushing or pulling; restriction on stooping, bending and climbing. Other – Not able to breakup lights, unable to walk rounds. **Duration and Specification of restrictions**: Thursday, 08/31/20XX. **08/01/20XX**: The patient complained of moderately severe frequent neck pain on both sides, moderately severe frequent mid back pain and moderately severe frequent low back pain. The neck pain on both sides is unchanged from the last visit, the mid back pain is the same as the last visit, and the low back pain is unchanged from the last treatment. The patient also complained of moderately severe frequent pain in both knees and Present difficulty in sitting. The pain in both knees is the same as the last visit. She also reported symptoms of present difficulty in standing, Present difficulty in bending and present difficulty in walking. **Assessment**: In my opinion she is feeling a little better. **Disability Certificate**: Has been under my professional care and was totally incapacitated from 08/04/20XX to 08/11/20XX. **Remarks**: Due to acute related injuries. **08/09/20XX**: The patient reported indications of moderate frequent neck pain on both sides, moderate frequent mid back pain and moderate frequent low back pain. The neck pain on both sides is a little improved over the previous visit, the mid back pain is mildly improved over her last visit, and the low back pain is slightly better since the last visit. This patient also reported moderate frequent pain in both knees. Present difficulty in sitting and present difficulty in standing. The pain in both knees is a little improved over the previous visit difficulty in sitting is, patient also reported indications of present difficulty in bending. **Assessment**: In my clinical opinion this patient is feeling somewhat better. **Reviewer's Comment: Multiple chiropractic therapy visits had been combined and elaborated in a single row for ease of reference.*	
08/13/20XX	KK Chiropractor Center Corinne A. Kennedy, DC	**Final Chiropractic Therapy Visit for Neck pain, Mid Back Pain, Low Back Pain, and Bilateral Knee Pain:** The patient reported moderate frequent neck pain on both sides; this is unchanged from the last treatment. She also reported symptoms of moderate frequent mid back pain, moderate frequent low back pain, moderate intermittent pain in both knees and present difficulty in sitting. The mid back pain is unchanged from the last visit, the low back pain is unchanged from the last visit, and the pain in both knees is unchanged from the last visit. This patient also reported present difficulty in standing and present difficulty in bending. **Objective**: Muscle hypertonicity at the cervical region, the cervical trapezius musculature, the mid to upper thoracic region, and the lumbar region bilaterally. Tenderness revealed in both knees. Reduced motion was evident bilaterally in the cervical region and lumbar region. Maximum cervical compression test of the cervical region bilaterally was positive. Extension Compression Test was found to be positive. Shoulder Depression Test of the cervical region bilaterally	122-123, 113

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		was positive. Bilaterally Cervical Compression Test of the cervical region was elicited to be negative. Gaenslen's test, Ely's sign, Mennel's Test, and Hibb's Test, generated a result of positive bilaterally. A result of negative was obtained from Yeomen's Test of the lumbar region bilaterally. **Diagnoses**: Cervical sprain. Thoracic sprain. Lumbar sprain. Muscle spasms. Right knee pain. Left knee pain. **Assessment**: It is my opinion that this patient is feeling somewhat better. **Treatment**: Manipulation was administered to the lower cervical region, the upper thoracic region, and the lower lumbar region. She received ultrasound to both knees. The treatment she received included percussion therapy to the complete spinal region. The treatment the patient received consisted of interferential therapy to the full spine to the complete spinal region. Hot packs were administered to the complete spinal region. **Plan of Action**: A treatment schedule of two visits per week will be followed. This patient also was directed to use hot packs at home. She may return to work with a reduced schedule. **Work Excuse:** The patient has an appointment at this office for back pain on 08/13/20XX. Please excuse this absence. **08/16/20XX**: Missed appointment *(* Reviewer's Comment Further record is not available for review)*	
00/00/0000	Multiple Providers	**Other Related Records:** Blank page, medical bills, consent.	1-2, 9-10, 14-15, 82-86, 106-107