Patient Name: Lester Tester
Account # [Z 0003]
Date of Visit: 02/10/13
Provider: Dr John Doe

INITIAL CONSULT:
The patient, Mr. Lester Tester, a 49 year old male, was seen today in the office for an initial consultation. According to Mr. Tester, the reason for this visit is a motor vehicle accident that just occurred. We discussed the patient's history, and current functional limitations due current symptoms. The exam process, determination of diagnosis, and proposed care plan were explained. Alternative options, risks and benefits were discussed. The patient consented to care. X-Rays were done to determine the official diagnosis.
Auto Accident Description: The patient was the driver of the vehicle when the accident occurred. The impact caused his body to jerk around. Lester was not rendered unconscious but was shaken and disoriented. He did not receive medical attention at the scene of the accident. A police report was filled out at the scene.

SUBJECTIVE COMPLAINTS:
As a direct result of the car accident, the patient complains of constant pain, soreness and tightness in the neck that has definitely increased since the accident. The painful symptoms are moderate-to-severe and fairly constant. The pain scale level is on a scale of 0 (none) to 10 (severe) is a 9. Lester also states that since the accident, he has experienced some anxiety and nervousness. There are functional limitations in activities of daily living. Lester states that twisting and turning of the neck is limited due to pain. Sleeping through the night is difficult as a result of the painful symptoms.

PATIENT HISTORY:
Medical History:
Patient Medical History: Asthma, Back Pain, Joint Pain, Vascular Disease
Family History: Diabetes, Heart Disease, High BP, Obesity, Vascular Disease
Current Medications: Aspirin, Codeine
Known Allergies: Dust, Latex Tape, Mold, Sulfas
Past Surgeries/Procedures: Hammertoe
Social History:
Smoking Status: Current Some Day Smoker. Cessation Offered: A smoking cessation program was discussed.
Alcohol Status: Currently Drinks >2 per Day
Relationship Status: Single
Vitals:
Date of Vitals - 10/12/12 (The patient's vitals are over 90 days old)
Height - 72 inches. Weight - 179 lbs. Body Mass Index (BMI) - 24.2
Blood Pressure – 115/78 Temperature - 98.6 degrees. Pulse - 70 b.p.m.

REVIEW OF SYSTEMS:
Constitutional: Good Orientation of Time, Place and No Signs of Depression or Anxiety
Musculoskeletal: Arthritis, Fractured Finger, and Subluxation
Neurological: WNL

PHYSICAL EXAMINATION:
Visual Evaluation:
The patient has anterior head carriage with rounded shoulders, and does not seem to be in any extreme distress. There is slight antalgic head position to the Right. The condition seems to result in an overall guarded appearance.
Neurological:
Sensation was normal in the upper and lower extremities. Motor strength +5/5 bilaterally in the upper extremities. Deep Tendon Reflexes…Upper extremities +2/2 bilaterally, lower extremities patellar +2/2 bilaterally, and S1 +2/2 bilaterally.
Range of Motion:
Cervical Range of Motion is decreased with moderate discomfort. Lumbosacral ROM is within normal limits.

Orthopedic Tests:
Axial Compression Test negative with moderate pain bilaterally. Shoulder Distraction Test is negative with moderate pain bilaterally. Valsalva Test is normal and Swallow Test normal. Heel Walk Test is found to be normal. Toe Walk test normal. Straight Leg Raise Test is normal. Patrick-Fabere's Test normal.

RADIOLOGY FINDINGS:
AP-Lateral X-rays of the cervical region will be taken and fully reviewed today.

DIAGNOSES:
1. Cervical Spine Sprain/Strain.
2. Subluxation of the Cervical Region.
3. Tension Headaches.

CAUSE OF SYMPTOMS:
The patient's symptoms appeared to have come on as a result of the motor vehicle accident in question with the one described in this report. The history, subjective, and objective findings show evidence from a medical viewpoint that this condition is due to the current injury only and no contributing factors are present from preexisting conditions. The patient's condition is a result of a bony/soft tissue injury that has resulted in an undetermined impairment at this time.

PROGNOSIS:
The likelihood of nearly complete symptomatic relief within 90 days is excellent. The patient should reach maximum medical improvement in three-to-six months. Chiropractic treatment shall continue as per treatment plan.

TREATMENT/PLAN:
Treatment Plan:
After completing an initial examination evaluation, I have selected the plan of treatment that should return this patient to a pre-injury status and minimize the possibility of future residuals. Treatment will consist of chiropractic manipulation, chiropractic physical therapy, and observation, decreasing in frequency as the patient's condition allows. I feel it is too early to determine whether this patient will have any residuals or permanent disability.

Short Term Goals:
Reduction of painful condition.
Improve spinal function and biomechanics of the cervical region.
Improve Flexibility of the neck.
Reduce any and all functional limitations.
Long Term Goals:
Eliminate painful condition.
Maximum medical improvement.
Elimination of all functional limitations affecting ADL's.
Return to normal daily environment without any restrictions.

Visits:
The patient will be scheduled for visits 3x per week for an initial period of 4 weeks.

Dr Jonathan Doe
Feb. 10, 2013