

April 17, 2009

Legal Consultation Associates  
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USA Insurance  
1212 Melrose Ave.  
Suite 103  
Seattle, WA 98102

Patient : DOE, JANE S  
Address : 1234 S. Maple Street  
Seattle, WA 98102  
Social Security No. : 123-45-6789  
Employer : NA  
Occupation : Homemaker  
Claim No. : 846786  
Venue : 441316-54  
Date Of Birth : December 1, 1968  
Date Of Injury : April 10, 2009  
Date Of Examination : April, 17, 2009

#### INITIAL/FINAL EVALUATION

Dear Mr. Smith:

This is the report detailing my medical/legal evaluation and treatment of Jane Doe. I initially saw the patient on April, 17, 2009, when she reported to my office suffering from injuries caused by a traffic accident which developed on April 10, 2009.

Mrs. Doe's evaluation, injury history, examination, diagnosis and treatment are discussed below.

#### INJURY DETAILS

The patient explained that she was the driver of a car when it was rear-ended by a van causing slight damage to the car that the patient was driving. She described that she was unprepared at the moment of the incident. At the time, the patient was wearing a shoulder/lap type seat belt. Her head and neck were pitched through a forward and backward motion. Due to the crash Mrs. Doe also struck the back of her head on

the head rest. She maintained conscious awareness. After the incident, Mrs. Doe revealed that she felt shaky and stunned. Later on, Mrs. Doe developed discomfort on the back of her head. Mrs. Doe was not given any emergency care at the scene, however she drove herself to Harborview. While there, although she was not admitted, James Yamoto, MD administered treatment to both sides of her neck using ice packs. Furthermore, x-rays were taken of her neck. Later, the patient went home. That evening, the patient reported she began to feel discomfort on both sides of her neck. Due to continuing complaints, the patient sought care in this office.

#### CURRENT SYMPTOMATOLOGY AND COMPLAINTS

- Anxiety, nervousness and dizziness.
- Headaches. In regard to the headaches, the patient remarked that these happen daily and last throughout waking hours. They are described as dull sensations occurring in the bifrontal area of the cranium. They usually start in the morning but do not wake Mrs. Doe from sleep.
- Persistent nagging neck soreness and stiffness on both sides, moderate in intensity becoming severe with repetitive movement. Medication and rest will basically alleviate the symptoms.

#### MEDICAL RECORDS

This document was reviewed:

Document	Facility	Doctor	Date
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ER Records	Harborview	James Yamoto, MD	4/10/09

#### PREVIOUS MEDICAL HISTORY

The patient's past medical history is positive for the following: anemia, bronchitis, chicken pox, depression, high cholesterol, high triglycerides, measles, mumps, pneumonia and hepatitis. With the exception of the above, the patient confirms that she enjoyed generally good health prior to the aforementioned accident. Other accidents, illnesses, surgeries and traumas are also denied.

#### ALLERGIES

Mrs. Doe noted that she is allergic to dust, sulfa and penicillin.

#### PERSONAL HISTORY

The patient has completed school through the 4th year of college, is married, has two children, is a social drinker and never smokes cigarettes. Her hobbies include reading and writing intermittently and jogging.

#### MEDICAL HISTORY OF FAMILY

Mrs. Doe's family medical history is positive for hypertension, cancer, arthritis and diabetes on her mother's side and heart disease on her father's side.

#### REVIEW OF SYSTEMS

Cardiorespiratory:

The patient has no history of hypertension, shortness of breath, chest pain, palpitations, previous heart murmur, cough, hemoptysis or sputum production. No tuberculosis or pneumonia.

Gastrointestinal:

There is no history of dysphagia, indigestion, nausea, vomiting, anorexia, flatulence, diarrhea, constipation, melena, hematemesis, hemorrhoids, rectal bleeding or rectal itching.

Genitourinary:

There is no history of hematuria, polyuria, dysuria, urgency, hesitancy or backache, soiling, dribbling, or discharge from the urethra.

Skin:

There is no history of rashes.

Gynecological:

There is no history of vaginitis or vaginal discharge.

Hematic/Lymphatic:

There is no history of anemia or bleeding tendencies.

Musculoskeletal:

Mrs. Doe has no history of weakness, atrophy, loss of equilibrium, joint disturbance or limited range of motion. No pedal edema.

Vascular:

There is no history of arterial or venous disease of the extremities.

Neurological:

There is no history of anesthesia, nervous tics, strokes, pinched nerves, slipped discs, numbness, paralysis or lameness, seizures or paresthesia.

Endocrine:

No diabetes or thyroid or adrenal dysfunction.

COMPREHENSIVE PHYSICAL EXAMINATION

GENERAL APPEARANCE

Mrs. Doe was pleasant. This 40 year old female appeared to be her reported age and is normally developed. She is not pregnant. The last menstrual period occurred on April 1, 2009. She is right-handed. She is 5'4" tall. She weighs 120. She seemed in slight acute distress due to her pain. Mrs. Doe's posture was good. The patient's movements were restricted but she was able to walk normally.

VITAL SIGNS:

Blood Pressure:

120/80

Pulse:	60 bmp
Respiration:	16
Temperature:	98.6 F

HEAD:

The head appeared normocephalic in shape and size.

EYES:

Extraocular motions were bilaterally intact, and no nystagmus was noted. The pupils were round and regular with consensual pupillary reaction to light and accommodation.

EARS:

The otoscope examination proved negative. Tympanic membranes appeared intact and translucent bilaterally. There was no complaint of tinnitus nor any gross auditory defects.

NOSE:

No scarring was observed. There was no deviation of the bony septum and the nasal airways were free of cartilaginous obstruction. The nasal mucosa were moist and pink.

MOUTH:

Swelling or inflammation of the oropharyngeal mucosa was not evident. The teeth appeared free of any gross disease.

LUNGS:

There was good respiratory excursion. Breathing sounds were vesicular to auscultation, and percussion revealed no dullness over the lung fields.

HEART:

Normal sinus rhythm without murmurs and no palpable cardiomegaly.

ABDOMEN:

Examination of the abdominal region revealed no palpable tenderness over the liver, spleen, kidneys, or other major organs. Peristalsis was present and normal.

CERVICAL SPINE:

Visual examination revealed moderate limitation of range of motion.

Evaluation of the cervical spine showed the presence of palpable spasm throughout both lower trapezius muscles, 2+ tenderness upon both cervical areas and 1+ tenderness on both upper trapezius muscles. The range of motion testing revealed that cervical spine maneuvers were limited.

Films reveal no conclusive roentgenological evidence of recent fracture, dislocation, luxation or other gross osteopathology. The vertebral bodies and disc spaces are intact and uniform, as are the neural arches.

THORACIC SPINE:

Deep compression of the thoracic spine was negative for tenderness or muscle spasm.

#### LUMBAR SPINE:

Digital palpation of the paralumbar spine was negative for tenderness or muscle spasm. There was no indication of abnormal results in the range of motion testing of the lumbar spine.

#### UPPER EXTREMITIES:

Testing of the upper extremities verified normal ranges of motion, and no muscle spasms or palpable tenderness.

#### LOWER EXTREMITIES:

Examination of both lower extremities confirmed normal ranges of motion, and no muscle spasms or palpable tenderness.

#### NEUROLOGICAL EXAMINATION

##### Sensorium:

She was alert and responsive, and well-oriented to time, place and person.

##### Cranial Nerves:

Serially tested, II through XII, and found to be grossly within normal limits.

##### Sensory:

There was normal stereognosis, pressure sense and two-point discrimination. Pinprick, light touch, and temperature senses were intact.

##### Deep Tendon Reflexes:

Deep tendon reflexes were normal in the right biceps, in the left biceps, in the right brachioradialis, in the left brachioradialis, in the right triceps, in the left triceps, in the right extensor digitorum and in the left extensor digitorum.

##### Motor:

There was no evidence of arm drift or significant atrophy in the upper and lower extremities.

##### Coordination:

On coordination testing, good finger-nose-finger, heel-knee-shin, and rapid alternating movements of the hands and feet tests were all normal. No pendular reflexes or rebound phenomena were noted.

#### X-RAY FINDINGS

X-rays were taken on April 10, 2009 of the lateral view of the the cervical spine.

Cervical Spine:

Films reveal no conclusive roentgenological evidence of recent fracture, dislocation, luxation or other gross osteopathology. Intactness and uniformity are noted in the vertebral bodies, neural arches and disc spaces.

DIAGNOSIS

- Acute Moderate Cervical Sprain And Strain Injury.

CONCLUSIONS AND RECOMMENDATION

The injuries mentioned above came about as a result of a vehicle accident that happened on April 10, 2009. In the course of the examination, I attempted to determine the severity of the injuries so that I could establish an effective treatment plan. As I explained to Mrs. Doe, the objective findings of the examination were compatible with the presenting complaints.

In discussion after the examination, a series of physical therapy sessions was recommended which included massage for the cervical spine. The value of conscientious participation in the therapy program was stressed. Mrs. Doe was issued a cervical collar for support and immobilization of the injured region. Mrs. Doe was ordered to have a CAT scan done. Also, due to the nature of Mrs. Doe's complaints, I referred her to an orthopaedist for further consultation.

The patient was placed on partial temporary disability beginning on April 17, 2009 to May 17, 2009 with instructions to refrain from work activities which include use of her right and left arm, use of her right and left shoulder and use of both sides of her neck. Also, she is given instructions to avoid use of the the upper extremities at or above shoulder level, neck flexion/extension, rotation of the head, use of the cervical musculature and use of the shoulder musculature.

PATIENT PROGNOSIS

Although the patient may in the future face exacerbation episodes, I am optimistic that her general prognosis is good.

I will be glad to answer any questions you may have concerning Mrs. Doe's condition; please do not hesitate to get in touch with me at your convenience.

Sincerely,

Dan E. Frist, D.C.  
DEF/amp

Enclosures:

- ER Records

(This report was dictated but not proofread.)

This medical report must not be considered as a substitute for a comprehensive general health physical examination. I have only reviewed the symptomatology which was or might have been a direct result of the aforementioned injury. The patient should undergo a complete medical physical examination from her personal physician to determine her overall general health if she so desires and/or feels is necessary.

This report was prepared by me. I took the history, reviewed the medical records, and conducted the physical examination. When medically indicated, a technician conducted appropriate tests, at my direction and under my supervision. If tests were conducted outside of my office, they are noted in the body of this report.