Re: Ms. Jan Bon Jovi - Visit Date: Tuesday, October 24, 2006

Date of Injury/Onset: June 10, 2006

To Whom it May Concern:

The patient named above came to our office on October 24, 2006 for treatment of her complaints arising from a motor vehicle accident that she was involved in on June 10. 2006.

DESCRIPTION OF INJURY:
Ms. Bon Jovi stated that she was the front seat passenger in a car which was proceeding along. She stated that the other vehicle struck her vehicle on the left front side.

She also stated that she did not see the accident coming, and therefore was not braced for the impact. Also, she was wearing her seat belt and had her shoulder harness on. The patient's body struck the inside of her vehicle on impact, "severely jolted upon impact." She stated that she did not lose consciousness during the accident. According to the patient, the police showed up at the scene. An accident report was filled out at that time.

INITIAL COMPLAINTS:
Immediately following the accident the patient's main complaints included problems with sleeping, stiffness in the neck, nervousness, headaches, pain in the mid back, neck pain, dizziness and pain in the low back. Following the accident Ms. Bon Jovi was taken by ambulance to the hospital emergency room,

SUBJECTIVE COMPLAINTS:
Ms. Bon Jovi's current signs and symptoms were assessed today. Her first symptom is dull, aching shooting, spastic, tingling and cramping pain in the neck bilaterally. She reported that the pain radiates into both shoulders and the right arm. It occurs between one half and three fourths of the time when she is awake, and causes *serious* diminution in her capacity to carry out daily activities.

Ms. Bon Jovi's second stated symptom is dull, spastic and cramping pain in the low back bilaterally. It occurs between one half and three fourths of the time when she is awake, and causes *serious* diminution in her capacity to carry out daily activities.

She stated her third symptom is dull, aching and throbbing bilateral occipital headaches. It occurs between one half and three fourths of the time she is awake, and causes *serious* diminution in her capacity to carry out daily activities.

Her next symptom is dull, aching spastic and cramping pain in the upper back bilaterally. It occurs between one half and three fourths of the time when she is awake, and causes *serious* diminution in her capacity to carry out daily activities.

OBJECTIVE EVALUATION:
Grip Strength Evaluation: This evaluation was performed with a Jamar Dynamometer. Three readings of the involved hand are averaged and compared to those of the opposite hand, which is usually normal. **Left Hand:**18.14, 18.14, 18.14 **Avg:** 18.1 kilograms. **Right Hand:** 13.60, 13.61, 13.61 **Avg:** 13.6 kilograms. (18.14 - 13.61) divided by 18.14 = **24.99% Strength loss Index**. **Sensory Deficit Testing:** The following dermatomes showed evidence of sensory deficits: on the right side at C5, hypo-esthesia was noted which is forgotten during activity. **Postural Evaluation:** The patient's spine, extremities, gait, etc., were thoroughly inspected visually revealing anomalies which included cervical muscle tension on the right side and thoracic muscle tension bilaterally.

Range of Motion Studies: In order to evaluate the patient's present condition with regard to spinal joint motion, she was examined with the following results: **Cervical Spine:** Flexion: 20 degrees (norm = 50). Extension: 20 degrees (norm = 60). Left lateral flexion: 16 degrees (norm = 45). Right lateral flexion: 16 degrees (norm = 45). Left rotation: 17 degrees (norm = 80). Right rotation: 17 degrees (norm = 80).

Lumbar Spine: Flexion: 20 degrees (norm = 60+). Extension: 10 degrees (norm = 25). Left lateral flexion: 16 degrees (norm = 25). Right lateral flexion: 16 degrees (norm = 25).

Qrthopedic Tests: Standing Tests: **Kemp's Test** was positive bilaterally. Sitting Tests: **The Maximum Cervical Compression Test** was positive bilaterally. Supine Tests: **The Lasegue (Straight Leg Raise) Test** was positive. On this patient, moderate pain at low back was elicited at 20 degrees, which may indicate low back radiculopathy or possibly a lumbar disk lesion. **Soto-Hall Test** was positive, with the patient's pain being localized at C-5.

Palpation Evaluation: Paraspinal Studies: Palpating the left paracervical muscles revealed severe muscle spasms, and severe pain. The right paracervical muscles demonstrated severe muscle spasms, and severe pain. Palpation of the left upper thoracic group of the dorsum disclosed severe muscle spasms, and severe pain. The right upper thoracic group of the dorsum revealed severe muscle spasms, and severe pain. Palpation of the left thoracolumbar group disclosed severe muscle spasms, and severe. The right thoracolumbar group revealed severe muscle spasms, and seven pain. Palpating the left iliolumbar group of the low back disclosed severe muscle spasms, and severe pain. The right iliolumbar group of the low back revealed severe muscle spasms, and severe pain.

ASSESSMENT/TREATMENT:
Today's Assessment:
It appears this patient will respond as expected to treatment and will experience favorable results.

FUTURE CARE PLAN:
Present Care Phase: Currently, we have the patient in a relief phase of care.

Future Treatment Plan: My recommendation for future treatment consists of EMS (electrical muscle stimulation), intersegmental mobilization and chiropractic adjustments three times a week for four weeks

Goals of Treatment: The preceding treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms and increasing range of motion.