

September 20th, 2007

To: David J. Freeland, Attorney at Law
2171 Chile Pepper Blvd.
San Chalopos, CA 93001

Re: Sample, Manuel

Date of Injury/Onset: May 1, 2007

Dear Mr. Freeland:

On May 7, 2007, Mr. Manuel Sample presented himself for an initial examination and evaluation of his complaints arising from a motor vehicle accident that he was involved in on May 1, 2007.

PERSONAL INJURY FINAL NARRATIVE REPORT

ACCIDENT DESCRIPTION:

The time was 7:00pm. Mr. Sample stated that he was the driver in a SUV which was stopped at a traffic light. According to the patient, the other vehicle involved was travelling at approximately 25-30 m.p.h. He stated that the other vehicle struck his vehicle in the rear end.

Mr. Sample also reported that, at the time of the accident, the road conditions were clean and dry. In addition, he stated the damage to his SUV was mild due to the fact that the other car hit his trailer hitch. Damage to the other vehicle was moderate. He also stated that he did not see the accident coming, and therefore was not braced for the impact. Also, he was wearing his seat belt and had his shoulder harness on. On impact, neither the driver's or the front passenger's air bag deployed.

His SUV was equipped with headrests. He also noted that he had his head facing straight forward at the moment of impact. On impact the patient's body did not strike the inside of his vehicle. He stated that he did not lose consciousness during the accident. Mr. Sample reports that he and his wife went to Seton Medical Center the following day. They were given a prescription for Ibuprofen, an analgesic, and Soma, a muscle relaxer and released. On release he was

given instructions to rest and ice his injuries. The patient did not have x-rays taken following his injury.

INITIAL SUBJECTIVE COMPLAINTS:

Immediately following the accident, the patient's main complaints included neck pain and stiffness, pain in the low back, fatigue, and pain in the upper back. Following the accident Mr. Sample drove himself home.

INITIAL SUBJECTIVE COMPLAINT ASSESSMENT:

Mr. Sample's current signs and symptoms were assessed today. His first symptom is sharp, aching and spastic pain in the neck bilaterally. He reported that the pain radiates into both shoulders. It occurs between three fourths and all of the time when he is awake, and causes *serious* diminution in his capacity to carry out daily activities. It is aggravated by bending forward, bending backward, bending to the left, bending to the right, twisting to the left, twisting to the right, coughing, sneezing, straining and by lifting.

Mr. Sample's second stated symptom is sharp, aching and spastic pain in the low back bilaterally. It also radiates into his buttocks. It occurs between three fourths and all of the time when he is awake, and causes *serious* diminution in his capacity to carry out daily activities. It is aggravated by bending forward, bending backward, bending to the left, bending to the right, twisting to the left, twisting to the right, coughing, sneezing, straining, standing and by lifting.

He stated his third symptom is dull, aching and spastic pain in the upper back bilaterally. It occurs between three fourths and all of the time he is awake, and is tolerated but it does cause *some* diminution in his capacity to carry out daily activities. It is aggravated by bending forward, bending backward, bending to the left, bending to the right, coughing, sneezing, straining, standing and by lifting.

HISTORY:

Mr. Sample indicated that he had not experienced prior symptoms similar to his current complaints, and was symptom free at the time of the aforementioned accident/onset of May 1, 2007.

I have determined that Mr. Sample's history has not contributed to his present condition.

Prior Treatment Information:

The patient reported that prior to his first visit to this office, he was treated at Seton Medical Center. His first visit there was on May 2, 2007. During his visits to that office, Mr. Sample received examination and pain meds, which he reported had little, if any, benefit. The patient is no longer receiving treatments at that office.

INITIAL ASSESSMENT/DIAGNOSIS:

It is expected that Mr. Sample will experience favorable results from his treatments.

Acute, moderate, constant, sprain/strain of the cervical spine with associated cervicalgia. Acute, moderate, constant sprain/strain of the lumbar spine with associated low back pain. Acute, slight, constant sprain/strain of the thoracic spine with associated thoracic pain. Subluxations of the cervical, thoracic, and lumbar spine and pelvis.

ICD-9 Coding: 847.0, 847.2, 847.1, 724.2, 723.1, 739.1, 739.3, 739.2, 724.1

PROGNOSIS:

At this time, Mr. Sample's prognosis is good. His case is somewhat complicated, but continued improvement is expected, despite some permanent residuals being a possibility.

TREATMENT PROTOCOL USED:

Chiropractic Manipulative Treatment: Chiropractic Diversified and Drop Table full-spine adjusting.

Physical Therapy: Microcurrent for tissue healing and pain control. Ice or heat as needed to reduce pain and inflammation. Therapeutic stretching and strengthening exercises to restore functional biomechanics.

Nutritional support: Nutritional supplementation consisting of Omega-3 Fatty Acids, Glucosamine and Chondroitin Sulfates, and MSM to reduce pain and inflammation and to facilitate the connective tissue healing processes.

Goals of Treatment Plan: The goals intended to be achieved with the preceding treatment plan are decreasing pain, decreasing swelling and inflammation, decreasing muscle spasms, increasing ranges of motion, increasing the ability to perform normal activities of daily living, increasing strength, returning the patient as close as possible to her pre-accident status, increasing function, retarding spinal degeneration, correcting muscle imbalance, increasing flexibility, reducing frequency and severity of probable exacerbations and improving spinal alignment.

SUBJECTIVE COMPLAINTS – FINAL

Mr. Sample has no current complaints. His Oswestry Neck Disability Index, his General Pain Disability Index, and his Visual Analog Pain Scale scores have all been reduced dramatically.

	<u>Initial Exam</u>	<u>Final Exam</u>
Oswestry Neck Disability Index	26%	0%
General Pain Disability Index	35%	0%
Visual Analog Pain Scale	5 (back), 6.5 (neck)	.5 (back), .5 (neck)

(0 = No pain, 10 = Worst pain ever)

FINAL OBJECTIVE EXAMINATION FINDINGS:

Ranges of Motion were all within normal limits and without pain.

Orthopedic tests were all negative.

Palpation findings were minimal.

CLOSING COMMENTS/PROGNOSIS

Though he is not in pain currently it is possible that Mr. Sample may have some minimal residual effects from this incident that may require some occasional additional care, especially in the cervicothoraco junction (C6-T1), and the lower lumbar (L4-L5). These areas will likely be prone to reinjury and onset of traumatic osteoarthritic type conditions. Overall, Mr. Sample appears to have done remarkably well in healing his injuries. He was conscientious at keeping his appointments and following instructions for his care. I could not have asked for a more compliant patient. I believe we have achieved most of the goals of the treatment plan. Currently, he is doing well and is released from my care at this time.

PRIMARY TREATING PHYSICIAN:

I declare that this report is true and correct to the best of my knowledge.

Signature:

Executed at: *Second the Motion Chiropractic*

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Date: 05/15/07

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