

FIRST DAY REPORT –Patient: Ms. Lisa S S-20** (DOB: 7/20/78)

HISTORY AND PRESENTING COMPLAINTS:

7/14/06: Ms. S presented seeking treatment for injuries received in a MVC on or about 6/17/06. She stated that she was restrained driver of a Toyota sedan that was stopped at a red light. He further stated that as the light turned green, the vehicle in front of her did NOT move. She told us, therefore, she sat and waited but while doing so, the car behind her, a Toyota Corolla, lurched forward and struck her rear bumper with some degree of force. She said she felt a huge jolt at the moment of impact and that the momentum thrust her forward and back in her car seat. She added that her head slammed into the steering wheel creating a large gash at the time. She stated that she was facing forward in her car and that the accident came as a complete surprise. The force of the impact threw her car forward several feet at which point she slammed into the rear of the car in FRONT of her as well. Thus, she experienced two impacts within seconds of each other. She stated further that she felt dazed and very dizzy moments after impact. She stated further that police and EMTs were quickly summoned to the scene. Due to the fact that she had her three kids with her (securely fastened in their seats), she opted to drive home herself. She stated that the pain really “hit” her the next day. Although she was in pain at the moment of impact, it simply became so much worse by the following day. She stated further that she attempted to see her PCP on Monday but he couldn’t see her. She stated further that by Wednesday, she did get to see her PCP; a Dr. Wolf who immediately sent her into PT. The time line is important henceforth in this case so a calendar should be consulted to coordinate the following dates:

6/23/06: She started PT and massage at Northbay Rehab Center. She stated that she went four times there; 6/23, 6/26, 6/28, 6/30.

7/1-4: The facility was apparently closed for holiday. She stated that she was experiencing more and more pain and that it was getting worse. As such, she stated that she didn’t really feel like going to more PT so she stayed home.

7/1: She packed her stuff and moved, as previously planned, to Somerville.

7/6 or 7/7: She stated that she experienced an at home miscarriage. She claims to not even having known she was pregnant. She told me that she has had her tubes tied heretofore so the pregnancy came as a total shock and surprise.

*This all explains the delay in presenting to my office as of today.

As we spoke, she stated that her main areas of pain were in the C-spine, R/L shoulders and the mid back. She stated that all areas were sharp in pain, less sharp in the mid back. She stated further that the pain is constant where movement or lying down(?) aggravates all three areas and that stretching, rotating seem to offer some relief. She claims to be allergic to most meds. She added that she gets splitting headaches of a constant, pounding fashion. She added that along with that she experiences dizziness, blurry vision and photophobia. She stated that she sees her PCP several times/year.

She stated that she does not smoke and enjoys a social drink. She informed us she had a physical exam performed about two months ago and the results were normal at that time. She added that she wasn't feeling any of these pain issues prior to the accident. Her past medical history is rather colorful: Apparently she was a highly abused child. Of her three children, the father of the oldest child (8 year old) shot Ms. Spooner with a hand gun on three different occasions. Old scars can be easily seen; left biceps, 1 breast, left shoulder. All of this happened 9/10 years ago. She added that she was stabbed in the R/L forearms (see scars) and was also stabbed in her left leg to which an additional scar bears testament to this. She added that in 1997 she had an additional MVC in which she claims to have suffered frontal lobe damage which resulted in years of epilepsy, right side of body numbness and an incredible ability for her brain to shut down cognitive functions, so she says. She added that the epilepsy and numbness have gone away but she does undergo apparent somnambulistic periods from time to time. She also says she has retro-grade amnesia frequently. Upon further questioning, she could not recall any other significant personal or family medical history including traumatic accidents. She further stated that the accident has disrupted her ADLs.

JOB DESCRIPTION: Unemployed mother of three.

GENERAL PHYSICAL EXAMINATION:

Ms. S presented as an alert, cooperative, right handed, 28 year old, obese CF standing 5'6" and weighing 262.4 lbs. Body fat was electronically measured at 42.1%. Appearance, mood, intelligence and thought process appeared appropriate. Her blood pressure was 120/82 on the right. Temperature was normal. Her radial pulse was 82 bpm. Respiration's were 20 pm. She was afebrile but in considerable discomfort. Gait appeared normal. A general query of the review of systems was performed and included constitutional symptoms, nervous system, muscular/skeletal system, skin/integument, ophthalmic, ear/nose/throat, respiratory, cardiovascular, gastrointestinal, genital/urinal, endocrine, immune/allergic, hemopoietic/lymphatic, and psychological. ***We reviewed all 14 ROS. The only ROS (Review of Systems) that were pertinent to the patient's chief complaints were as follows:***

Cerebrovascular Craniocervical:

1. Subclavian/Carotid: No carotid or subclavian artery bruits were auscultated. If positive-vertigo, visual disturbances, nausea, syncope or nystagmus. Indicates vertebral, basilar, or carotid artery stenosis or compression.
2. Vertebral Arteries: No ischemic reactions noted during rotation and hyperextension.

Vertebrobasilar Artery Tests:

1. **Hallpike Maneuver:** Dr. performs hyperextension and rotation holding for 15-45 seconds with the patient supine at the end of the examination table. Positive-if vertigo, blurred vision, nausea, syncope and/or nystagmus. Indicates vertebrobasilar vascular compromise. This is basically an exaggerated DeKleyn's Test.
2. **DeKleyn's Test:** Patient supine with his/her head extended off the end of the examination table. The patient rotates and hyperextends the neck to one side and holds that position for 15 to 45 seconds. The examiner may provide minimal support for the weight of the skull. The maneuver is repeated for the opposite side. The

production of vertigo, visual disturbance, nausea, syncope, or nystagmus indicates vertebrobasilar circulation compromise. ***Both were negative.**

Constitutional symptoms –The patient presented with fatigue.

Nervous system – See below

Muscular/skeletal system – See below

Skin/integument – WNL

Ophthalmic –Cardinal Fields of Gaze: (SO4LR6) SR-CN III, LR-CN VI, IR-CN III...IOblq.-CN III, MR-CN III, SO-CN IV. (Normal)

Ear/nose/throat -WNL

Respiratory –WNL-lung sounds were normal.

Cardiovascular –WNL

Gastrointestinal –WNL based upon history

Genital/urinal – WNL based upon history

Abdomen- WNL

Endocrine –WNL based upon history

Immune/allergic -Hx

Lymphatic –**Lymph nodes:** Pre-Auricular, Post Auricular, Occipital, Tonsillar, Submaxillary, Submental, Superior Cervical, Posterior Cervical Chain, Deep Cervical Chain and Supraclavicular: All appeared normal on investigation.

Psychological – Hx.

The ROS did not reveal any other significant findings pertinent to the patients' chief complaints.

TODAY'S OUTCOME FINDINGS: Tabulations for the C/L spine OSWESTRY

Questionnaires are as follows:

C-Spine: (25 points ÷ 50) X 100 = 50% = Severe Disability

L-Spine: (19 points ÷ 50) X 100 = 38% = Moderate Disability

Analog PAIN Scale C-spine: 8 of 10 (10 being the worst)

Analog PAIN Scale L-spine: 8 of 10 (10 being the worst)

OUTCOME INDICATORS: Note the back of the daily note sheets. There is a pain figurine and an Analog pain scale on each. We have the patient fill this out every visit or couple of visits.

NEUROLOGICAL EXAMINATION:

Deep tendon reflexes were 2+ and equal bilaterally in both upper and lower extremities.

Cranial nerves I-XII were intact and there was no evidence of pathological reflex.

Sensation to pin and light touch was preserved in both upper and lower extremities.

Motor strength testing was +5 in upper/lower extremities. Position sense and two point discrimination were intact.

PALPATORY AND ORTHOPEDIC EXAMINATION:

The cervical and thoracic spine ranges of motion were found to be considerably decreased in some vectors and pathomechanical. This was performed actively and

passively and both elicited pain. Myospasms muscles were noted in the anterior/posterior cervical/thoracic spine musculature. Noted further were pathomechanics of the C-T spine.

		<i>Normal</i>
<i>Cervical ROM:</i> Flexion:	32	50
Extension:	40	60
LLF:	32	45
RLF:	41	45
LR:	42	80
RR:	38	80

The lumbar spine ranges of motion were also found to be moderately decreased globally and pathomechanical. Noted also were pathomechanics of the SI joint. This was performed actively and passively and both elicited pain. Hypertonic tone muscles were noted in the lumbar spine musculature.

		<i>Normal</i>
<i>Lumbar ROM:</i> Flexion:	39	90
Extension:	42	25
LLF:	23	25
RLF:	22	25

**The “Dualer” electronic inclinometer was used to measure ROM in Degrees, as per AMA Guidelines.*

DYNAMOMETER: In Kgs.

L: 22, 20, 19
R: 12, 10, 09

ORTHOPEDIC TESTS:

The following orthopedic tests were performed and are indicated as a positive or negative finding. The results of these orthopedic tests were used to DDX the patient’s presenting complaints and condition. The specific location of pain is also identified. WR=Whole Region. *NB: The cervical spine was so painful that no tests could be done. Ditto with the low back. Thus it is safe to say all tests would have been positive had I forced the issue. Suffice it to say the patient has at least a Grade II cervico-genic strain/sprain. I’ll dispense with listing all the tests.

The Thoracic Spine:

Amoss	+ Entire Dorsal Region
Adam’s Position	+ Entire Dorsal Region
Schepelmann’s Sign	+ Entire Dorsal

	Region
Spinal Percussion	+ Entire Dorsal Region

DDX TESTS:

Cervical Spine:

Bakody's Sign: While seated, the patient actively places the palm of the affected extremity on top of the head, raising the elbow to a height approximately level with the head. By elevating the supra-scapular nerve, traction of the lower trunk of the Brachial Plexus is relieved. The sign is present when radiating pain is relieved.

Brachial Plexus Tension Test: A positive test in this inventory strongly suggests a cervical root problem, most likely at C5.

Distraction test-local pain is increased on distraction then muscle strain, spasm, ligamentous sprain or facet capsulitis is suspect. Relief of local or radicular pain is indicative of either foraminal encroachment or a disc defect.

Foraminal Compression-localized pain may indicate foraminal encroachment without nerve root pressure or apophyseal capsulitis, radicular pain may indicate nerve root involvement.

Hautant's Test: With the patient seated and the eyes closed, the patient extends both arms out in front with the palms up. The patient extends and rotates the head to one side. The patient repeats this move in the opposite direction. Drifting of the arms, vertigo, blurred vision, nausea, syncope, and nystagmus are signs of a positive test. The test indicates vertebral, basilar, or carotid artery stenosis.

Jackson's Compression Test: A positive sign suggests nerve involvement from a space-occupying lesion, subluxation, inflammatory swelling, exostosis or DJD, less so a tumor or disc herniation.

Lhermitte's Sign: A positive response with this test suggests a form of cervical myelopathy such as cord compression. Disc herniation is a strong suspect as is inflammation.

Maximum Cervical Compression: This test is performed bilaterally. Pain on the same side of testing suggests nerve root or facet involvement. Pain on the opposing side indicates muscular strain.

O'Donoghue Maneuver -localized pain indicative on resisted ranges of motion suggests muscular strain and on passive range of motion equates to ligamentous sprain.

Shoulder Depression Test -local pain on the side being tested indicates shortening of the muscles, muscular adhesions, muscle spasm, or ligamentous injury. Radicular pain may indicate compression of the neurovascular bundle, adhesion of the dural sleeve, or TOS. If pain is elicited on the opposite side being tested it may indicate a decrease in the foraminal interval, facet pathology, or disc defect.

Soto Hall-evidence of local pain may indicate ligament, muscular, osseous pathology or injury or cervical cord disease.

Thoracic Spine:

Amoss's Sign: The recumbent patient places the hands far behind the body and tries to arise from the supine position to the seated position. The patient can also be side-lying. The examiner should note the patient's position of comfort and any spinal complaints that the patient presents. The patient arises from the side-lying position to a sitting position. The sign is present when either action elicits a localized thoracic or thoraco-lumbar pain.

The sign suggests ankylosing spondylitis, severe sprain or inter-vertebral disc syndrome.

Adam's Position: With the patient standing upright and the examiner standing behind the patient, the patient is asked to flex forward without bending the knees. Spinal curves such as scoliosis can be observed in this position. If the patient has an S or C scoliosis, the curvature may straighten out when the spine is flexed forward. If it does, it is a negative sign and evidence of functional scoliosis. A positive sign is noted when the scoliosis is not improved after flexion and suggests pathologic or structural scoliosis, trauma or subluxations.

Schepelmann's Sign: This sign identifies rib integrity and thoracic muscle tension. The patient raises his/her arms while seated and then bends laterally. If pain is created on the concave side, it is due to intercostals neuritis. Pain on the convex side suggests intercostals myofascitis.

Spinal Percussion Test: The examiner percusses the spinous processes and the associated musculature of each of the thoracic vertebrae with a neurologic reflex hammer. Evidence of localized pain indicates a possible fractured vertebrae. Evidence of radicular pain indicates a possible disc lesion.

Lumbar Spine:

Bilateral Leg Lowering Test: The patient lowers the straightened legs from a 90 Degree angle to a 45 degree angle. The test is positive if the legs drop or if the move produces pain. A positive test indicates lumbo-sacral involvement, disc lesions or exostoses.

Bragard's Sign: A raised leg is lowered to the point of discomfort. The foot is then dorsiflexed. The sign is present if pain is increased. The presence of the sign is a finding associated with sciatic neuritis, spinal cord tumors, IVD lesions, spinal nerve irritations.

Double Leg Raiser: With the patient supine, the examiner performs a SLR test on each of the lower extremities, noting the angle at which the pain is produced. Next, both lower limbs are raised together. If pain is produced at an earlier angle by raising both legs together, then the test is positive: vertebral instability with lumbar pain, SI pathology with SI pain.

Ely's Test: A positive response in this test indicates femoral nerve inflammation or radicular stress of same. This test will irritate inflammation of the lumbar nerve roots.

Kemp's test- localized lower back pain with no radicular component is indicative of lumbar muscle spasm or facet capsulitis.

Minor Sign: The patient is seated and asked to stand. The examiner observes how the patient rises from the seated position. The sign is present if the patient supports weight on the uninvolved side by balancing on the healthy leg, placing one hand on the back, and flexing the knee and hip on the affected side. Present with SI lesions, L-S strain/sprains, fractures and disc lesions.

Nachlas test-stretching the quadriceps muscles causes the sacroiliac joint and the lumbosacral joints to move inferiorly, pain in the buttock may indicate a sacroiliac joint

lesion, pain in the lumbosacral joint may indicate a lumbosacral lesion. Radicular pain into the anterior thigh may indicate a compression or irritation of the L2, L3 and L4 nerve roots by a disc defect, spur, or mass.

Straight Leg Raise test- if pain is elicited or is exacerbated after 70 degrees of hip flexion, the sciatic nerve roots tense over the inter-vertebral disc. If pain is elicited after 70 degrees then lumbar joint pain is suspect. At 35-70 degrees of hip flexion, the sciatic nerve roots tense over the IVD, if the radicular pain begins or is increased at this level suspect sciatic nerve root pathology irritated by an IVD pathology or an intra-dural lesion. Pain at 0-35 degrees is indicative of spastic piriformis muscle or sacroiliac joint lesions.

Erichsen's Test: This test suggests pain and problems in the SI complex.

Hibb's Test: This test also suggests pathomechanics of the SI complex.

Sacral Apex Test: With the patient prone, the examiner places both hands at the sacral apex. Pressure is brought to bear causing the sacrum to shear in relation to the ilium. The test may indicate an SI lesion if there is pain reproduced over the joint.

Squish Test: A positive response to this test suggests a problem such as a sprain with the posterior SI ligament.

Yeoman's Test: This maneuver places extra stress on the SI joint and surrounding holding elements. Pain here suggests an SI lesion.

RADIOLOGICAL EXAMINATION:

A clinical decision was made to take the necessary X-rays on this patient today in the form of a Davis Series. Findings are as follows:

C-Spine: The AP shot appears skewed slightly dextro. This particular shot also appears to have been accidentally exposed to light, partially in the upper skull area. There seems to be no evidence of DJD of the unco vertebral joints. The L lateral bending shot reveals lateral bending with theta Y coupling rotation. The right lateral bending shot reveals more limited lateral tilting with no theta Y coupled rotation in any of the segments. The APOM appears WNLs in all respects. The lateral view reveals an anterior tilted C-spine relative to the shoulders. The spine is **completely alordotic**. Disc and body heights appear well maintained. The forward flexion has some flexion motion. The extension view shows more head motion but reveals absolutely no extension at all.

No evidence of fractures, dislocations or neoplastic activity was visualized on this film.

**800 Rare Earth Systems were used with lead shielding collimation and the inclusion of the thick lead gonadal shield to absorb lower limb/abdomen scatter. Technique was good in this set. All views were weight bearing; sitting for cervicals.*

DIAGNOSIS (original):

Initial working diagnosis: Based on the patient's subjective comments, the case history, and the **DDX analysis** during the physical exam, it was opined that the patient sustained a Cervical-Thoracic strain/sprain Grade II, with full spine pathomechanics, ballistically induced headaches, shoulder strain/sprains (bilateral, grade I) and myospasms, all as a result of the accident the patient suffered on or about 6/17/06. This is to a reasonable degree of medical certainty.

TREATMENT DISCUSSION & PLAN:

We have decided to accept the patient for care. All findings will be explained to her. This data will include all relevant physical, orthopedic, neurological and roentgenological findings. We will also explain to her exactly what manipulative therapy is and how it will affect her. As well, all risks inherent with manipulative therapy will be explained to the patient, although we do not foresee any complications with her. We will explicitly not guarantee results. Our stated goals in this case are threefold: **Primary/Short Term, Intermediate and Long Term**. The *short-term goals* are to reduce the strain/sprain incident of the musculoskeletal system dysfunction, to educate the patient, initiate low level aerobics and strive towards intrinsic and global kinematic correction. Our *intermediate goals* are to create strength and flexibility for kinematic function and initiate kinematic activity. Finally, *our long-term goals* are to restore normal intrinsic, global and kinematic function, increase aerobic capacity and continue with kinematic activity. Our initial feeling is to initiate a clinical trial of 2 weeks of treatment on a 4-5x/week basis which will include CMT following Diversified protocols, and perhaps a form of therapy such as interferential current and/or low force intersegmental traction for pain relief. Manipulative reductions performed by me in the cervical spine consist of coupled reductions with a lateral thrust. There is never a rotational component in these moves. Lumbar reductions are more often than not, spinous pushes or pulls. If the patient responds as anticipated, then we will continue for an additional 2 weeks and then perform a formal re-examination to assess objective and subjective progress/response to care. Targeted joints for this rationale will be the cervical, thoracic, lumbar, sacral spine. Spinal manipulation performed will consist of specific spinal adjustment and will be indicated in her daily treatment SOAP notes. The purpose of the manipulative procedures is for correction of the interosseous dis-relations, reduce fixations, improved range of motion and free articular anatomy for the reduction and/or removal of neurological dysfunction. The supportive therapeutics or procedures utilized will include: 1). electrical muscle stimulation for reduction of muscle spasms, edema and pain control; 2). mechanical traction of either the cervical or intersegmental full spine to help restore spinal curve, relax tense muscles, increase circulation, reduction of fixations and adhesions.

We may opt to put the patient on a therapeutic exercise regime (rehabilitation) utilizing physical therapy if home exercises do not meet our short-term goals. If the patient has not shown any signs of improving within the first 2 weeks, then we may opt to obtain a second opinion, physical therapy, and/or advanced imaging. The patient appeared to understand everything explained to her thus far and made an informed decision to be treated today with therapy and plans to follow up as indicated. She understood that further explanations will follow when the X-Ray films are reviewed.

PROGNOSIS:

Based on the mechanism of injury, patient's presenting complaints and the results of her objective initial examination, it is anticipated that the patient will respond favorably to

our care. The patient's final prognosis will be determined at a later date after she has responded to our care and a permanent and stationary status has been achieved.

DISABILITY NOTIFICATION:

Pursuant to the *M.G.L. Chapter 90, Subsection 34M*; it was opined with clinical judgement and the patient's testimony that she was totally disabled from 6/17/06 and ongoing, due to the beforementioned diagnosis. This means that the patient has difficulty/had difficulty performing the activities of daily living /and her typical occupational demands are compromised due to her disability, which was a causal result of the motor vehicle crash on or about 6/17/06.

SUGGESTIONS: No more luxuriating in extra long hot showers since the heat will increase swelling.

HIPAA NOTIFICATION:

The patient was given a detailed PRIVACY notice. This was explained and understood by the patient. The patient signed an acknowledgment form indicating that they have received a copy of the PRIVACY notice.

I am a duly licensed chiropractic physician, licensed to practice in the Commonwealth of Massachusetts. Subscribed and sworn to under the pains and penalties of perjury.

Sincerely,

John J Haberströh, DC
Chiropractic Physician

JJH/

NB: The patient was put on pain inhibiting modalities today that included intersegmental traction(15M, T-L spin), E-stim(C-spine, right shoulder 11V, 15M) and ice (C-spine, 15M). Also;

We discussed with the patient was the correct postural biomechanics involved with the proper use of the cervical spine support pillow and the recommended home application.

Also discussed with the patient was the correct application of cryotherapy, valerian root and other postural considerations at home and work. Also, we discussed how excess heat should NOT be applied post-injury. The patient stated an understanding of our lengthy discussion.