MEDICAL CHRONOLOGY

Ms. [redacted]

DOB [redacted]

DOL – 10/04/2016

Note: *Type-A Medical Chronology is a more concise format consisting of a detailed summary of the case focus period, and the damage/treatment period. However, the rehabilitation visits/therapy records are not captured as individual visits, and are rather combined as a narrative description. Also, in this type of summary, we do not summarize the prior medical records.*

Past Medical History: Hypertension, hyperlipidemia, weather-induced asthma, neck pain, back pain, scoliosis, keloids, breast implants

Past Surgical History: Fallopian tube removal, laparoscopic cholecystectomy, appendectomy

Previous Injuries: Auto accident in 2014 resulting in soft tissue injuries to her neck and low back.

Allergies: Penicillin

Date	Provider	Notes	Page No.
10/06/2016 – 11/28/2016	Tomlinson Chiropractic & Acupuncture [redacted]	**Chiropractic Evaluation Report & Treatment Notes** **History of Present Illness:** [redacted] was the driver in a vehicle that was involved in a MVA at 12th and Minnesota in Kansas City on 10/04/2016. She stated, "I was driving down the street getting ready to turn into parking spot and a truck hit me." She felt nervous immediately following the accident. The following day, she noted headaches, neck pain and back pain. Her symptoms had progressively worsened since the accident. She either had difficulty or was unable to perform activities that she did prior to her accident. She walked with a slight limp since the accident. **Chief Complaints:** • Headaches, rated as 8 to 9 on a scale of 10 • Neck pain, rated as 10 on a scale of 10 • Low back pain, rated as 10 on a scale of 10	150-158, 163, 169-173, 184-187

		• Thoracic pain, rated as 8 to 9 on a scale of 10 • Bilateral hip pain/paresthesia, rated as 9 to 10 on a scale of 10 • Right leg pain/paresthesia, rated as 9 to 10 on a scale of 10 • Difficulty sleeping • Fatigue • Anxiety **Modifying Factors:** [redacted] symptoms worsened with any work-related activities, standing, bending forward or backward, lifting, and with activities of daily living. **Subjective Functional Problems** • Work (limited capacity) • Housework (limited capacity) • Exercising (limited capacity) • Activities of daily living (limited capacity) **Objective Findings:** • Anterior cervical translation indicated possible hypolordosis • Palpation of the suboccipital musculature revealed guarding • Palpation of the trapezius muscle indicated spasm/hypertonicity/trigger point • Swelling indicated the presence of localized edema in the tissues of the trapezius • Multiple muscle spasms and guarding present • Noted cervical pain and loss of range of motion • Tenderness to palpation at C2, C4-7 • O'Donoghue test was positive • Paraspinal musculature of cervical spine had guarding and myospasm • Palpation elicited severe tenderness with recent history of trauma and indicated possible thoracic sprain/strain • Severe tenderness at spinous of facet	

		joint in thoracic and lumbar region • Tenderness to palpation at T1-3, T4-5, T9-10 • Paraspinal musculature of thoracic spine had guarding and myospasm • Tenderness to palpation at L2, L3-5, and S1 • Positive Kemp's, Mennel's and O'Donoghue test • Lumbar paraspinal musculature had guarding and myospasm • Noted dorsolumbar loss of range of motion • Antalgic gait **Review of Imaging Data:** • **Cervical spine X-rays** – Cervical spine was hypolordotic, with mild reverse of the lordosis. There was mild disc degeneration at C4-C5, with small osteophytes at C4 and C5. Uncinate process hypertrophy was present at C5, C6 and possibly C7, with possible articular pillar degeneration at C6-C7 right-sided. There was an osseous density anterior to and bridging the C6-C7 disc, which may represent anomalous formation of the C6 and C7 transverse processes, with an accessory articulation between these structures of possibly partial fusion • **Thoracic Spine X-rays** – There was a slight concavity within the superior endplate of T7, without definitive findings of trabecula impaction. There was some reduction of thoracic kyphosis. Significant degenerative changes were not apparent. An obvious scoliosis did not appear to be present • **Lumbar Spine X-rays** – Bilateral sacralization of L5 was present, with a spina bifida occulta at this level. T12 through L5 were visualized and were of normal height, without compression fractures. Small osteophytes were present at L2 and L3, with mild disc	

		degeneration at L2-L3, as well as articular facet degeneration at L2-L3, L3-L4 and L4-L5. Upper lumbar spine was mildly hypolordotic with anterior weight bearing. There was pelvic unleveling, being low on the right side, estimated at 20 mm, with only minimal compensation in the lumbar spine. Sacroiliac joints and hips were only partially visualized, but appeared to be of good diameter **Assessment:** • Cervical Spine: Cervical sprain/strain, cervical segmental dysfunction, cervical facet joint fixation, cervical myospasm, cervical hypolordosis, headache, cervical degenerative joint disease • Thoracic Spine: Thoracic sprain/strain, thoracic segmental dysfunction, thoracic facet joint fixation, thoracic myospasm • Lumbar Spine: Lumbar sprain/strain, lumbar segmental dysfunction, lumbar facet joint fixation, lumbar myospasm, pelvic unleveling • Acute pain due to trauma • Posttraumatic headache • Anxiety/Depression • Difficulty sleeping • Fatigue **Prognosis:** [redacted] may have residual pain, soreness and weakness after treatment is completed. The treatment may be prolonged due to severity of condition, underlying degenerative problems, or lack of compliance with the treatment plan. **Plan:** [redacted] was recommended chiropractic treatment 2 to 3 times per week for 4 weeks, followed by a re-evaluation. **Treatment Summary:** [redacted] attended 9 sessions of chiropractic treatment between 10/06/2016 and 11/28/2016. She was recommended to continue treatment as	

		scheduled. **Dates of Treatment:** 10/06/2016, 10/12/2016, 10/13/2016, 10/19/2016, 10/26/2016, 11/02/2016, 11/10/2016, 11/23/2016, 11/28/2016 **Treatment:** • Chiropractic adjustments • Intersegmental traction • Electro-therapy • Acupuncture	
10/14/2016	Midwest Radiology Consultants [redacted]	**Radiology Report** **Date of Films:** 10/06/2016 **Exam:** X-rays of Cervical & Lumbar Spine **Impression:** • No obvious findings of acute fractures or signs of instability • Reversed cervical lordosis on the basis of the partially oblique lateral view • Mild disc degeneration at C4-C5, with Luschka hypertrophy from C4 through C7 • Anomalous appearing C6 and C7 transverse processes • Bilateral sacralization of L5 • Mild lumbar spondylosis with disc degeneration at L2-L3, as well as articular facet degeneration at L2-L3, L3-L4 and L4-L5 • Pelvic unleveling • Mildly hypolordotic lumbar spine with anterior weight bearing **Clinical Comment:** The biomechanical changes were suggesting soft tissue injury and muscle spasm. Chiropractic management and follow-up evaluation should be utilized as clinically indicated.	166
11/09/2016	Premier Anesthesia & Pain Management	**Office Visit**	140-143

	[redacted]	**Chief Complaint:** • Neck pain • Low back pain **History of Present Illness:** [redacted] complained of low back pain radiating to her right lower extremity, right buttock pain and right hip pain following a motor vehicle collision 4 weeks ago. She described her pain as constant, burning, aching, sharp, numbness and tingling, and rated it as 8 to 10 on a scale of 10. Pain interfered with her sleep and with work. Aggravating factors included extension, twisting, lifting, and moving from sit to stand, sitting and standing. She stated that medications did not help in allowing her to perform activities of daily living. **Review of Systems:** • Muscle aches • Arthralgias/joint pain • Back pain **Physical Examination:** • Ambulated with a limp • Tenderness over neck region • Restricted lumbar spine range of motion • Tenderness of paraspinal muscles on the right side from L3-L5 • Pain with palpation over lumbar facet **Assessment:** • Lumbosacral spondylosis without myelopathy • Low back pain • Headache • Neck pain/cervicalgia **Discussion:** [redacted] presented with concerns of low back pain radiating from her right lumbar spine into her buttocks, hip and lateral thigh. She described being the driver of a vehicle struck on the passenger side, on 10/04/2016 in Kansas. She did not require ER visit following the MVC. She had been evaluated and received conservative	

		chiropractic care over the last five weeks; however, her pain had not resolved. She was currently taking NSAID medication. [redacted] opined that with a reasonable level of medical certainty, [redacted] current diagnoses and associated symptoms were a result of an acute injury in the presence of a pre-existing condition. Her injuries associated with the MVC on 10/04/2016 were the major contributing factor causing her current medical condition and associated diagnoses. [redacted] was recommended right lumbar diagnostic medial branch blocks at L2, 3, 4, dorsal rami L5. She was advised to keep a pain log for every 30 minutes. She was deemed to be a candidate for lumbar radio frequency ablation with greater than 50% improvement during the diagnostic period. She was prescribed Ibuprofen. She was advised to use ice/heat to her lumbar spine throughout the treatment process, and continue conservative chiropractic care for her neck pain and headaches.	
11/17/2016	Blue Valley ASC, PA [redacted]	**Office Visit** [redacted] followed up for her scheduled procedure. **Procedure:** • Diagnostic medial branch block, right, at L2, 3, 4, dorsal rami L5 **Anesthesia:** Local [redacted] tolerated the procedure well, and was taken to recovery in a stable condition. She was provided post block instructions, and advised to continue with her current plan of care.	136-140
12/01/2016	Blue Valley ASC, PA [redacted]	**Office Visit** [redacted] presented for her scheduled procedure, following a positive diagnostic test.	131-136

		Procedure: • Radiofrequency ablation of right lumbar medical branch nerves **Anesthesia:** IV sedation **Preoperative & Postoperative Diagnosis:** • Lumbar spondylosis [redacted] tolerated the procedure well. She was then transferred to recovery and observed for a period of time, and discharged home in stable condition. She was advised to continue with her current plan of care. Planned to continue to monitor her contralateral lumbar spine and cervical spine, considering treatment in the near future.	
12/15/2016	Premier Anesthesia & Pain Management [redacted]	**Office Visit** [redacted] returned for a follow-up evaluation. She described near complete resolution of her pain in the right lumbar spine region. She stated her pain was greater than 90% improved. She reported that the pain in her left lumbar spine was much more noticeable as the right side improved. [redacted] was recommended left lumbar diagnostic medial branch blocks at L2, 3, 4, dorsal rami L5. She was advised to continue using Ibuprofen and ice/heat to her lumbar spine throughout the treatment process. She was instructed to continue conservative chiropractic care with [redacted] for her neck pain.	129-131
12/19/2016	Blue Valley ASC, PA [redacted]	**Office Visit** [redacted] presented for her scheduled [redacted] he complained of continued symptoms. She rated her pain as 6 to 8 on a scale of 10. **Procedure:** • Diagnostic medial branch block, left, at	125-129

		L2, 3, 4, dorsal rami L5 **Anesthesia:** Local [redacted] tolerated the procedure well. She was then transferred to recovery and observed for a period of time, and discharged home in stable condition. She was provided post block instructions, and advised to continue with her current plan of care. She was recommended lumbar radiofrequency ablation with greater than 50% improvement during the diagnostic period.	
12/27/2016	Blue Valley ASC, PA [redacted]	**Office Visit** [redacted] presented for her scheduled procedure. **Procedure:** • Radiofrequency ablation of left lumbar medical branch nerves **Anesthesia:** IV sedation **Preoperative & Postoperative Diagnosis:** • Lumbar spondylosis [redacted] tolerated the procedure well. She was then transferred to recovery and observed for a period of time, and discharged home in stable condition. She was advised to continue with her current plan of care, and follow-up in 2 weeks.	120-124
01/10/2017	Premier Anesthesia & Pain Management [redacted]	**Office Visit** [redacted] presented for a follow-up evaluation. She complained of continued, but improved pain in her left buttock and left hip. She rated her pain as 1 to 5 on a scale of 10. She described soreness consistent with normal healing. **Assessment:** • Lumbosacral spondylosis without	118-120

		myelopathy • Low back pain • Neck pain [redacted] was recommended to continue using Ibuprofen and ice/heat to her lumbar spine. She was advised to follow-up in 1 month for evaluation.	
02/10/2017	Premier Anesthesia & Pain Management [redacted]	**Office Visit** [redacted] returned for a follow-up evaluation. She complained of left buttock pain, rated as 2 to 3 on a scale of 10. **Physical Examination:** • Restricted lumbar spine range of motion • Tenderness over paraspinal muscles on the left L4-L5 region • Tenderness of the sacroiliac joint • Pain with palpation over lumbar facet and left sacroiliac joint **Assessment:** • Lumbosacral spondylosis without myelopathy • Low back pain [redacted] was recommended to continue using Ibuprofen and ice/heat to her lumbar spine. She was advised to begin water and yoga exercises to improve flexibility and core strength. She was instructed to follow-up in 1 month for consideration of discharge.	115-117
03/10/2017	Premier Anesthesia & Pain Management [redacted]	**Office Visit** [redacted] presented for a follow-up evaluation after completion of lumbar RFA. She described continued healing and improvement of her pain. She noted near resolution of her back pain with only mild discomfort with physical activity. She was happy with her overall improvement, and a result she was discharged from care with instructions to follow-up as needed.	113-115

		Although [redacted] had responded very well to interventional pain management treatment, [redacted] opined that with a reasonable level of medical certainty, [redacted] would require future medical treatment to maintain her improvement.	
03/29/2017	Premier Anesthesia & Pain Management [redacted]	**Correspondence Note – Future Treatment** [redacted] presented to the clinic on 11/09/2016 complaining of severe low back pain radiating across her lumbar spine and into her buttock, hip and lateral thigh, greater on the right than left. She described the onset of pain following a motor vehicle collision on 10/04/2016, in Kanas, in which she was the driver of a vehicle struck on the passenger side. [redacted] described her pain as an aching, deep, pressure across her lumbar spine, with occasional sharp pain in her low back with activity. She rated her pain as 7 to 8 on a scale of 10. She stated her pain resulted in difficulty with sleeping, walking, working, driving, leisure and exercise activities as well as completing activities of daily living. **Prior Injuries:** Significant for back pain following a motor vehicle collision approximately two years prior to her most recent MVC. She described resolution of her back pain following that MVC with conservative chiropractic care. **Assessment & Plan:** [redacted]opined that with [redacted]ble level of medical certainty, Ms. [redacted] current diagnoses and associated symptoms were a result of acute injuries to her lumbar spine, sustained in the 10/04/2016 MVC, in the presence of a pre-existing condition. [redacted] lumbar spondylosis was treated with radio frequency ablation, preceded by a positive diagnostic test. This treatment,	1

		completed bilaterally, had resulted in near complete resolution of her pain. [redacted] opined that with a reasonable level of certainty, [redacted] would require future medical care for her lumbar spondylosis. She would require 2 to 3 additional radio frequency ablation treatments to her left and right lumbar spine over the next 5 years. Treatment expenses included physician fees and ambulatory surgery center facility fees. The estimated, combined total expense to complete a single radio frequency ablation, averaged over the next five years, was [redacted] per single treatment.	