

Accent on Health Chiropractic and Massage, 359 National Highway, 2nd Floor, LaVale, MD 21502
Patient Visit SOAP Note Date of Service: Wednesday, April 18, 2007

PATIENT NAME: Amy Test

SUBJECTIVE:

Amy presents with a chief complaint of bilateral posterior cervical region symptoms and thoracic region symptoms, between her shoulders and she states this is a aching, dull pain and this radiates into her right lateral region at the elbow and she reports this feels like a tingling sensation. Amy appeared to be in pain but was cooperative throughout the visit. She states she is currently employed. She states she does not smoke or use tobacco products. She denies the use of alcohol. She has no recollection of a prior occurrence of these or of similar symptoms at any time in the past. There is also concern in her family history with mother with a history of hypertension and father with a history of cardiovascular disease. Her review of systems is normal and unremarkable. "Severe pain" at 7/10 on the pain rating scale was selected today. This is a persistent and nearly constant problem that bothers Amy between 76-99% of the time and she rarely has moments when it is not present. There is definite effect on her ability to perform her routine daily activities of living because of the current symptoms. Amy feels that his overall lifestyle has been moderately altered due to this problem. Amy states she must significantly change the way she approached every activity to avoid making the symptoms worse or causing pain. Amy reports that her problem is aggravated or made worse as a result of sitting any length of time and with certain body positions. She states that her symptoms are generally decreased or relief is provided after resting and after the use of any kind of therapeutic heat. Amy states that care for her problem, prior to presenting to this office, included an emergency room visit, prescribed anti-inflammatory medication, muscle relaxants, and previous x-rays of the area (these were reviewed). Her problem is reportedly the result of an accident 4/2/2007.

The patient was an occupant of a mid-size two door car. The patient states the other vehicle was a mid-size four door car. The speed of the patient's vehicle at the time of impact is reported to be 0. The other vehicle's speed at the time of impact was estimated to be around 35 mph. Amy was the driver of the vehicle. Her hands were on the steering wheel at impact. Patient was totally unaware of the impending collision and did not brace for impact. This is likely to have increased the extent of her injury. She says that consciousness was lost immediately after impact. Patient was wearing a seatbelt. The patient's seat did not break as a result of the collision. The airbag did not deploy on impact. Amy states she had her foot on the brake at the moment of impact. The patient's vehicle was struck on the rear of the vehicle. Impact site of the other vehicle was on the front of the vehicle. When questioned about her head position at the time of impact she states her head was about 45 degrees to the left. The road conditions were dry and clear. The described symptoms began immediately after the impact. Amy was asked about the police report and she stated it was not available.

She was driven to the ER of Memorial hospital immediately after the impact and was seen by Dr May. X-rays of her lumbar spine were obtained and she was given meds and sent home. Over the next few days her neck and arm began to bother but she was unable to be seen for care due to illness of her child who was being treated in Morgantown, WV. When she returned to the ER a week after the accident she was complaining of the neck, mid back and arm pain in addition to the low back. Dr Janotka suggested she see a chiropractor or a neurologist for her neck and no additional diagnostic studies were performed.

OBJECTIVE:

She is 30 years of age. Her height was measured to be 5 feet 6 inches. Her weight was 130 Lbs. Resting heart rate was recorded at 93 BPM. Oxygen (O2) saturation was measured with a finger monitor to be 99% . Seated resting blood pressure in her left arm was 130/93 mmHg. She has a body habitus of an ectomorph which is that of a person with a thin non-muscular body. I noted no abnormalities during visual inspection. Her muscle strength was normal in the upper and lower extremities at 5/5 bilaterally, the upper and lower deep tendon reflexes were normal at +2 bilaterally in her biceps, brachioradialis, triceps, patellar and achilles and her superficial sensation was normal when tested with a pinwheel in the upper and lower extremities over her C6, C7, C8, T1, L4, L5 and S1 dermatomes but she had some slight loss of sharp sensation in her right C5 dermatome.

CERVICAL (neck) ROM (range of motion) normal values:

Forward flexion / 45 degrees

Extension / 45 degrees

Left Lateral Flexion / 45 degrees

Right Lateral Flexion / 45 degrees

Left Lateral Rotation / 80 degrees

Right Lateral Rotation / 80 degrees

Abnormal active motion with flexion abnormal at 50 degrees, extension abnormal at 30 degrees, left rotation abnormal at 70 degrees, right rotation abnormal at 75 degrees, left lateral flexion abnormal at 20 degrees, right lateral flexion abnormal at 30 degrees with pain.

VBI Test, VAS or vertebral artery screening test (George's Test) is positioning the neck to screen for risk of dissecting (tearing) of the vertebral artery during a neck adjustment, and/or who may be at risk of having a stroke due to a neck adjustment. The test was normal with no increased risk identified today. She has no increased symptoms in her cervical or cranial region with Valsava's maneuver today. Dejerine's Triad Sign was negative and is used to rule out a mechanical obstruction from a herniated disc, tumor or bony closure. The sign is considered positive when coughing, sneezing or straining at the bowels increases the intrathecal pressure and causes an increase in radicular pain. Shoulder Depression Test was positive on her right side. This test is done with the patient supine. The examiner standing at the head of the patient, flexes the neck to the side opposite to the shoulder being tested while pushing the shoulder caudad. Then, while maintaining the depression of the shoulder, the head is rotated, again to the side opposite to the shoulder

being tested. If radicular pain is either produced or aggravated the first action and then confirmed by the second, the test is considered positive. A positive test indicates adhesions of the dural sleeves, the spinal roots, or the adjacent structures of the joint capsule on the side of the shoulder being depressed. Jackson's Compression Test, which is usually indicative of nerve root compression, was positive on the right side. In this test, the patient, sitting upright, attempts to laterally flex the neck and head toward the affected shoulder. Then the examiner exerts downward pressure with clasped hands on top of the patient's head. The test is positive if this action exacerbates the patient's cervical and/or radicular pain indicating nerve root compression. Evaluation to rule out thoracic outlet syndrome was performed using the costoclavicular maneuver that is specific for costoclavicular syndrome. This test is performed by having the patient's shoulders drawn downward and back and is positive if her extremity symptoms are reproduced and/or her radial pulse is diminished. The maneuver was normal. Cervical Distraction Test was positive on her right side today and was performed while Amy was seated and actively rotating her head and neck until radicular pain was produced. The examiner then rotates the head to the same extent but with strong upward traction added to the motion. If this action gives relief or significantly reduces the patient's cervical and/or radicular pain, the test is considered positive, indicating nerve root compression. If the patient can't actively rotate the head or neck because of pain, the examiner can still do this test by adding traction with or without rotation. Slump test was negative. This test is performed with the patient in a sitting posture while maintaining thoracic and cervical flexion; knee extension (pseudo-SLR) and foot dorsiflexion. Since the pain was reproduced but the release of the cervical flexion brought about no change, the test was deemed negative or normal for "neural tension", as alteration of the distant component brought about no difference in her symptoms. Soto-Hall Test was normal bilaterally with no pain produced. With the patient supine and the examiner exerting pressure on the sternum to prevent either lumbar or thoracic flexion, the examiner places the other hand under the patient's occiput and flexes the head and neck slowly and forcibly upon the sternum. This causes more and more of a pull on the posterior spinous ligaments, starting at the Ligamentum Nuchae, moving downward until it reaches the spinous process of the involved vertebra. There the pull acts as a lever compressing the vertebral body, thus causing localized pain. This test is mainly used to diagnose and localize vertebral bony disease and injuries, particularly of the compression type.

LUMBAR (low back) ROM (range of motion) was compared to the following normal values:

Flexion / 90 degrees

Extension / 30 degrees

Left lateral flexion / 35 degrees

Right lateral flexion / 35 degrees

Left rotation / 30 degrees

Right rotation / 30 degrees

Abnormal active motion with flexion abnormal at 70 degrees, and extension abnormal at 30 degrees.

The Toe Walk Test was performed and was normal. In this test the patient walks on the toes about seven steps forward, turns while still on her toes, then walks back the seven steps. The patient's inability to do this easily can indicate a loss of integrity of fibers from the S1-2 nerve roots. Heel-Walk Test was normal bilaterally. The patient walks on the heels several steps forward, then back the same way. If the patient has low back complaints and is unable to perform this action because of either pain or weakness, then a lesion of the fibers of the L5 nerve root would be suspected. Kemp's Test was normal with no pain increase reported. This test can be done with the patient standing or sitting. While stabilizing the pelvis, the patient's shoulder is firmly forced obliquely backward, downward and medial. The idea is to put the lower spine on the opposite side to the one being tested, into a combined position of rotation, lateral bending, and extension. The test is considered positive when low back pain radiates into the lower extremity, indicating facet syndrome, fracture or disc involvement. The Lasegue (Straight Leg Raise) Test was negative bilaterally. This test is done with the patient supine and with the knee in extension. The examiner, actively flexes each thigh slowly while holding the other hand on the knee to prevent its flexion. The leg is lifted 90 degrees or until pain prevents further motion. The final angle of flexion at which pain occurs, as well as the location and intensity of the pain are noted by the examiner. This test is considered positive when the straight leg cannot be raised to 90 degrees without pain. There were spinal restrictions noted as: C4, C6, C7 and Spinal segmental fixations or restrictions: right C2. Vertebral motion limitations: bilateral L4 and L5. Extraspinal motion limitations noted: right glenohumeral shoulder joint.

RADIOLOGY IMPRESSIONS:

A diagnostic study on the patient was performed outside of this office on the day of the accident in the ER. Plain film radiographs were taken of her lumbar spine. These films were not available for review today but have been requested. Lumbar AP view of the spine revealed Other radiographical findings in her lumbar views include a mild AP curvature and some facet jamming at L4/5 and L5/S1.

RADIOLOGY IMPRESSIONS:

A diagnostic study on the patient was requested to be performed outside of this office at ADR in LaVale, MD. Plain film radiographs were requested of her cervical spine. The studies were to be performed today. The report on these views is available as a separate document.

DIGITAL POSTURE ANALYSIS:

On the lateral view Amy's head is in an abnormal anterior position over her thoracic or chest cavity. The forward head posture is an abnormality of posture routinely observed in subjects with a wide variety of musculoskeletal complaints. Both medical and chiropractic researchers have devised reliable methods to assess the posture and skeletal alignment of the spine and skull of patients with such abnormalities. Methods which have been shown to reduce the magnitude of the forward head posture include both the McKenzie protocols of neck retraction exercise and extension traction protocols. She has an increase in her lumbar lordosis or curvature referred

to as hyperlordosis. Postural changes can be a risk factor for low back pain. Abnormal posture creates a strain on ligaments and muscles that indirectly affects the curvature of the lumbar spine. An increase in lordosis in the lumbar spine can also increase stress loads on the facet joints of the lumbar spine, contribute to a spondylolisthesis or disc herniation. The right shoulder is high on observation from the rear. Palpation of the soft tissue structures were normal in her upper body with the exception of spasm and trigger point activity in the posterior cervical muscles on the right and in the right trapezius. In addition, during palpation of the soft tissues I noted spasm muscles of the left lumbar area and muscles of the right lumbar area. Muscle strength was normal (Lovett 5-Normal 5-complete range of motion against gravity with full resistance) in the upper and lower extremities.

ASSESSMENT:

The following is my initial diagnosis in this case:

723.3 - (cervical brachial syndrome) - describing a combination of nerve root irritation producing pain in the cervical or neck region causing pain or loss of function in the shoulder, arm and/or wrist and hand. 739.1 - segmental dysfunction of the cervical and cervical thoracic region. 738.2 - (hypolordotic cervical spine) - a loss of the normal curvature of the cervical spine that places greater stress loads on the discs, ligaments and muscles of the cervical spine. It is frequently associated with headache and cervicogenic pain. 847.0 - (cervical sprain strain) - this is a tearing of the muscles, ligaments and other soft tissues of the neck associated with overuse, misuse or trauma. 724.2 - (lumbago) - low back pain related to spasm, joint and other soft tissue sources. 719.55 - joint stiffness and restriction in the pelvic region.

719.41 and/or 719.51 (shoulder pain and/or restriction of joint motion). 728.85 - (muscle spasm) - hypertonicity of muscles associated with splinting an injured or inflamed area to prevent motion associated with local pain and loss of joint mobility. 719.99 (aberrant motion) - abnormal joint motion detected by palpation.

She has a good prognosis in this case. There is a possibility of permanency. Amy's treatment begins today with therapeutic intensive care. She has postural abnormalities that may cause some degree of problem in resolving her problem quickly.

PLAN:

SHORT TERM TREATMENT GOALS:

Alleviate her symptoms.

LONG TERM TREATMENT GOALS:

Clear the noted joint restrictions. Eliminate the regional muscle spasm in the areas associated with her complaints. Increase her cervical range of motion (ROM) to normal. Increase her lumbar range of motion (ROM) to normal. Return the abnormal objective findings from her examination to normal.

INITIAL TREATMENT SCHEDULE:

She will be seen everyday for 10 visits.

3 visits a week for 6 weeks.

X-ray is indicated at this time and has been requested. (See chart for orders and report).

PURPOSE OF CARE:

Purpose of care is to reduce her pain, to improve or restore her posture, to improve the ROM (range of motion) to normal, to make a positive change in her level of function. I have recommended the application of cold packs at home. The application of cold may help relieve muscle spasms, acute low back pain, and acute inflammation. Cold may be applied using an ice bag or a cold pack. The spread of cold on the skin depends on the skin's thickness, the thickness of underlying fat and muscle, the water content of the tissue, and the rate of blood flow. I explained to her to be careful to avoid tissue damage by following the acronym "CBAN". This stands for Chilling, Burning, Aching and finally Numbness. The ice pack should be applied for no more than 15 minutes or until the area becomes numb. I explained how to keep a towel layer between the skin and the ice pack. The ice pack is to be applied over the posterior cervical area and posterior right shoulder region.

She will be seen again in 2 days. She is about the same with no significant change in her condition.

Seen by: Dr. David A. Bohn, D.C. - This note has been electronically signed.

Therapist Initial Only When All Therapies Have Been Completed As Ordered: _____ visit: ____ / ____