November 15, 2007

ACME Insurance
1234 Any Place
Anytown, CA 95248

Regarding
Employee: John Doe
SS# : 123-45-6789
DOB : 01-23-54
EMPL : ACME Widgets
DOI : 08-23-30
DOFE : 08-25-30
DOLE : 012-23-30

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT

History of Injury
(As related by the patient)

John Doe is a 53-year-old male who has been working for ACME Widgets for approximately 5 years. His duties included but were not limited to: constant standing, heavy lifting, bending, and twisting, 10 hours a day, 5-6 days per week. He built widgets, which weighed from 70-80 pounds.

On August 23, 2030, he lifted a 50x65 widget and tried to place it in a horizontal position, twisting his body to the left. As he did so, he felt a sharp pulling pain extending from his left upper extremity all the way to his neck and back. He immediately reported the accident to his supervisor, Kris Mass, however, he was ignored and not offered medical attention at that time.

He continued to complain but, unfortunately, no treatment was provided. He continued to have persistent complaints in his neck, upper extremity, and low back. The pain extended to both legs as well, right greater than left. One particular day, as he continued to work, he felt increased pain in his low back and felt pain in his knee as well. He states he began noticing his knee pain due to the required prolonged standing, which increased his bilateral leg and foot pain. Due to the pain, he was required to get special insoles to help him with the stress in his ankles and legs that he was feeling at that time. He states this helped a little, but his right knee pain continued to worsen.

On July 21, 2030, due to persistent pain in his right knee, he sought medical attention at ACME Walk-In Health Center in Santa Ana. Unfortunately, the doctor at that time said it was only an infection in his knee and documented as such.

He continued to have persistent complaints. He was prescribed medication.

On September 27, 2030, John sought treatment at this office. He reported that it was an industrial injury and he had persistent right upper extremity, neck, mid back, low back and bilateral lower extremity complaints. He deferred his Workers' Compensation benefits and preferred to pay on his own.

Unfortunately, the pain became intolerable due to the persistent workload that he was required to do, as there was no modified work at that time.

Due to persistent complaints, the patient returned to this office on November 15, 2030. He was not sure if his supervisor reported the persistent complaints and injury to his employer. John spoke with Mann Hombre, the owner of ACME Widgets, who told him that it was too late for him to report the injury and that he needed a diagnosis and a letter from an M.D. He then told Mann that he would make a claim for his injury and put it through the Workers Compensation carrier.

The patient states he self-procured treatment with another doctor by the name of Espalda, D.O. In a letter dated December 9, 2030, Dr. Espalda writes: "This is to advise that the above mentioned patient was seen in my office today with complaints of pain in the cervical spine, right knee, and right elbow areas. Mr. Doe has weakness in his right arm and decreased range of motion of the cervical spine. I believe these injuries are the result of a work-related injury and the patient needs to be referred to a neurologist for further evaluation."

John was referred to Neurologist, Dr. Joel Cerebro, in Santa Ana, who said that it was going to require a significant amount of money, because he needed further studies and more follow-ups.

The patient came to seek relief, once again, at my office and paid for his treatment. He indicated this was an industrial claim again and he needed to be covered by the Workers Compensation carrier. Due to failure of his employer to send him to the company physician, he presented to my office for care. As a result, I became his Primary Treating Physician.

COMPLAINTS

Initial Evaluation Complaints:

The patient complains of persistent neck pain radiating into the head, right upper extremity and occasionally into the left upper extremity. He has headaches. He experiences numbness and tingling extending to the fingers of his right and left hand. He rates the neck pain as a 9 on a scale of 0 to 10. The pain increases with prolonged neck positions. He avoids any heavy lifting because he feels increased tension and pain in his neck and right upper extremity.

He also complaints of mid back pain. He rates the midback pain as a 9 on a scale of 0-10. The pain increases with bending, heavy lifting, and twisting activities.

John also complains of right shoulder pain. He rates the shoulder pain as a 9 on a scale of 0-10. The pain increases with pushing, pulling, and activities over the shoulder. When he does work with his right hand, the pain radiates into his right upper extremity and he has to stop his work activities and rest.

He complains of right elbow pain. He rates the pain as an 8-9 on a scale of 0-10. The pain increases with pushing, pulling, and gripping activities. He has difficulty sleeping due to pain in his right upper extremity. He denies pain in his wrists or hands, but he has numbness and tingling in his right fingers, which increases early in the mornings.

John complains of low back pain. He rates the pain as a 9 on a scale of 0-10. The pain increases with bending activities. The pain radiates into legs, right greater than left.

He also complains of pain in his knees. He rates the pain in his right knee as a 7-8 on a scale of 0-10. The pain increases with bending activities. He has difficulty getting up from a sitting position due to the knee and low back pain.

Final Evaluation Complaints:

The patient indicates that overall he has felt improvement. He feels stronger and better conditioned than he did before starting his treatment and rehabilitation program. Unfortunately, he continues to be symptomatic.

In relation to the neck, he states that overall he feels better. He still experiences headaches on occasion, but they have decreased in frequency and intensity. He rates his neck pain as a 6/10 at its best and as a 7/10 at its worst.. He continues to experience numbness and tingling in his upper extremities bilaterally, especially at night. His neck

pain increases with prolonged neck activities, as well as with frequent movements of his neck.

As it relates to his right shoulder, he complains of pain primarily with lifting and over the shoulder activities. He describes the pain as a sharp pain in the anterior aspect of his shoulder. He rates his shoulder pain as a 6/10.

His right elbow pain has improved, however, he experiences an achy "burning" pain in his forearm, especially when his right wrist pain increases. Pain is sharp and shooting, radiating down to his fingers and up to the shoulder blade area. His pain increases with pushing, pulling, gripping, and grasping activities. He rates his pain as a 4/10 at its best and as a 6/10 at its worst.

He complains of bilateral wrist pain. He describes his pain as achiness which extends into the forearm region and into the elbow. He describes numbness and tingling into both his wrists/hands, greater on the right when compared to the left. He rates his wrist pain as a 4/10 at its best, but the numbness and tingling as a 5/10 because it interferes with his day to day routine and it wakes him up at night.

In relation to his mid and low back, he continues to complain of pain associated with "shooting" type pain into his lower extremities. He currently rates his pain as a 6/10 at its best and 7/10 at its worst. His low back pain increases with sitting, standing, bending, stooping, and lifting activities. The pain wakes him up at night occasionally.

In relation to his right knee, his pain increases with standing, walking, squatting, and kneeling activities. He rates his knee pain as a 6/10 at its best and as a 7/10 at its worst. When he rises from a seated position he has to walk for a few minutes for the stiffness to decrease.

ACTIVITIES OF DAILY LIVING:

Self Care, Personal Hygiene: The patient indicates that he has difficulty getting dressed, especially when putting on his socks and shoes. Combing, washing his hair and bathing increases his right upper extremity pain.

Physical Activity: The patient has significant pain when he sits or stands longer than one hour. He has difficulty climbing stairs as well.

Travel: The patient complains of pain with gripping and grasping activities, as a result he has increased right upper extremity pain while gripping the steering wheel. He cannot drive longer than one hour without having to stop and take a break, due to increased low back pain.

Sexual Function: The patient complains of pain and limitation when having intimate relations.

Sleep: The patient is not able to sleep at night due to increased pain and discomfort. As a result, he wakes up frequently throughout the night. He feels exhausted throughout the day and has a hard time focusing on his day-to-day tasks.

Medical History

In relation to the above-described symptomatology, the patient had no prior accidents or injuries causing any self or medically imposed restrictions.

Prior to this date of injury, John considered himself in good physical shape.

Occupational History

John Doe has been working for ACME Widgets for approximately 5 years with the above-described requirements.

PHYSICAL EXAMINATION

*The motor and range of motion examinations were performed using the JTECH Computerized Objective Functional Testing equipment. The numbers found and noted below are based on an average and are in compliance with the AMA Guides to Evaluation, 5th Edition.

CERVICAL SPINE EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On Initial Evaluation

There is moderate to severe tenderness on palpation of the upper trapezius bilaterally, right greater than left.

There is moderate tenderness on palpation of the interscapular region with trigger points noted, bilaterally.

On Final Evaluation:

There was slight to moderate tenderness and muscle guarding noted in the cervical spine paraspinals bilaterally, upper traps, and suboccipitals bilaterally. There were trigger points noted in the interscapular region as well as in the suboccipitals.

Cervical Ranges of Motion

	Initial Evaluation	**Final Evaluation**
Flexion	5/55	22/55
Extension	10/45	16/45
Right lat flex	10/40	16/40
Left lat flex	10/40	26/40
Right rotation	5/80	65/80
Left rotation	5/80	60/80

Orthopedic Tests

	Initial Evaluation	**Final Evaluation**
Cervical Distraction Test	(+) on the right	(+) slightly on the right
Max Foraminal Compression	(+) on the right	(+) on the right
Shoulder Depression Test	(+) on the right	(-) bilaterally with pain
Spurling's Test	(+) on the right	(-) bilaterally with pain
Vasalva's Test	(+)	(-)
Maignes's Test	(-) bilaterally with pain	(-) bilaterally with pain
Soto Hall Test	(+) C5-C7	(+) slightly from C5-7

Deep Tendon Reflexes

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
Biceps	1/4	2/4	2/4	2/4
Brachioradialis	2/4	2/4	1/4	2/4
Triceps	1/4	2/4	1/4	2/4

Pulses

	Initial Evaluation	Final Evaluation
Carotid	normal and symmetrical	
Radial	normal and symmetrical	

Muscle Testing

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
C5 Shoulder abduction	4/5	5/5	4/5	5/5
C6 Wrist extension	4/5	5/5	-5/5	5/5
C7 Wrist Flexion	4/5	5/5	4/5	5/5
C8 Finger to Finger	5/5	5/5	+4/5	5/5
T1 Finger Abduction	5/5	5/5	+4/5	5/5

Grip Strength Testing

	Initial Evaluation	Final Evaluation
Jamar Test Dyno 2nd Notch:		
Right hand	40/40/40	31/36/35
Left hand	75/80/70	46/51/43

The patient is right hand dominant. The patient demonstrated full effort.

Mensuration
(In inches)

On initial evaluation:

Landmark from AC joint to bulk of the muscle: Arm: right, 13; left, 12.50.
Landmark from Epicondyle to bulk of the muscle: Forearm: 11.25; left, 11.

On Final Evaluation:

Landmark from AC joint to bulk of the muscle: Arm: right, 13; left, 12.75.
Landmark from Epicondyle to bulk of the muscle: Forearm: 11.25; left, 11.25

Sensory Examination:

Sensory examination of the upper extremities revealed hypoesthesia following the median nerve distribution, bilaterally.

THORACOLUMBAR SPINE EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On Initial Evaluation:

There is marked tenderness on palpation with jumping tenderness in deeper palpation of the lower lumbar spine.

On Final Evaluation:

There was slight to moderate tenderness and guarding noted in the lumbar spine paraspinals and quadratus lumborum bilaterally.

Thoracolumbar Ranges of Motion

	Initial Evaluation	Final Evaluation
Flexion	20/90	28/90
Extension	10/30	4/30
Right lat flex	5/30	10/30
Left lat flex	10/30	15/30
Right rotation	10/30	20/30
Left rotation	5/30	20/30

Orthopedic Tests

	Initial Evaluation	Final Evaluation
SLR Test	(+) bilaterally	(+) bilaterally
Kemp's Test	(+) bilaterally	(-) bilaterally with LBP
SP Compression Test	(+) from L3-5	(+) from L3-5
Schepelmann's Test	(+) bilaterally	(-) bilaterally
Vasalva's Test	(+)	(-)
Chest Compression Test	(+) for Thoracic pain	(-)
Milgram’s Test	(+) bilaterally	(+) bilaterally for LBP
Sitting Root Test	(+) bilaterally	(+) bilaterally
Brudzinski Test	(-)	(-) bilaterally

SI Joint and Hip

	Initial Evaluation	Final Evaluation
Patrick's Test	(-) bilaterally	(-) bilaterally
Yeoman's	(+) bilaterally	(+) slightly bilaterally

Muscle Testing

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
L1-L3 Flexed thigh	5/5	5/5	4/5	5/5
L2-L3 Extended leg	4/5	5/5	-5/5	5/5
L4 Foot	5/5	5/5	5/5	5/5
L5 Foot	4/5	5/5	+4/5	5/5
S1 Foot	4/5	5/5	+4/5	5/5

Deep Tendon Reflexes

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
Patellar (L4)	1/4	2/4	1/4	2/4
Hamstring (L5)	2/4	2/4	1/4	2/4
Achilles (S1)	1/4	2/4	2/4	2/4

Mensuration
(In inches)

On Initial Evaluation:

Landmark from patella to bulk of the muscle: Thigh: right, 20.25; left, 20.
Landmark from lateral Condyle of the muscle: Leg: right, 15.75; left, 15.25.

On Final Evaluation:

Landmark from patella to bulk of the muscle: Thigh: right, 20.; left, 20.
Landmark from lateral Condyle of the muscle: Leg: right, 15.5; left, 15.25.

Sensory Examination:

The sensory examination of the lower extremities revealed hypoesthesia following the right L4-5 dermatomal distribution.

SHOULDER EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On Initial Evaluation:

There is moderate to severe tenderness on palpation of the right shoulder and posterior aspect of the right shoulder.

On Final Evaluation:

There was slight to moderate tenderness noted in the right supraspinatus, infraspinatus, teres minor, subscapularis, anterior and middle deltoid musculature.

Shoulders Ranges of Motion

	Initial Evaluation		**Final Evaluation**	
	Right	**Left**	**Right**	**Left**
Flexion	40 /180	180/180	136/180	180/180
Extension	10/30	30/30	17/30	30/30
Adduction	10/45	45/45	30/45	45/45
Ext Rotation	30 /80	80/80	84/80	80/80
Abduction	50/180	180/180	118/180	180/180
Int. Rotation	10/60	60/60	25/60	60/60

Orthopedic Tests

	Initial Evaluation	**Final Evaluation**
Yerganson's Test	(+) on the right	(+) on the right
Codman's Drop Arm	(+) on the right	(+) on the right
Supraspinatus Test	(+) on the right	(+) on the right
Hawkins-Kennedy Test	(+) on the right	(+) on the right

Muscle Testing

Please refer to cervical examination.

Deep Tendon Reflexes

Please refer to cervical examination.

ELBOW EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On initial evaluation:

There is moderate to severe tenderness on palpation of the lateral and medial aspects of the right elbow.

On Final Evaluation:

There was slight to moderate tenderness noted over the right common flexor and extensor tendons. There was slight to moderate tenderness and hypertonicity noted over the right wrist flexor tendons.

Ranges of Motion of the Elbow
(in degrees)

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
Flexion	10/140	140/140	127/140	140/140
Extension	30/180	180/180	180/180	180/180
Supination	10/85	85/85	60/85	85/85
Pronation	20/75	75/75	70/75	75/75

Orthopedic Tests

	Initial Evaluation	Final Evaluation
Valgus and Varus Test	(+) on the right	(+) on right for pain
Cozen's Test	(+) on the right	(+) on the right
Golfer's Test	(+) on the right	(+) on the right
Tinel's Test	(+) on the right	(+) on the right

WRIST EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On Initial Evaluation:

There is tenderness on palpation of the bilateral wrists, right greater than left.

On Final Evaluation:

There was tenderness over the carpal tunnels bilaterally. There was slight to moderate tenderness noted over the wrist flexor tendons bilaterally.

Ranges of Motion of the Wrist (in degrees)

	Initial Evaluation		Final Evaluation	
	Right	**Left**	**Right**	**Left**
Dorsal Flex	40/65	50/65	59/65	56/65
Palmar Flex	50/70	60/70	53/70	59/70
Ulnar Dev	30/40	35/40	23/40	23/40
Radial Dev	10/20	15/20	23/20	23/20

Orthopedic Tests

	Initial Evaluation	Final Evaluation
Phalen's Test	(-) bilaterally	(+) bilaterally
Finkelstein's Test	(-) bilaterally	(-) bilaterally
Froments Test	(-) bilaterally	(-) bilaterally
Tinel's Test	(+) bilaterally	(+) bilaterally

KNEE EXAMINATION

Inspection

There are no bruises, edema, deformities, scars, or lacerations.

Palpation

On Initial Evaluation:

There is moderate tenderness on palpation of the middle joint line and inferior to the medial aspect of the joint of the right knee.

On Final Evaluation:

There was slight to moderate tenderness noted in the right infrapatellar region, as well as over the ITB and medial joint line.

Ranges of Motion of the Knee (in degrees)

	Initial Evaluation	Final Evaluation
Flexion	50/130	105/130
Extension	160/180	180/180

Orthopedic Tests of the Knee

	Initial Evaluation	Final Evaluation
Valgus Stress Test	(+) on the right	(+) on the right
Varus Stress Test	(+) on the right	(+) on the right
McMurray's Test	(+) on the right	(+) on the right
Apley's compression Test	(+) on the right	(+) on the right
Anterior Drawer's Test	(+) on the right	(-) bilaterally
Posterior Drawer's Test	(+) on the right	(-) bilaterally
Noble Compression Test	(+) on the right	(+) on the right

Sensory Examination

Please refer to lumbar spine examination.

Muscle Testing

Please refer to lumbar spine examination.

INITIAL DIAGNOSIS

1. CERVICAL SPRAIN/STRAIN WITH BILATERAL RADICULOPATHY, RIGHT GREATER THAN LEFT.
2. THORACIC SPRAIN/STRAIN
3. LUMBAR SPRAIN/STRAIN
4. BILATERAL LEG RADICULOPATHY, RIGHT GREATER THAN LEFT
5. RIGHT ELBOW SPRAIN/STRAIN RULE OUT ULNAR TUNNEL SYNDROME
6. BILATERAL WRIST SPRAIN/STRAIN - RULE OUT CARPAL TUNNEL SYNDROME
7. RIGHT KNEE SPRAIN/STRAIN - RULE OUT MENISCAL INTERNAL DERANGEMENT
8. DEPRESSION - PER PATIENT

FINAL DIAGNOSIS

1. CERVICAL SPRAIN/STRAIN WITH RADICULOPATHY AND UNDERLYING DIFFUSE DISC BULGES MEASURING 3-4 MM AT C3-4, C4-5, AND C5-6 DISC LEVELS
2. THORACIC SPRAIN/STRAIN
3. LUMBAR SPRAIN/STRAIN ASSOCIATED WITH DIFFUSE DISC BULGES AT L3-4, L4-5, AND L5-S1 MEASURING 2-3 MM
4. BILATERAL LOWER EXTREMITY RADICULOPATHY, RIGHT GREATER THAN LEFT
5. RIGHT ELBOW SPRAIN/STRAIN
6. BILATERAL WRIST SPRAIN/STRAIN ASSOCIATED WITH TENOSYNOVITIS OF THE FLEXOR CARPI RADIALIS AND EFFUSION OF THE ULNAR STYLOID PROCESS WITH UNDERLYING CARPAL TUNNEL SYNDROME
7. RIGHT KNEE SPRAIN/STRAIN – GRADE II SIGNAL OF THE POSTERIOR HORN OF THE MEDIAL MENISCUS ASSOCIATED WITH MODERATE EFFUSION
8. RIGHT SHOULDER SPRAIN/STRAIN ASSOCIATED WITH A SUBCORACOID BURSAL EFFUSION AND TENOSYNOVITIS INVOLVING THE BICEP TENDON WITH AN UNDERLYING IMPINGEMENT SYNDROME
9. DEPRESSION –PER DR. CHAPEL

TREATMENT COURSE AND MANAGEMENT/DISCUSSION

DECEMBER 9, 2007, LETTER FROM LENNY ESPALDA, D.O., indicating:

> *"This is to advise you that the above mentioned patient was seen in my office today complaints of pain in the cervical spine, right knee, and right elbow areas. Mr. Doe has weakness of his right arm and decreased range of motion cervical spine. I believe these injuries are the result of a work related injury and that the patient needs to be referred to a neurologist for further evaluation."*

Due to persistent increasing pain, the patient came in to my office for an evaluation and treatment of his condition. As a result, I became his Primary Treating Physician.

MAY 25, 2006, INITIAL TREATMENT RECOMMENDATIONS.

> *"Appears that as a result of the lifting/pushing, the patient lifting a heavy 60x90 inch shutter had sprained/strained his neck, back, upper extremity and knee and as*

a result has developed persistent symptomatology in that area. Due to the injury, continued work, and lack of medical treatment, caused the condition to become chronic.

The patient has radiculopathy to the right upper extremity and positive Tinel's test in bilateral wrists, it is recommended the patient to undergo NCV/EMG studies to determine the level of neural compromise..

He is also recommended to undergo an MRI study to rule out derangement in his neck.

The patient has a positive supraspinatus test on the right shoulder and limited range of motion; therefore, he is recommended to have an MRI study of the right shoulder.

Because of the positive Tinel's test and pain in the right elbow with moderate tenderness, the patient may have torn a muscle in that region or caused compression of the nerve, therefore, it is recommended the patient to have an MRI study of the right elbow.

He also has a positive McMurray's test on the right knee, it would be best for the patient to have an MRI of the knee to rule out meniscal derangement.

In addition, due to significant findings, he should be co-treated with an orthopedic specialist. Ultimately may lead to a pain management specialist to control the radicular complaints.

The patient states he has not been sleeping well. He feels depressed about his injuries and he is nervous about his future. Due to his injuries and symptomatology, the patient should have a psychological consultation and treatment if deemed industrially necessary.

At this point, he will begin an aggressive three-week return to work program.

John will receive adjustments to the spine and extremities plus physiotherapy in the form of myofascial release, mechanical traction, and diathermy. Treatment may vary slightly depending on Tomas' response to treatment.

It would be appropriate to see him daily, for up to 8 visits, during the acute phase of his care. The treatment will work in conjunction with a work-conditioning

program, to avoid de-conditioning, for the next two weeks. Subsequently, he will be re-evaluated.

Once his condition responds, he will be tested using the latest technology in Functional Capacity Evaluation Testing, designed to test deficiencies, strengths all in order to determine a safe and effective return to work program.

Following the testing, he may begin a two-day work-hardening program, to help address fear factors, avoid de-conditioning, and address safety techniques.

We anticipate Tomas' condition will come to a resolution within 11 visits. Following the program, to help determine improvements, deficiencies, impairment, or disability John will be tested in a Final Functional Capacity Evaluation.

***On the thirteenth day**, John will have a Permanent and Stationary Evaluation. This will include, an approximate 25-page report consisting of summarized patient records to include but not limited to: Patient's History, Initial and Final Complaints, Initial and Final Examination findings, Initial and Final Diagnosis, treatment records, outside doctor reports, MRI, neurodiagnostic studies, discussions on Causation, Apportionment, Description of Disability, Work Preclusions, and Future Medical Care if indicated. Also, data will be re-inputted into the AMA Calculator to help determine if any, Final Whole Person Impairment, with supportive calculations, chapter, section and page numbers.*

A Notice to Return to Work, including any work preclusions will be immediately faxed, if available, to the Employer.

If everything goes as planned, as you can see he will only be on disability less than one month. However this may be disrupted, with delayed authorizations, significant MRI and/or NCV/EMG findings that may require orthopedic intervention.

When even the simplest injuries are delayed treatment, the patient's condition can rapidly deteriorate with guarding which creates adhesive build-up, chronicity, pain, fear factors, and result in further disability and/or impairment. In order for this program to be successful, time is of the essence; therefore treatment will be initiated immediately."

DECEMBER 17, 2007, INITIAL NEUROLOGICAL CONSULT, JOEL CEREBRO, M.D.:

The patient complained of daily headaches, which were near constant, neck pain, right elbow pain, bilateral wrist pain, mid back pain, low back pain, and right knee pain.

Dr. Cerebro indicating that based on his examination, the patient had findings consistent with carpal tunnel syndrome, bilaterally, as well as cervical and lumbar radiculopathy.

Under treatment recommendations, Dr. Cerebro recommended an MRI of the cervical and lumbar spine. He recommended electrodiagnostic studies of the upper and lower extremities. He prescribed medication and advised the patient to follow up in four weeks.

JANUARY 7, 2007, MRI of the CERVICAL SPINE by GEORGE VOLTAR, M.D.:

1. *Diffuse disc bulge 3-4 mm at C3-4, C4-5, and C5-6 disc levels*

JANUARY 7, 2007, MRI of the RIGHT KNEE by GEORGE VOLTAR, M.D.:

1. *Grande II signal of posterior horn of medial meniscus*
2. *Moderate effusion*

JANUARY 7, 2007, MRI of the LUMBAR SPINE by GEORGE VOLTAR, M.D.:

1. *Diffuse disc bulge 2-3 mm at L3-4, L4-5, L5-S1 disc levels*

JANUARY 7, 2007, MRI of the RIGHT ELBOW by GEORGE VOLTAR, M.D.:

1. *Normal magnetic resonance imaging of the right elbow*

JANUARY 7, 2007, MRI of the LEFT WRIST by GEORGE VOLTAR, M.D.:

1. *Tenosynovitis flexor carpi radialis.*
2. *Effusion styloid process, ulna*

JANUARY 7, 2007, MRI of the RIGHT WRIST by GEORGE VOLTAR, M.D.:

1. *Tenosynovitis flexor carpi radialis.*
2. *Effusion radioulnar joint*

JANUARY 7, 2007, MRI of the RIGHT SHOULDER by GEORGE VOLTAR, M.D.:

1. *Subcoracoid bursal effusion*
2. *Tenosynovitis bicep tendon*

APRIL 9, 2007, PROGRESS REPORT:

"Patient stated treatment has helped. Had a recent visit to Mexico and had to seek medical attention. Recommended, which I concur, EMG/NCV and MRI (C/S, L/S, Right shoulder). There is increased ROM in upper extremity, C/S, L/S. Flexion of C/S increased to 25 degrees, previously 5 degrees. L/S flexion increased to 50 degrees, before it was 20. Still concern with radiation, + MFC, and SLR. Recommend continue program with 7 treatments.

APRIL 15, 2007, ELECTRODIAGNOSTIC STUDIES, INTERPRETED BY DR. CEREBRO:

Impressions: essentially normal study both lower extremities

APRIL 16, 2007, PROGRESS REPORT:

Patient indicates treatment helped. He sleeps better. There is increase in cervical flexion range of motion 20/55, previously 5/55. Cervical extension increased to 20/45, previously 10/45. Also increased right shoulder range of motion, but with a positive supraspinatus test. There is still concern due to the + MFC, but we are still pending the MRI and NCV/EMG results. To prevent deconditioning, patient should do a 2-day work hardening program to help face fear factors and address proper biomechanics. Recommend a pre and post FCE to determine any final impairment/disability.

APRIL 18, 2007, PRELIMINARY FUNCTIONAL CAPACITY EVALUATION:

Impairment Summary

All impairment estimates are based on the Guides to the Evaluation of Permanent Impairment, Fifth Edition published by the American Medical Association.

The final whole person impairment is 40%

- ***Cervical spine ROM Method whole person impairment is 4%***
- ***Thoracic spine ROM Method whole person impairment is 2%***
- ***Lumbar spine ROM Method whole person impairment is 8%***
- ***Right upper extremity combined whole person impairment is 16%***
- ***Right lower extremity combined whole person impairment is 9%***

Adjustment to overall whole person impairment: 6%

Summary:

Patient has the following deficits:

Cervical ROM	***Norm***	***Result***	***Difference***	***% Deficit***
Cervical Flexion	*50°*	*30°*	*20°*	*40%*
Cervical Extension	*60°*	*32°*	*28°*	*47%*
Cervical Lateral Left	*45°*	*30°*	*15°*	*33%*
Cervical Lateral Right	*45°*	*19°*	*26°*	*58%*

Thoracic ROM	***Norm***	***Result***	***Difference***	***% Deficit***
Thoracic Minimum Kyphosis	*0-40°*	*220°*	*–*	*–*
Thoracic Flexion	*50°*	*10°*	*40°*	*80%*
Thoracic Lateral Left	*45°*	*17°*	*28°*	*62%*
Thoracic Lateral Right	*45°*	*10°*	*35°*	*18%*

Lumbar ROM	***Norm***	***Result***	***Difference***	***% Deficit***
Lumbar Flexion	*60°*	*45°*	*15°*	*25%*
Lumbar Extension	*25°*	*7°*	*18°*	*72%*
Lumbar Lateral Left	*25°*	*14°*	*11°*	*44%*
Lumbar Lateral Right	*25°*	*12°*	*13°*	*52%*

Upper Extremity ROM - Right Active	***Norm***	***Result***	***% Deficit***
Elbow Flexion	*150°*	*132°*	*12%*
Wrist Flexion	*60°*	*44°*	*17%*
Wrist Extension	*60°*	*34°*	*43%*
Wrist Radial Deviation	*20°*	*11°*	*45%*
Wrist Ulnar Deviation	*30°*	*21°*	*30%*

Lower Extremity ROM - Right Active	***Norm***	***Result***	***% Deficit***
Knee Flexion	*150°*	*112°*	*25%*

Mr. Doe has been treated aggressively with an intense chiropractic, physiotherapy, and work-conditioning program. The patient's mechanical muscoloskeletal dysfunction has reached a plateau with conservative treatment. The following attached areas show patients' deficiencies and as they relate to specific job-related critical demands.

Work Posture	***Ability***	***Preliminary***	***Final***
Standing/Walking	*Frequent*	*240 minutes*	
Sitting	*Frequent*	*180 minutes*	
Neck Flexion	*Occasional*	*120 minutes*	
Waist Flexion	*Occasional*	*120 minutes*	

The patient was tested for several hours to assess his ability to perform certain tasks and demands described in his job description. He was not capable to perform at a level that would allow him to compete and/or safely return in the open labor market.

Mr. John Doe has been co-operative and eager to return to work.

In order to reach this goal, an attempt must be made to increase pain tolerance, endurance, face fear factors, and avoid de-conditioning, for a safer and early return to work. A four-day work-hardening program would be appropriate, requested and implemented, based on ACOEM guidelines.

Following the program, Mr. Doe will be re-assessed in a Comprehensive Functional Capacity Evaluation for improvement, deficiencies, impairment, and/or work preclusions. Subsequently, if condition remains stable, absent any invasive procedures, patient should be declared Permanent and Stationary and returned to work.

Medical Necessity/Work Preclusions

Based on functional deficits observed and reported by the patient during the initial physical examination, objective computerized testing was ordered to evaluate the patient's physical performance, quantify the functional losses and establish a baseline functional level. The objective data will also be used to develop an appropriate treatment plan, track patient's response to treatment and to modify the treatment plan accordingly.

March 16, 2007, Appeal to Notice of Non-Certification (FCE)

I received a physician peer review from the P&S Network performed by Alec Wigham, D.C. On page 2 of his review, Dr. Wigham states: "Medical records fail to demonstrate any subjective or objective physical examination findings to support the diagnosis let alone an extensive rehabilitation program. Records also fail to document any long-term absence or diminished capacity to perform clearly defined essential job tasks. The records also lacked any indication that the patient has attempted to return to work or modified duty in which on-the-job rehabilitation can occur. The medical necessity for this request has not been clearly demonstrated. Therefore my recommendation is to non-certify

the requested functional capacity evaluation."

The remainder of Dr. Wigham's review is simply the ACOEM guidelines, page 137-138.

I would respectfully disagree with Dr. Wigham's opinions and conclusions. Dr. Wigham clearly insists that there is no subjective or objective physical examination findings to support the diagnosis, however, subjectively, based on my examination of February 12, 2007 Mr. John Doe had the following subjective complaints:

The patient complains of persistent neck pain radiating into the head, right up extremity and occasionally into the left. He has headaches. He experiences numbness and tingling extending to his right fingers and left hand. He rates the neck pain as a 9 on a scale of 0 to 10. The pain increases with prolonged position increases the pain. He avoids any heavy lifting because he feels like creates tension and pain in his neck and right upper extremity.

He also complains of mid back pain. He rates the midback pain as a 9 on a scale of 0-10. The pain increases with bilateral bending, heavy lifting, and twisting activities.

John also complains of right shoulder pain. He rates the shoulder pain as a 9 on a scale of 0-10. The pain increases with pushing, pulling, and activities over the shoulder. When he does work with his right hand, the pain radiates into his right upper extremity and he has to stop his work activities.

He complains of right elbow pain. He rates the pain as an 8-9 on a scale of 0-10. The pain increases with pushing, pulling, and gripping activities. He has difficulty sleeping due to pain in his right upper extremity. He denies pain in his wrists or hands, but he has numbness and tingling in his right fingers, which increases early in the mornings.

John complains of low back pain. He rates the pain as a 9 on a scale of 0-10. The pain increases with bending activities. The pain radiates into bilateral legs, right greater than left.

He also complains of pain in his knees. He rates the pain in his right knee as a 7-8 on a scale of 0-10. The pain increases with bending activities. He

has difficulty getting up from a sitting position due to the knee and low back pain.

Objectively based on my examination dated February 12, 2007, Mr. John had moderate to severe tenderness on palpation of the bilateral upper trapezius musculature, and interscapular region. Mr. Doe had significant loss of cervical range of motion, positive distraction, and compression tests. The DTRs were decreased at C5 and C7 on the right. There was decreased motor strength of the right upper extremity as well as decreased grip strength of the right hand.

This is simply the cervical spine exam findings. There is a multitude of positive objective exam findings for the lumbar spine, right shoulder, right elbow, right wrist, and right knee. (Please refer to report dated February 12, 2007)

Furthermore, MRI studies performed on 3/7/07, 3/8/07, and 3/22/07 and interpreted by George Voltar, M.D. revealed the following:
1. MRI of the left wrist: tenosynovitis, flexor carpi radialis and effusion, styloid process of the ulna
2. MRI of the right wrist: flexor carpi radialis tenosynovitis and effusion of the radioulnar joint
3. MRI of the right knee: grade II signal posterior horn of medial meniscus with moderate effusion
4. MRI of the lumbar spine: diffuse disc bulge 2-3 mm at L3-4, L4-5, and L5-S1 disc levels
5. MRI of the cervical spine: diffuse disc bulge 3-4 mm at C3-4, C4-5, and C5-6 disc levels
6. MRI of the right shoulder: subcoracoid bursal effusion and biceps tendon tenosynovitis

As such, Dr. Wigham's comments that there are no subjective or objective examination findings are not accurate.

Dr. Wigham states that medical necessity for an FCE has not been demonstrated, however, as noted hereinabove, the patient is clearly in need of a functional evaluation. Based on the ACOEM guidelines, page 137-138: "The employer or claim administrator may request functional ability evaluation, also known as functional capacity evaluations, to further asses current work capability. These assessments also may be ordered by the treating or evaluation physician, if the physician feels the

information from such testing is crucial."

Based on my evaluation of the patient, I found that a functional capacity evaluation was crucial.

Moreover, Dr. Wigham stated: "Mr. Doe is a 43 year-old patient with a date of injury February 12, 2007. According to the carriers records the patient has not worked since the date of injury. He was diagnosed with a cervical and lumbar sprain and strain. A March 19, 2007 report states that the patient had suffered an initial injury June 21, 2006. It is unclear what treatment was rendered at that time or if it was in fact and accepted industrial injury."

With all due respect, it is apparent Dr. Wigham did not have all the records available for review. February 12, 2007 was my initial date of examination, not the patient's date of injury. As such, Dr. Wigham's opinions and conclusions are not accurate, simply based on the fact that he did not have the opportunity to review all the records available.

Based on all the above information, and based on the ACOEM guidelines, page 137-138, there are sufficient subjective and objective physical examination findings to support the diagnosis as well as an extensive rehabilitation program.

APRIL 22, 2007, SUPPLEMENTAL REPORT:

It should be added under the History of Injury as stated in Dr. Cerebro's, Neurological Evaluation, that John suffered a second injury in mid 2006. John remembers the date as 6-21-2006 at 2:40pm. He slipped, carrying 10" by 20" piece of wood, on an oily floor (WD-40 overspray) in a sitting position, hitting his left arm against the table. This aggravated his low back and left arm pain. He reported the injury to the supervisor, Juan Venado, the following day, but was not offered medical attention.

Also, it should be added that John feels he has suffered a decrease in sexual performance. An internal specialist should see him to determine if this is industrially related. I request authorization John be seen by an internal special regarding this issue.

APRIL 23, 2007, PROGRESS REPORT:

Patient states work hardening has helped. He feels stronger and greater endurance (see attached log). Tomorrow perform final FCE to determine final current impairment from a conservative point of view. He should follow up with ortho.

APRIL 25, 2007, PROGRESS REPORT:

At this point patient states treatment has helped. However still concerned with positive supraspinatus test of the right shoulder and (+) Tinel's of the bilateral wrist. Positive McMurray's of the right knee. Recommend ortho consult regarding shoulder, knee and hands. Concern regarding pain traveling into inguinal region, request internal specialist. Patient continues to be anxious, depressed and unable to sleep. Recommend psychological evaluation. Waiting for NCV/EMG results, see MRI report attached. Unfortunately FCE data inadvertently omitted the right shoulder (see attached data which includes right shoulder and increased WPI).

APRIL 29, 2007, ORTHOPEDIC REPORT, DR. LEONARD MCCOY , M.D.:

The patient complained of neck, low back, right shoulder, right elbow and bilateral wrist complaints. Dr. McCoy found decreased range of motion and tenderness associated with the cervical spine, right knee, right shoulder, and lumbar spine. He found evidence of meniscal injury to the right knee. He requested the neurodiagnostic studies from Dr. Cerebro, recommended that the patient continue with conservative care, and advised the patient to follow up in 6 weeks.

MAY 2, 2007, FINAL FUNCTIONAL CAPACITY EVALUATION:

When performing ranges of motion several muscle groups were noted to be guarded and in some instances spasmatic. Although, Mr. Doe has greatly improved in various ranges of motion of the neck, thoracic and lumbar spine, wrists and elbow, in today's examination there were still a few planes of motion that recorded some deficit, and the clinical findings noted above were present.

- *Cervical left lateral flexion 13% improvement*
- *Cervical right lateral flexion 16% improvement*
- *Thoracic left lateral flexion 35% improvement*
- *Thoracic right lateral flexion 20% improvement*
- *Lumbar extension 14% improvement*
- *Right wrist flexion 16% improvement*

- *Right wrist extension 50% improvement*
- *Right wrist radial deviation 100% improvement and 58% ulnar improvement*
- *Neck flexion muscle test 38% improvement*
- *Neck extension muscle test 7% improvement*
- *Right elbow flexion muscle 18% improvement*
- *Right elbow extension muscle test 7% improvement*
- *See also Pre and Post F.C.E. handwritten log*
- *Total whole person improvement 1%*
    - *(Preliminary F.C.E. 39% impairment & Final F.C.E 40%)*
    - *For the purpose of comparison, ROM method and computerized muscle testing were utilized.*

Work Posture	***Ability***	***Preliminary***	***Ability***	***Final***
Standing/Walking	*Frequent*	*240 minutes*	*Frequent*	*210 minutes*
Sitting	*Frequent*	*180 minutes*	*Frequent*	*180 minutes*
Neck Flexion	*Occasional*	*120 minutes*	*Occasional*	*120 minutes*
Waist Flexion	*Occasional*	*120 minutes*	*Occasional*	*120 minutes*

Mr. John Doe showed occasionally facial expressions of discomfort and pain while performing tasks that required prolonged cervical, lumbar, elbow and knee motions (bicycle, pipe tree, assembly, janitorial, gaming, interactive boxing simulator, gym). Other areas that were previously injured showed the same patterns of distress such as repetitive forceful gripping.

The WPI (Whole Person Impairment) established above does not accurately describe Mr. John Doe's disability. He was tested for eight hours to assess his ability to perform certain tasks/demands described in his job description, and although there were much improved, he is still not capable to perform to a level that would allow him to compete in the open labor market.

JUNE 11, 2007, PROGRESS REPORT:

Persistent increase in upper back pain. Patient states treatment helps him. Patient should still follow up with ortho for the next step. No further chiro/PT required.

JUNE 11, 2007, NEUROLOGIC PROGRESS REPORT:

Patient complained of neck, mid back, low back, right elbow and bilateral wrist pain. The patient remained neurologically unchanged and he recommended medication, continue with conservative care and to follow up in four weeks.

JULY 9, 2007, PROGRESS REPORT:

Received ortho report dated 3/27/07 requesting results from NCV/EMG, I forwarded records. Subjective/objective same, except for recent increase in LBP. There was a positive SLR test. Patient indicated treatment helped, recommended to continue stretching at home. Follow up with orthopedist for further recommendations.

JUNE 20, 2007, NEUROLOGIC PROGRESS REPORT:

Dr. Cerebro indicates the patient continued having neck, mid and low back complaints. The patient was having trouble sleeping so he prescribed sleep medication. Neurologically, the patient remained the same. Dr. Cerebro prescribed medication, recommended continue conservative care, and for the patient to follow up in four weeks.

JULI 7, 2007, PSYCHOLOGICAL PERMANENT AND STATIONARY REPORT, BY DR. CHRISTINE CHAPEL, PhD.:

On this date, Dr. Chapel indicated: "The percentage of total causation of the patient's current mental disorder was estimated at a higher level beyond the legal threshold of industrial causation of more than 51%."

In relation to apportionment, Dr. Chapel indicated: pursuant to Labor Code 4663 and 4664, the permanent residual disability based on causation is 100% industrially related to the injuries sustained on a continuous basis from March 1998 until May 12, 2007.

As it relates to work restrictions, Dr. Chapel indicated the patient should avoid ordinary amounts of emotional stress in order to prevent exacerbation of his present emotional condition.

Dr. Chapel found the patient to have a Global Assessment of Functioning (GAF) score of 61, which correlates to a 14 % whole person impairment (WPI).

JULY 7, 2007, PROGRESS REPORT:

Recent visit with pain specialist, Dr. Mickey recommended an epidural injection. I concurred and requested the same. No chiro/PT requested. Requested psychological evaluation. There was a positive MFC and a positive SLR.

JULY 9, 2007, ORTHOPEDIC PROGRESS REPORT:

The patient continued complaining of low back pain. Dr. McCoy found a positive SLR and recommended pain management as well as continued conservative care.

SEPTEMBER 15, 2007, PROGRESS REPORT:

The patient returns today due to persistent low back pain with radiculopathy. The patient is also complaining of numbness and tingling in his hands bilaterally. At this point we are waiting for, and requesting authorization for lumbar epidural injections. The patient states the treatment gives him temporary relief. He is recommended to continue his home exercise program with emphasis on stretching.

SEPTEMBER 12, 2007, NEUROLOGIC PROGRESS REPORT:

The patient was complaining of low back pain with radiation, mid back pain, neck pain, and headaches. Neurologically the patient remained the same. He was recommended to ice the sole of his right foot, take medications and to follow up in 4 weeks.

SEPTEMBER 18, 2007, PROGRESS REPORT:

The patient returns today with obvious signs of low back pain. Today's examination reveals the patient to be slightly antalgic and he has difficulty rising from a seated position. The lumbar spine range of motion was limited in all planes. The SLR test was positive. We are pending authorization for a pain management (epidural injections) consultation from the carrier. I am therefore continuing to request authorization for epidural injections.

OCTOBER 9, 2007, NEUROLOGIC PROGRESS REPORT:

The patient was complaining of low back pain with radiation, mid back pain, neck pain, and headaches. Neurologically the patient remained the same. He was recommended to take medications and to follow up in 4 weeks.

OCTOBER 16, 2007, PROGRESS REPORT:

"The patient returns to this office due to persistent low back pain and radicular symptoms into his lower extremities, right greater than left. Today's examination revealed decreased lumbar range of motion, associated with a positive SLR bilaterally. There was hypoesthesia noted following the L4/L5 dermatomal distribution. I concur, and incorporate Dr. McCoy's opinions and conclusions, as such, the patient is recommended to undergo a pain management consultation. I have yet to receive authorization from the carrier. I request that the authorization be done on an expedited basis as he has persistent weakness in his lower extremities, most notably with great toe extension. He indicated today's treatment helped, however he requires further treatment as noted above."

DECEMBER 14, 2007, PROGRESS REPORT:

"We have not had cooperation from the carrier as it relates to authorization for epidural injections. Medically, he would likely improve if he were to undergo said procedure. Unfortunately, we have not received authorization. As a result, he will undergo a final evaluation using the latest technology in range of motion and strength testing. I will utilize Jtech equipment with proper protocols from the AMA guides to evaluation. I reserve the right to amend my report, should such authorization be provided at a later date. It would be medically reasonable to find the patient medically eligible for vocational rehabilitation. In the meantime he is to remain on TTD."

NOVEMBER 13, 2007, DATA FROM TODAY'S MOTOR AND RANGE OF MOTION TESTING USING THE JTECH EVALUATION SYSTEM, BASED ON THE AMA GUIDES TO EVALUATION, 5TH EDITION PROTOCOLS:

Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

Cervical ROM	Norm	Result	Difference	% Norm
Cervical Flexion	50°	22°	28°	44%
Cervical Extension	60°	16°	44°	27%
Cervical Lateral Left	45°	26°	19°	58%
Cervical Lateral Right	45°	16°	29°	36%

Thoracic ROM	Norm	Result	Difference	% Norm
Thoracic Minimum Kyphosis	0-40°	44°	–	–
Thoracic Flexion	50°	4°	46°	8%
Thoracic Lateral Left	45°	13°	32°	29%
Thoracic Lateral Right	45°	5°	40°	11%

Lumbar ROM	Norm	Result	Difference	% Norm
Lumbar Flexion	60°	25°	35°	42%
Lumbar Extension	25°	3°	22°	12%
Lumbar Lateral Left	25°	13°	12°	52%
Lumbar Lateral Right	25°	6°	19°	24%
Straight Leg Raise Left	–	30°	–	–
Straight Leg Raise Right	–	26°	–	–

The table(s) above show current test results compared to American Medical Association normative values.

Spine Range of Motion Progress

		Previous Exam			Current		
Cervical Recent Change	**Norm**	**Date**	**Result**	**% Norm**	**Result**	**% Norm**	**Change**
Cervical Flexion	50°	3/21/2007	21°	42%	22°	44%	5%
Cervical Extension	60°	3/21/2007	29°	48%	16°	27%	-45%
Cervical Lateral Left	45°	3/21/2007	34°	76%	26°	58%	-24%
Cervical Lateral Right	45°	3/21/2007	22°	49%	16°	36%	-27%

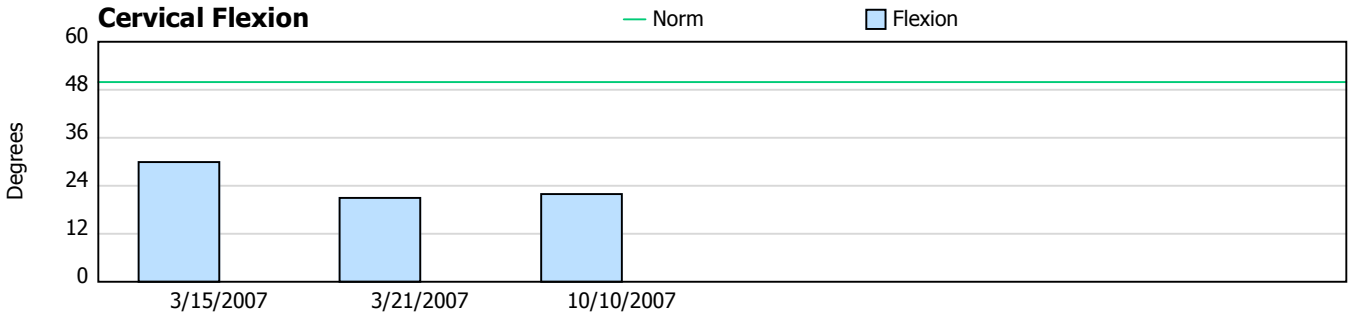
		Previous Exam			Current		
Thoracic Recent Change	**Norm**	**Date**	**Result**	**% Norm**	**Result**	**% Norm**	**Change**
Thoracic Minimum Kyphosis	0-40°	3/21/2007	16°	–	44°	–	175%
Thoracic Flexion	50°	3/21/2007	93°	186%	4°	8%	-96%
Thoracic Lateral Left	45°	3/21/2007	23°	51%	13°	29%	-43%
Thoracic Lateral Right	45°	3/21/2007	12°	27%	5°	11%	-58%

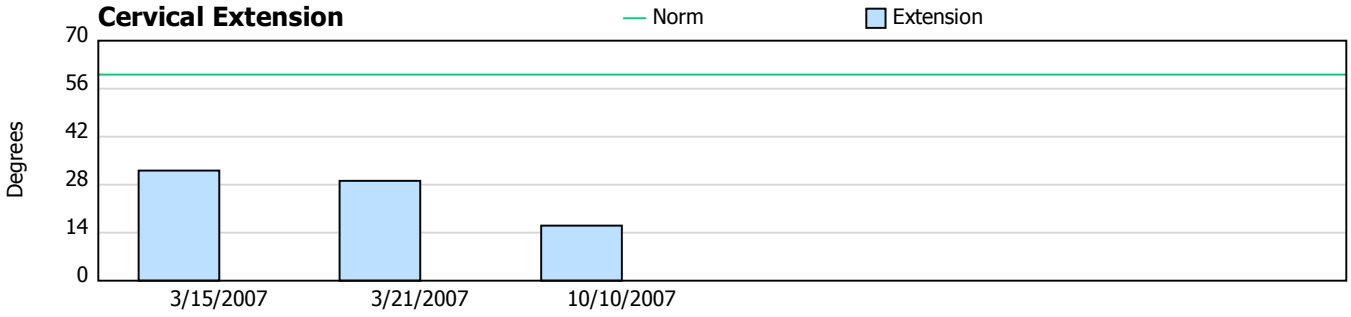
		Previous Exam			Current		
Lumbar Recent Change	**Norm**	**Date**	**Result**	**% Norm**	**Result**	**% Norm**	**Change**
Lumbar Flexion	60°	3/21/2007	43°	72%	25°	42%	-42%
Lumbar Extension	25°	3/21/2007	8°	32%	3°	12%	-63%
Lumbar Lateral Left	25°	3/21/2007	10°	40%	13°	52%	30%
Lumbar Lateral Right	25°	3/21/2007	12°	48%	6°	24%	-50%
Straight Leg Raise Left	–	3/21/2007	33°	–	30°	–	-9%
Straight Leg Raise Right	–	3/21/2007	37°	–	26°	–	-30%

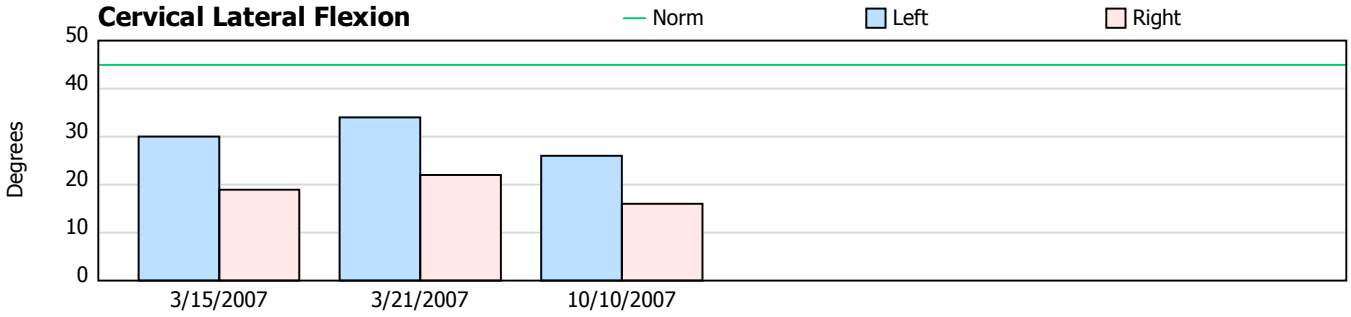
		Initial Exam			Current		
Cervical Overall Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Cervical Flexion	*50°*	*3/15/2007*	*30°*	*60%*	*22°*	*44%*	*-27%*
Cervical Extension	*60°*	*3/15/2007*	*32°*	*53%*	*16°*	*27%*	*-50%*
Cervical Lateral Left	*45°*	*3/15/2007*	*30°*	*67%*	*26°*	*58%*	*-13%*
Cervical Lateral Right	*45°*	*3/15/2007*	*19°*	*42%*	*16°*	*36%*	*-16%*

		Initial Exam			Current		
Thoracic Overall Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Thoracic Minimum Kyphosis	*0-40°*	*3/15/2007*	*220°*	*–*	*44°*	*–*	*-80%*
Thoracic Flexion	*50°*	*3/15/2007*	*10°*	*20%*	*4°*	*8%*	*-60%*
Thoracic Lateral Left	*45°*	*3/15/2007*	*17°*	*38%*	*13°*	*29%*	*-24%*
Thoracic Lateral Right	*45°*	*3/15/2007*	*10°*	*22%*	*5°*	*11%*	*-50%*

		Initial Exam			Current		
Lumbar Overall Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Lumbar Flexion	*60°*	*3/15/2007*	*45°*	*75%*	*25°*	*42%*	*-44%*
Lumbar Extension	*25°*	*3/15/2007*	*7°*	*28%*	*3°*	*12%*	*-57%*
Lumbar Lateral Left	*25°*	*3/15/2007*	*14°*	*56%*	*13°*	*52%*	*-7%*
Lumbar Lateral Right	*25°*	*3/15/2007*	*12°*	*48%*	*6°*	*24%*	*-50%*
Straight Leg Raise Left	*–*	*3/15/2007*	*39°*	*–*	*30°*	*–*	*-23%*
Straight Leg Raise Right	*–*	*3/15/2007*	*37°*	*–*	*26°*	*–*	*-30%*






Cervical Lateral Flexion
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Right
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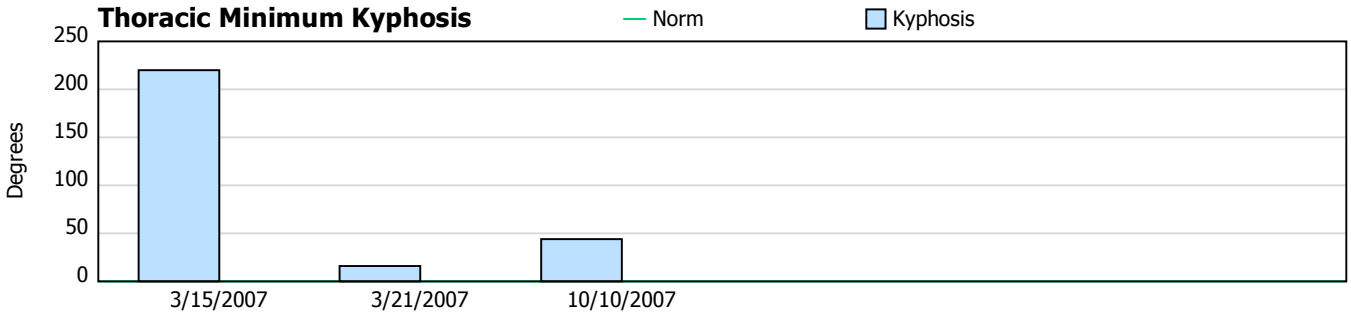
3/15/2007
3/21/2007
10/10/2007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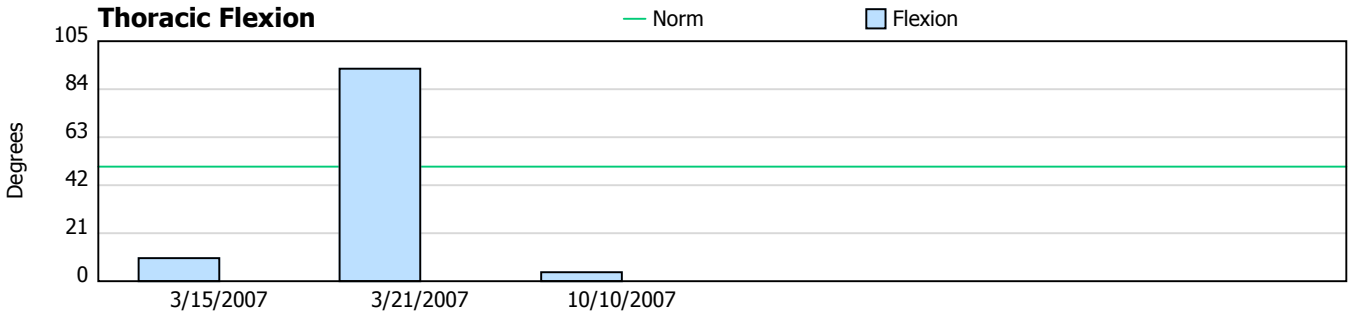
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Degrees
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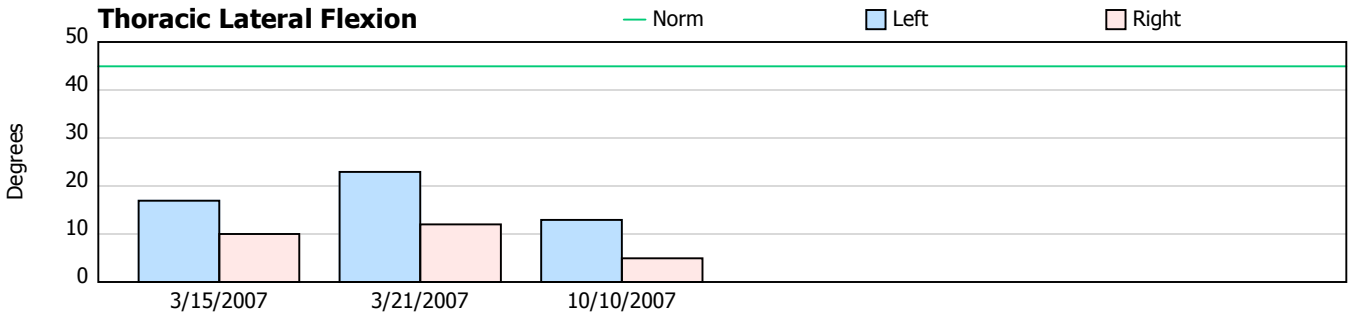
10/10/2007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Right
Degrees
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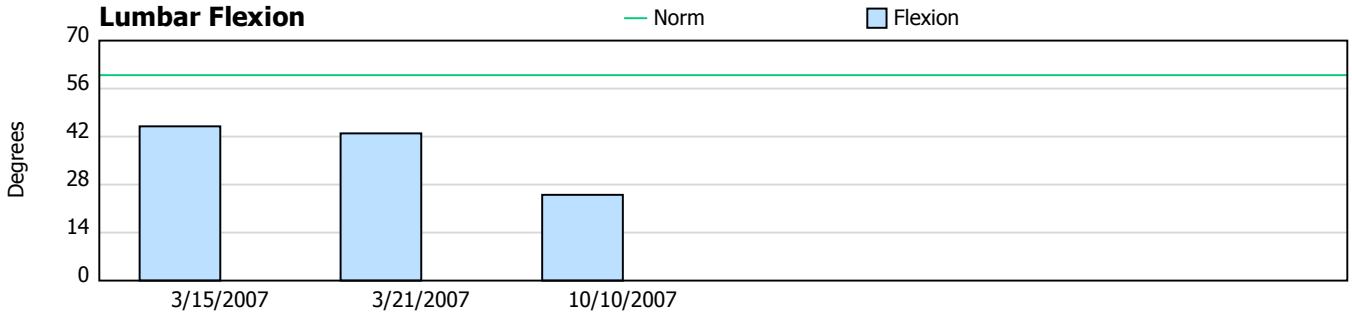
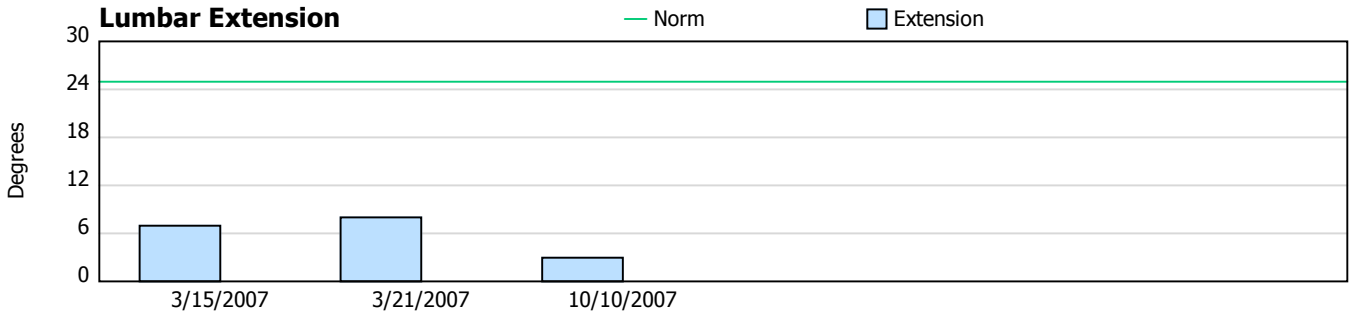
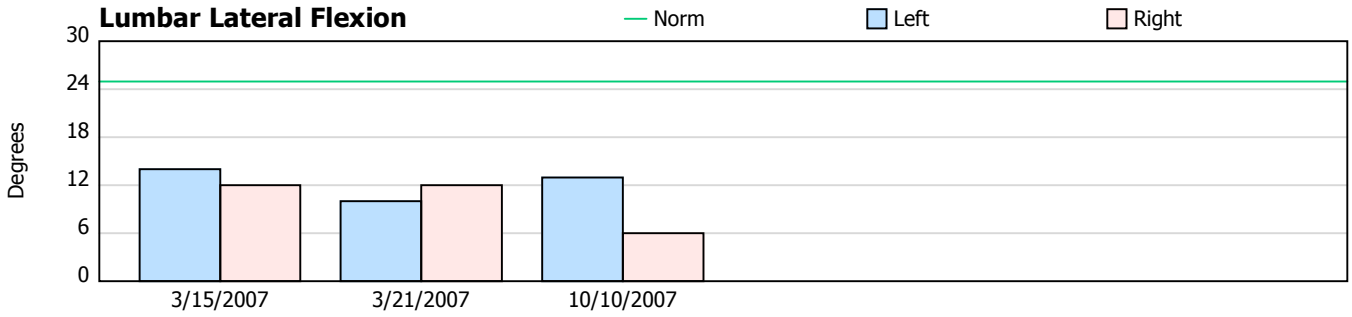
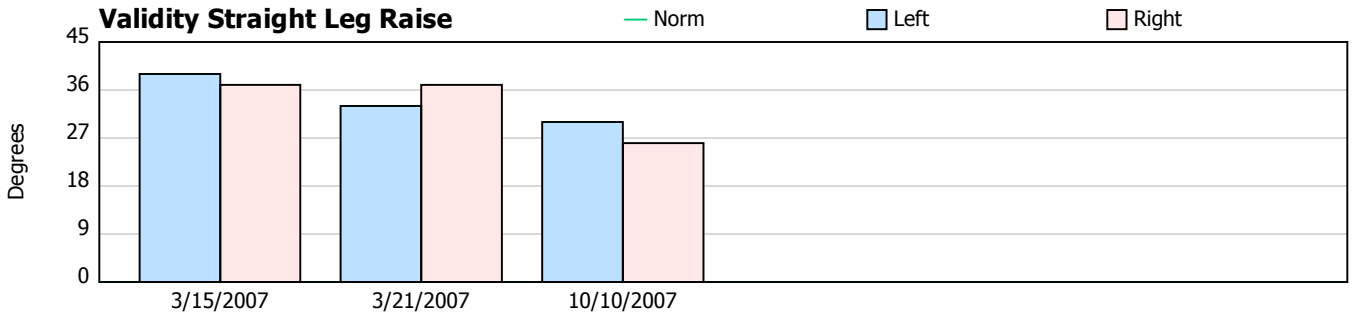
3/15/2007
3/21/2007
10/10/2007









Range of Motion - Goniometry

Upper Extremity ROM

Range of motion (ROM) for the upper extremity joint motions indicated below were evaluated and compared to normative values published by the American Medical Association in the Guides to the

Evaluation of Permanent Impairment, Fifth Edition.

Upper Extremity ROM - Left Active	***Norm***	***Result***	***% Norm***
Shoulder Flexion	*180°*	*137°*	*76%*
Shoulder Extension	*50°*	*24°*	*48%*
Shoulder Abduction	*180°*	*118°*	*66%*
Shoulder Adduction	*50°*	*33°*	*66%*
Shoulder Internal Rotation	*90°*	*31°*	*34%*
Shoulder External Rotation	*90°*	*77°*	*86%*
Elbow Flexion	*150°*	*126°*	*84%*
Elbow Extension	*0°*	*0°*	*–*
Wrist Flexion	*60°*	*56°*	*93%*
Wrist Extension	*60°*	*64°*	*107%*
Wrist Radial Deviation	*20°*	*24°*	*120%*
Wrist Ulnar Deviation	*30°*	*25°*	*83%*

Upper Extremity ROM - Right Active	***Norm***	***Result***	***% Norm***
Shoulder Flexion	*180°*	*139°*	*77%*
Shoulder Extension	*50°*	*20°*	*40%*
Shoulder Abduction	*180°*	*120°*	*67%*
Shoulder Adduction	*50°*	*31°*	*62%*
Shoulder Internal Rotation	*90°*	*25°*	*28%*
Shoulder External Rotation	*90°*	*88°*	*98%*
Elbow Flexion	*150°*	*132°*	*88%*
Elbow Extension	*0°*	*0°*	*–*
Wrist Flexion	*60°*	*62°*	*103%*
Wrist Extension	*60°*	*57°*	*95%*
Wrist Radial Deviation	*20°*	*26°*	*130%*
Wrist Ulnar Deviation	*30°*	*25°*	*83%*

Upper Extremity ROM Progress

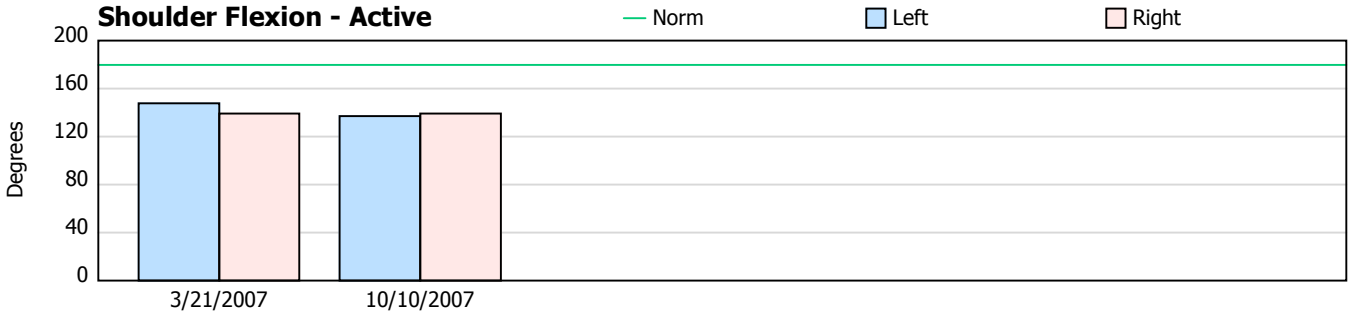
		Previous Exam			***Current***		
Left Active Upper Ext. Recent Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Shoulder Flexion	*180°*	*3/21/2007*	*148°*	*82%*	*137°*	*76%*	*-7%*
Shoulder Extension	*50°*	*3/21/2007*	*25°*	*50%*	*24°*	*48%*	*-4%*
Shoulder Abduction	*180°*	*3/21/2007*	*132°*	*73%*	*118°*	*66%*	*-11%*
Shoulder Adduction	*50°*	*3/21/2007*	*42°*	*84%*	*33°*	*66%*	*-21%*
Shoulder Internal Rotation	*90°*	*3/21/2007*	*28°*	*31%*	*31°*	*34%*	*11%*
Shoulder External Rotation	*90°*	*3/21/2007*	*72°*	*80%*	*77°*	*86%*	*7%*
Elbow Flexion	*150°*	*3/21/2007*	*130°*	*87%*	*126°*	*84%*	*-3%*
Elbow Extension	*0°*	*3/21/2007*	*0°*	*–*	*0°*	*–*	*–*
Wrist Flexion	*60°*	*3/21/2007*	*48°*	*80%*	*56°*	*93%*	*17%*
Wrist Extension	*60°*	*3/21/2007*	*60°*	*100%*	*64°*	*107%*	*7%*
Wrist Radial Deviation	*20°*	*3/21/2007*	*18°*	*90%*	*24°*	*120%*	*33%*
Wrist Ulnar Deviation	*30°*	*3/21/2007*	*31°*	*103%*	*25°*	*83%*	*-19%*

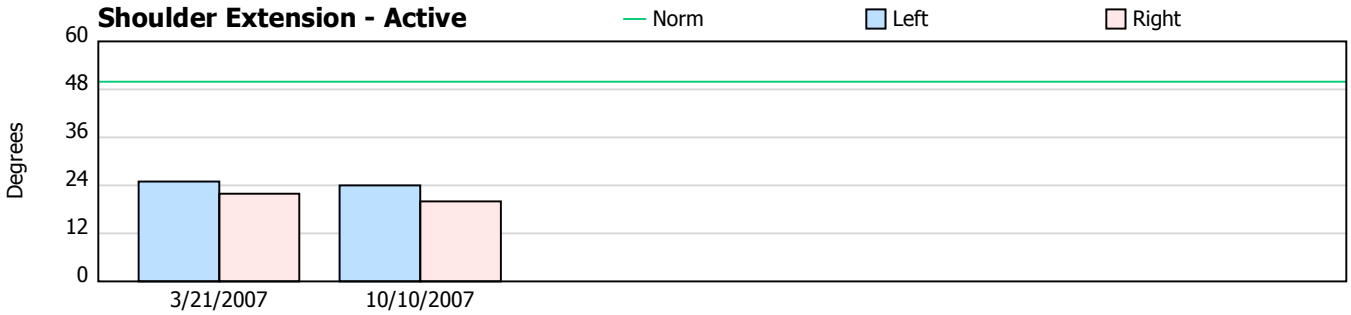
		Previous Exam			Current		
Right Active Upper Ext. Recent Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Shoulder Flexion	*180°*	*3/21/2007*	*139°*	*77%*	*139°*	*77%*	*0%*
Shoulder Extension	*50°*	*3/21/2007*	*22°*	*44%*	*20°*	*40%*	*-9%*
Shoulder Abduction	*180°*	*3/21/2007*	*119°*	*66%*	*120°*	*67%*	*1%*
Shoulder Adduction	*50°*	*3/21/2007*	*28°*	*56%*	*31°*	*62%*	*11%*
Shoulder Internal Rotation	*90°*	*3/21/2007*	*13°*	*14%*	*25°*	*28%*	*92%*
Shoulder External Rotation	*90°*	*3/21/2007*	*82°*	*91%*	*88°*	*98%*	*7%*
Elbow Flexion	*150°*	*3/21/2007*	*130°*	*87%*	*132°*	*88%*	*2%*
Elbow Extension	*0°*	*3/21/2007*	*0°*	*–*	*0°*	*–*	*–*
Wrist Flexion	*60°*	*3/21/2007*	*51°*	*85%*	*62°*	*103%*	*22%*
Wrist Extension	*60°*	*3/21/2007*	*51°*	*85%*	*57°*	*95%*	*12%*
Wrist Radial Deviation	*20°*	*3/21/2007*	*24°*	*120%*	*26°*	*130%*	*8%*
Wrist Ulnar Deviation	*30°*	*3/21/2007*	*33°*	*110%*	*25°*	*83%*	*-24%*

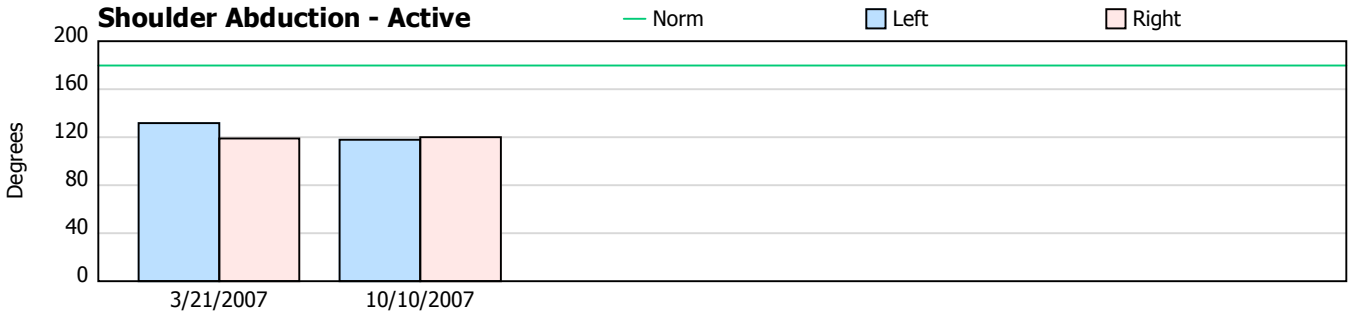
		Initial Exam			Current		
Left Active Upper Ext. Overall Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Shoulder Flexion	*180°*	*3/21/2007*	*148°*	*82%*	*137°*	*76%*	*-7%*
Shoulder Extension	*50°*	*3/21/2007*	*25°*	*50%*	*24°*	*48%*	*-4%*
Shoulder Abduction	*180°*	*3/21/2007*	*132°*	*73%*	*118°*	*66%*	*-11%*
Shoulder Adduction	*50°*	*3/21/2007*	*42°*	*84%*	*33°*	*66%*	*-21%*
Shoulder Internal Rotation	*90°*	*3/21/2007*	*28°*	*31%*	*31°*	*34%*	*11%*
Shoulder External Rotation	*90°*	*3/21/2007*	*72°*	*80%*	*77°*	*86%*	*7%*
Elbow Flexion	*150°*	*3/15/2007*	*126°*	*84%*	*126°*	*84%*	*0%*
Elbow Extension	*0°*	*3/15/2007*	*0°*	*–*	*0°*	*–*	*–*
Wrist Flexion	*60°*	*3/15/2007*	*41°*	*68%*	*56°*	*93%*	*37%*
Wrist Extension	*60°*	*3/15/2007*	*60°*	*100%*	*64°*	*107%*	*7%*
Wrist Radial Deviation	*20°*	*3/15/2007*	*15°*	*75%*	*24°*	*120%*	*60%*
Wrist Ulnar Deviation	*30°*	*3/15/2007*	*18°*	*60%*	*25°*	*83%*	*39%*

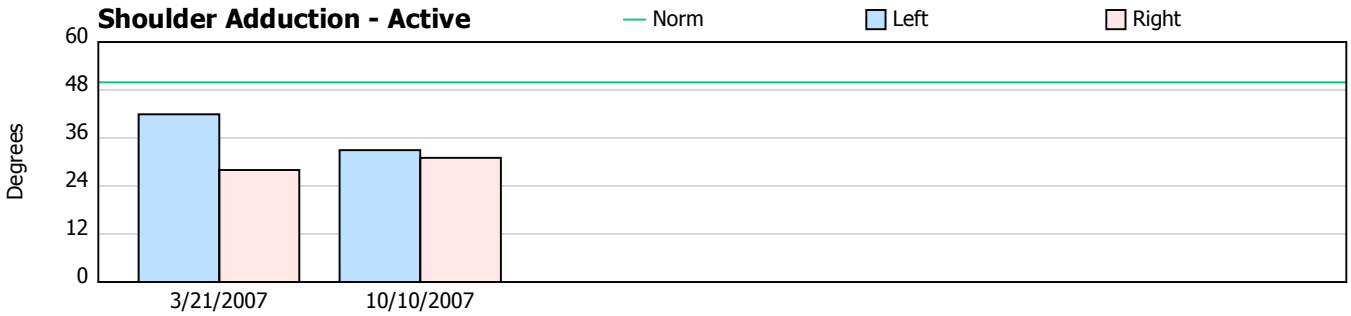
		Initial Exam			Current		
Right Active Upper Ext. Overall Change	***Norm***	***Date***	***Result***	***% Norm***	***Result***	***% Norm***	***Change***
Shoulder Flexion	*180°*	*3/21/2007*	*139°*	*77%*	*139°*	*77%*	*0%*
Shoulder Extension	*50°*	*3/21/2007*	*22°*	*44%*	*20°*	*40%*	*-9%*
Shoulder Abduction	*180°*	*3/21/2007*	*119°*	*66%*	*120°*	*67%*	*1%*
Shoulder Adduction	*50°*	*3/21/2007*	*28°*	*56%*	*31°*	*62%*	*11%*
Shoulder Internal Rotation	*90°*	*3/21/2007*	*13°*	*14%*	*25°*	*28%*	*92%*
Shoulder External Rotation	*90°*	*3/21/2007*	*82°*	*91%*	*88°*	*98%*	*7%*
Elbow Flexion	*150°*	*3/15/2007*	*132°*	*88%*	*132°*	*88%*	*0%*
Elbow Extension	*0°*	*3/15/2007*	*0°*	*–*	*0°*	*–*	*–*
Wrist Flexion	*60°*	*3/15/2007*	*44°*	*73%*	*62°*	*103%*	*41%*
Wrist Extension	*60°*	*3/15/2007*	*34°*	*57%*	*57°*	*95%*	*68%*
Wrist Radial Deviation	*20°*	*3/15/2007*	*11°*	*55%*	*26°*	*130%*	*136%*
Wrist Ulnar Deviation	*30°*	*3/15/2007*	*21°*	*70%*	*25°*	*83%*	*19%*

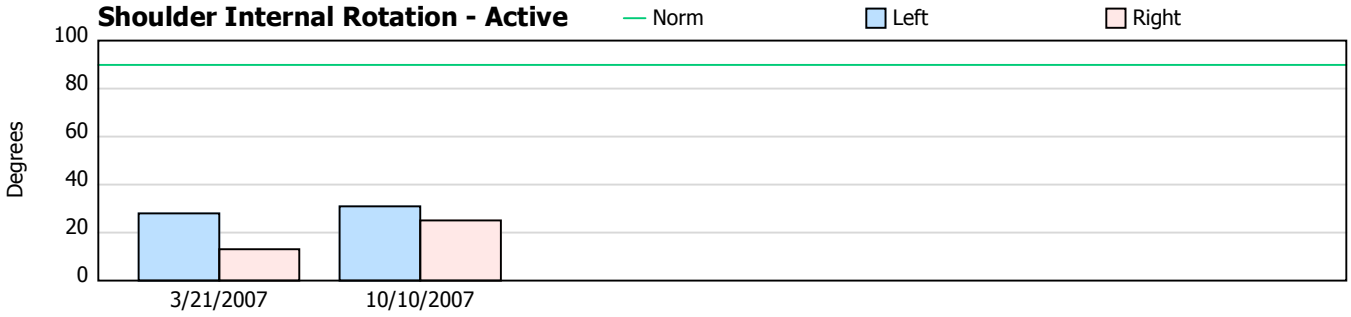
DATE: AUGUST 25, 2030

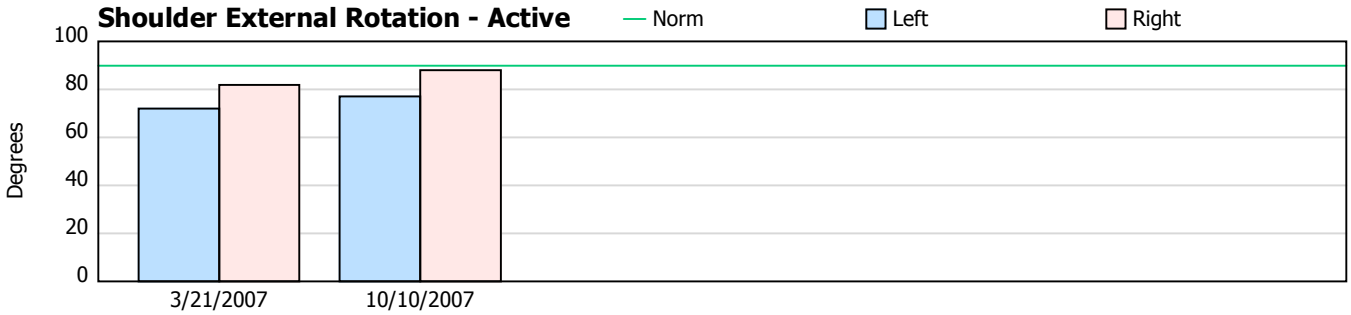


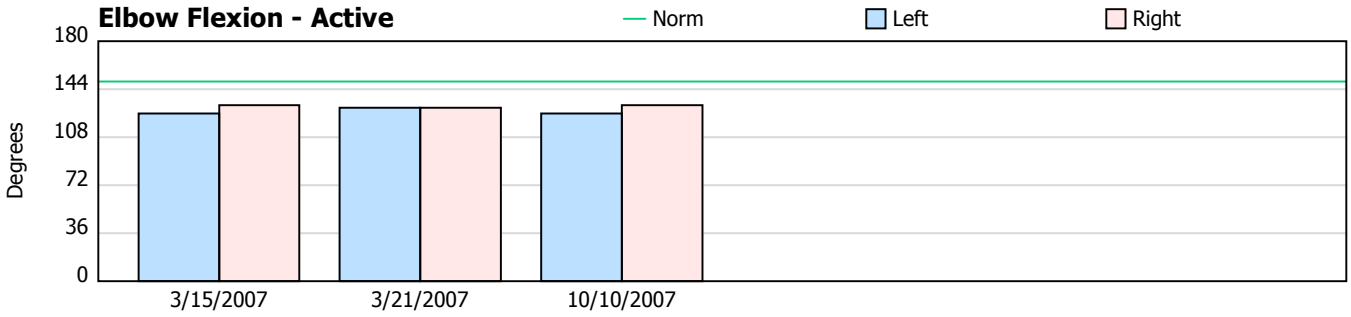


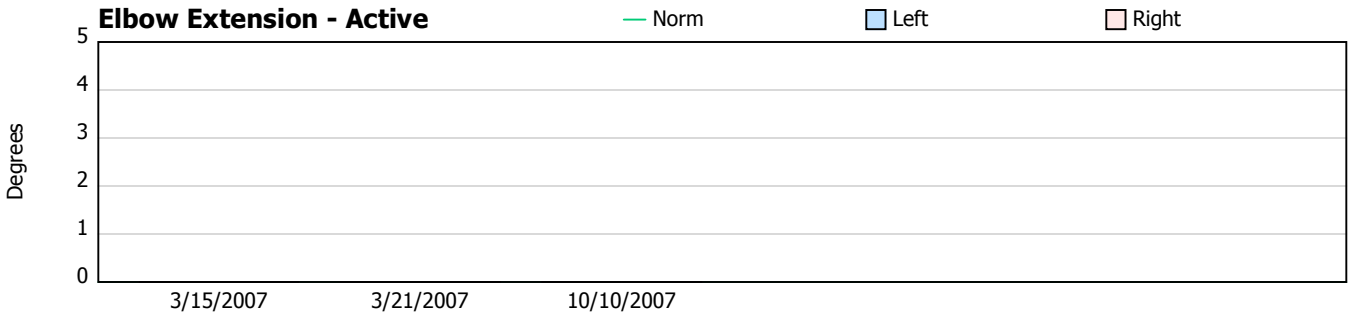


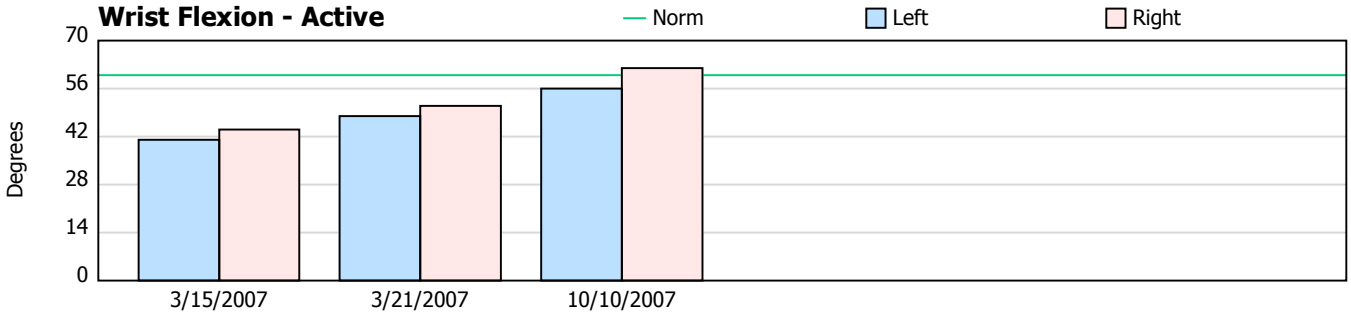


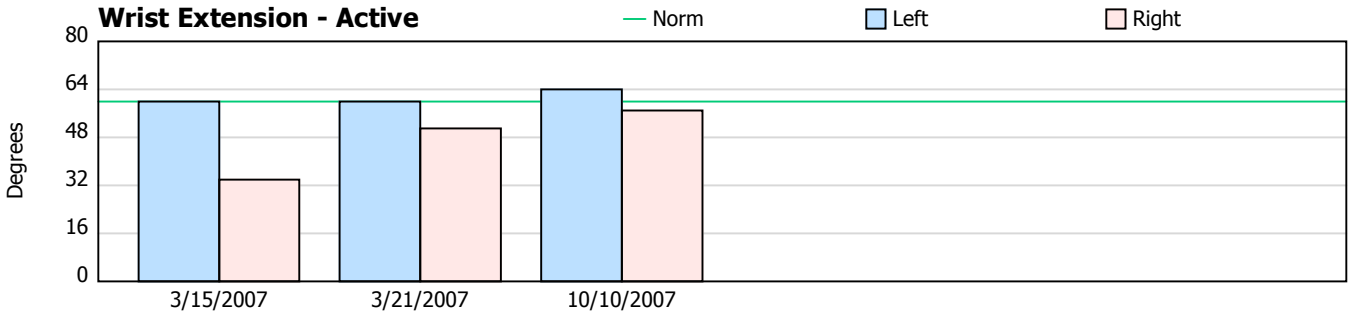

Shoulder Internal Rotation - Active
Norm
Left
Right
Degrees
100
80
60
40
20
0
3/21/2007
10/10/2007

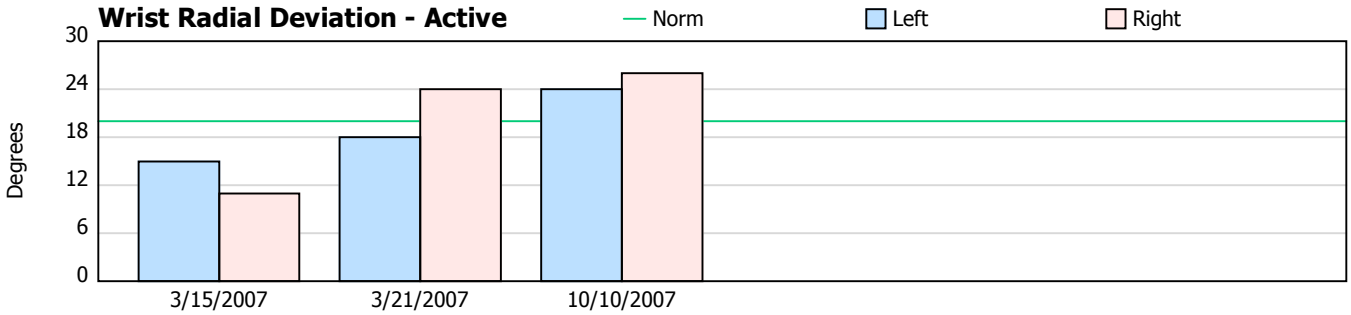

Shoulder External Rotation - Active
Norm
Left
Right
Degrees
100
80
60
40
20
0
3/21/2007
10/10/2007

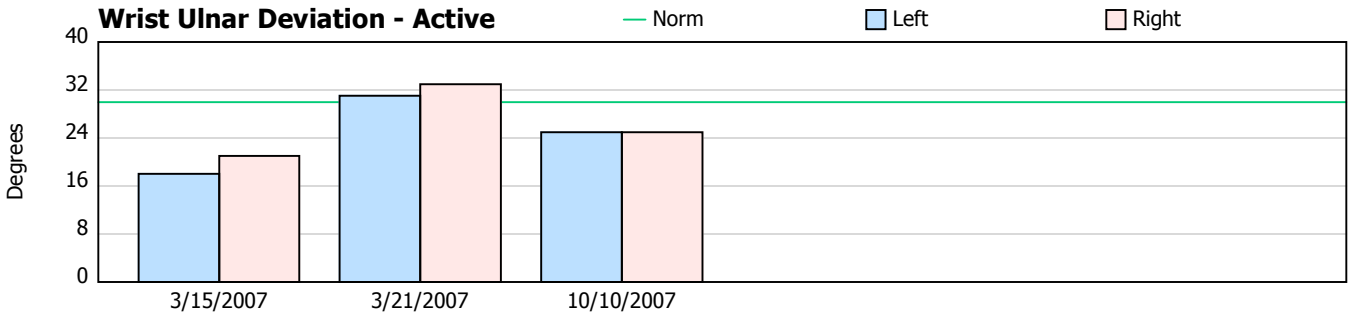

Elbow Flexion - Active
Norm
Left
Right
Degrees
180
144
108
72
36
0
3/15/2007
3/21/2007
10/10/2007


Elbow Extension - Active
Norm
Left
Right
Degrees
5
4
3
2
1
0
3/15/2007
3/21/2007
10/10/2007









Lower Extremity ROM

Range of motion (ROM) for the lower extremity joint motions indicated below were evaluated and compared to normative values published by the American Medical Association (AMA) in the Guides to the Evaluation of Permanent Impairment, Fifth Edition.

Lower Extremity ROM - Left Active	*Norm*	*Result*	*% Norm*
Knee Flexion	*150°*	*145°*	*97%*
Knee Extension	*0°*	*0°*	*–*

Lower Extremity ROM - Right Active	*Norm*	*Result*	*% Norm*
Knee Flexion	*150°*	*106°*	*71%*
Knee Extension	*0°*	*0°*	*–*

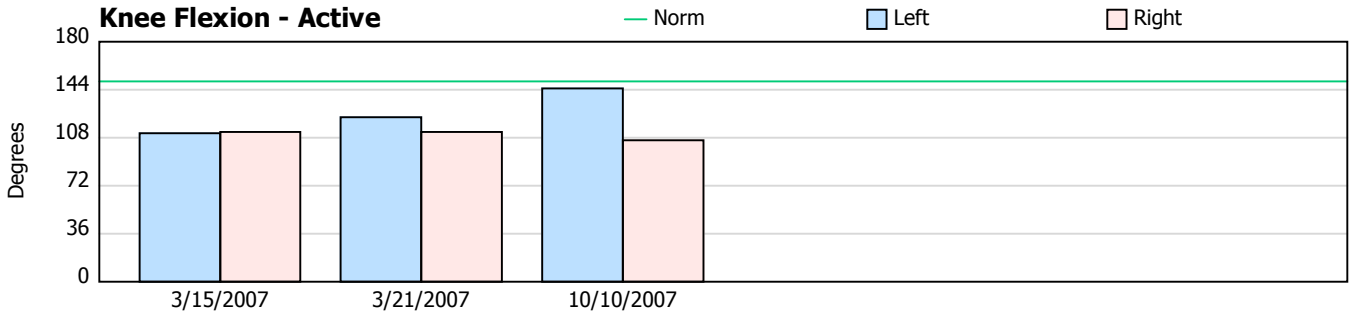
Lower Extremity ROM Progress

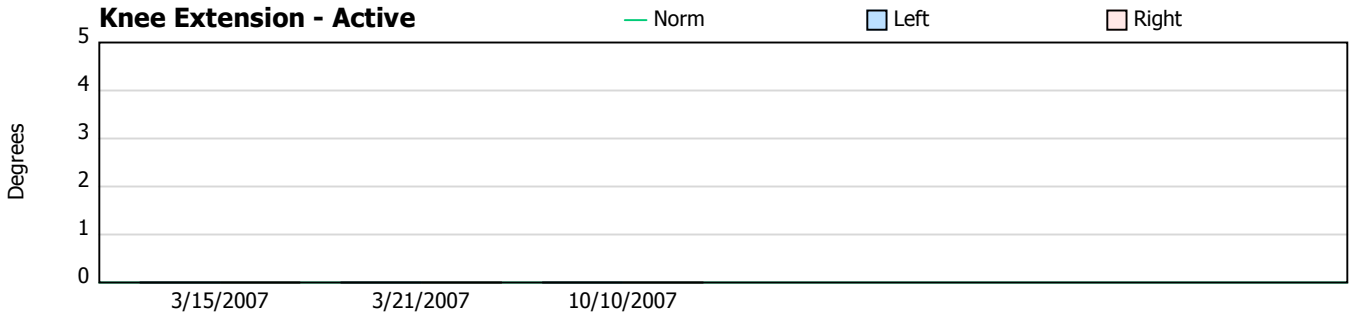
		Previous Exam			*Current*		
Left Active Lower Ext. Recent Change	*Norm*	*Date*	*Result*	*% Norm*	*Result*	*% Norm*	*Change*
Knee Flexion	*150°*	*3/21/2007*	*123°*	*82%*	*145°*	*97%*	*18%*
Knee Extension	*0°*	*3/21/2007*	*0°*	*–*	*0°*	*–*	*–*

		Previous Exam			*Current*		
Right Active Lower Ext. Recent Change	*Norm*	*Date*	*Result*	*% Norm*	*Result*	*% Norm*	*Change*
Knee Flexion	*150°*	*3/21/2007*	*112°*	*75%*	*106°*	*71%*	*-5%*
Knee Extension	*0°*	*3/21/2007*	*0°*	*–*	*0°*	*–*	*–*

		Initial Exam			*Current*		
Left Active Lower Ext. Overall Change	*Norm*	*Date*	*Result*	*% Norm*	*Result*	*% Norm*	*Change*
Knee Flexion	*150°*	*3/15/2007*	*111°*	*74%*	*145°*	*97%*	*31%*
Knee Extension	*0°*	*3/15/2007*	*0°*	*–*	*0°*	*–*	*–*

		Initial Exam			*Current*		
Right Active Lower Ext. Overall Change	*Norm*	*Date*	*Result*	*% Norm*	*Result*	*% Norm*	*Change*
Knee Flexion	*150°*	*3/15/2007*	*112°*	*75%*	*106°*	*71%*	*-5%*
Knee Extension	*0°*	*3/15/2007*	*0°*	*–*	*0°*	*–*	*–*





Muscle Testing

The patient was tested using the JTECH Tracker system, a computerized muscle strength evaluation system. When compared to the opposite side, a strength difference greater than 15% is generally recognized as an indication of motor deficit.

Neck/Trunk Muscle Tests	***Left***	***Right***	***Difference***
Neck Flexion	*10.4 lbs*		*–*
Neck Extension	*10.3 lbs*		*–*
Neck Lateral Flexion	*11.7 lbs*	*11.1 lbs*	*-5% R*

Upper Extremity Muscle Tests	***Left***	***Right***	***Difference***
Shoulder Flexion	*18.4 lbs*	*19.8 lbs*	*-7% L*
Shoulder Extension	*24.2 lbs*	*20.2 lbs*	*-16% R*
Shoulder Abduction	*18.2 lbs*	*17.9 lbs*	*-2% R*
Shoulder Horizontal Adduction (Sternal)	*18.6 lbs*	*22.1 lbs*	*-16% L*
Shoulder Internal Rotation	*9.8 lbs*	*15.0 lbs*	*-35% L*
Shoulder External Rotation	*15.1 lbs*	*14.1 lbs*	*-7% R*
Elbow Flexion (Forearm Neutral)	*24.6 lbs*	*21.4 lbs*	*-13% R*
Elbow Extension	*19.1 lbs*	*16.7 lbs*	*-13% R*
Wrist Flexion	*16.8 lbs*	*17.0 lbs*	*-1% L*
Wrist Extension	*19.8 lbs*	*16.7 lbs*	*-16% R*

Lower Extremity Muscle Tests	***Left***	***Right***	***Difference***
Knee Flexion (Leg Neutral)	*26.2 lbs*	*17.0 lbs*	*-35% R*
Knee Extension	*23.5 lbs*	*21.6 lbs*	*-8% R*

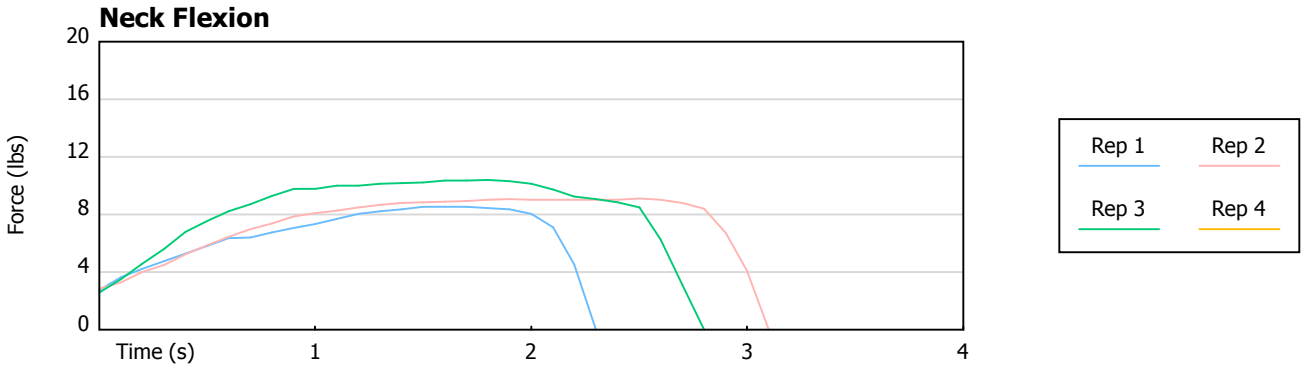
Neck/Trunk Strength Ratio	***Motion***	***Max***	***Motion***	***Max***	***Ratio***
Neck Flexion/Extension	*Flexion*	*10.4*	*Extension*	*10.3*	*1.01*

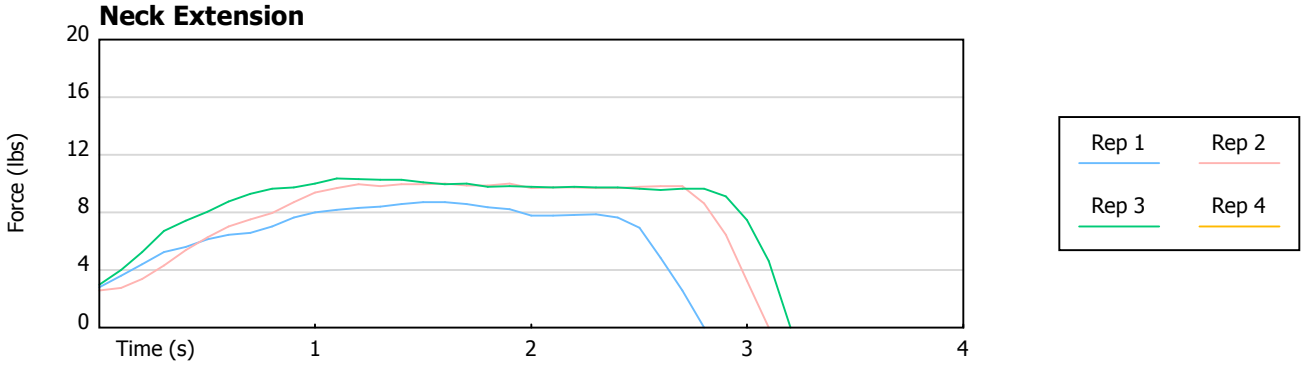
Left Upper Extremity Strength Ratio	***Motion***	***Max***	***Motion***	***Max***	***Ratio***
Shoulder Flexion/Extension	*Flexion*	*18.4*	*Extension*	*24.2*	*0.76*
Shoulder Internal/External Rotation	*Internal*	*9.8*	*External*	*15.1*	*0.65*
Elbow Flexion/Extension	*Flexion*	*24.6*	*Extension*	*19.1*	*1.28*
Wrist Flexion/Extension	*Flexion*	*16.8*	*Extension*	*19.8*	*0.85*

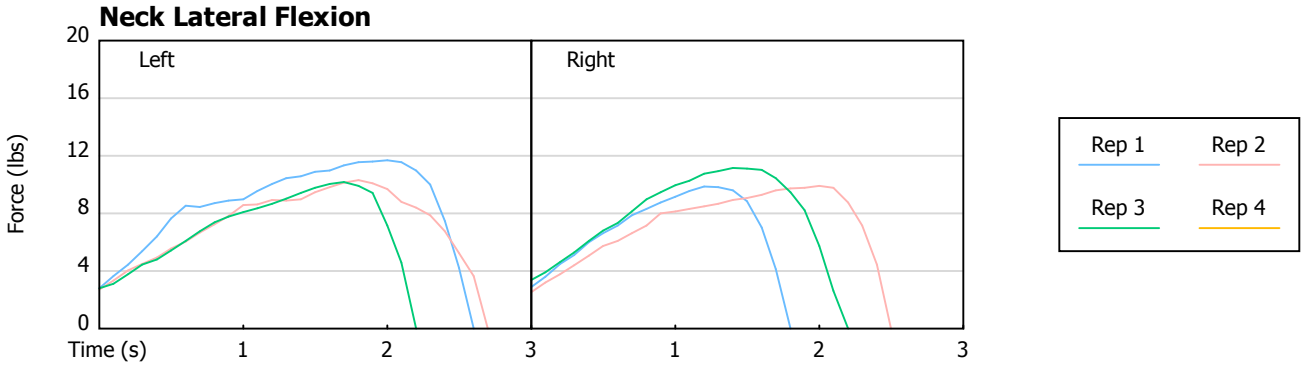
Right Upper Extremity Strength Ratio	***Motion***	***Max***	***Motion***	***Max***	***Ratio***
Shoulder Flexion/Extension	*Flexion*	*19.8*	*Extension*	*20.2*	*0.98*
Shoulder Internal/External Rotation	*Internal*	*15.0*	*External*	*14.1*	*1.06*
Elbow Flexion/Extension	*Flexion*	*21.4*	*Extension*	*16.7*	*1.28*
Wrist Flexion/Extension	*Flexion*	*17.0*	*Extension*	*16.7*	*1.02*

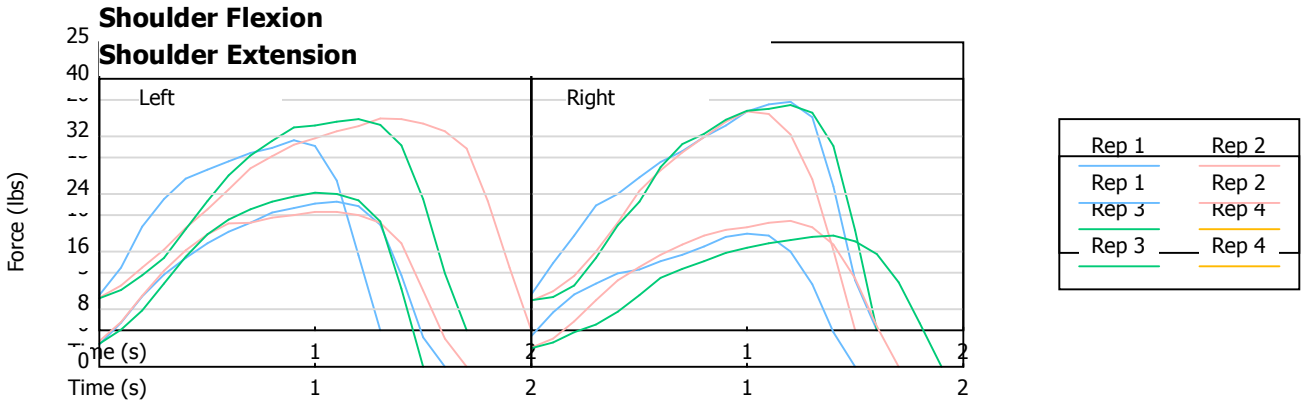
Left Lower Extremity Strength Ratio	***Motion***	***Max***	***Motion***	***Max***	***Ratio***
Knee Flexion/Extension	*Flexion*	*26.2*	*Extension*	*23.5*	*1.12*

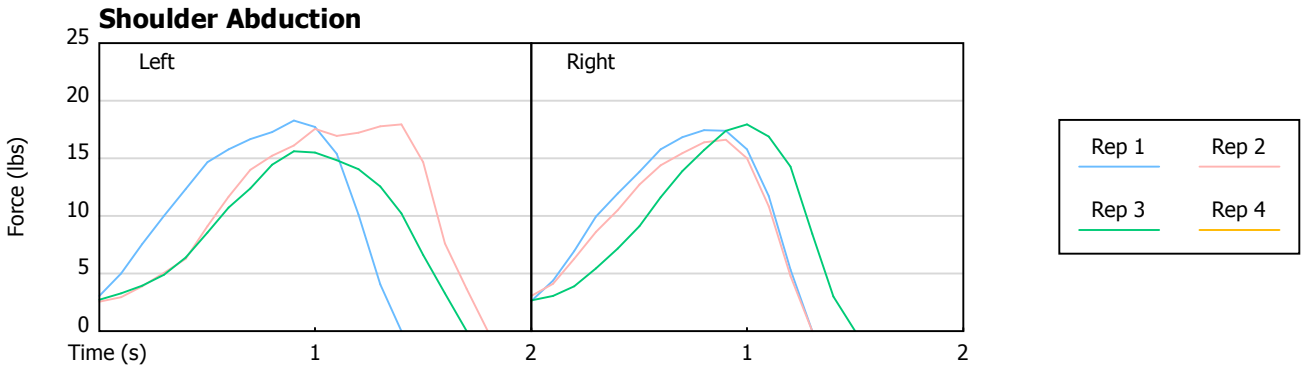
Right Lower Extremity Strength Ratio	***Motion***	***Max***	***Motion***	***Max***	***Ratio***
Knee Flexion/Extension	*Flexion*	*17.0*	*Extension*	*21.6*	*0.79*

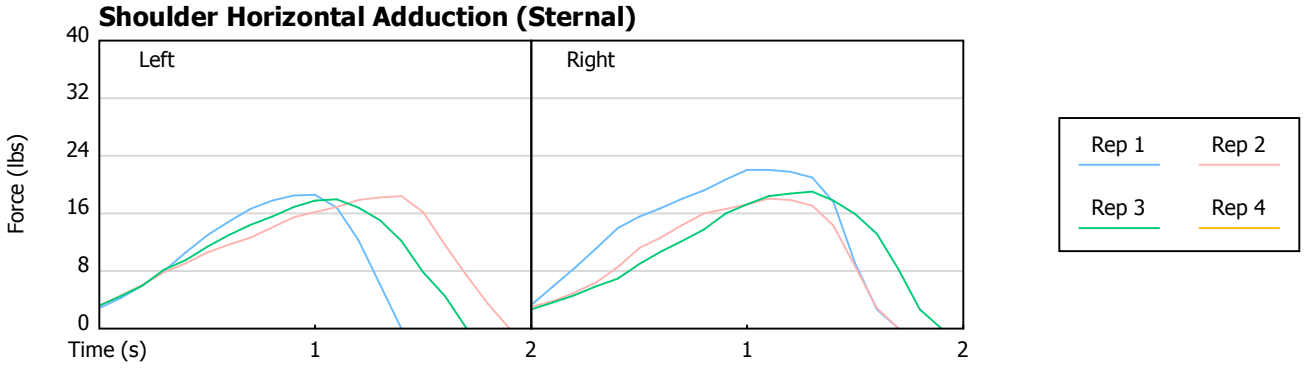


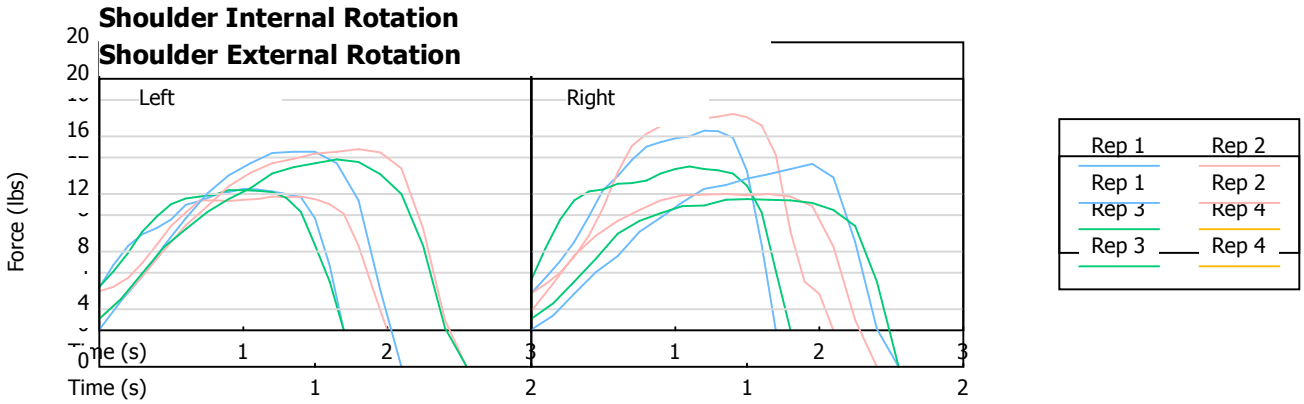


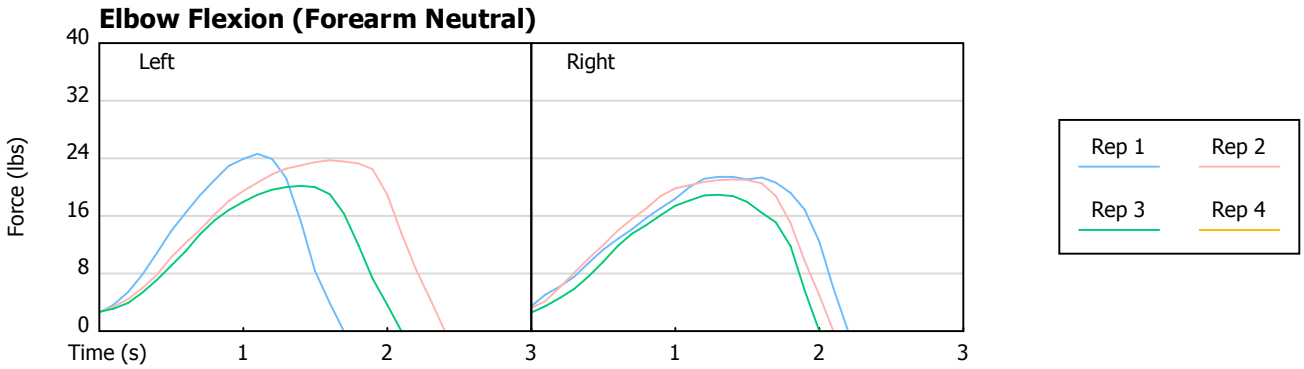

Neck Lateral Flexion
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4

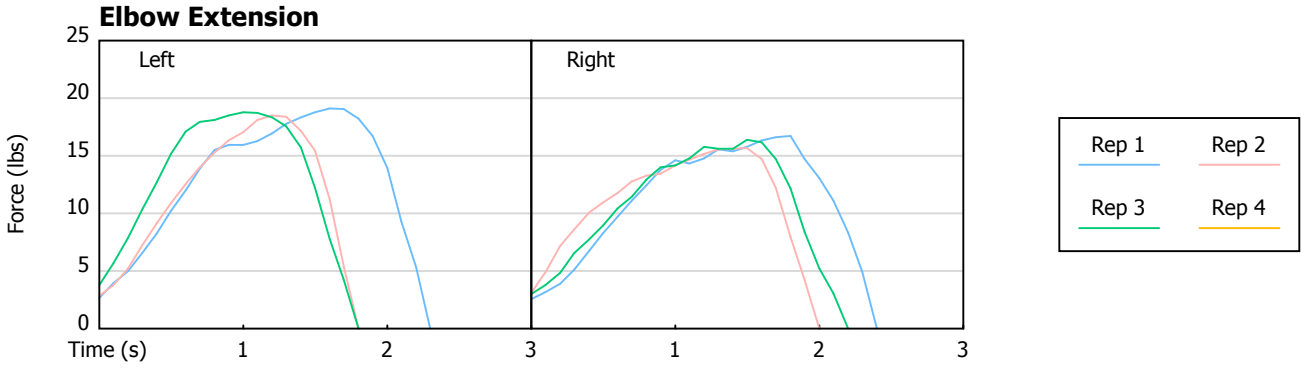

Shoulder Flexion
Shoulder Extension
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4

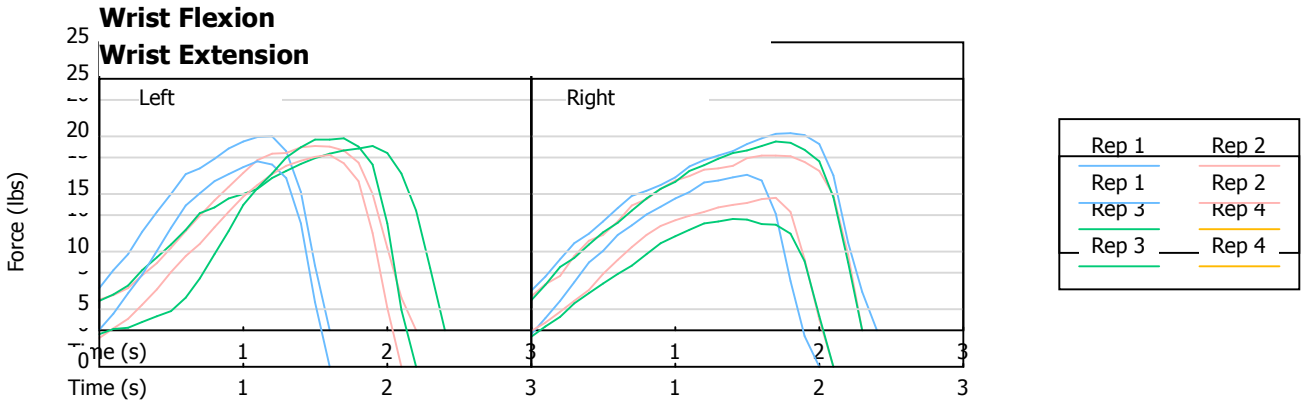

Shoulder Abduction
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4

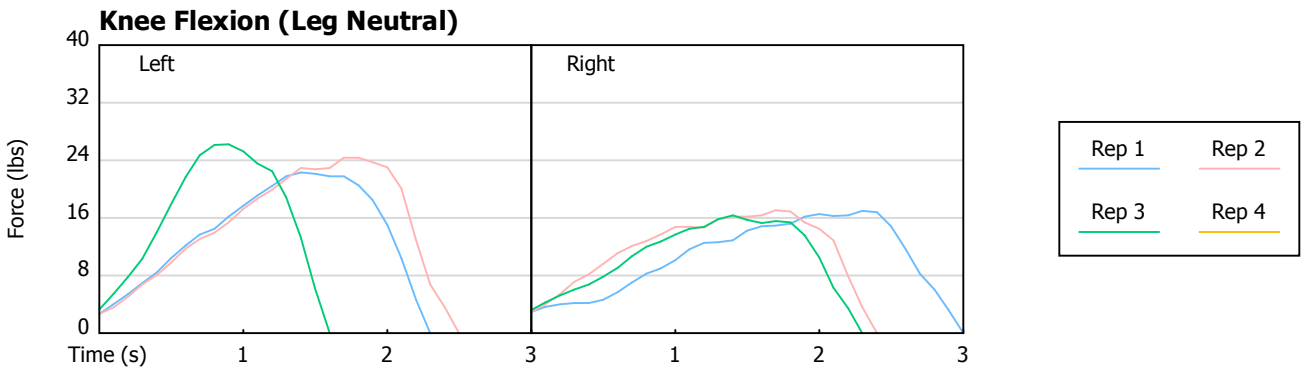

Shoulder Horizontal Adduction (Sternal)
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4

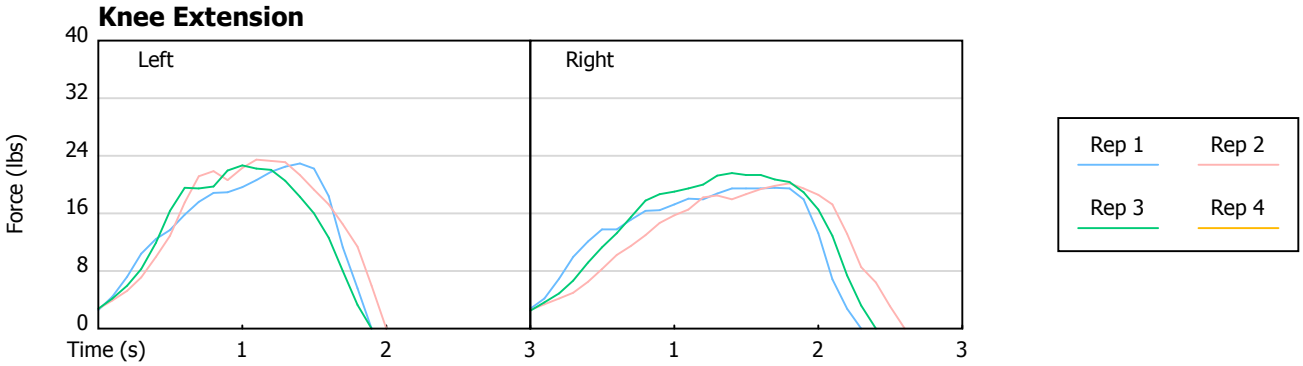

Shoulder Internal Rotation
Shoulder External Rotation
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4


Elbow Flexion (Forearm Neutral)
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4


Elbow Extension
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4


Wrist Flexion
Wrist Extension
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4


Knee Flexion (Leg Neutral)
Left
Right
Force (lbs)
Time (s)
Rep 1
Rep 2
Rep 3
Rep 4



Muscle Test Progress

	Previous Exam				Current			Change	
Neck/Trunk Recent Change	***Date***	***Left***	***Right***	***Diff***	***Left***	***Right***	***Diff***	***Left***	***Right***
Neck Flexion	*3/21/2007*	*13.7 lbs*		*–*	*10.4 lbs*		*–*	*-24%*	
Neck Extension	*3/21/2007*	*12.4 lbs*		*–*	*10.3 lbs*		*–*	*-16%*	
Neck Lateral Flexion	*3/21/2007*	*12.7 lbs*	*11.4 lbs*	*-10% R*	*11.7 lbs*	*11.1 lbs*	*-5% R*	*-8%*	*-2%*

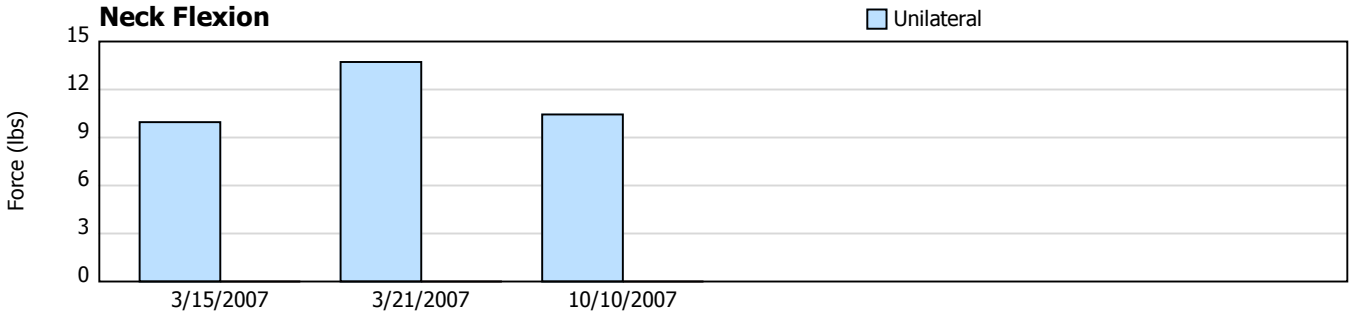
	Previous Exam				Current			Change	
Upper Extremity Recent Change	***Date***	***Left***	***Right***	***Diff***	***Left***	***Right***	***Diff***	***Left***	***Right***
Shoulder Flexion	*3/21/2007*	*28.1 lbs*	*21.4 lbs*	*-24% R*	*18.4 lbs*	*19.8 lbs*	*-7% L*	*-35%*	*-8%*
Shoulder Extension	*3/21/2007*	*23.9 lbs*	*21.8 lbs*	*-9% R*	*24.2 lbs*	*20.2 lbs*	*-16% R*	*1%*	*-7%*
Shoulder Abduction	*3/21/2007*	*16.1 lbs*	*18.4 lbs*	*-12% L*	*18.2 lbs*	*17.9 lbs*	*-2% R*	*14%*	*-3%*
Shoulder Horizontal Adduction (Sternal)	*3/21/2007*	*18.9 lbs*	*25.1 lbs*	*-25% L*	*18.6 lbs*	*22.1 lbs*	*-16% L*	*-2%*	*-12%*
Shoulder Internal Rotation	*3/21/2007*	*12.1 lbs*	*13.0 lbs*	*-7% L*	*9.8 lbs*	*15.0 lbs*	*-35% L*	*-19%*	*15%*
Shoulder External Rotation	*3/21/2007*	*14.3 lbs*	*11.8 lbs*	*-17% R*	*15.1 lbs*	*14.1 lbs*	*-7% R*	*6%*	*19%*
Elbow Flexion (Forearm Neutral)	*3/21/2007*	*23.6 lbs*	*20.4 lbs*	*-14% R*	*24.6 lbs*	*21.4 lbs*	*-13% R*	*4%*	*5%*
Elbow Extension	*3/21/2007*	*17.0 lbs*	*19.5 lbs*	*-13% L*	*19.1 lbs*	*16.7 lbs*	*-13% R*	*13%*	*-14%*
Wrist Flexion	*3/21/2007*	*14.9 lbs*	*13.8 lbs*	*-7% R*	*16.8 lbs*	*17.0 lbs*	*-1% L*	*13%*	*24%*
Wrist Extension	*3/21/2007*	*20.6 lbs*	*18.6 lbs*	*-10% R*	*19.8 lbs*	*16.7 lbs*	*-16% R*	*-4%*	*-10%*

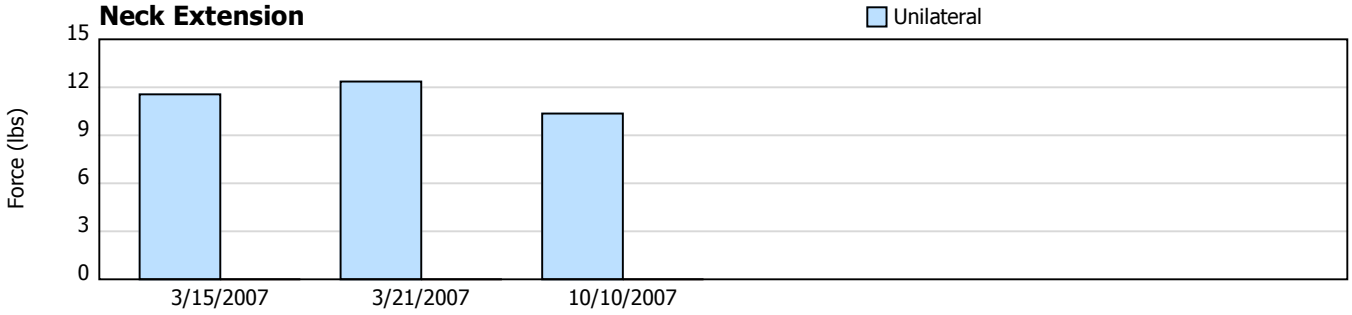
	Previous Exam				Current			Change	
Lower Extremity Recent Change	***Date***	***Left***	***Right***	***Diff***	***Left***	***Right***	***Diff***	***Left***	***Right***
Knee Flexion (Leg Neutral)	*3/21/2007*	*22.3 lbs*	*19.4 lbs*	*-13% R*	*26.2 lbs*	*17.0 lbs*	*-35% R*	*18%*	*-12%*
Knee Extension	*3/21/2007*	*28.8 lbs*	*22.9 lbs*	*-21% R*	*23.5 lbs*	*21.6 lbs*	*-8% R*	*-18%*	*-6%*

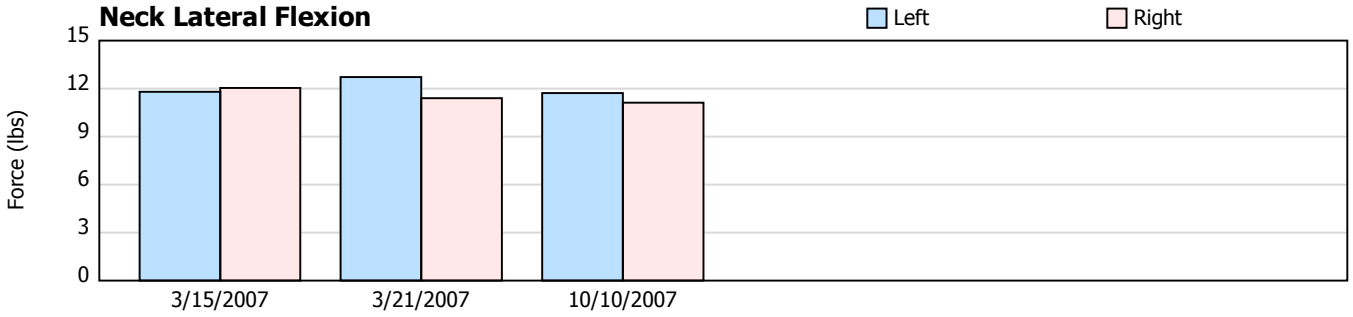
	Initial Exam				Current			Change	
Neck/Trunk Overall Change	***Date***	***Left***	***Right***	***Diff***	***Left***	***Right***	***Diff***	***Left***	***Right***
Neck Flexion	*3/15/2007*	*10.0 lbs*		*–*	*10.4 lbs*		*–*	*5%*	
Neck Extension	*3/15/2007*	*11.6 lbs*		*–*	*10.3 lbs*		*–*	*-11%*	
Neck Lateral Flexion	*3/15/2007*	*11.8 lbs*	*12.0 lbs*	*-2% L*	*11.7 lbs*	*11.1 lbs*	*-5% R*	*-1%*	*-8%*

	Initial Exam				Current			Change	
Upper Extremity Overall Change	**Date**	**Left**	**Right**	**Diff**	**Left**	**Right**	**Diff**	**Left**	**Right**
Shoulder Flexion	*3/21/2007*	*28.1 lbs*	*21.4 lbs*	*-24% R*	*18.4 lbs*	*19.8 lbs*	*-7% L*	*-35%*	*-8%*
Shoulder Extension	*3/21/2007*	*23.9 lbs*	*21.8 lbs*	*-9% R*	*24.2 lbs*	*20.2 lbs*	*-16% R*	*1%*	*-7%*
Shoulder Abduction	*3/21/2007*	*16.1 lbs*	*18.4 lbs*	*-12% L*	*18.2 lbs*	*17.9 lbs*	*-2% R*	*14%*	*-3%*
Shoulder Horizontal Adduction (Sternal)	*3/21/2007*	*18.9 lbs*	*25.1 lbs*	*-25% L*	*18.6 lbs*	*22.1 lbs*	*-16% L*	*-2%*	*-12%*
Shoulder Internal Rotation	*3/21/2007*	*12.1 lbs*	*13.0 lbs*	*-7% L*	*9.8 lbs*	*15.0 lbs*	*-35% L*	*-19%*	*15%*
Shoulder External Rotation	*3/21/2007*	*14.3 lbs*	*11.8 lbs*	*-17% R*	*15.1 lbs*	*14.1 lbs*	*-7% R*	*6%*	*19%*
Elbow Flexion (Forearm Neutral)	*3/15/2007*	*17.9 lbs*	*17.2 lbs*	*-4% R*	*24.6 lbs*	*21.4 lbs*	*-13% R*	*37%*	*24%*
Elbow Extension	*3/15/2007*	*17.3 lbs*	*18.2 lbs*	*-5% L*	*19.1 lbs*	*16.7 lbs*	*-13% R*	*10%*	*-8%*
Wrist Flexion	*3/15/2007*	*16.9 lbs*	*17.5 lbs*	*-3% L*	*16.8 lbs*	*17.0 lbs*	*-1% L*	*0%*	*-2%*
Wrist Extension	*3/15/2007*	*22.8 lbs*	*22.1 lbs*	*-3% R*	*19.8 lbs*	*16.7 lbs*	*-16% R*	*-13%*	*-25%*

	Initial Exam				Current			Change	
Lower Extremity Overall Change	**Date**	**Left**	**Right**	**Diff**	**Left**	**Right**	**Diff**	**Left**	**Right**
Knee Flexion (Leg Neutral)	*3/15/2007*	*18.7 lbs*	*14.9 lbs*	*-20% R*	*26.2 lbs*	*17.0 lbs*	*-35% R*	*40%*	*14%*
Knee Extension	*3/15/2007*	*27.7 lbs*	*24.6 lbs*	*-11% R*	*23.5 lbs*	*21.6 lbs*	*-8% R*	*-15%*	*-12%*



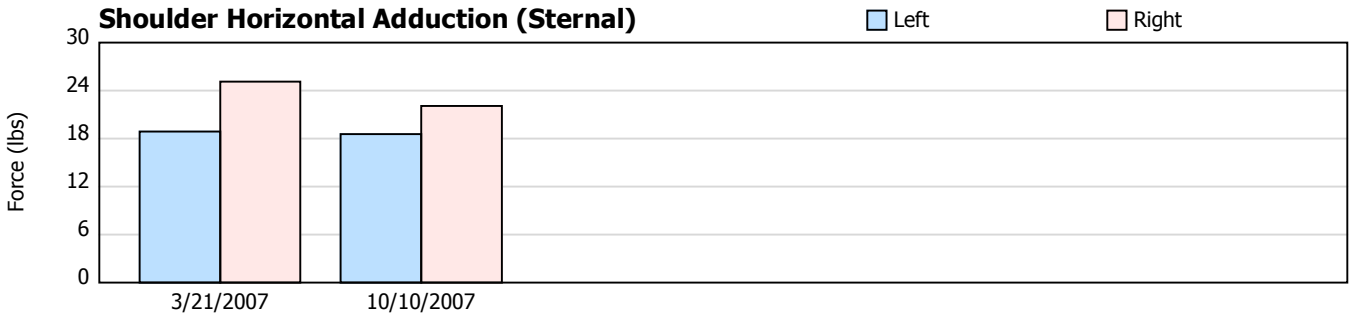



Neck Lateral Flexion
Left
Right
Force (lbs)
15
12
9
6
3
0
3/15/2007
3/21/2007
10/10/2007


Shoulder Flexion
Left
Right
Force (lbs)
35
28
21
14
7
0
3/21/2007
10/10/2007

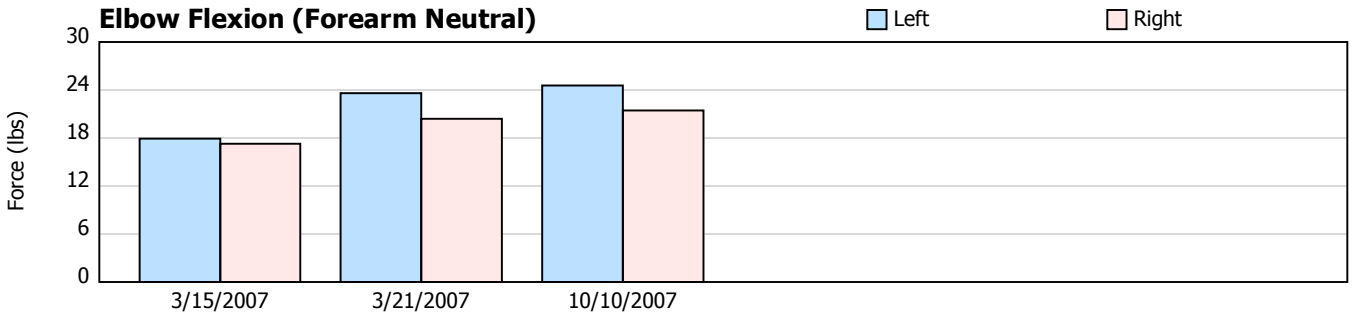

Shoulder Extension
Left
Right
Force (lbs)
30
24
18
12
6
0
3/21/2007
10/10/2007

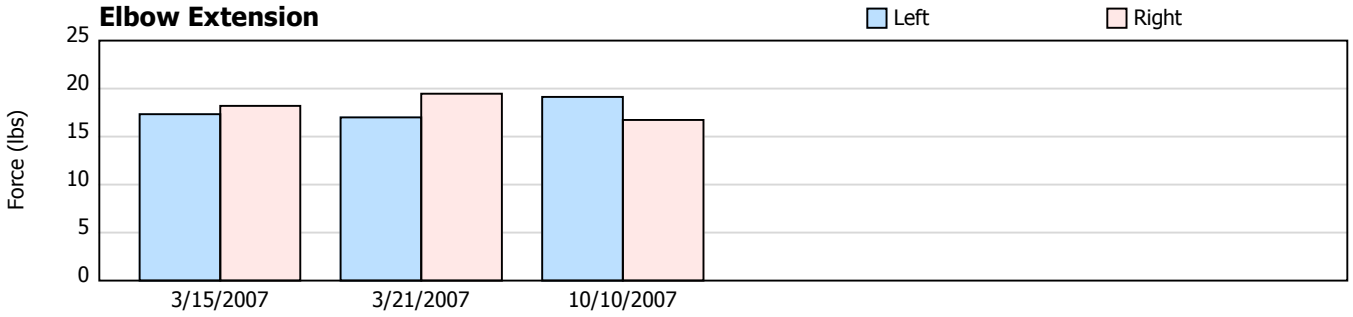

Shoulder Abduction
Left
Right
Force (lbs)
20
16
12
8
4
0
3/21/2007
10/10/2007

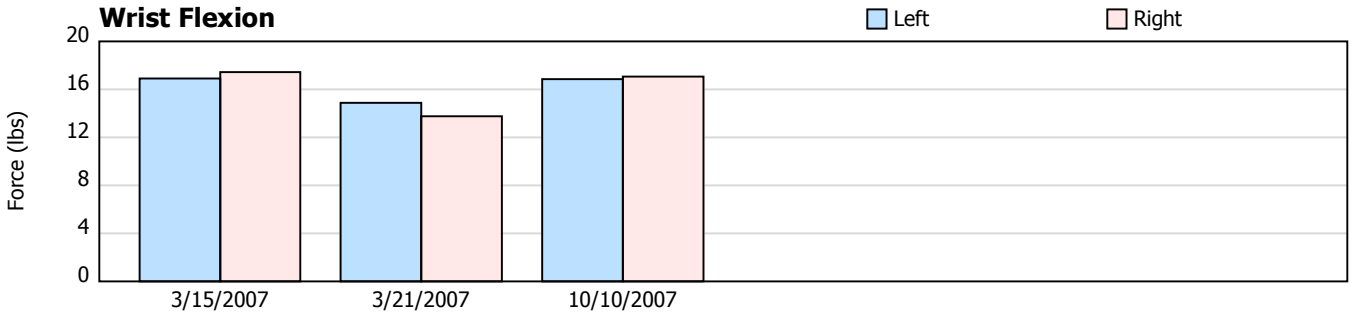

Shoulder Horizontal Adduction (Sternal)
Left
Right
Force (lbs)
30
24
18
12
6
0
3/21/2007
10/10/2007

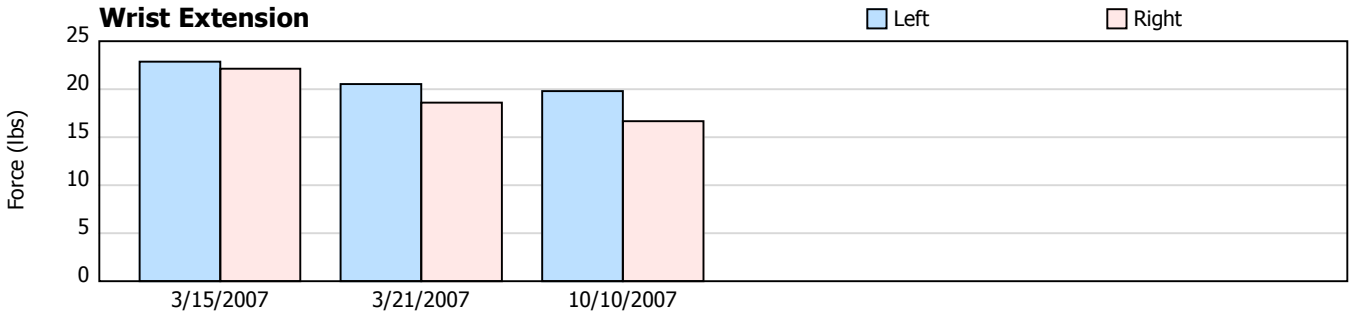

Shoulder Internal Rotation
Left
Right
Force (lbs)
20
16
12
8
4
0
3/21/2007
10/10/2007

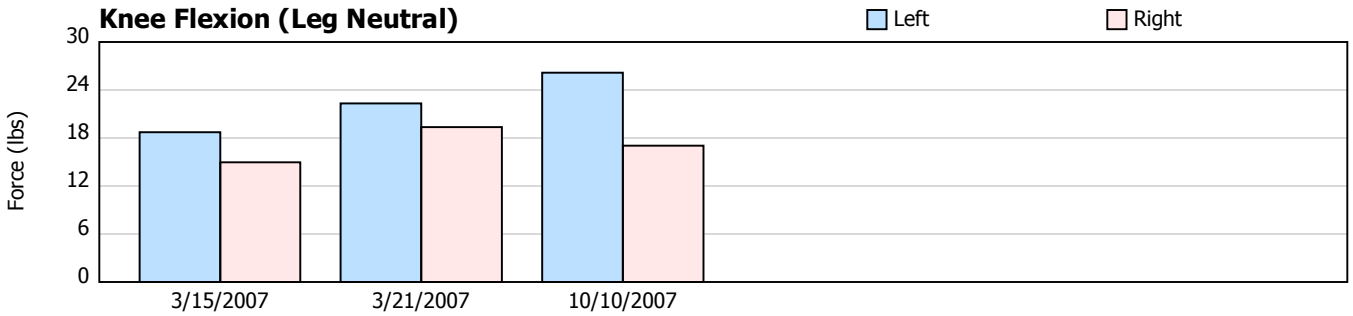

Shoulder External Rotation
Left
Right
Force (lbs)
20
16
12
8
4
0
3/21/2007
10/10/2007

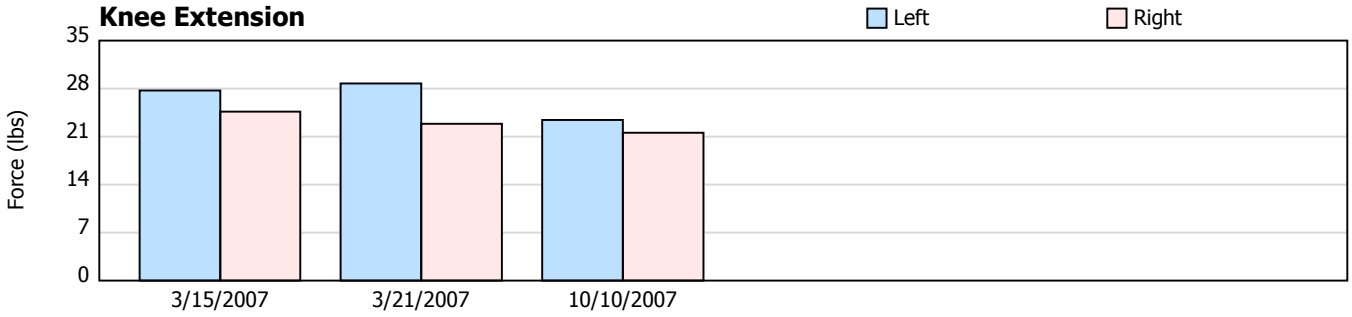

Elbow Flexion (Forearm Neutral)
Left
Right
Force (lbs)
30
24
18
12
6
0
3/15/2007
3/21/2007
10/10/2007


Elbow Extension
Left
Right
Force (lbs)
25
20
15
10
5
0
3/15/2007
3/21/2007
10/10/2007


Wrist Flexion
Left
Right
Force (lbs)
20
16
12
8
4
0
3/15/2007
3/21/2007
10/10/2007


Wrist Extension
Left
Right
Force (lbs)
25
20
15
10
5
0
3/15/2007
3/21/2007
10/10/2007


Knee Flexion (Leg Neutral)
Left
Right
Force (lbs)
30
24
18
12
6
0
3/15/2007
3/21/2007
10/10/2007



Grip Strength Testing

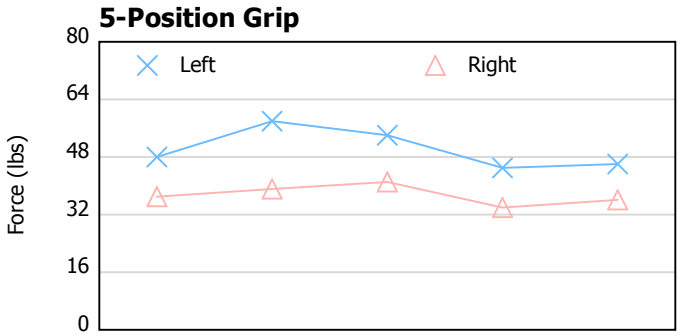
5-Position Grip Test

The patient's grip strength was tested with the Tracker computerized grip dynamometer at all five rung positions.

Position	Left Average	Left CV	Right Average	Right CV	% Diff
1	*48.7 lbs*	*9%*	*37.4 lbs*	*8%*	*-24% R*
2	*58.9 lbs*	*4%*	*39.7 lbs*	*1%*	*-34% R*
3	*54.3 lbs*	*6%*	*41.3 lbs*	*6%*	*-23% R*
4	*45.4 lbs*	*2%*	*34.6 lbs*	*8%*	*-17% R*
5	*46.7 lbs*	*2%*	*36.1 lbs*	*5%*	*-20% R*

Consistency of the patient's grip strength effort was evaluated using coefficient of variation (CV) with consistency indicated by successive repetitions falling below 15%.

The presence of a bell-shaped curve from the 5-position grip test results is typically indicative of maximum effort for both injured and uninjured people alike (Stokes, 1983).

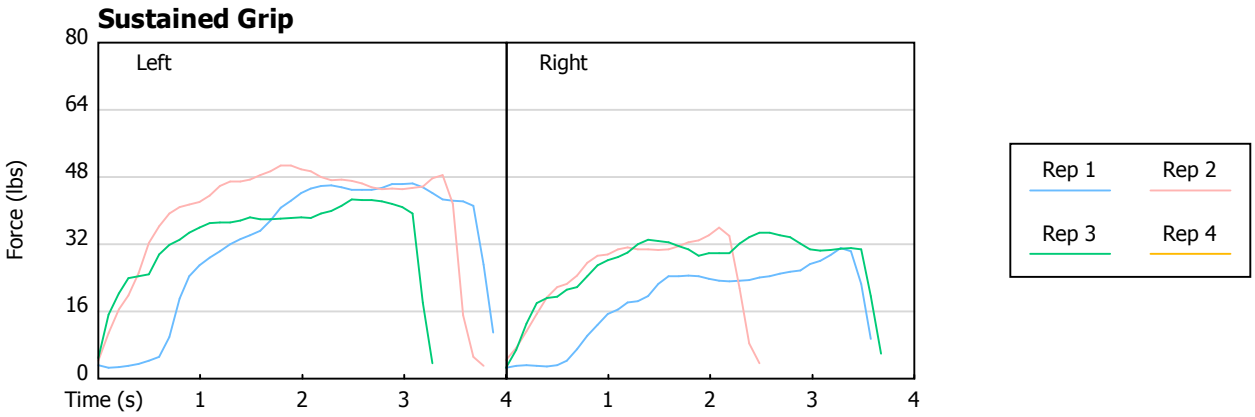


Sustained Grip Test

The patient's maximum grip strength and the ability to sustain a contraction over time were evaluated using the Tracker computerized grip dynamometer from JTECH Medical. The Tracker system documents sustained grip ability by graphing grip strength force over time.

Rung 2				
Side	***Maximum***	***Average***	***CV***	***% Diff***
Left	*50.7*	*46.5*	*7%*	*–*
Right	*36.0*	*33.9*	*6%*	*-29%*

Consistency of the patient's sustained grip strength effort was evaluated using coefficient of variation (CV) with consistency indicated by successive repetitions falling below 15%.



Change Since Last Exam								
Previous Exam				***Current Exam***			***% Change***	
Date	***Left***	***Right***	***% Diff***	***Left***	***Right***	***% Diff***	***Left***	***Right***
3/21/2007	*59.83 lbs*	*38.714 lbs*	*-35% R*	*50.699 lbs*	*35.966 lbs*	*-29% R*	*-15%*	*-7%*

Overall Change								
Initial Exam				***Current Exam***			***% Change***	
Date	***Left***	***Right***	***% Diff***	***Left***	***Right***	***% Diff***	***Left***	***Right***
3/15/2007	*63.506 lbs*	*39.966 lbs*	*-37% R*	*50.699 lbs*	*35.966 lbs*	*-29% R*	*-20%*	*-10%*

Grip results are displayed using the maximum of completed repetitions.

Static Strength Testing

NIOSH Static Strength Testing

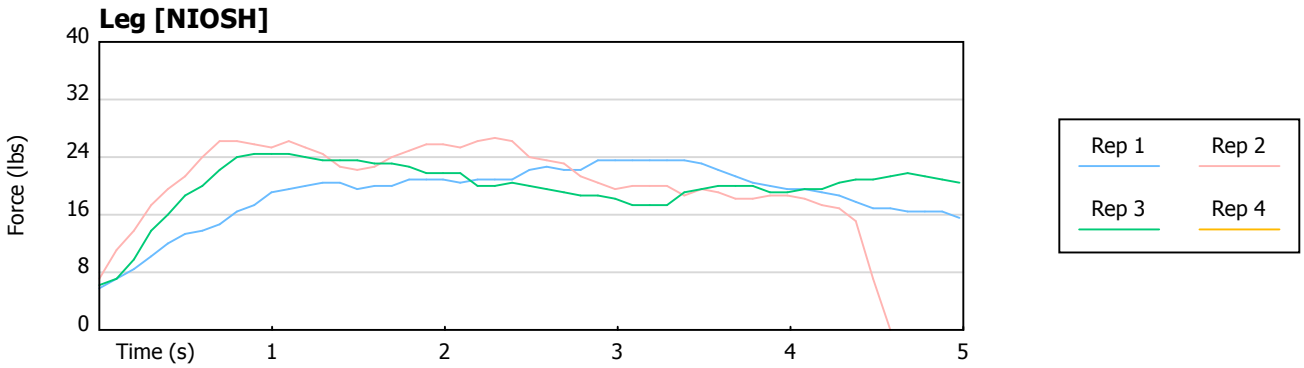
The examinee was tested using the JTECH computerized static strength evaluation system and standard lift evaluation protocols outlined by NIOSH in the Work Practices Guide for Manual Lifting, 1981. The examinee's NIOSH population percentile is determined by comparing lift strength results with published norms with the 50th percentile indicating the average for the patient's gender. NIOSH has determined a minimum of the 25th percentile should be demonstrated for the worker to safely perform that type of lift on the job.

NIOSH Static Strength Tests	Maximum	Highest Mean	CV	NIOSH %
Leg [NIOSH]	27 lbs	21 lbs	5%	<10%

A Coefficient of Variation (CV) less than 15% may be indicative of consistent effort (Chaffin, 1976).

NIOSH Test Dynamic Rating	Highest Mean	Occasional	Frequent	Constant
Leg [NIOSH]	21 lbs	7 lbs	4 lbs	1 lbs

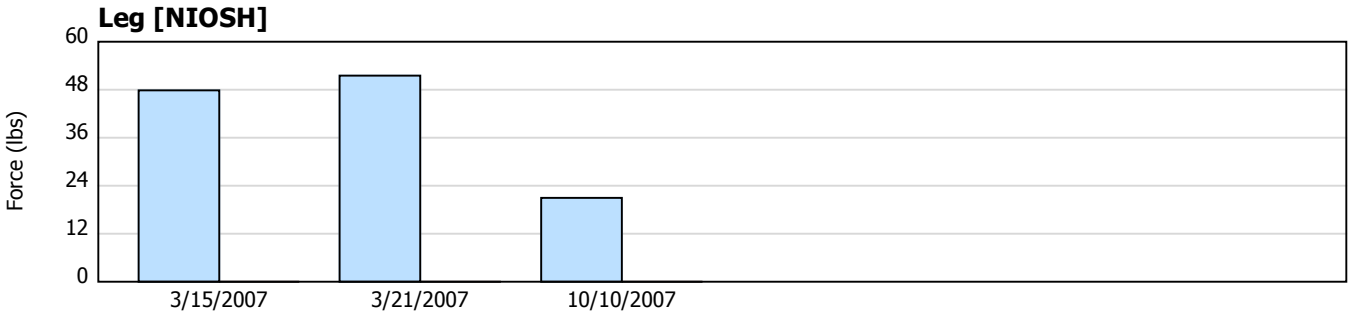
Dynamic Rating is based on the Highest Mean static lifting test score and indicates the theoretical load a subject may be able to lift dynamically on an occasional basis (Blankenship, 1990). Frequent and constant values are derived from the occasional lift value using percentages from the Dictionary of Occupational Titles, 1991.



NIOSH Static Strength Progress

	Previous Exam		Current Exam	
NIOSH Recent Change	Date	Strength	Strength	Change
Leg [NIOSH]	3/21/2007	51 lbs	21 lbs	-59%

	Initial Exam		Current Exam	
NIOSH Overall Change	Date	Strength	Strength	Change
Leg [NIOSH]	3/15/2007	48 lbs	21 lbs	-56%



DISABILITY STATUS

Although, Mr. Doe may continue to improve with further treatment such as acupuncture, scheduled chiropractic visits, orthopedic consultation, surgery and/or pain management, we are limited by outside factors to include A.C.O.E.M Guidelines, SB899, and response from the carrier.

Regretfully, he was declared permanent and stationary for rating purposes. However, I reserve the right to amend my report if I receive information indicating otherwise.

HISTORY OF DISABILITY

The patient was placed on temporary total disability on April 15, 2007. The patient remained on temporary total disability through November 13, 2007.

SUBJECTIVE FACTORS OF DISABILITY

In relation to the spine, the subjective factors of disability are characterized as intermittent slight to moderate pain becoming moderate with heavy lifting, repetitive bending and stooping activities.

In relation to the right elbow and bilateral wrist condition, the subjective factors of disability are characterized as constant slight pain becoming intermittent moderate with repetitive forceful gripping, torquing and twisting activities.

In relation to the right knee, the subjective factors of disability are characterized as constant slight to moderate pain becoming intermittently moderate with repetitive bending of the knee.

OBJECTIVE FACTORS OF DISABILITY

1. JANUARY 7, 2007, MRI of the CERVICAL SPINE by GEORGE VOLTAR, M.D.:

    1. Diffuse disc bulge 3-4 mm at C3-4, C4-5, and C5-6 disc levels

2. JANUARY 7, 2007, MRI of the RIGHT KNEE by GEORGE VOLTAR, M.D.:

    1. Grande II signal of posterior horn of medial meniscus
3. Moderate effusion

4. JANUARY 7, 2007, MRI of the LUMBAR SPINE by GEORGE VOLTAR, M.D.:

    1. Diffuse disc bulge 2-3 mm at L3-4, L4-5, L5-S1 disc levels

5. JANUARY 7, 2007, MRI of the LEFT WRIST by GEORGE VOLTAR, M.D.:

    1. Tenosynovitis flexor carpi radialis.
    2. Effusion styloid process, ulna

6. JANUARY 7, 2007, MRI of the RIGHT WRIST by GEORGE VOLTAR, M.D.:

    1. Tenosynovitis flexor carpi radialis.
    2. Effusion radioulnar joint

7. JANUARY 7, 2007, MRI of the RIGHT SHOULDER by GEORGE VOLTAR, M.D.:

    1. Subcoracoid bursal effusion
    2. Tenosynovitis bicep tendon

8. Hypoesthesia noted following the right L5/S1 dermatomal distribution
9. Weakness noted in the L5 myotome as noted above
10. Hypoesthesia noted following the median nerve distribution bilaterally
11. Decreased cervical, lumbar, right shoulder, right elbow and bilateral wrist range of motion as noted above.

IMPAIRMENT SUMMARY:

Cervical DRE Category II - Clinical history and exam findings 7 % WPI

Clinical history and examination findings are compatible with a specific injury; findings included muscle guarding or spasm observed at the time of the examination, and asymmetric loss of range or motion.

AMA Guides (5th Edition) p. 392, Table 15-5

Lumbar DRE Category II – History and exam findings compatible 7% WPI

Clinical history and examination findings are compatible with a specific injury; findings include significant muscle guarding observed at the time of the examination, asymmetric loss of range or motion, and non-verifiable radicular pain.

AMA Guides (5th Edition) p. 384, Table 15-3

SPINE COMBINED WHOLE PERSON IMPAIRMENT = 14%
(Utilizing The Combined Values Chart, Page 604, AMA Guides)

Right Shoulder Impairment:

Figure 16-40, page 476
I_F (Flexion) 136 degrees = 3% impairment upper extremity
I_E (Extension) 17 degrees = 2% impairment upper extremity

Figure 16-43, page 477
I_{ABD} (Abduction) 118 degrees = 3% impairment upper extremity
I_{ADD} (Adduction) 30 degrees = 1% impairment upper extremity

Figure 16-46, page 479
I_{ER} (External Rotation) 84 degrees = 0% impairment upper extremity
I_{IR} (Internal Rotation) 25 degrees = 4% impairment upper extremity

Impairment Rating= $I_F + I_E + I_{ABD} + I_{ADD} + I_{ER} + I_{IR=}$ upper extremity impairment
3%+2%+3%+ 1% + 0% + 4%= 13% upper extremity impairment

Right Elbow Impairment:

Figure 16-34, page 472
I_F (Flexion) 127 degrees = 1% impairment upper extremity
I_E (Extension) 0 degrees = 0% impairment upper extremity

Figure 16-37, page 474
I_P (Pronation) 70 degrees = 1% impairment upper extremity
I_S (Supination) 60 degrees = 1% impairment upper extremity

Impairment Rating= $I_F + I_E + I_P + I_S =$ upper extremity impairment
1%+0%+1%+ 1% = 3% upper extremity impairment

Left Wrist Impairment:

Figure 16-28, page 467
I_F (Flexion) 59 degrees = 0% impairment upper extremity
I_E (Extension) 56 degrees = 1% impairment upper extremity

Figure 16-31, page 469
I_{RD} (Radial Deviation) 23 degrees = 0% impairment upper extremity
I_{UD} (Ulnar Deviation) 23 degrees = 1% impairment upper extremity

Impairment Rating= $I_F + I_E + I_{RD} + I_{UD} =$ upper extremity impairment
0%+1%+0%+ 1% = 2% upper extremity impairment

Right Wrist Impairment:

Figure 16-28, page 467
I_F (Flexion) 53 degrees = 1% impairment upper extremity
I_E (Extension) 59 degrees = 0% impairment upper extremity

Figure 16-31, page 469
I_{RD} (Radial Deviation) 23 degrees = 0% impairment upper extremity
I_{UD} (Ulnar Deviation) 23 degrees = 1% impairment upper extremity

Impairment Rating= $I_F + I_E + I_{RD} + I_{UD} =$ upper extremity impairment
1%+0%+0%+ 1% = 2% upper extremity impairment

There was 13% upper extremity impairment for the right shoulder

There was 3% upper extremity impairment for the right elbow
There was 2% upper extremity impairment for the left wrist
There was 2% upper extremity impairment for the right wrist

COMBINED UPPER EXTREMITY IMPAIRMENT= 20% left upper extremity impairment
(Utilizing the Combined Values Chart, Page 604, AMA Guides)

***20% upper extremity impairment = 12% Whole Person Impairment (Table 16-2, page 439) for the upper extremities**

Right Knee Impairment:

Figure 17-10, page 537
I_F (Flexion) 105 degrees = 10 % impairment lower extremity
I_E (Extension) 180 degrees = 0% impairment lower extremity

Right knee lower extremity impairment of 10 %= 4% WPI (Table 17-3, page 527)

*Christine Chapel PhD., Dr. Chapel found the patient to have a Global Assessment of Functioning (GAF) score of 61, which correlates to a **14 % whole person impairment (WPI).**

-Spine WPI: 14%
-Upper extremity WPI: 12 %
-Lower extremity WPI: 4 %
-Psychological WPI: 14 %

FINAL COMBINED WHOLE BODY IMPAIRMENT = 38%
(Utilizing The Combined Values Chart, Page 604, AMA Guides)

The 38 % WPI includes the spine, right upper extremity, left upper extremity, left knee, and psychological impairments. The above noted WPI more than adequately encompasses pain as well as difficulties with ADLs.

WORK PRECLUSIONS/LOSS OF PRE-INJURY CAPACITY

The patient underwent a final functional capacity evaluation which clearly revealed the patient continues to have significant objective findings. Therefore, it would be more accurate and medically reasonable for Mr. Doe to be considered precluded from heavy lifting, repetitive bending and stooping activities, from a spinal point of view. This contemplates the patient has lost 50% of his pre-injury capacity to lift, bend and stoop. In relation to his right elbow and bilateral wrist condition, the patient should avoid repetitive

forceful gripping, torquing and twisting activities. In relation to his right knee, he should avoid repetitive bending activities. The above noted work restrictions are imposed for the purpose of allowing the patient's condition to resolve easier and return to pre-injury work capacity for gainful employment in the open labor market, and to avoid the frequency of flare-ups and possibility of aggravating his condition, which would increase his current disability.

FUTURE MEDICAL CARE

Based upon the patient's current complaints and my findings and physical examination, it would be reasonable to conclude that he will experience episodes of increased pain requiring future medical treatment.

From a chiropractic standpoint, I recommend the patient have access to chiropractic care to include adjustments and/or physical therapy, and other modalities, procedures, or exercises, which may be used to alleviate the patient's condition, upon exacerbation of pain.

Mr. Doe may improve with further treatment such as acupuncture, scheduled chiropractic visits, orthopedic consultation, surgery and/or pain management. However this is limited by outside factors as stated under the Disability Status section above. Furthermore, the patient was recommended a course of epidural injections, unfortunately these were not authorized. It is within all reasonable medical probability that this recommendation was necessary to cure or relieve the patient of his current spinal ailments. As such, these should be provided in the future should they be deemed necessary by a pain management specialist.

Should symptoms increase, he should also have access to an orthopedic consultation and/or surgery if deemed necessary.

CAUSATION/APPORTIONMENT

Per Labor Code 4663, apportionment of permanent disability shall be based on causation. Per Labor Code 4664, the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

In relation to the patient's current complaints given the absence of admitted or observed pre-existing disability or known previous trauma, and given the consistency of the injury, (i.e., symptom on-set), with the biomechanics of the injured's employment, it would

appear reasonable to assign full causation of the symptomatic on-set described above to his routine job activity while employed at ACME Widgets.

As noted above, the patient performed repetitive and constant lifting, twisting, standing, and carrying activities which in time caused inherent weakness in his neck, mid back, low back, right knee, right shoulder, right elbow, and both wrists. The repetitive nature of his usual and customary duties caused his condition to present itself in March 2005 and worsened as he continued to work, subsequently worsening the above noted symptoms.

As a result, based on the above noted facts, the patient's disability/impairment is 100% due to the cumulative effects of his employment with ACME Widgets.

VOCATIONAL REHABILITATION/VOUCHER

The patient is no longer performing the same type of work, which resulted in the injury. Based on all the subjective as well as objective factors and findings noted above, it is within all reasonable medical probability his ability to compete in the open labor market has been affected. His current impairment/disability is, and will hinder his future earning potential, therefore, he is considered a qualified injured worker, and should be provided with an educational voucher.

REVIEW OF MEDICAL RECORDS

1. Initial evaluation dated 02-12-07.
2. Initial neurological evaluation, by Dr. Cerebro 02-15-07
3. MRI of the cervical spine by Dr. Voltar 03-7-07.
4. MRI of the right knee by Dr. Voltar 03-7-07.
5. MRI of the lumbar spine by Dr. Voltar 03-7-07.
6. MRI of the right elbow by Dr. Voltar 03-7-07.
7. MRI of the left wrist by Dr. Voltar 03-8-07.
8. MRI of the right wrist by Dr. Voltar 03-8-07.
9. MRI of the right shoulder by Dr. Voltar 03-8-07.
10. Progress Report dated 03-5-07.
11. Progress report dated 03-13-07.
12. PFCE 03-15-07
13. Electrodiagnostic studies 03-12-07
14. Appeal to Notice of Non-Certification 03-16-07
15. Supplemental Report 03-19-07
16. Progress report 03-20-07.
17. Progress report 03-22-07.
18. Orthopedic initial report 03-27-07
19. Progress report 04-5-07.

20. Progress report 05-3-07.
21. Neurological progress report 05-17-07
22. Psychological permanent & stationary report 06-01-07
23. Progress report 06-4-07.
24. Orthopedic progress report 06-06-07
25. Progress report 07-9-07.
26. Amendment to initial 7-31-07
27. Neurology progress report 8-9-07
28. Progress report 8-15-07
29. Neurology progress report 09-06-07
30. Progress report 9-13-07
31. Progress report 10-8-07
32. Final Functional Capacity Evaluation (F.C.E.) dated 10-10-07.
33. Neurology progress report 10-18-07

I have reviewed the dated reports of Dr. McCoy, Dr. Voltar, and I agree and hereby incorporate the same herewith.

DISCLOSURE NOTICE

FACE-TO-FACE TIME: 1 HOUR AND 30 MINUTES

NON-FACE-TO-FACE TIME (REVIEW OF RECORDS): 1 HOUR 45 MINUTES.

I personally evaluated this patient and prepared this report. On occasions, Abraham Lopez, D.C., Licensed Chiropractor, assists with mensuration and blood pressure. If others have performed any other services in connection to this report, outside of clerical preparation, their name and qualifications are noted herein.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Dr. Black, who was raised in a bilingual household of English and Spanish, did the interpretation. Dr. Black communicates proficiently in both languages.

If you have any further questions, please do not hesitate to contact my office at (714) 835-1111.

Sincerely,

Harold S. Black, D.C.	Dictated in the County of Orange on
License Number 23498	This Date.

HSB: mt