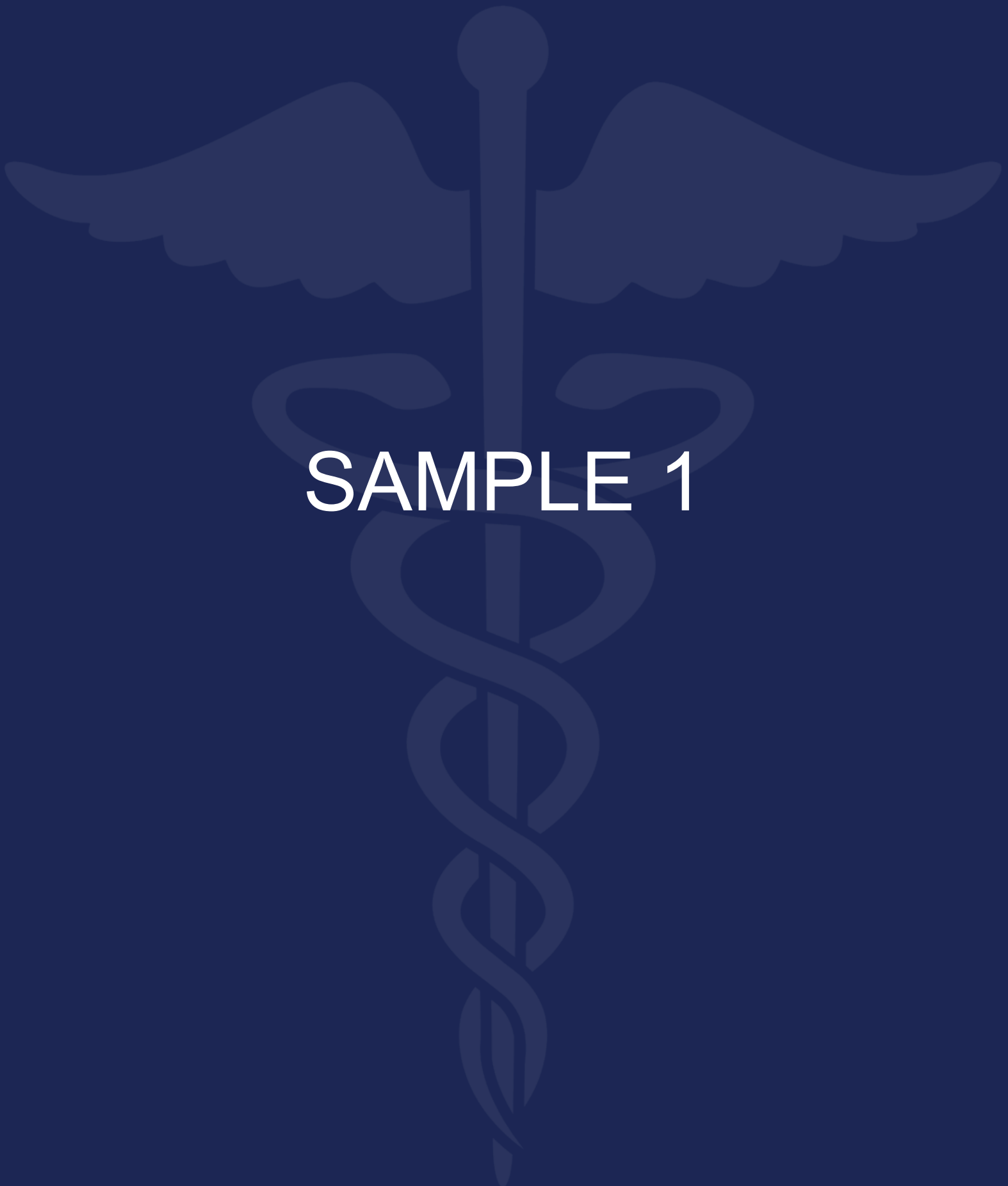
Sample Reports


SAMPLE 1

SAMPLE 1

Records reviewed

1. Records from AAA
2. Records from BBB

Ms. XXX was admitted on 06/07/2013 at YYY. She was struck as a pedestrian by a cargo van and had loss of consciousness. Her initial GCS was 3. EMS arrived at scene and reported that the patient was able to provide name and followed commands. She complained of headaches. She was transported to hospital. Upon arrival, she was awake, somnolent, but arousable. Initial GCS was 12. On exam, she had midline tenderness in the cervical spine. No focal neurologic deficits were seen. Labs and diagnostic studies were obtained. She was admitted to the SICU.

CT of the head without contrast on 06/07/2013 revealed midline occipital skull fracture with small occipital epidural hematoma. There were bilateral 5 mm subdural hematomas, posttraumatic subarachnoid blood and bilateral frontal hemorrhagic contusions, left worse than right. The study also showed extracranial soft tissue swelling overlying the right parieto-occipital region. There was some compression of the fourth ventricle due to mass effect. There was a small amount of blood along the tentorium on the left.

CT of the cervical spine without contrast revealed no acute bony trauma in cervical spine. Skull base fractures were noted. The occipital bone fracture extended across the foramen magnum through anterolateral occipital bone near the occipital condyle, then through petrous apex of the temporal bone and through carotid canal. There was the possibility of nondisplaced fracture in the right sphenoid as well that extended through the right carotid canal. There was a small amount of air present in the left carotid canal anterior to the artery. Soft tissue windows disclosed air in the left parapharyngeal and masticator space, perhaps, related to a penetrating injury. Air extended into the left jugular foramen.

CT of the chest, abdomen and pelvis with contrast was obtained and revealed no acute posttraumatic findings.

Chest x-ray showed no radiographic evidence of acute pulmonary disease.

CT angiogram of the neck revealed no evidence of vascular injury to the carotid or vertebral arteries. There was traumatic sequela including epidural and intracranial hemorrhage, occipital and petrous bone fractures.

CT of the head was repeated on 06/08/2013 revealed no significant change in size of intracranial foci of hemorrhage (bilateral hemorrhagic contusion of frontal lobes – left more than right, left temporal subdural hematoma and midline posterior fossa subdural/epidural hematoma, left middle fossa small subdural hematoma, and small foci of subpleural/epidural hemorrhage along the left hemisphere). There was fracture at occipital midline and left temporal lobe. There was mild diffuse enlargement of the sulci at the brain, especially on the left. There was no evidence of significant midline shift.

CT of the head and temporal bones was obtained on 06/09/2013 and compared to the study of 06/08/2013. CT temporal bones revealed overall no significant interval change in the size of intracranial foci of hemorrhage. There was midline occipital fracture that extended across the foramen magnum through anterolateral occipital bone near the occipital condyle, then through petrous apex of the temporal bone and through carotid canal. Head CT showed evolving post-traumatic changes with hemorrhagic contusions in the bilateral frontal and temporal lobes (slightly more apparent in the left temporal region). There was scattered subarachnoid hemorrhage – left greater than right without significant change. There was 2-3 mm midline shift toward the right side without change. There was left (5 mm) greater than right (2 mm) parietal extra-axial hemorrhage and a small foci of extra-axial hemorrhage in the anterolateral right middle cranial fossa that had decreased from 11 mm to 9 mm. Again seen was extra-axial hemorrhage in the posterior fossa midline posteriorly with mild regional mass effect (mild effacement of the fourth ventricle and posterior fossa cisterns without change). Ventricular size was stable. There were occipital, calvarial, and left temporal bone fractures, nondisplaced. The inferior extent of the left temporal bone fracture involved the left occipital condyle. There was focal soft tissue prominence in the region of the left nasolabial fold, possibly post-traumatic, though other etiologies were not excluded.

Ms XXX was discharged on 06/12/2013. The discharge diagnoses was status post pedestrian struck with traumatic brain injury, epidural hematoma, subdural hematoma, subarachnoid hemorrhage, cerebral contusion, occipital skull fracture with extension into the occipital condyle, and hypertension. After the injury, the patient was seen at the trauma bay with GCS of 11, which shortly improved to 15. She was discovered to have a traumatic brain injury and admitted to ICU and was seen by neurosurgery and was placed on Dilantin and observed. She was instructed to wear a Miami J for protection of her occipital condyle fracture. She was cleared for discharge home. She was prescribed Percocet, Norvasc and Dilantin. Dr. xxx advised her to follow up with xxx , the neurosurgeon and to follow up with her primary care physician regarding her hypertension.

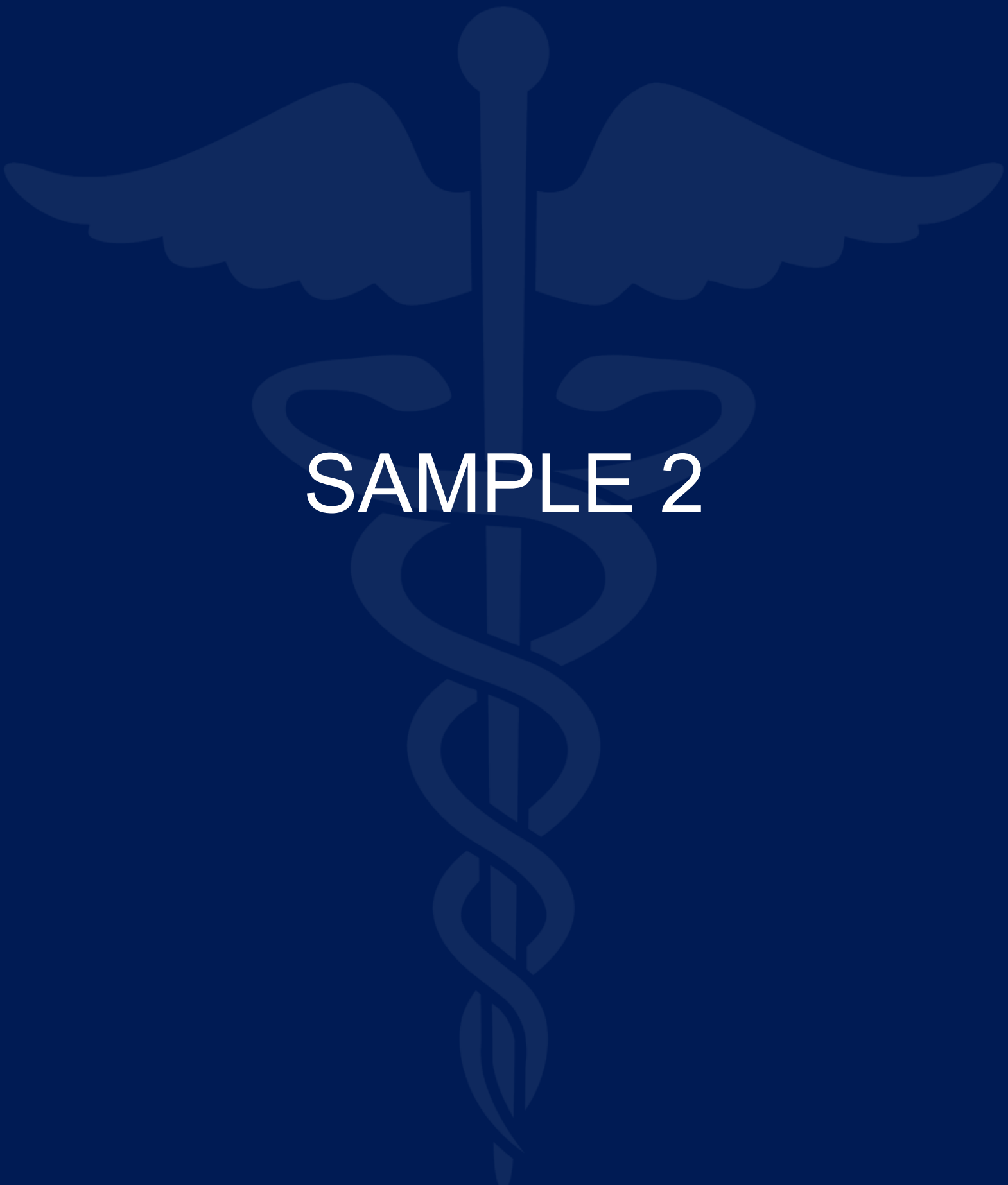
Ms. Xxx had an MRI of brain on 07/01/2013 at Open MRI, read by xxx. The study showed multiple areas of intracranial hemorrhage, including an intraparenchymal hematoma at the anterior pole of the right middle temporal gyrus, and additional areas of intraparenchymal hemorrhage which was greatest in the left frontal lobe with reactive edema/gliosis. There were additional areas of subarachnoid and minimal subdural hemorrhage. No evidence of brain herniation or other significant mass effect; there was no midline shift. The small left to right midline shift described in the CT report of 06/09/2013 was no longer evident. The earlier occipital fracture with adjacent epidural hematoma was no longer seen as well as tentorial hemorrhage which was also not seen on this study, although there was mild thickening of the posterior tentorium near the torcular Herophili. There were moderate inflammatory changes, and possibly post-traumatic changes, in the left maxillary sinus and in the sphenoid sinus, soft tissue thickening and edema along the left side of the patient's nose, and mild inflammatory type signal in the lower left mastoid bone.

The patient had a neurologic reevaluation by xxx on 08/06/2013. In the interval, she had had MRIs of the cervical spine, thoracic spine and lumbar spine were done on 07/15/2013. She was seen by Dr. xx and continued physical therapy was recommended and she was referred to ENT because of balance and hearing problems. She was referred to Dr. xx for posttraumatic stress symptomatology and for ortho consult for left shoulder subacromial bursitis. The provisional diagnoses made by Dr. xx was post-traumatic stress syndrome, post-concussion syndrome,

cerebral concussion with loss of consciousness, subdural and intraventricular hematoma, cervical spine injury with nerve root involvement, displacement of cervical intervertebral disc without myelopathy, bursitis, tendinitis or rotator curt syndrome and left clavicle, left axillary neuropathy, sprain/strain thoracic, lumbar spine injury with nerve root involvement, displacement of lumbar intervertebral disc without myelopathy, internal derangement of the left knee, sprain/strain of the right ankle and left peroneal nerve palsy (acute) (tardy). Ms. Xxx was advised MRI of left shoulder to evaluate rotator cuff tear. EMG/NCV of the left upper and left lower extremity was recommended to confirm the clinical suspicion of cervical and lumbar radiculopathy.

Ms. Xxx had initial physical therapy evaluation at xxx Rehab Center on 10/17/2013 for dizziness and giddiness and difficulty walking. She was recommended to attend rehabilitative therapy three times a week for four weeks.

Ms. Xxx was discharged from physical therapy at xxx on 03/24/2014. She attended five sessions of therapy. The prognosis on discharge was fair. She was discharged secondary to insurance limitations.


SAMPLE 2

Sample 2

July 13, 2014

To,

_____

PATIENT NAME:	**XXX, XXX**
DATE OF BIRTH:	**01/09/1968**
DATE OF INJURY:	**02/23/11**
DATE OF REVIEW:	**07/13/14**

ORTHOPEDIC CASE REVIEW

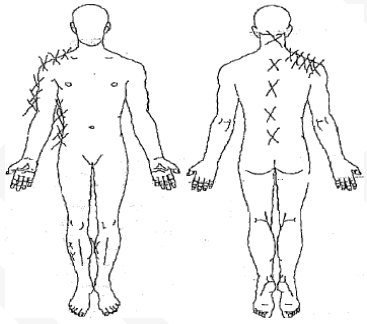
Dear Dr. XX:

I received and reviewed the following reports:

1. 11/09/10 *State of XX*– Traffic collision report. The hit and run accident occurred on XXX. Weather condition was clear and road condition was dry. Party #1 (P1) (Unknown) was driving vehicle #1 (xx) northbound 1-405 to eastbound xxx Boulevard within the #1 traffic lane at an unknown speed. Party #2 (xxx) was driving vehicle #2, (Ford) northbound 1-405 to eastbound xxx Boulevard within the #2 traffic lane stopped for stop traffic. P1 made an unsafe turning movement form the #1 traffic lane into the #2 traffic lane causing the right rear of the V #1 to collide with the left front of V #2. After the traffic collision P #1 fled the scene in V #1 and P #2 awaited CHP arrival. V#2 sustained minor collision damage consisting but not limited to broken left door mirror, left front fender well tire scuff, left front running board tire scuff, and unknown steering damage. There were no prior mechanical defects noted or observed on V#2.

2. 03/08/11 *XXX of YYY* – Chiropractic initial evaluation report. The chief complaint was neck pain, right shoulder pain, right upper extremity radiations, increased lower back pain, headaches, left leg bruise, right leg cuts from the shattered glass. The patient was involved in a motor vehicle accident on 03/05/11. She was a restrained front seat passenger in a small vehicle,

which approached a male and female beating up another male on the street. The driver of the vehicle started honking his horn and completely stopped in front of the altercation. The two attackers hurried and got into their vehicle, which was parked along the curb next to patient's vehicle. One of the attackers started the vehicle and accelerated out of the parking position, striking the side of the patient's vehicle, as well as striking the rear of a vehicle parked in front of where the attacker's vehicle was parked. They sped away and tried to flee the scene. The driver of the patient's vehicle followed the offending vehicle to get a license plate which was reported to the police department. The patient complained of pain in her neck, shoulder and back, which had progressively worsened since the time of injury. A pain diagram identified the symptomatic areas as shown below:



Her past medical history included motor vehicle accident in February 2010, where she had injured her neck and lower back, which required treatment for eight to nine months. Her past surgical history included cesarean section, tubal ligation, cholecystectomy, tonsillectomy and appendectomy. On examination, (only positive findings documented in review) there was mild laceration over the right leg. The cervicothoracic range of motion on flexion was 40 degrees, extension 25 degrees, bilateral lateral bending 20 degrees, right rotation 60 degrees, and left rotation 40 degrees. There was mostly left-sided cervicothoracic pain throughout range of motion. Maximum cervical compression elicited left-sided cervicothoracic pain. Spurling's test was positive for radicular findings on the left. Cervical distraction was positive for cervical myalgia, left side greater than right. There was spasm in the cervicothoracic musculature with moderate to marked tenderness on the left, and mild to moderate tenderness on the right. Valsalva's maneuver was positive for left-sided upper trapezius region pain. The shoulder examination showed, abduction 120 degrees, adduction 25 degrees, flexion 115 degrees, extension 30 degrees, external rotation 80 degrees and internal rotation 70 degrees. There was pain over the superior and anterior glenohumeral area

during the range of motion, mostly noticeably with flexion, abduction, and external rotation. Palpation revealed mild to moderate tenderness over the posterior and lateral glenohumeral region, and a moderate to marked tenderness over the anterior glenohumeral region. O'Brien's test was positive with internal and external rotation for possible labral involvement. Hawkins' supraspinatus impingement sign was present. Supraspinatus isolation was positive. Yergason's and Speed's were positive for biceps tendon involvement. Thoracolumbopelvic spine range of motion flexion 45 degrees, extension 20 degrees, right lateral bending 30 degrees, and left lateral bending 25 degrees. There was pain in the thoracolumbar region during flexion. Palpation showed spasms with moderate tenderness in the thoracolumbar region. Kemp's test elicited localized thoracolumbar pain. Left lower extremity showed mild bruising over the left leg proximal anteromedial region of the tibia. There was tenderness to palpation. Right lower extremity showed multiple mild healing lacerations which occurred from the shattered glass. Perception of pinprick and light touch was +2/2 throughout the upper and lower extremities. Motor strength was guarded +4/5 for the right rotator cuff. Her functional rating index was 100%. The impression was ***"Cervicothoracic musculoligamentous injury, clinical facet mediated pain left greater than right, clinical left cervical radiculalgia, posttraumatic headaches, injuries superimposed over recently resolved cervical whiplash February 2010. Right shoulder, labral sprain and rotator cuff strain. Thoracolumbar musculoligamentous injury, injury superimposed over prior unresolved lumbar injury February 2010. Left leg ecchymosis. Right lower extremity small lacerations. Difficulty in sleeping."*** Dr. XXX opined that the patient's mechanism of injury, subjective complaints and objective findings were consistent and causally related to the motor vehicle accident. The treatment frequency was initially three times per week. She was to follow up in three to five weeks for reevaluation.

3. 04/13/11 through 05/16/11 *XXX* – Chiropractic office visit notes. Chiropractic routine office visits documenting ongoing care were reviewed. Total 16 visits.

4. 06/30/11 *XXX* – Discharge summary. The patient was injured in a motor vehicle accident on 03/05/11. She received therapeutic injections over multiple areas including the right scapula, the lumbosacral region, and the left knee. Overall, she

significantly benefited from the therapy which only lasted a few months. The discharge physical examination revealed a slight decrease in range of motion of the cervical spine with bilateral lateral bending. There was very minimal point tenderness over the base of the occiput or over the cervical spine and paraspinal muscles. The right shoulder examination revealed very minimal tenderness over the scapula or scapular spine. Dorsal spine examination revealed minimal tenderness over the upper, mid, and lower thoracic spine or paraspinal musculature. Lumbar spine examination revealed very mild tenderness over the region of the bilateral sacroiliac joint and ligaments. There was slight decreased range of motion with bilateral lateral bending. Manual muscle strength of the bilateral upper extremity was 4+/5. The patient felt significantly improved to the point where she felt she was ready for discharge. Therapeutic injections received had provided her significant relief. She was discharged from care. The discharge diagnoses were **"Left knee sprain/strain injury. Thoracic sprain/strain injury. Lumbosacral sprain/strain injury."**

5. 07/22/11 *XXX of YYY Center* – Report of an MRI of the right shoulder, without contrast. The acromioclavicular junction was intact. There were no significant hypertrophic changes or undersurface spurring. Mild lateral downsloping of the acromion process was present. The acromion had a mildly curved undersurface. Focal increased signal intensity was seen within the distal supraspinatus anteriorly near the insertion on the greater tuberosity at least a partial undersurface tear was present. A subtle full-thickness component was suspected. Fluid was seen within the subacromial subdeltoid bursa. There was no evidence of muscle retraction. The infraspinatus, subscapularis and teres minor appeared normal. The long head of the biceps tendon was appropriately located and appeared normal. The insertion on the labrum appeared intact. The contours and signal intensity of the labrum appeared normal. The contours of the osseous surface appeared normal. Subcortical cystic changes were seen along the greater tuberosity. The signal intensity of the bone marrow otherwise appeared normal. There was no evidence of bone marrow edema or bone contusion. The impression was **"High grade partial thickness tear the distal supraspinatus. Subtle full thickness component is difficult to exclude. No muscle retraction is seen."**

6. 09/24/11 *XXX of YYY Medical Center* – Emergency physician record. The patient was status post motor vehicle accident in which she was the seat-belted front seat passenger of a car. She was ambulatory at the scene. She complained of moderate pain in the head, neck, and upper back rated at an 8/10. Medications included lisinopril. Review of systems was positive for neck and back pain. Her past history was positive for hypertension. On examination, she was in mild to moderate distress. A pain diagram identified the symptomatic areas as shown below:

Back examination revealed muscle spasm and limited range of motion. X-rays of the cervical spine and thoracic spine were performed and reviewed. The impression was ***"Cervical strain. Thoracic strain."*** The patient was discharged home in a good condition.

7. 11/21/10 *XXX*– Deposition. Mr. XXX was the consultant specializing in the technical aspect of accident reconstruction. All his work had the potential for litigation or forensic in nature. He opined that the subject accident was caused by the defendant driver permitting his right rear, top trailer tire to make contact with the plaintiff's vehicle. He believed that was caused by the off-tracking of the tracking of the tractor/trailer rig. He opined that that the change in speed of the plaintiff's vehicle was more likely in the range of 7 to 8 miles per hour. He also noted that the position of the plaintiff was an odd one, where he had his right hand on the passenger side seat and his left hand was at 11 0' clock on the steering wheel. So when he was impacted and the vehicle rotated in a clockwise direction, and he was moved forward, the impact to the left tire could jerk the steering wheel at about the same time that he had been accelerated by the impact to the tire. Other than the plaintiff's testimony regarding the movement of his vehicle, there was the damage to the vehicle that indicated a delta V or a change in speed to cause the damage seen, but there was no physical measurement of that movement or any evidence on the pavement such as debris pattern or skids. If the center of gravity did not move, the vehicle would not have a delta V, but it would be expected that the suspicion would rock under those circumstances, as the delta V normally referred to the

center of gravity movement. Mr. XXX relied to some degree upon the repair estimate of the plaintiff's vehicle in formulating his opinions. It corroborated the photographic evidence and possibly the testimony of the plaintiff.

8. 12/10/13 *Plaintiff*– Plaintiff's answers to first interrogatories.

Interrogatory # 2 Prior injuries, claims, and treatment.
Response # 2 On 02/12/10, XXX was involved in a motor vehicle accident. She was the passenger in a vehicle that was struck by a vehicle that ran a red light. She sustained injuries to her left shoulder, upper and lower back and chest. XXX was treated by XXXXXXXX. Her symptoms completely resolved and she was released from treatment.

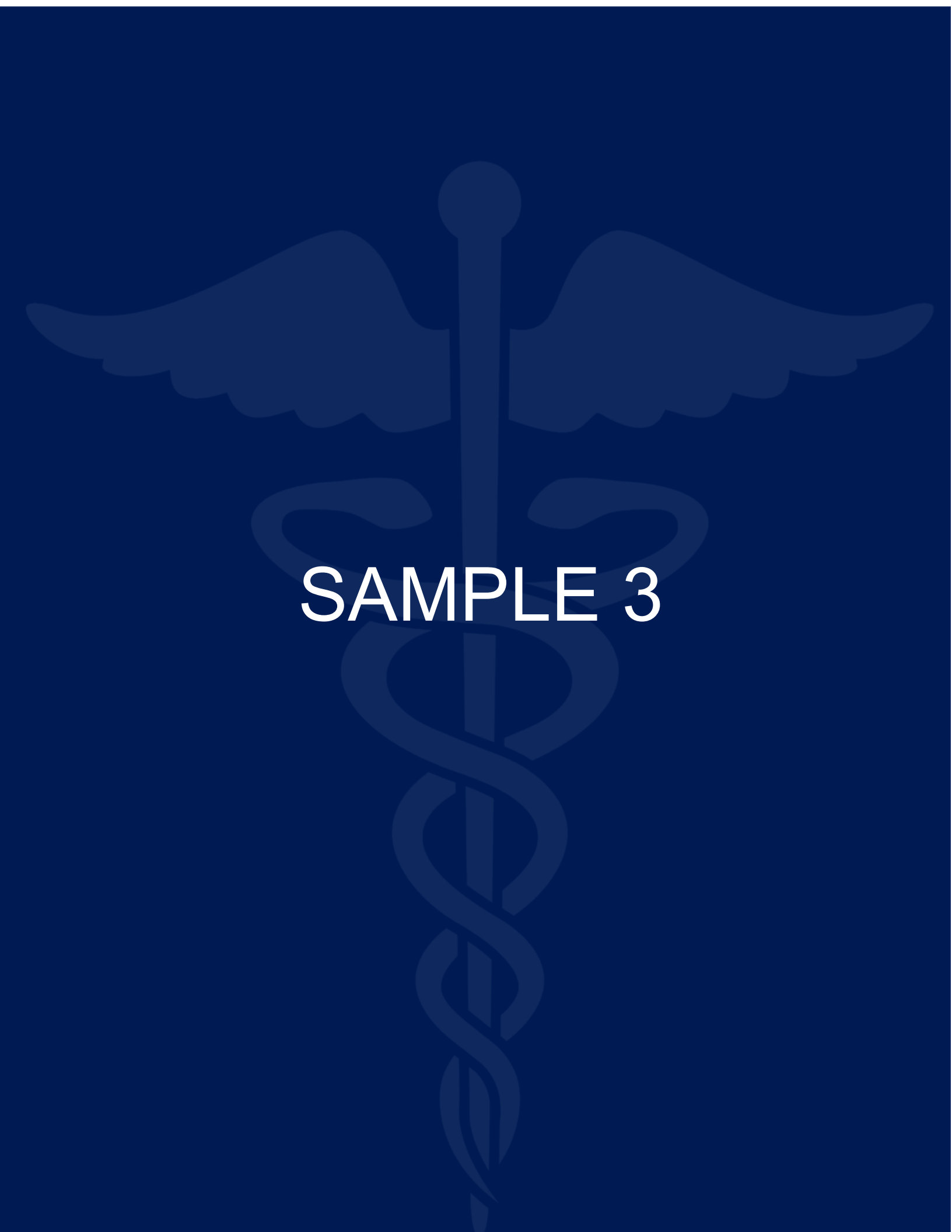
Interrogatory #3

Interrogatory #4

Interrogatory #5

Computation of Damages

	Provider	Charges
1	A	$2,948.00
2	B	$745.00
3	C	Pending
4	D	$27,650.42
5	E	$20,243.50
6	F	$3,535.16
7	G	$5,100.00
8	H	$3,160.00
9	I	$46,814.34
10	J	$4,178.23
Total Special Damages		**$114,374.65**


SAMPLE 3

Sample 3

PATIENT NAME: **xxx**
DOB: **xxx**
DOI: **xxx**

INDICES OF RECORDS

1. 02/13/13 XXX– Doctor's first report of occupational illness or injury. The patient heard a pop on her right shoulder while she was mopping. She complained of dull moderate pain to right shoulder, wrist and hand. On physical examination, there was decreased range of motion of the metacarpophalangeal/interphalangeal joints and shoulder and tenderness over trapezius, deltoid or upper extremity muscles. **Impression: Sprain shoulder/arm NEC, right. Sprain of wrist NEC, right. Sprain of hand NEC, right.** X-rays of the right hand, wrist and shoulder were performed which were negative. The patient was to start therapy three times per week for two weeks. He was dispensed cold pack, custom touch, support times two, thermacare times two and polar frost. He was prescribed acetaminophen 500 mg, orphenadrine 100 mg and nabumetone 750 mg. The patient was released to modified duty from 02/15/13 with restrictions including limited use of right hand, limited overhead work, limited lift, pull and push up to 10 pounds, must wear splint and remain off balance of shift. The patient was to return to clinic on 02/15/13.

2. 02/13/13 XXX – Report of x-rays of right hand, three views. There was no evidence of bony joint space or soft tissue abnormality. No fracture was observed. **Impression: Negative study. Recommend clinical correlation and if there remains a high degree of suspicion for fracture, follow up evaluation in seven to ten days may be helpful to exclude a fracture which is initially poorly defined or radiographically occult.**

3. 02/13/13 XXX of YYY – Report of x-rays of right shoulder, three views. There is no evidence of bony, joint space or soft tissue abnormality. No fracture was observed. **Impression:** Negative study. Recommend clinical correlation and if there remains a high degree of suspicion for fracture, follow-up evaluation in 7-10 days may be helpful to exclude a fracture which is initially poorly defined or radiographically occult.

4. 02/15/13 XXX of YYY – Primary treating physician's progress report. The patient reported no improvement. On examination, there was swelling over right wrist and thumb and tenderness to the right wrist and shoulder. Range of motion of the wrist was decreased. **Impression: Sprain of right wrist. Sprain of right shoulder.** The patient was administered Toradol injection intramuscularly and was provided wrist support with support of right thumb. She was advised not to sleep with wrist support. She

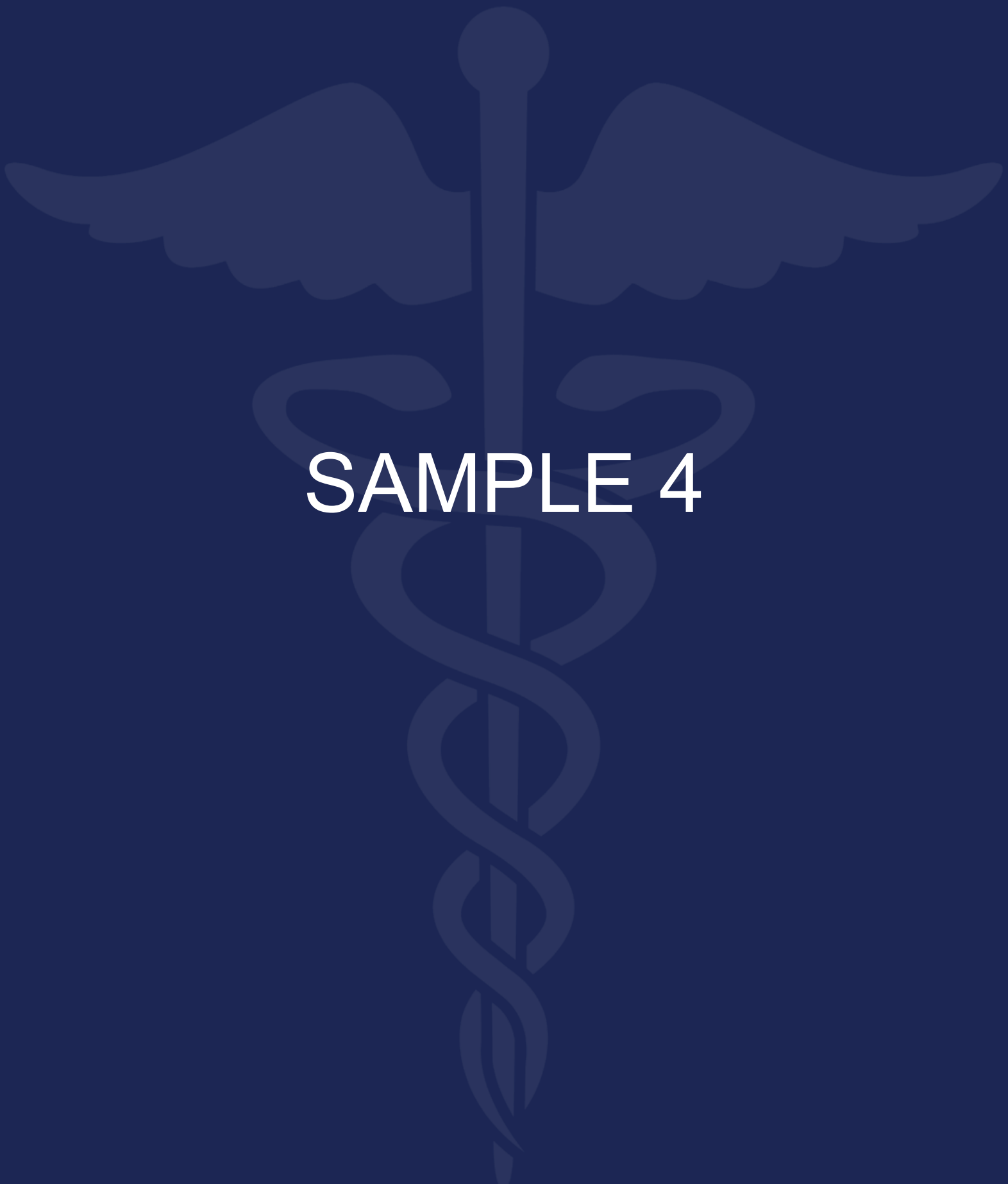
was to continue therapy. The patient was released to work on 02/15/13 with restrictions including limited use of right hand, limited overhead work, limited lift, pull and push up to 10 pounds and must wear splint. She was expected to return to full duty on 02/28/13. She was to return to clinic on 02/20/13.

5. 02/28/13 XXX – Rehabilitation evaluation. The patient complained of constant sharp left shoulder and hand pain that increased with activity and rated as 6/10. On physical examination of the shoulder the range of motion of the right shoulder was with pain. The cervical range of motion revealed flexion 58 degrees, extension 62 degrees with pain, left side rotation 54 degrees with pain, right side rotation 62 degrees, left rotation 80 degrees and right rotation 62 degrees with pain. There was moderate to severe tenderness at right thenar eminences and first MCP's. There was tenderness at right posterior cuff and upper trapezius. Special tests were not performed secondary to pain. Short term and long term goals were discussed. She was recommended physical therapy for three times per week for two weeks.

6. 03/27/13 XXX – Report of EMG/NCV of right upper extremity. **Impression: This is an abnormal EMG and nerve conduction study of the right upper extremity. The study showed a mild right carpal tunnel syndrome, with prolonged median sensory latencies across the wrist. There is no evidence of ulnar and radial neuropathy or significant cervical radiculopathy.** The patient was advised to follow up with the treating physician to discuss the test result.

7. 03/28/13 XXX – Initial orthopedic consultation. The patient reported that she got some right shoulder pain while she was mopping. The symptoms were predominantly in her right trapezius and right medial scapular region, also radiating down into her right arm and wrist with occasional numbness in her hand. She had been seen and treated at XXX. She was seen initially by Dr. XXX and subsequently by XXX. She underwent physical therapy on five occasions and had medications. On physical examination, there was tenderness in the right para-musculature and right trapezius. Cervical compression was positive for medial scapular pain and flexion. Range of motion of her shoulder created discomfort in her right trapezius. Phalen's test was positive. Diagnostic testing was reviewed. X-rays of right shoulder and right wrist were normal. **Impression: Rule out cervical radiculopathy. Rule out shoulder sprain/strain.** Per Dr. XXX, the injury was a result of and caused by the industrial exposure of 02/09/13. A trial of corticosteroids was

recommended. Prednisone was dispensed. Consideration of diagnostic testing for neck and shoulder was recommended if the injections and medications failed to relieve her symptoms. The EMG/NCV was reviewed which documented mild carpal tunnel syndrome. The patient was released to modified duty.



SAMPLE 4

Sample 4

Medical Time Line

Medical providers:

1. Dr. A
2. Dr. B
3. Dr. C

Pertinent Past Medical History / Social History:

- Diabetes
- Hypertension
- High cholesterol

Imaging studies:

- 06/07/11 CT scan of abdomen and pelvis.
- 06/09/11 X-rays of left elbow.
- 06/09/11 CT scans cervical spine.
- 06/09/11 CT scan of brain.

Procedures:

- 06/16/11 Trigger point injections bilateral cervical and lumbar paraspinous muscles and occipitals.
- 07/06/11 Selective nerve root blocks at L4 on left side with transforaminal placement of epidural corticosteroid.

Medical Time Line

PRE INJURY RECORDS

DATE OF INJURY/ACCIDENT: 06/09/2011

06/09/11 American Medical response
Patient care record

HPI
- Unintentional fall from chair to ground
- Back pain
- Acute onset of pain and dizziness.

PMH
- Diabetes
- Hypertension
- High cholesterol

PE
- Head tenderness.
- Neck abrasions.
- Glasgow coma scale 15.

Narrative
- Complained of pain and slight dizziness that was intermittent
- Upper back pain due to fall out of chair.
- While sitting on back of chair, it gave out.
- Pain rated at 5/10 and described as throbbing.

Impression
1. Pain-body traumatic
2. Neuro-vertigo/dizziness
3. Musculoskeletal trauma secondary to fall from chair.
4. Transported to Facility.

06/09/11 Facility
Provider
Type of report

HPI
- Patient was sitting on chair, which broke and he fell on back and struck his head and left elbow.
- He experienced minor headache.
- Also had some back pain and left elbow pain.
- Pain worsened with movements.
- Pain described as sharp and constant.

PE
- Midline tenderness in back, minor tenderness of cervical spine.
- Minor diffuse tenderness on elbow.

Impression
1. Contusion, head
2. Contusion elbow
3. Back pain
4. Neck pain.

Emergency department course

- Given Percocet with moderate relief of pain.
- X-rays of left elbow, CT brain and cervical spine done and reviewed.
- Discharged home with prescription of Norco.
- He was to follow up at Lied clinic.

06/09/11 Facility
Provider
X-rays of left elbow

Findings
- No evidence of acute fracture or dislocation.
- Alignment was within normal limits.
- Articular surfaces and joint spaces were within normal limits.
- No evidence of joint effusion or soft tissue abnormality.

Impression
1. No evidence of acute left elbow fracture.

06/09/11 Facility
Provider
CT scan cervical spine, without contrast.

Findings
- Loss of normal lordosis probably related to positioning/spasm.
- Slight relative deformity of right side of body of C2 seen for example on axial image 29 which did not appear to be acute with no significant nearby soft tissue swelling.
- Otherwise no acute fracture, dislocation or destructive osseous lesion.
- Moderate degenerative changes seen.
- Chronic fragments next to tips of multiple spinous processes.
- Some mucosal thickening in paranasal sinuses.
- Scattered vascular calcifications.

Impression
1. No evidence of acute osseous abnormality of cervical spine.

06/14/11 Active Life Health and Wellness
Provider
Chiropractic initial note

HPI
- Injured on 06/09/11.
- Complained of neck pain, low back pain, bilateral shoulders and left elbow pain.
- Had associated headaches, dizziness and blurry vision.
- Pain was present 50% of time.
- Upper back pain rated 8/10 exacerbated with twisting and alleviated with medications.
- Low back pain rated 9/10 and exacerbated with laying in bed, sitting, bending, twisting and lifting.

PE

- Cervical spine range of motion decreased with pain.
- Palpable muscle spasms over right suboccipitals and posterior neck.
- Positive translation at C6-7 and C7-T1.
- Left deltoid muscle weakness.
- Slow movements.
- Tenderness to palpation over mid back and lower back with spasms.
- Lumbar spine range of motion decreased with pain.
- Muscle strength 4 over left anterior deltoid and over bilateral gluteus medius, psoas and tensor fascia lata.

Assessment

1. Multiple cervical subluxations.
2. Cervicalgia.
3. Cervical myospasms.
4. Cervical myalgia.
5. Loss of cervical lordosis.
6. Upper extremity subluxation.
7. Upper extremity tissue pain.
8. Thoracic subluxation.
9. Thoracic myospasm.
10. Thoracic myalgia.
11. Lower extremity subluxation.
12. Lumbar subluxation.
13. Lumbago.
14. Lumbar myospasm.
15. Lumbar myalgia.
16. Lumbar neuritis.
17. Sacroiliac subluxation.

Plan

- Start chiropractic treatment.

06/16/11 Provider

Orthopedic initial consultation report

Reason for visit

- Referred by XXX
- Neck pain with headaches, parascapular and upper extremity radiation of symptoms.
- Low back pain with lower extremity radiation of symptoms.

HPI

- Mainly complained about neck pain with headaches and radiation of pain to shoulders and periscapular area.
- Low back pain with radiation to the left buttocks and lateral thigh, with cramping in left toes.
- Ongoing symptoms since fell backwards as the back of chair broke on 06/09/11.
- He landed on head and back and also struck left elbow.

- Prolonged sitting, standing or walking aggravated symptoms.

PMH
- Crick in neck in 1991
- Diabetes
- Hypercholesterolemia
- Hypertension

PSH
- Adhesion removed from prostate in 2007.

ROS
- Muscle/joint pain.

PE
- Appeared uncomfortable and proffered to be in dark room.
- Limited movement of head.
- Tenderness to palpation of the occipitals
- Bilateral cervical and thoracic paraspinals muscle tenderness and spasm.
- Midline spinous process tenderness.
- Range of motion limited in all directions.
- Straight leg raise test was positive bilaterally, which referred to back and left leg, and back on right.
- Motor strength weak on left grip, opponens and thumb extension.

Impression
1. Post-traumatic cervical radiculopathy
2. Post-traumatic neck pain and low back pain with sprain/strain and symptoms consistent with displaced intervertebral discs and facet arthropathy.
3. Post-traumatic lumbar radiculopathy
4. Post-traumatic myofascial pain with spasm.
5. Post-traumatic headaches consistent with cervicogenic cephalgia.
6. History of diabetes, hypertension and hypercholesterolemia.

Plan
- Hydrocodone prescribed and risks and benefits were discussed.
- MRI cervical and lumbar spine and brain.
- Administered trigger point injections.
- Check blood glucose every several hours and drink plenty of water.
- Continue chiropractic therapy
- Fitted with lumbar support orthotic.
- Follow up in two weeks

06/16/11 Provider

Procedure report

Procedure performed
- Trigger point injections bilateral cervical and lumbar paraspinous muscles and occipitals.

Post-procedure evaluation
- Some relief of myofascial pain without complete symptomatic relief.

06/16/11 Facility
Provider
MRI lumbar spine, without contrast

Findings

- Last intervertebral disc space was designated as L5-S1.
- No lumbar vertebral compression deformities or osseous destructive lesions.
- Typical appearing hemangiomas in T12, L2, L3, L5 and S1 vertebrae
- Conus medullaris of normal caliber and signal intensity, positioned at L1-2 level.
- L1-2, L2-3 and L3-4 levels, with normal signal intensity of discs, preservation of disc space heights, no intervertebral disc bulging, spinal canal or neural foraminal stenosis.
- L4-5, normal signal intensity of disc and preservation of disc space height, facet arthropathy, left foraminal annular fissure and 3 mm left foraminal disc protrusion, effacing fat within anterior aspect of inferior recess of left neural foramen, facet arthropathy, mild left neural foraminal stenosis and patent right neural foramen.
- L5-S1, normal signal intensity and disc preservation of disc space height, facet arthropathy, no intervertebral disc bulging, spinal canal or neural foraminal stenosis.

Impression

1. Multiple scattered vertebral body hemangiomas.
2. L4-5 left foraminal annular fissure and disc protrusion, associated with mild left neural foraminal stenosis.

06/17/11 Facility
Chiropractic therapy daily note

- Therapy done.

06/20/11 Facility
Chiropractic therapy daily note

- Therapy done.

06/30/11 Provider
Follow up report

Reason for visit

- Pain in lower back, headaches, neck pain, and some tingling in left leg.

Changes since last visit.

- No change.
- Low back pain hurting more than neck.
- Still had tingling in left leg and headaches
- Following up with chiropractor and receiving physical therapy.
- MRI lumbar and cervical spine dated 06/16/11 reviewed.

PE
- Cervical and lumbar paraspinous muscle tenderness and spasm
- Motor strength weak on left grip, opponens, and thumb extension.

Impression
- Remained unchanged

Plan
- Continue chiropractic and physical therapy.
- Selective nerve root block at L4 left with transforaminal epidural placement of corticosteroid was to be considered.
- If lumbar symptoms improved cervical procedure was to be considered on the next visit.
- Follow up in one week after procedure.
- Received clearance from Dr. XX for procedure.
- Prescribed ibuprofen.

07/11/11 Facility
Provider
Cytology report

Specimen
- Urine

Result
1. Negative for diagnostic malignant cells.
2. Moderately severe acute inflammation, numerous benign squamous cells benign urothelial cells, scattered bacteria and histiocytes noted.

08/16/11 Facility
Provider
Neurology consultation report

HPI
- Date of injury 06/09/11.
- Injured while sitting at outside patio table at a coffee shop, when back of chair gave way causing to fall backwards.
- Landed on back and head.
- After 24 hours of fall, he developed headache as well as neck and lower back pain.
- Initially evaluated at XX Medical Center and was discharged home with medications.
- Originally had swelling at the back of his head since he hit concrete quite forcefully, which had resolved.
- Since that time he had constant headaches located bi-frontally, which occurred throughout day and lasted for 15 to 30 minutes.
- Rated at 6-8/10.
- Undergoing physical therapy at XXX

ROS
- Bilateral tinnitus
- Somnolence

- Radicular pain into upper and lower extremities from neck and lower back respectively.

PMH
- Diabetes mellitus
- Hyperlipidemia
- Hypertension

PE
- Overweight, 200 pounds.
- Sensory system revealed stocking glove distribution of sensory loss in lower extremities more than upper extremities to lower sensory modalities.
- Deep tendon reflexes 3+.

Impression
1. Traumatic brain injury, secondary to fall from chair, presenting with bifrontal headaches three times per day, lasting approximately 15 minutes at a time, rated as 6-8/10 on visual analog scale.
2. Currently using ibuprofen, Lortab, and resting with good response.
3. Secondary complaint of bilateral tinnitus, which becomes louder when surroundings are quiet.
4. Abnormal MRI of brain revealed extensive signal abnormality in periventricular deep and subcortical white matter secondary to severe microvascular disease versus shearing injury.
5. MRI evidence of cervical and lumbar disc disease with multilevel neural foraminal stenosis.

Plan
- Vitamins for prophylaxis of headaches.
- Continue ibuprofen and Lortab
- Transcranial doppler ultrasound ordered for assessment of patency of vessels of the circle of Willis.
- EMG/NCV of bilateral upper and lower extremities.
- Referred to ENT.
- Follow up after completion of testing.

09/08/11 Facility
Providere
EMG/NCV of upper extremities

Impression
1. Moderate in severity carpal tunnel syndrome bilaterally right more than left.
2. No electrodiagnostic evidence for ulnar neuropathy at the elbow bilaterally.
3. No electrodiagnostic evidence for ulnar neuropathy.
4. No electrodiagnostic evidence for axonal or demyelinating sensory motor peripheral neuropathy.

5. No electrodiagnostic evidence for overt axonal loss C5 through T1 radiculopathy bilaterally.

Median Nerve

Rec Site: APB	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C.V. (m/s)	
Stim Site	L	R	L	R	L	R	L	R	L	R	L	R
Wrist	3.8	4.0	5.1	4.7	8.5	6.0	26.0	15.3				
Elbow	7.9	8.5	5.8	5.7	7.8	5.2	25.0	15.2	220	230	53.9	51.1
Rec Site: ADM	**Lat (ms)**		**Dur (ms)**		**Amp (mV)**		**Area (mVms)**		**Dist (mm)**		**C.V. (m/s)**	
Stim Site	L	R	L	R	L	R	L	R	L	R	L	R
Wrist	3.8	3.4	4.3	4.6	11.1	8.3	25.8	18.0				
B.Elbow	7.3	7.4	4.9	5.3	10.4	7.8	26.0	19.1	200	200	55.8	50.0
A.Elbow	9.5	9.8	5.3	5.6	9.8	7.0	25.4	19.1	100	100	46.2	41.4

Med/Uln/Rad Nerve

Stim Site: Wrist	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C.V. (m/s)	
Rec Site	L	R	L	R	L	R	L	R	L	R
R.Thumb	2.0	1.9	2.6	2.5	19.7	22.0	100	100	50.0	53.1
Index	2.7	2.8	3.6	3.8	11.0	15.0	140	140	52.2	50.6
5th dig	3.2	2.9	4.1	3.7	11.7	13.7	140	140	43.8	48.3

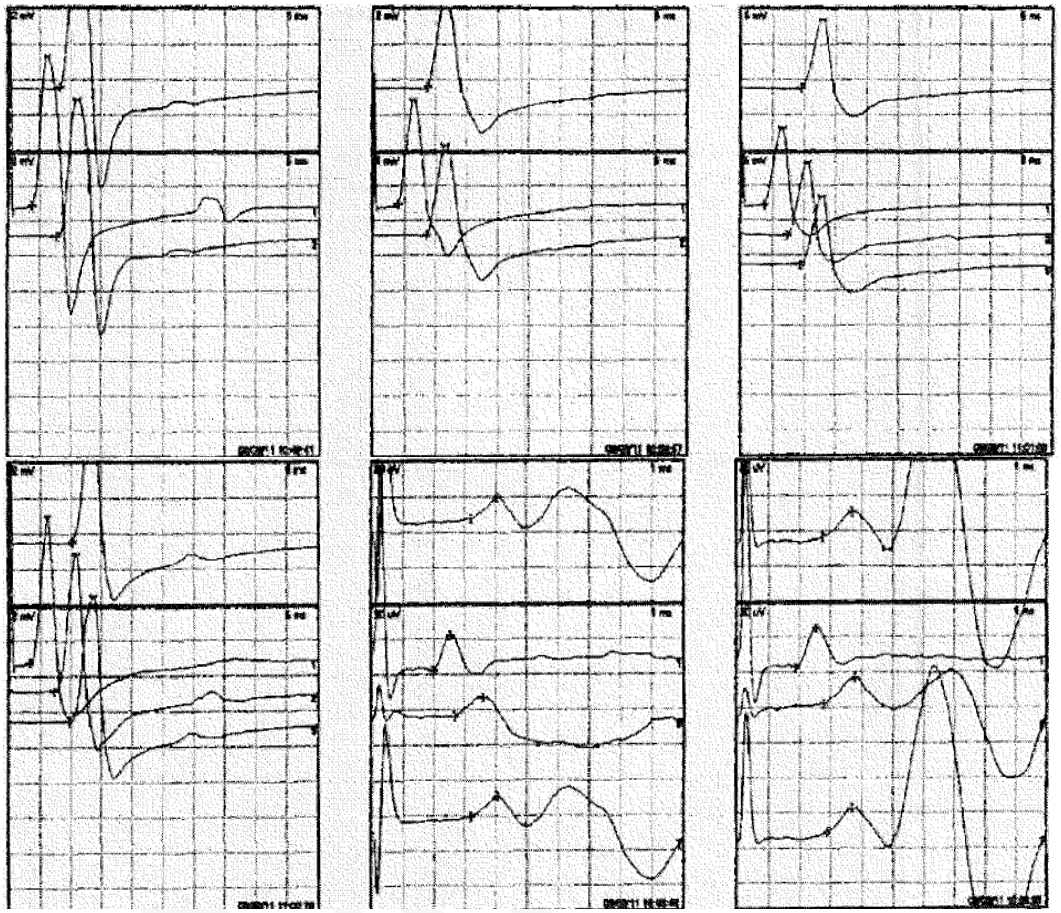
Median Nerve
Rec Site: APB
Stim Site: Wrist

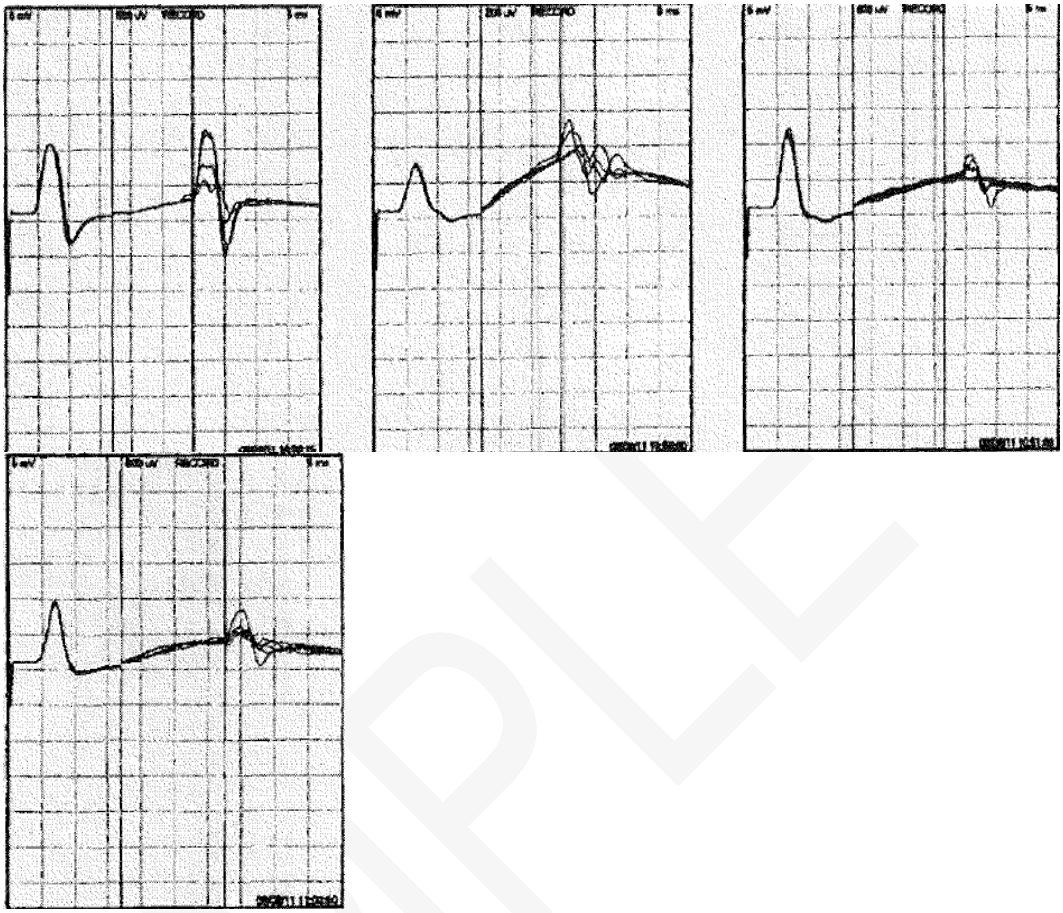
	Latency ms		Amplitude mV	
	L	R	L	R
M wave	4.17	4.08	13.583	7.917
F wave	29.67	29.50	1.500	1.497
F-M	25.50	25.42		

Ulnar Nerve
Rec Site: ADM
Stim Site: Wrist

	Latency ms		Amplitude mV	
	L	R	L	R
M wave	2.33	3.75	13.333	10.083
F wave	31.58	32.67	1.483	1.500
F-M	29.25	28.92		

Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
L. Deltoid	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Biceps Brachi	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Brachialis	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Pronator Ter.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Ext.Dig.Com	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Deltoid	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Biceps Brachi.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Brachialis	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Pronator Ter.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Ext.Dig.Com	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm





09/13/11 Facility
Provider
EMG/NCV of lower extremities

Impression

1. Moderate in severity predominantly sensory distal symmetric peripheral neuropathy due to underlying diabetic peripheral neuropathy.
2. No electrodiagnostic evidence for peroneal neuropathy at the fibular neck or tibial neuropathy at the popliteal fossa.
3. No electrodiagnostic evidence for overt axonal loss L2 through S2 radiculopathy bilaterally.

Motor Nerve Study

Peroneal Nerve

Rec Site: EDB	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C.V. (m/s)	
Stim Site	L	R	L	R	L	R	L	R	L	R	L	R
Ankle	5.3	5.8	4.1	4.4	6.3	5.1	14.8	11.6				
Fib.Head	12.6	12.3	5.3	6.7	5.4	3.3	14.6	9.7	310	320	42.3	49.9
Pop.Fos.	15.0	14.3	5.4	6.2	4.9	3.0	14.0	9.5	100	100	41.4	48.0

Tibial Nerve

Rec Site: AH	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C.V. (m/s)	
Stim Site	L	R	L	R	L	R	L	R	L	R	L	R
Ankle	5.6	5.9	4.8	4.4	4.8	5.4	11.3	9.5				
Pop.Fos.	13.7	13.9	6.8	5.7	4.3	3.8	13.3	9.8	330	340	40.8	42.5

Sensory Nerve Study

Peroneal Nerve

Rec Site: dors.ft	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C.V. (m/s)	
Stim Site	L	R	L	R	L	R	L	R	L	R
Lower leg	NR	NR								

Sural Nerve

Rec Site: Ankle	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C.V. (m/s)	
Stim Site	L	R	L	R	L	R	L	R	L	R
mid calf	NR	NR								

Peroneal Nerve
Rec Site: EDB
Stim Site: Ankle

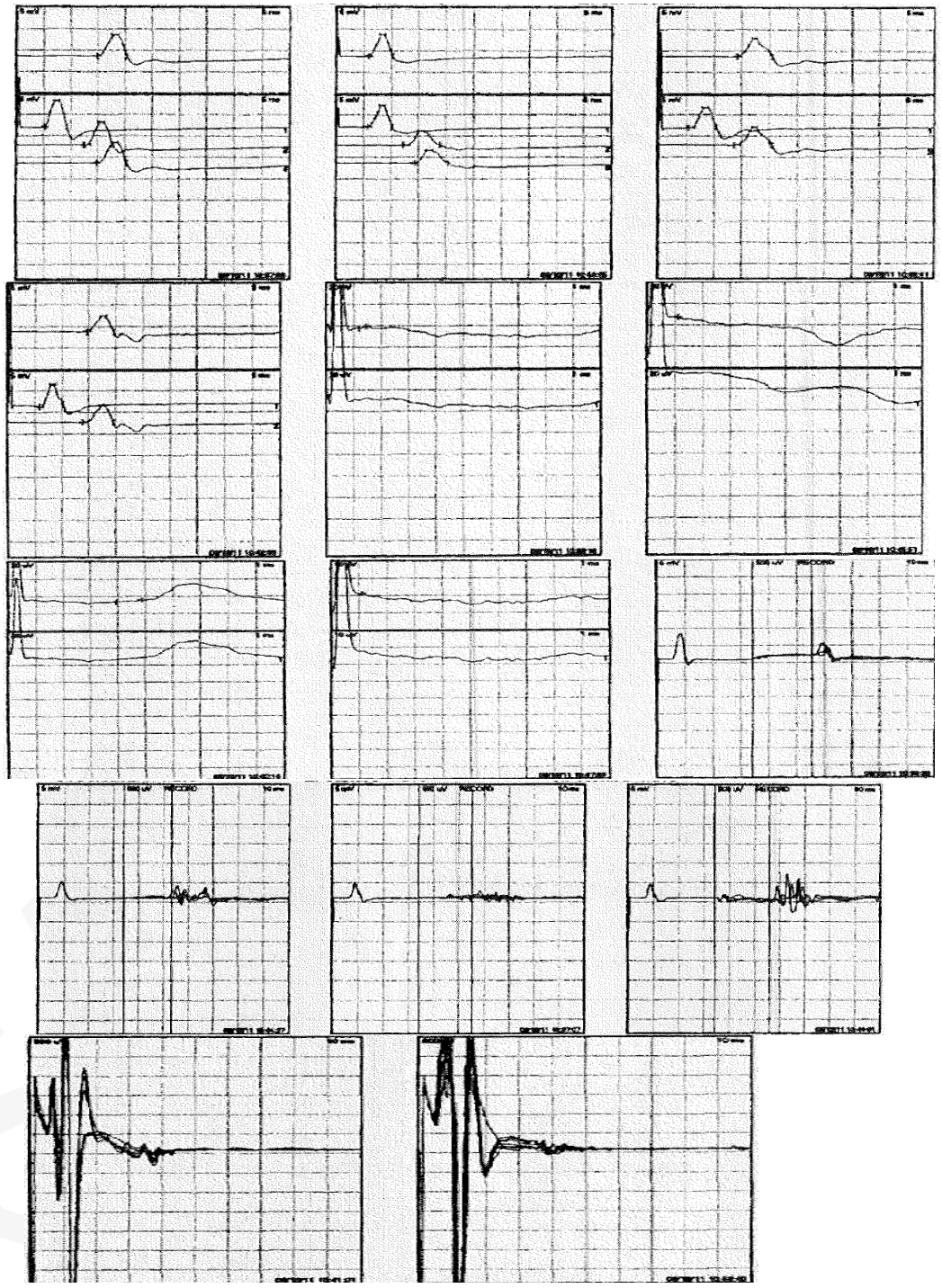
	Latency ms		Amplitude mV	
	L	R	L	R
M wave	5.33	6.17	8.667	4.333
F wave	55.50	53.50	1.500	1.500
F-M	50.17	47.33		

Tibial Nerve
Rec Site: AH
Stim Site: Ankle

	Latency ms		Amplitude mV	
	L	R	L	R
M wave	5.83	7.17	4.417	4.333
F wave	55.17	55.83	1.500	1.497
F-M	49.33	48.67		

Tibial Nerve
Rec Site: Soleus
Stim Site: Pop.Fos.

	Latency ms		Amplitude mV	
	L	R	L	R
M wave	4.00	3.50	3.500	3.500
H wave	32.17	32.33	2.500	2.500



Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
L. Tibialis Ant.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Peroneus Lo.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Gastroc.Med.H.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Gastroc.Lo.H.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Vastus Lat.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Flx.Dig.Lo.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Vastus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Gluteus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Tibialis Ant.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Peroneus Lo.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Gastroc.Med.H.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Gastroc.Lo.H.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Flx.Dig.Lo.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Vastus Lat.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Vastus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Gluteus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Default	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Default	norm	none	none	none	none	norm	norm	norm	norm	norm

05/29/14 Deposition –XXX

Page 12

- Currently taking Norco 5 mg p.r.n.

Page 13

- Probably take one to two day and at times need an additional one.
- Trying to just suffer through the pain as much as possible
- Prescribed by Dr. XX.

Page 14

- Before Dr. XX, prescribed by Dr. XXX

Page 15

- Dr. XXX was her doctor since 2003.

Page 16

- Treated with XXX related to the September 2006 accident.

Page 17

- Also on Lidoderm patches since May 2011 accident.
- Tried Lidoderm patches even before May2011 accident.

Page 18

- Using patches daily since May 2011 accident.
- Using it on low back and occasionally on neck.
- Using it a couple to a few times a week.

Page 19

- Also on hydroxyzine, prescribed by Dr. XXX for allergies.

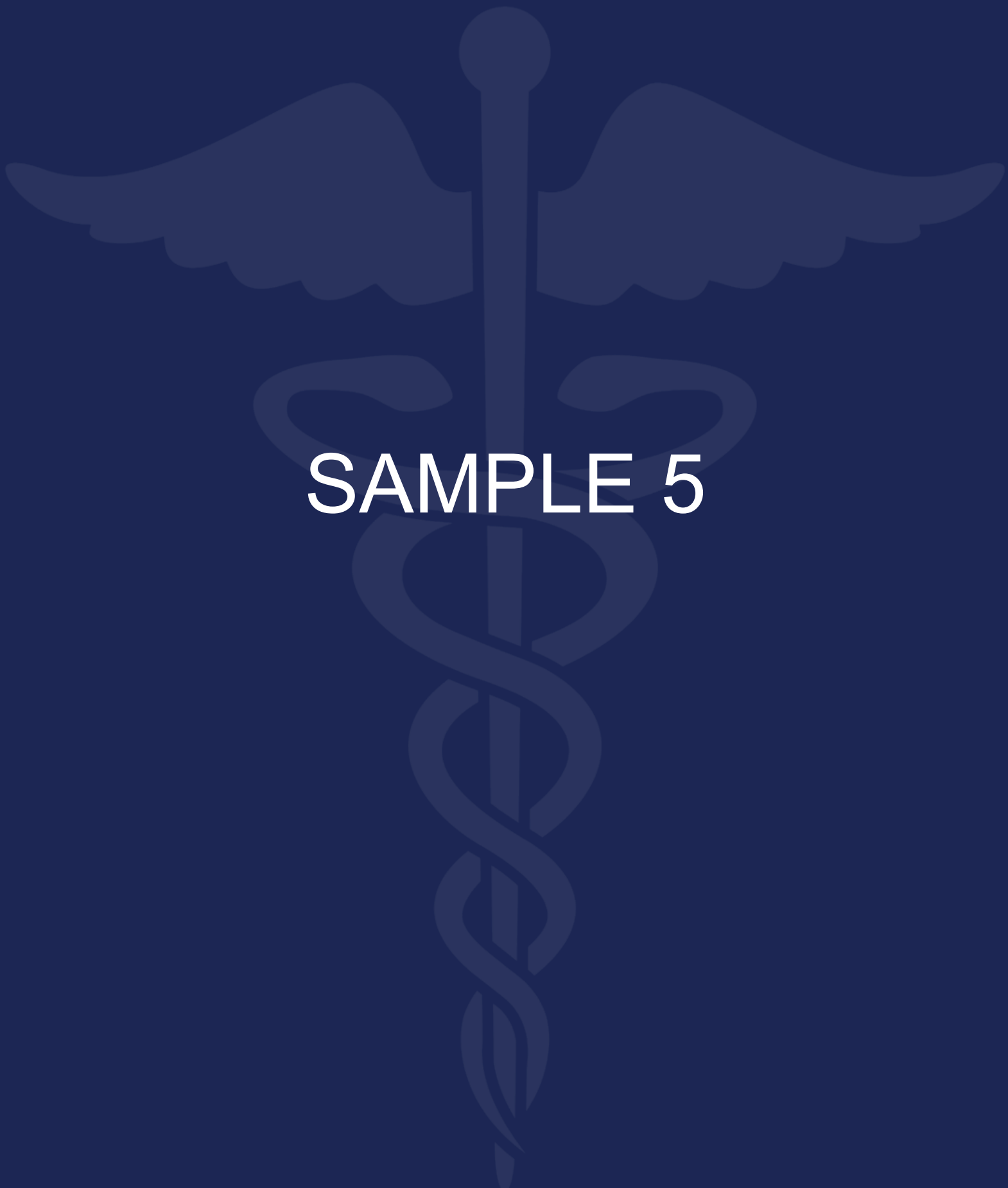
Page 20

- On Singulair and ranitidine
- On Nuvigil for chronic fatigue, prescribed by Dr. XXX.

Page 21

- Benadryl as needed.
- Magnesium.

- Since 2011 May accident, also took hydrocodone for a while, prescribed by Dr. XX.
- Stopped taking it because of amount of acetaminophen.
- Was on gabapentin for a while



SAMPLE 5

MEDICAL RECORDS REVIEW: _____

Date of Accident: August 15, 2015

Billings:

- Samimi Orthopedic Group, Inc, 03/07/16 – 04/04/16 (therapy) $6,220.00
- Kaiser Foundation Health Plan, 08/15/15 – 08/16/15, $772.00
- Kaiser Foundation Health Plan, 08/15/15, $2,326.35
- Loma Linda University Medical Center, 08/15/15 – 08/16/15, $3,800.47
- Loma Linda University Medical Center, 08/15/15 – 10/27/15, $1,622.00
- David Ramin, MD, 02/04/16, $910.00
- Redlands Advanced Imaging, 02/13/16, $2,860.00
- Beverly Radiology Medical Group, 02/13/16, $2,860.00
- Samimi Orthopedic Group, Inc, 02/26/16, $2,255.00

Itemized billing can also be provided

Deposition: _____, November 10, 2017

- Appearances for the Plaintiffs: _____
- Appearances for the Defendants: _____
- Mr. XXX was involved in the subject accident on a Saturday, 08/15/15.
- He had been working for _____ as a driver for four to five months.
- His prior employer was _____ where he worked for a very short time.
- At the time of the accident, he was a driver for _____.
- He drove an 18-wheeler locally. He had a regular run. He drove from Carson to Colton in two turns and came back home.
- He was working about 11 to 12 hours a day at the time of the accident.
- He was currently driving an automatic freight liner. He started his run from Colton to go to Corona and Ontario. He said the most places that he went to, were Temecula. That was the farthest he went.
- Each day, he drove for about five hours. His total workday could be about 12 hours per day.
- The other seven hours were spent waiting, since he was transporting gas to stations and filling up their underground tanks.
- At _____, he was delivering human waste in the tractor and a trailer.
- He slapped some chemicals on the trailer and then preloaded the waste. Then the other drivers took them up to 58 Henderson.
- In the tractor that he was driving, he had to shift the gears and the clutch manually.
- Currently he was driving an automatic, though.
- He was involved in a motorcycle accident in 2011.

- He had injuries from that accident to his chest, jaw, and right knee. His jaw and right knee were cracked. He had a surgery on the right knee with screws. His jaw too had screws.
- He saw the medical providers at Kaiser, Loma Linda for treatment.
- He had injured his right index finger at work at _____. It got smashed.
- With regard to job duties, he had to climb up into the trailer, putting his feet on the tires, grabbing the bars, and climbing into the back. He had to climb up five tires. He did that twice per day.
- He would pick up the 18-wheeler in Colton and head out to Carson.
- He left his home around 5 or 6 in the afternoon and got home at about 5 or 6 am.
- Employment at _____ came to an end in 01/16 when he broke an arm off the trailer. He explained that he did not lift the landing gear high enough and it caught some gravel.
- He returned to work after that incident in January, after a month.
- During that month, he was able to do his job but he was still in a lot of pain in the left foot.
- At the time of the subject accident, he was heading home from the high desert where he had gone to visit his family members in Victorville. He went there on a Friday in the afternoon and spent the night there.
- His motorcycle that was involved in the subject accident was Suzuki.
- The accident happened on 210 eastbound.
- There were four eastbound lanes there.
- He had gotten onto the 210 Freeway from the 15 South.
- At that time, he had completed the transition and was about a mile or two from the 15.
- He entered the fourth lane from 15 and stayed there for about three minutes and then went to the third lane.
- He had been in the number three lane for about five minutes before the accident.
- He had reached a speed of 65 miles.
- He was wearing a protective jacket and a full-faced helmet. It was a DOT compliant helmet.
- The jacket was specifically designed for motorcycle riding.
- He had had his socks and low top Nike Air tennis shoes on.
- He had a scarf over his face.
- Traffic was flowing.
- He did not see the other vehicle before the accident.
- When he was in the middle part of the number three lane, there was a van in front of him going at about 65.
- He had been a quarter mile behind that vehicle immediately before the accident.
- At that time, he got hit from the back. His foot was crushed and he accelerated. His head got hit back sustaining a whiplash.
- The bike was falling and so he had to bring himself back up.

- At that time, he did not know what had happened and he brought the bike back up, and then saw the car that had hit him.
- Then both the drivers pulled over.
- At the impact, his bike started to go down to his right, but he was able to straighten it up.
- His foot was bleeding profusely.
- When he pulled over, the other driver approached him and offered to assist him and also wrapped a shirt around his foot and then gave a ride to the Kaiser facility nearby.
- The other driver stayed with him in the hospital.
- He was there for about three hours.
- His motorcycle was towed and was taken to his house.
- At the hospital, they cleaned his foot and took an x-ray and then wrapped it. They said it was fractured. They gave him crutches and medications.
- He told the medical personnel that his foot went into the car. He testified that his foot actually did not go into the car, but he said that to them, because he wanted to be worked on his foot as that was what he cared about most at that time.
- He said he was rear-ended by the other driver who thought Daniel was splitting lanes.

Form Interrogatories:

- Interrogatory 6.2: Identify each injury you attribute to the incident and the area of your body affected.
- Response 6.2: Left foot pain, left foot laceration, Left 5th metatarsal fracture.
- Interrogatory 6.3: Do you still have any complaints that you attribute to the incident.
- Response 6.3: Low back pain; remaining the same; daily, worsens with activity. Right leg, right knee, right foot; remaining the same; daily, worsens with activity. Loss of comfort, Loss of love; Loss of care; Loss of assistance; Loss of protection – Remaining the same; daily/constantly.
- Interrogatory 6.4: Did you receive any consultation or examination or treatment from a health care provider for any injury you attribute to the incident.
- Response 6.4: _____
- Interrogatory 6.5: Have you taken any medication, prescribed or not, as a result of injuries that you attribute to the incident.
- Response 6.5: Docusate Sodium Loo mg, Norco, ibuprofen, FMGPP Orthopedics, 08/25/15.
- Interrogatory 6.7: Has any health care provider advised that you may require future or additional treatment for any injuries that you attribute to the incident.
- Response 6.7: _____ recommendation left knee and ankle arthroscopic surgery; cost and expense for surgery around $55,000.00..
- Interrogatory 7.1: Do you attribute any loss of or damage to a vehicle or other property to the incident

- Response 7.1: 2004 Suzuki, rear damage, rear wheel and rear side.
- Interrogatory 8.1 Do you attribute any loss of income or earning capacity to the incident
- Response 8.1: Yes.
- Interrogatory 8.2: The nature of your work; (b) your job title at the time of the incident; and (c) the date your employment began
- Response 8.2: Truck driver, driver, 01/2014 to 8/15/2015.
- Interrogatory 8.4: State your monthly income at the time of the incident.
- Response 8.4: Average, $1,200.00/week.
- Interrogatory 20.8: State how the incident occurred, giving the speed, direction, and location of each vehicle involved
- Response 20.8: The responding party was traveling in the #3 lane of the Eastbound 210 Fwy and the defendant's also was in the #3 lane traveling behind responding party. b) the responding party was traveling in the #3 lane of the Eastbound 210 Fwy when the defendant's vehicle struck his bike. Both vehicles pulled over to the right shoulder.

Records prior to Incident:

DATE OF SERVICE: July 30, 2007
Head and neck surgery consultation/Dr. _____
Kaiser Permanente

Assessment:
1. Eustachian tube dysfunction.

DATE OF SERVICE: October 07, 2011
Operative report/ Dr. _____
Medical Center

Indication:
Chief complaint of malocclusion. Right subcondylar fracture status post motorcycle accident approximately four months ago.

Preoperative and postoperative diagnoses:
1. Right subcondylar fracture.
2. Malocclusion.

Procedure:
Bilateral sagittal split osteotomy

Records subsequent to Incident:

DATE OF SERVICE: August 15, 2015
Traffic collision report
Department of California Highway Patrol

Mr. _____ (P1) was driving silver Mazda Miata, 2003 (V1). Mr. _____ (P2) was driving Suzuki GSX, 2004 (V2). P1 was E/B on SR-210, using the right-hand portion of the #3 lane, travelling at approximately 65 mph. V1 was approaching V2 from the rear. For unknown reasons, P1 drove V1 forward, overtaking V2 from the rear. The right side of V1 struck the left foot peg of V2. The impact caused P1's left foot to be pushed inward, puncturing the skin. P2 was able to keep V2 upright and both vehicles came to a stop on the right shoulder. P2 called the auto club(AAA) to pick up his motorcycle. P1 then took P2 to Kaiser Hospital in Fontana for treatment. After being treated medically, P1 drove P2 to his residence.

DATE OF SERVICE: August 15, 2015
Emergency department record/ Dr. _____
Kaiser Permanente

Chief complaint:
Foot pain.

History of present illness:
Moderate left foot pain following am accident. He was riding a motorcycle and trying to make a turn. He turned into another car and his foot went into the wheel of the car. He had a laceration on his left foot.

Physical examination:
Left foot edema and tenderness. There was tenderness at the lateral side of the left foot. There was a 4 cm laceration at the lateral left foot.

ER course:
Laceration was repaired. X-rays of the left foot were obtained. Injection of xylocaine-epinephrine. The fracture was away from the lateral. Tdap was given. Ortho was called and recommended crutches and posterior splint. Crutches were given. He refused splint.

Diagnostics:
Left foot x-ray. Minimally displaced distal fifth metatarsal fracture.

Diagnoses:
1. Left foot fracture.
2. Left foot laceration.

Plan:
Discharged home with Norco and Keflex.

DATE OF SERVICE: August 15, 2015
Orthopedic consult/ Dr. _____
_____ Orthopedics

History
Status post motorcycle injury. Per provider, patient with superficial laceration around the lateral foot 10 cm proximal to the fracture site. Wound had been irrigated and closed. Provider requesting x-ray review and treatment recommendations for fracture care.

Diagnostics
Three views of the left foot show distal 5th metatarsal fracture in acceptable alignment.

Recommendations
Films reviewed without the benefit of examining the patient and relied on the examining physician, ??, to determine the acuity. Recommendations were for laceration care per ER provider, short leg 3-sided splint, non-weight bearing, crutches, and to follow up with Ortho 5-7 days, sooner if needed.

DATE OF SERVICE: August 15, 2015
Left foot x-rays/ Dr. _____
Kaiser Permanente

Clinical history: Foot pain and laceration.

Findings/impressions:
1. There is a mildly displaced fracture at the fifth metacarpal bone.
2. The alignment is satisfactory.
3. No significant joint disease is noted.
4. There is soft tissue swelling on the forefoot.

DATE OF SERVICE: March 7, 2016
Physical therapy initial evaluation/_____
Rebound Physical Therapy

History of present illness:

The patient was referred by _____ for evaluation of injuries sustained in a motor vehicle accident dated 08/15/15. He reported immediate left knee swelling and pain following the accident. He sustained left lateral foot fifth metatarsal fracture. He stated that left knee continued to swell, and walking was limited. He rated his pain at 6/10 in the left knee, ankle, and foot. He was unable to work as a truck driver. The pain was alleviated by ibuprofen and rest.

Physical examination:
Knee range of motion flexion 125 on the right and 115 on the left, extension 0 degrees. Ankle dorsiflexion -2 degrees on the left and 12 degrees on the right, plantarflexion 25 degrees left and 62 degrees right, eversion 30 degrees left and 35 degrees right, inversion 5 degrees left and 40 degrees right. Manual muscle strength testing revealed 4/5 left hip flexors, hip abductor and extensors, 4-/5 knee flexors, knee extensors and ankle dorsiflexors, 3+/5 peroneals. He was unable to do single leg heel raise. Moderate tenderness was noted along the arch of left foot, left ankle medial and lateral sides, left knee medial and lateral sides. Gait was limited due to increase in pain. He had decreased stance time of left lower extremity when fatigued.

Plan:
Therapy was recommended twice a week for six weeks.

DATE OF SERVICE: March 11, 2016 to April 4, 2016

Physical therapy notes
Rebound Physical Therapy

03/11/16, 03/16/16 The patient reported 4/10 left knee and ankle pain.

03/17/16, 03/18/16, 03/22/16 He reported 2/10 left knee and ankle pain.

03/23/16, 03/24/16, 03/28/16 He reported 3/10 left knee and ankle pain.

03/29/16, 03/30/16, 04/04/16 He reported 1/10 left knee and ankle pain.

DATE OF SERVICE: April 4, 2016

Discharge summary
_____ Physical Therapy

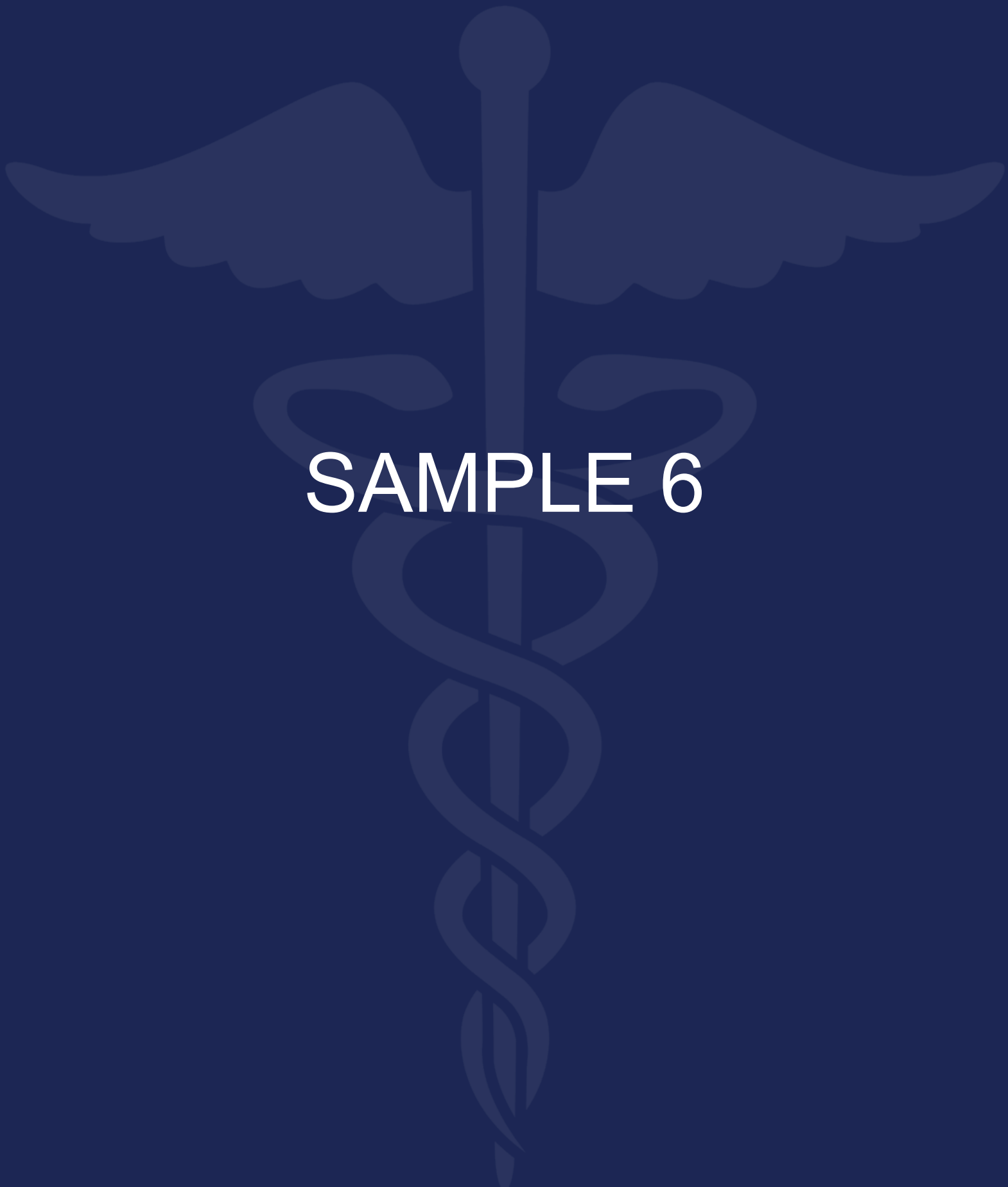
Diagnoses:
1. Left ankle sprain.
2. Left knee pain.

Subjective:

The patient felt overall improvement and rated the pain at 1/10. He anticipated returning to work.

Existing impairments:
Left knee and ankle range of motion within normal limits through all planes. Left ankle eversion 4+/5 compared to 3+/5 at the initial evaluation, all other planes 5/5. Pain in knee with squatting down. Walk/stand tolerance 20 minutes.

Plan:
He successfully met goals and was discharged with a home care and exercise program.



SAMPLE 6

MEDICAL RECORDS REVIEW: _____

Date of Accident: August 15, 2015

Billings:

- Samimi Orthopedic Group, Inc, 03/07/16 – 04/04/16 (therapy) $6,220.00
- Kaiser Foundation Health Plan, 08/15/15 – 08/16/15, $772.00
- Kaiser Foundation Health Plan, 08/15/15, $2,326.35
- Loma Linda University Medical Center, 08/15/15 – 08/16/15, $3,800.47
- Loma Linda University Medical Center, 08/15/15 – 10/27/15, $1,622.00
- David Ramin, MD, 02/04/16, $910.00
- Redlands Advanced Imaging, 02/13/16, $2,860.00
- Beverly Radiology Medical Group, 02/13/16, $2,860.00
- Samimi Orthopedic Group, Inc, 02/26/16, $2,255.00

Itemized billing can also be provided

Deposition: _____, November 10, 2017

- Appearances for the Plaintiffs: _____
- Appearances for the Defendants: _____
- Mr. XXX was involved in the subject accident on a Saturday, 08/15/15.
- He had been working for _____ as a driver for four to five months.
- His prior employer was _____ where he worked for a very short time.
- At the time of the accident, he was a driver for _____.
- He drove an 18-wheeler locally. He had a regular run. He drove from Carson to Colton in two turns and came back home.
- He was working about 11 to 12 hours a day at the time of the accident.
- He was currently driving an automatic freight liner. He started his run from Colton to go to Corona and Ontario. He said the most places that he went to, were Temecula. That was the farthest he went.
- Each day, he drove for about five hours. His total workday could be about 12 hours per day.
- The other seven hours were spent waiting, since he was transporting gas to stations and filling up their underground tanks.
- At _____, he was delivering human waste in the tractor and a trailer.
- He slapped some chemicals on the trailer and then preloaded the waste. Then the other drivers took them up to 58 Henderson.
- In the tractor that he was driving, he had to shift the gears and the clutch manually.
- Currently he was driving an automatic, though.
- He was involved in a motorcycle accident in 2011.

- He had injuries from that accident to his chest, jaw, and right knee. His jaw and right knee were cracked. He had a surgery on the right knee with screws. His jaw too had screws.
- He saw the medical providers at Kaiser, Loma Linda for treatment.
- He had injured his right index finger at work at _____. It got smashed.
- With regard to job duties, he had to climb up into the trailer, putting his feet on the tires, grabbing the bars, and climbing into the back. He had to climb up five tires. He did that twice per day.
- He would pick up the 18-wheeler in Colton and head out to Carson.
- He left his home around 5 or 6 in the afternoon and got home at about 5 or 6 am.
- Employment at _____ came to an end in 01/16 when he broke an arm off the trailer. He explained that he did not lift the landing gear high enough and it caught some gravel.
- He returned to work after that incident in January, after a month.
- During that month, he was able to do his job but he was still in a lot of pain in the left foot.
- At the time of the subject accident, he was heading home from the high desert where he had gone to visit his family members in Victorville. He went there on a Friday in the afternoon and spent the night there.
- His motorcycle that was involved in the subject accident was Suzuki.
- The accident happened on 210 eastbound.
- There were four eastbound lanes there.
- He had gotten onto the 210 Freeway from the 15 South.
- At that time, he had completed the transition and was about a mile or two from the 15.
- He entered the fourth lane from 15 and stayed there for about three minutes and then went to the third lane.
- He had been in the number three lane for about five minutes before the accident.
- He had reached a speed of 65 miles.
- He was wearing a protective jacket and a full-faced helmet. It was a DOT compliant helmet.
- The jacket was specifically designed for motorcycle riding.
- He had had his socks and low top Nike Air tennis shoes on.
- He had a scarf over his face.
- Traffic was flowing.
- He did not see the other vehicle before the accident.
- When he was in the middle part of the number three lane, there was a van in front of him going at about 65.
- He had been a quarter mile behind that vehicle immediately before the accident.
- At that time, he got hit from the back. His foot was crushed and he accelerated. His head got hit back sustaining a whiplash.
- The bike was falling and so he had to bring himself back up.

- At that time, he did not know what had happened and he brought the bike back up, and then saw the car that had hit him.
- Then both the drivers pulled over.
- At the impact, his bike started to go down to his right, but he was able to straighten it up.
- His foot was bleeding profusely.
- When he pulled over, the other driver approached him and offered to assist him and also wrapped a shirt around his foot and then gave a ride to the Kaiser facility nearby.
- The other driver stayed with him in the hospital.
- He was there for about three hours.
- His motorcycle was towed and was taken to his house.
- At the hospital, they cleaned his foot and took an x-ray and then wrapped it. They said it was fractured. They gave him crutches and medications.
- He told the medical personnel that his foot went into the car. He testified that his foot actually did not go into the car, but he said that to them, because he wanted to be worked on his foot as that was what he cared about most at that time.
- He said he was rear-ended by the other driver who thought Daniel was splitting lanes.

Form Interrogatories:

- Interrogatory 6.2: Identify each injury you attribute to the incident and the area of your body affected.
- Response 6.2: Left foot pain, left foot laceration, Left 5th metatarsal fracture.
- Interrogatory 6.3: Do you still have any complaints that you attribute to the incident.
- Response 6.3: Low back pain; remaining the same; daily, worsens with activity. Right leg, right knee, right foot; remaining the same; daily, worsens with activity. Loss of comfort, Loss of love; Loss of care; Loss of assistance; Loss of protection – Remaining the same; daily/constantly.
- Interrogatory 6.4: Did you receive any consultation or examination or treatment from a health care provider for any injury you attribute to the incident.
- Response 6.4: _____
- Interrogatory 6.5: Have you taken any medication, prescribed or not, as a result of injuries that you attribute to the incident.
- Response 6.5: Docusate Sodium Loo mg, Norco, ibuprofen, FMGPP Orthopedics, 08/25/15.
- Interrogatory 6.7: Has any health care provider advised that you may require future or additional treatment for any injuries that you attribute to the incident.
- Response 6.7: _____ recommendation left knee and ankle arthroscopic surgery; cost and expense for surgery around $55,000.00..
- Interrogatory 7.1: Do you attribute any loss of or damage to a vehicle or other property to the incident

- Response 7.1: 2004 Suzuki, rear damage, rear wheel and rear side.
- Interrogatory 8.1 Do you attribute any loss of income or earning capacity to the incident
- Response 8.1: Yes.
- Interrogatory 8.2: The nature of your work; (b) your job title at the time of the incident; and (c) the date your employment began
- Response 8.2: Truck driver, driver, 01/2014 to 8/15/2015.
- Interrogatory 8.4: State your monthly income at the time of the incident.
- Response 8.4: Average, $1,200.00/week.
- Interrogatory 20.8: State how the incident occurred, giving the speed, direction, and location of each vehicle involved
- Response 20.8: The responding party was traveling in the #3 lane of the Eastbound 210 Fwy and the defendant's also was in the #3 lane traveling behind responding party. b) the responding party was traveling in the #3 lane of the Eastbound 210 Fwy when the defendant's vehicle struck his bike. Both vehicles pulled over to the right shoulder.

Records prior to Incident:

DATE OF SERVICE: July 30, 2007
Head and neck surgery consultation/Dr. _____
Kaiser Permanente

Assessment:
1. Eustachian tube dysfunction.

DATE OF SERVICE: October 07, 2011
Operative report/ Dr. _____
Medical Center

Indication:
Chief complaint of malocclusion. Right subcondylar fracture status post motorcycle accident approximately four months ago.

Preoperative and postoperative diagnoses:
1. Right subcondylar fracture.
2. Malocclusion.

Procedure:
Bilateral sagittal split osteotomy

Records subsequent to Incident:

DATE OF SERVICE: August 15, 2015
Traffic collision report
Department of California Highway Patrol

Mr. _____ (P1) was driving silver Mazda Miata, 2003 (V1). Mr. _____ (P2) was driving Suzuki GSX, 2004 (V2). P1 was E/B on SR-210, using the right-hand portion of the #3 lane, travelling at approximately 65 mph. V1 was approaching V2 from the rear. For unknown reasons, P1 drove V1 forward, overtaking V2 from the rear. The right side of V1 struck the left foot peg of V2. The impact caused P1's left foot to be pushed inward, puncturing the skin. P2 was able to keep V2 upright and both vehicles came to a stop on the right shoulder. P2 called the auto club(AAA) to pick up his motorcycle. P1 then took P2 to Kaiser Hospital in Fontana for treatment. After being treated medically, P1 drove P2 to his residence.

DATE OF SERVICE: August 15, 2015
Emergency department record/ Dr. _____
Kaiser Permanente

Chief complaint:
Foot pain.

History of present illness:
Moderate left foot pain following am accident. He was riding a motorcycle and trying to make a turn. He turned into another car and his foot went into the wheel of the car. He had a laceration on his left foot.

Physical examination:
Left foot edema and tenderness. There was tenderness at the lateral side of the left foot. There was a 4 cm laceration at the lateral left foot.

ER course:
Laceration was repaired. X-rays of the left foot were obtained. Injection of xylocaine-epinephrine. The fracture was away from the lateral. Tdap was given. Ortho was called and recommended crutches and posterior splint. Crutches were given. He refused splint.

Diagnostics:
Left foot x-ray. Minimally displaced distal fifth metatarsal fracture.

Diagnoses:
1. Left foot fracture.
2. Left foot laceration.

Plan:
Discharged home with Norco and Keflex.

DATE OF SERVICE: August 15, 2015
Orthopedic consult/ Dr. _____
_____ Orthopedics

History
Status post motorcycle injury. Per provider, patient with superficial laceration around the lateral foot 10 cm proximal to the fracture site. Wound had been irrigated and closed. Provider requesting x-ray review and treatment recommendations for fracture care.

Diagnostics
Three views of the left foot show distal 5th metatarsal fracture in acceptable alignment.

Recommendations
Films reviewed without the benefit of examining the patient and relied on the examining physician, ??, to determine the acuity. Recommendations were for laceration care per ER provider, short leg 3-sided splint, non-weight bearing, crutches, and to follow up with Ortho 5-7 days, sooner if needed.

DATE OF SERVICE: August 15, 2015
Left foot x-rays/ Dr. _____
Kaiser Permanente

Clinical history: Foot pain and laceration.

Findings/impressions:
1. There is a mildly displaced fracture at the fifth metacarpal bone.
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Physical therapy initial evaluation/_____
Rebound Physical Therapy

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Plan:
Therapy was recommended twice a week for six weeks.

DATE OF SERVICE: March 11, 2016 to April 4, 2016
Physical therapy notes
Rebound Physical Therapy

03/11/16, 03/16/16 The patient reported 4/10 left knee and ankle pain.

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03/29/16, 03/30/16, 04/04/16 He reported 1/10 left knee and ankle pain.

DATE OF SERVICE: April 4, 2016
Discharge summary
_____ Physical Therapy

Diagnoses:
1. Left ankle sprain.
2. Left knee pain.

Subjective:

The patient felt overall improvement and rated the pain at 1/10. He anticipated returning to work.

Existing impairments:
Left knee and ankle range of motion within normal limits through all planes. Left ankle eversion 4+/5 compared to 3+/5 at the initial evaluation, all other planes 5/5. Pain in knee with squatting down. Walk/stand tolerance 20 minutes.

Plan:
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