10/23/02

To whom it may concern:
I Theresa Williams is writing this letter on behalf of my accident. I'm seeking $6,000 for my pain and suffering plus my medical bills which plus should be separate from my medical bills.

Please see attach for details TW.

Thank You
Theresa Williams
M. Williams

CITY OF MILWAUKEE
02 NOV 27 AM 9:11
RONALD D. LEONHARDT
CITY CLERK

RECEIVED
CITY ATTORNEY'S OFFICE
02 NOV 27 PM 3:41

...or proper documentation and handling of yo... injuries. Please be patient and ... This will help the doctor diagnose and manage your injuries most effectively. The staff and ... you if needed. - **Thank you very much.**

...TION-TYPE OF INJURY (CC)

...ury	___Machine Related	___Vehicle Related, Bicycle/Other
...ical	___Pedestrian/Vehicle	___Vehicle Related, Bus-County
...ness	___Repetitive Motion	___Vehicle Related, Bus-Other
...se of Structure	X Slip and Fall	___Vehicle Related, Bus-School
...Strain Something		___Vehicle Related, Commercial (Airplane, Ship
...Emotional Distress		...ubway, Train, Other)
...Falling Objects	___Vehicle Related-Auto (MVA)	___Vehicle Related, Motorcycle
...Gas/Fumes Exposure	___Vehicle Related-Boat	___Work Accident

___Other Accident: I fell and foot went into hole.

I.E-WAS A POLICE REPORT FILED? ____No ____By Police ____By Myself ____By Other: ____

I.F-WAS AN INCIDENT REPORT FILED? ____No ____Yes By ____

Location of accident: ____

Comment: ____

II.A) Describe How Accident Happened And How You Were Injured In This Accident.

I Theresa Williams was walking and I did not see the hole that's in the grass on the cross area. My right foot went into the hole and I fell down on both of my knees, my left chest area which is my breast. When I tried to catch myself [redacted] my middle finger on my left hand and my finger nail took completely off. I was in severe pain from the fall and from my finger nail being torn off.

Patient Name: Accident Code:

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

#2-First Hit #1_____ Relative Size to #1: ___smaller ___same size ___larger

Driver Details: M F ? Teens 20's 30's 40-50's 60-70's 80+ ?

Vehicle Status: __A/B out Vehicle Was: __unknown __left __driven away __pushed/pulled away __towed __hit & run ?

Visible Damage: __unknown __none __little __some __moderate __lot __totaled Dollar Damage: $_____

__front end __rear end __driver side __passenger side __roof __underneath

#3_____ #4_____

Other Details/Description of Accident and Injuries (Draw diagram of vehicular accident or write description of other type of accident):

- on 18th a Finn,
- hole in the ground, grassy
- slat
- walking (R) foot into hole & fell over onto face/chest/knees
- (R) hand hit ground, both knees, (R) breast hit dirt, hit lips
- able to get up by self & took about 1 minute,

How Patient Was Injured In MVA (☐ see above):

Prep. for Impact: Muscles tensed: __No __Some __Lot ? Neck/Head Facing: __ahead __left __right __up __down

Back/torso leaning twist/facing: __ahead __lean/twist to left __lean/twist to right __lean forward ___slouched

Motion Due to Impact: __forward/back direction __sideways direction __vertical direction __twist_____

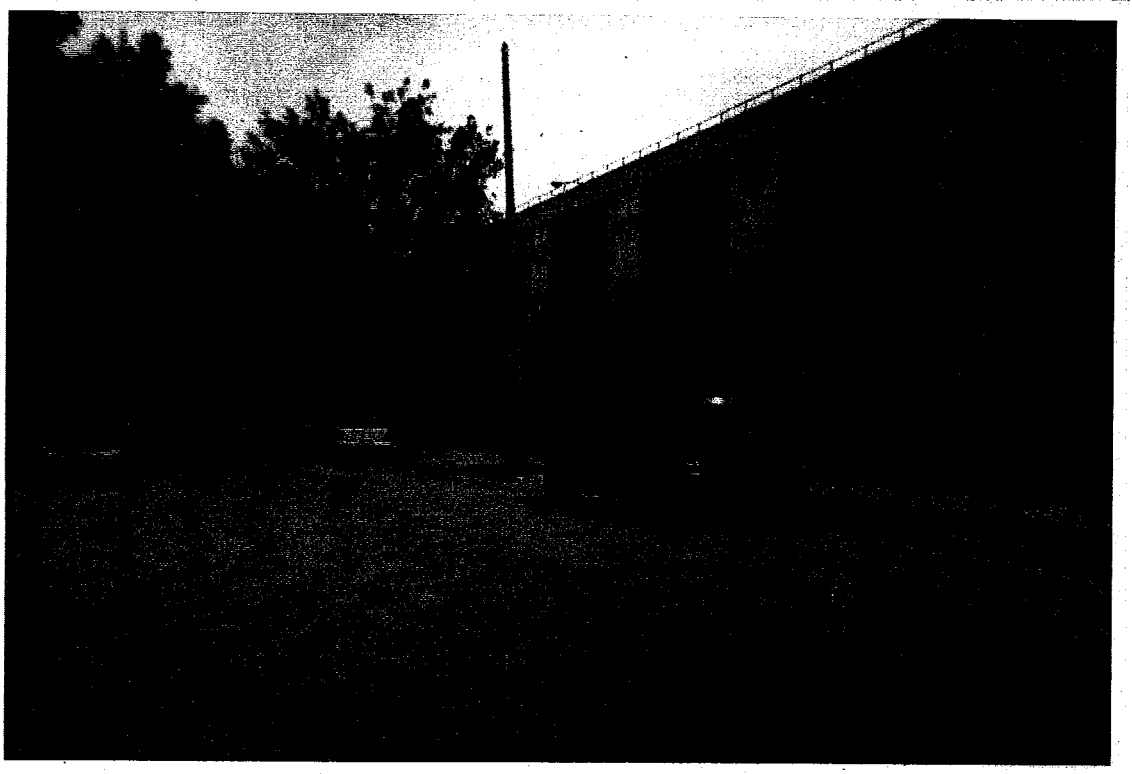
__remained in seat __out of seat/back in __out of seat_____

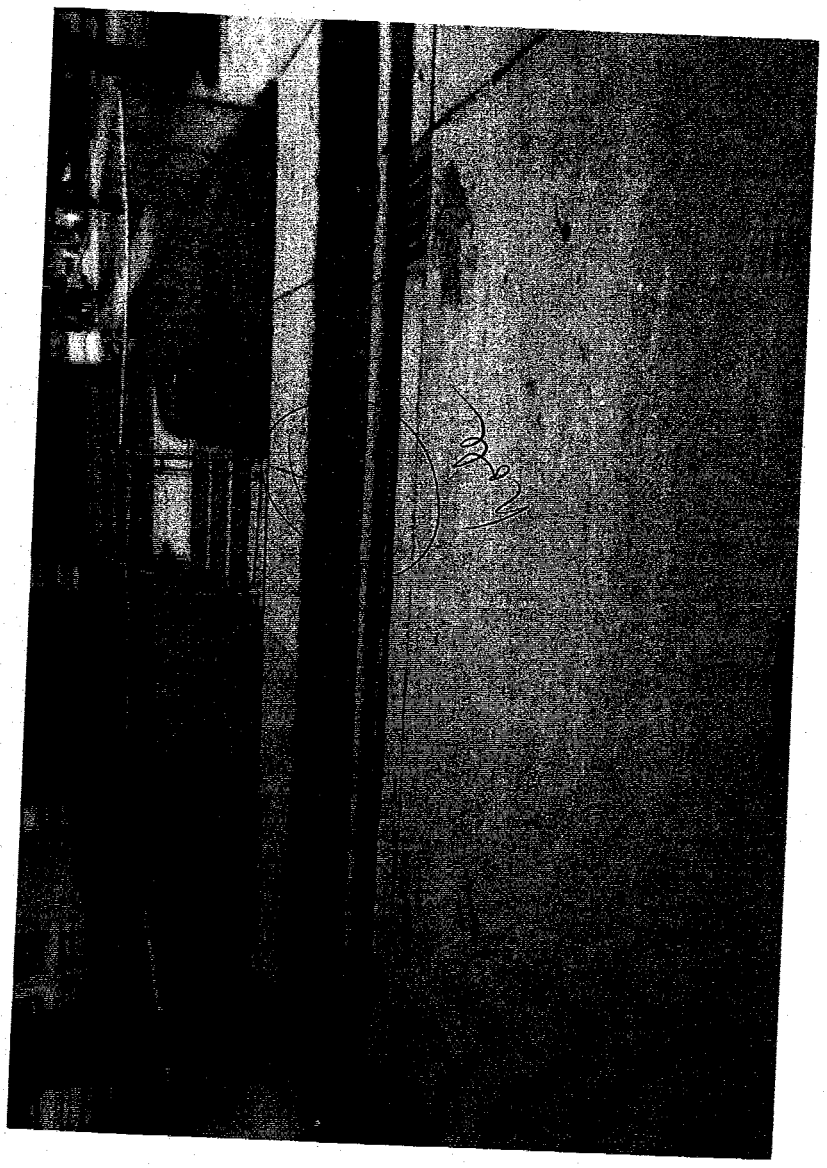
Direct Hit: __none or none recalled

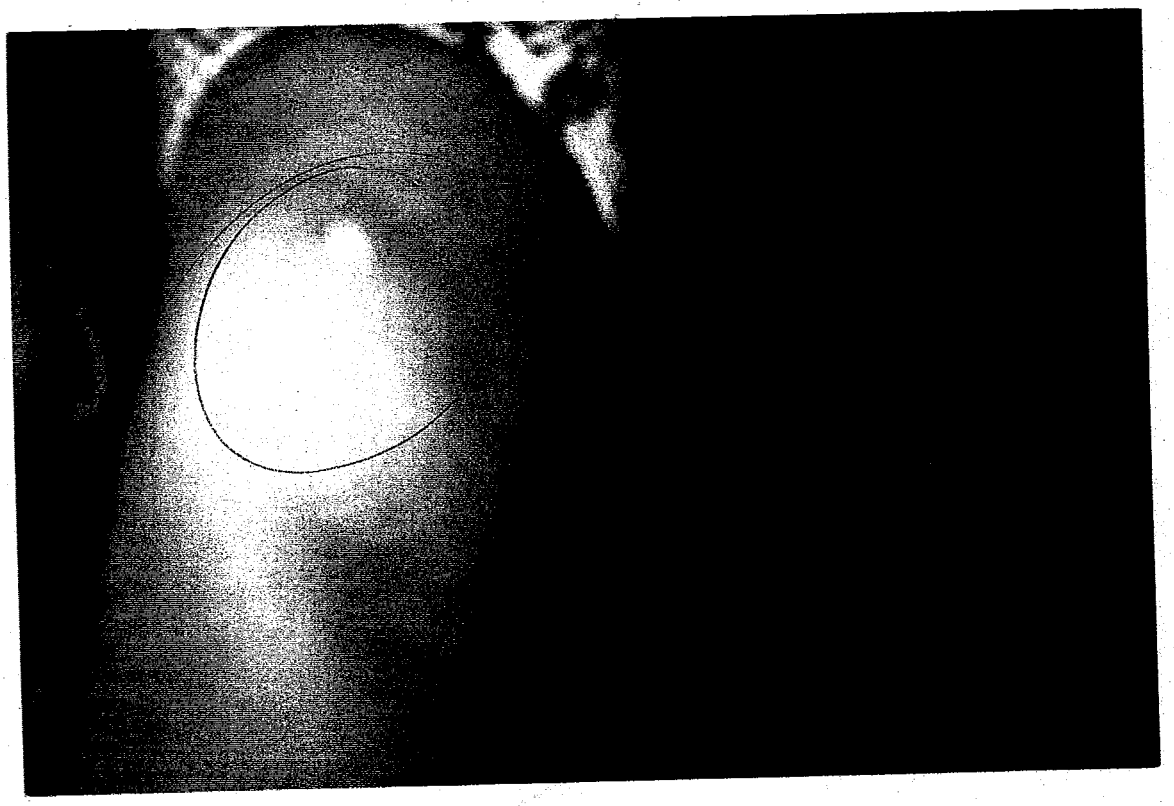
Jerk/snap/pop/twist/whipped/cracked: __none or none recalled

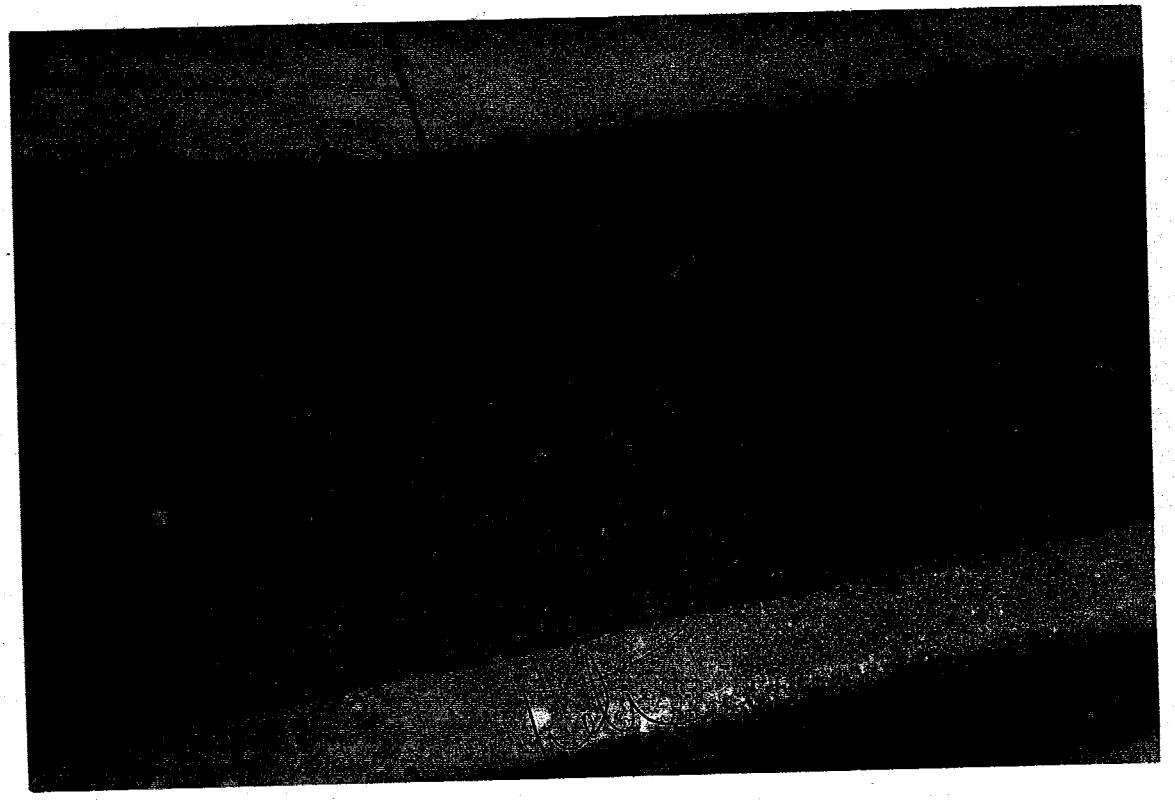
Jammed/push: __none or none recalled

Other Possible Mechanism(s) of Injury of Patient:_____

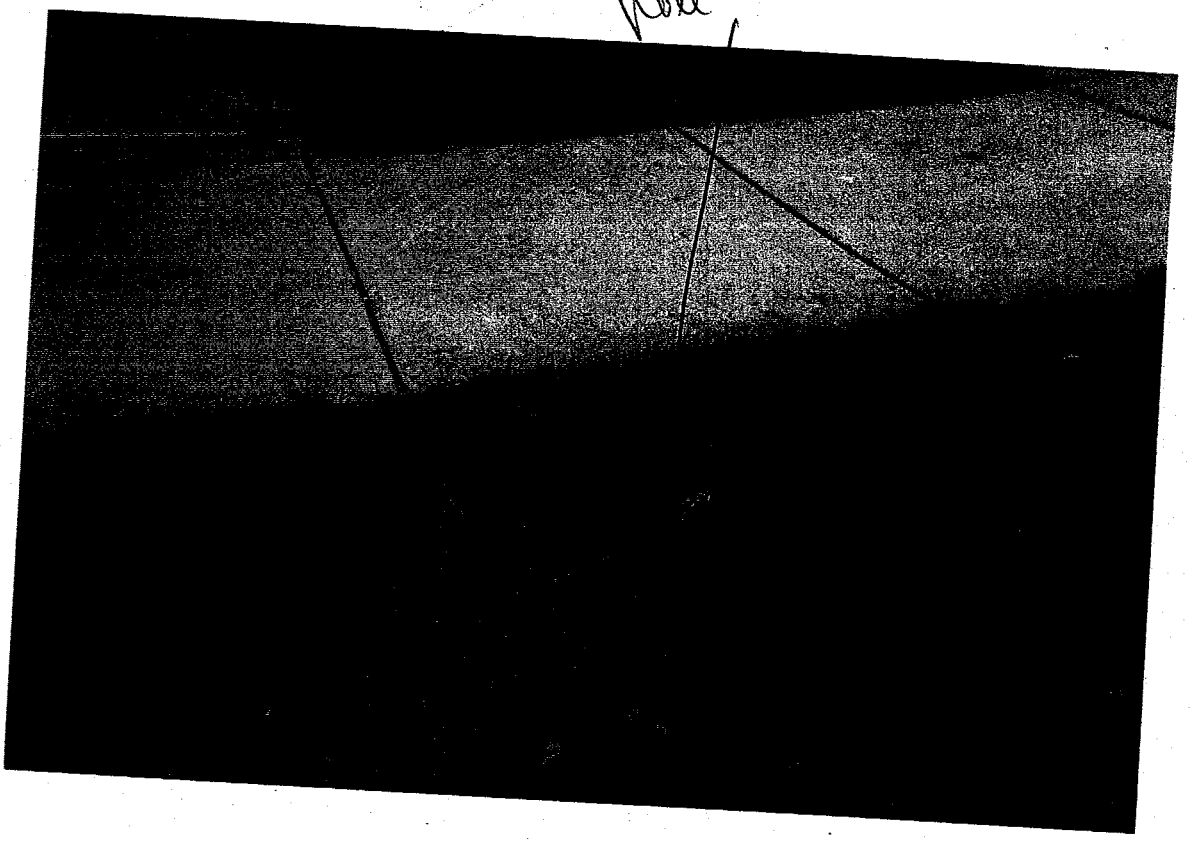


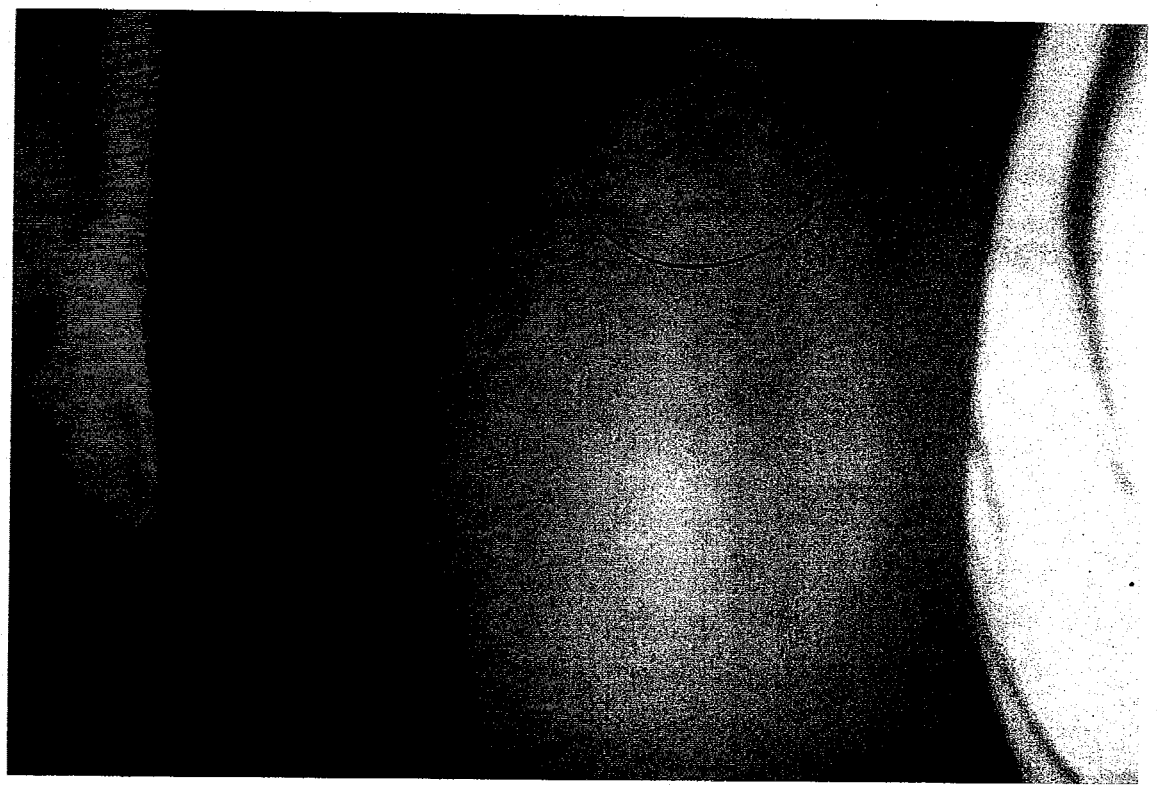


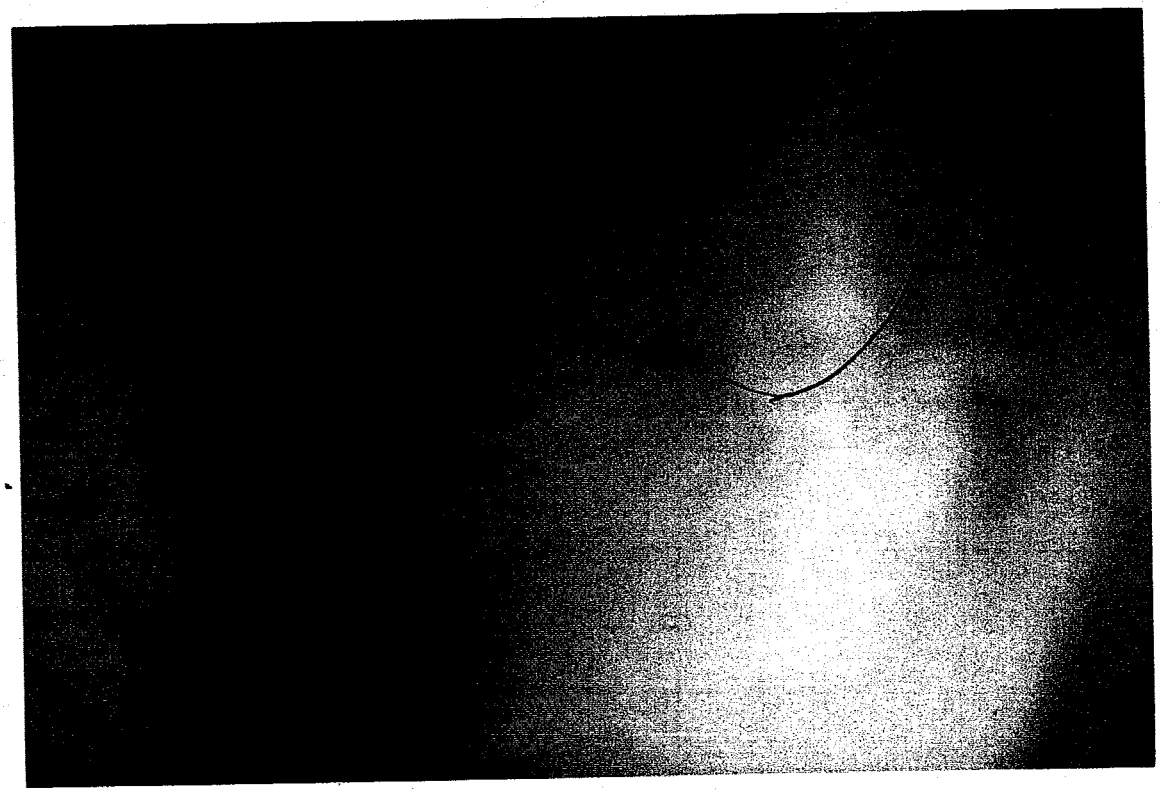




pole







MFM Medical Clinic
Offfice: 5140 N. Teutonia Avenue Mailing: PO Box 090498
Milwaukee, WI 53209
414-535-0072 fax 414-535-0450

Certification of Records/Billing

Todays Date: 10/10/200

Patient Information:

Accident Code	0211676
Patient Number	10405
Patient Name	THERESA A WILLIAMS
Date of Birth	8/7/1972

Date of Injury 7/26/2002 All Dates of Service: 7/30/2002 to 10/10/2002

We are sending: [X] Records for all dates of service

[ ] Records for the following dates of service

[ ] to [ ]

I, Janice Moreland, custodian of the medical records/bills for MFM Medical Clinic, do hereby certify that the attached photographic copy of the records and bills of

THERESA WILLIAMS

constitute a complete, accurate and legible duplication of the original on file.

Janice Moreland
Clinic Director
Records Custodian

Todays Date: 10/10/2002

Factors Known To Affect Falls 10/10/200

	Description of Fall Factor Rating(0 or empty is not present; 1-slight/minor, 2-mild/mod, 3-severe)	Rating
1	Blind or legally blind	
2	Poor eyesight but not legally blind	
3	Hard of hearing	
4	Neuropathy involving feet/legs	
5	Motor deficit lower extremities	
6	Motor deficit upper extremities	
7	Amputation lower extremities	
8	Amputation upper extremities	
9	Cerebellar Dysfunction	
10	Arthritis of hips/knees/legs	
11	Carrying/pushing/pulling objects one or both arms/hands	
12	Unaware of conditions of surface/area of fall	3.0
13	Very young-less than 12 years old	
14	Very old, over 70 or fragile elderly	
15	Disabled	
16	Using walker/cane/crutch	
17	In cast/splint/prosthesis/other device	
18	In wheelchair	
19	Lack of warning of abnormal status of surface	
20	Debris on surface(eg, paper, fragments glass-wood,etc, small trash)	3.0
21	Objects on surface larger than debris	
22	Strips/attachments/carpeting irregular or out of place	
23	Foreign substance on surface decreasing friction	
24	Foreign substance on surface increasing friction	
25	Surface made of material with low friction	
26	Pieces of wood/metal/other protruding out of surface abnormally	
27	Surface irregular visibly	
28	Surface irregular camouflaged	
29	Surface slanted upwards in direction of initial motion	
30	Surface slanted downwards in direction of initial motion	
31	Surface slanted sideways to left or right	
32	Surface with holes/pieces missing visible or not visible	
33	Steps/stairs irregular or pieces missing	
34	No hand support railing or railing/support broken/loose	
35	Surface very hard/rough	1.0
36	Poor surface of shoes	
37	Shoestrings/other untied	
38	Presence of shorts/minimal clothing	
39	Pants/skirts over shoes onto surface	
40	Loose shoes	
41	Very cold	
42	Very windy	
43	Contact with or by others in immediate area	
44	Area poorly lit	
45	Nigthtime conditions	
46		
47		
48		
49		
50		

Accident Code 0211676

Patient Number 10405

Date of Injury 7/26/2002

THERESA

WILLIAMS

Age 30.0

Sex Female

DOB 8/7/1972

Height in Inches 62.5

Weight in Pounds 133.0

Total Number Fall Factors Present

3.0

Sum of Fall Rating Factors

7.0

Average Fall Rating Per Factor

2.3

M F M M e d i c a l C l i n i c

5140 N Teutonia Avenue, Milwaukee, WI 53209(mailing:PO Box 090498)
414-535-0072 414-535-0450(fax) mfmenter@earthlink.net(e-mail)

Invoice for Services Rendered-All Services

Date 10/10/2002

Invoice Number 0211676

BARRY CYMERMAN,JD
LAW OFFICE OF PETER DONOHUE
610 SOUTH 5TH STREET
MILWAUKEE, WI 53204
414-272-2284

Primary Provider:
James Flowers,MD,MPH

ICDM

Code	Description
920.9	CONTUSION - FACE/SCALP/NECK
924.9	CONTUSION-LOWER LIMB
922.9	CONTUSION-TRUNK
923.9	CONTUSION-UPPER LIMB
845.0	SPRAIN-ANKLE
879.8	WOUND W/O COMPLICATIONS

Patient and Injury Details:

Patient Number: 10405 **Accident Code** 0211676
THERESA A WILLIAMS
4669 N 20TH STREET
MILWAUKEE, WI 53209
414-445-1352
DOB: 8/7/1972 **SSN:** 396-78-2531
DOI: 7/26/2002 **Type:** SLIP AND FALL **WC** No
Contact Patient Number
Insurance Patient Number

Case Status CLOSED AND NOT PAID
Company Tax ID No: 39-1904353

Date of Service	Code	CPT Code	Service Description	Service Charge
7/30/2002	4	99205	OFFICE VISIT-NEW COMPREHENSIVE	$269.00
8/1/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	304	97010	HOT PACK SINGLE SITE	$32.00
8/8/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	313	97110	THERAPEUTIC EXERCISE	$57.00
	342	97024	MAGNATHERMY ELECTROMAGNETIC DEEP	$43.00
8/13/2002	313	97110	THERAPEUTIC EXERCISE	$57.00
	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	304	97010	HOT PACK SINGLE SITE	$32.00
8/16/2002	313	97110	THERAPEUTIC EXERCISE	$57.00
	316	97022	FLUIDOTHERAPY/DRY WHIRLPOOL	$69.00

Date of Service	Office Code	CPT Code	Service Description	Service Charge
8/20/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	313	97110	THERAPEUTIC EXERCISE	$57.00
	342	97024	MAGNATHERMY ELECTROMAGNETIC DEEP	$43.00
8/23/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	304	97010	HOT PACK SINGLE SITE	$32.00
8/29/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	304	97010	HOT PACK SINGLE SITE	$32.00
9/3/2002	303	97124	MECHANICAL SOFT TISSUE MASSAGE	$38.00
	304	97010	HOT PACK SINGLE SITE	$32.00
	313	97110	THERAPEUTIC EXERCISE	$57.00
9/10/2002	8	99213	OFFICE VISIT-EST LIMITED	$81.00
10/10/2002	12	99215	OFFICE VISIT-FINAL COMPREHENSIVE	$215.00

Case Summary: THERESA A WILLIAMS **DOB:** 8/7/1972 **DOI:** 7/26/2002

First Date of Service	7/30/2002	Total Summary Case Charges	$1431.00
Last Date of Service	10/10/2002	Total Payments	
Date Closed	10/10/2002		
Summary of Case Visits	11		
Summary Number of Case Services	23	**Balance Due**	**$1431.00**

Summary of Injuries and Recovery 10/10/2002

Accident Code	0211676	Patient Number	10405	Date of Injury	7/26/2002
Type of Injury	SLIP AND FALL	WC	No	Dollar Damage Estimate	

THERESA **WILLIAMS**

8/7/1972	30.0	Black	Female

Height in Inches	62.5	Head Circumference (in)	
Weight in Pounds	133.0	Head to Neck Ratio	
BMI	23.9	Li Index 24.7	Neck Length
			Head Anterior to COG

Neck Circumference (in)

Diagnoses, Severity, Final Status of Injuries

AOF Initial	AOF Final
75.0	94.0
AOF % Change	25.3%
AOF Deficit	25
AOF Deficit Improvement	76.0%
Total Diagnoses	6
Total Severity	10
Average Severity	1.67
Sum of Final Status Scores-Final Severity	1.0
Average Final Status Score-Average Severity	0.2
Percent Improvement In Severity Deficit	90.0%

Office Code	ICDM Code	Description	DIAGNOSIS SEVERITY CODE	Diagnosis Final Status Code
65	920.9	CONTUSION - FACE/SCALP/NECK	1	0.0
66	924.9	CONTUSION-LOWER LIMB	2	1.0
67	922.9	CONTUSION-TRUNK	2	0.0
68	923.9	CONTUSION-UPPER LIMB	1	0.0
105	845.0	SPRAIN-ANKLE	2	0.0
124	879.8	WOUND W/O COMPLICATIONS	2	0.0

Summary of Injuries and Recovery 10/10/2002

Range of Motion Measurements Initial and Final

ROM Descriptions	Initial	Final	Percent Change
Neck -**Total** Rotation	110.0	140.0	27.3%
Neck-**Total** Lateral Bending			
Neck-**Total** Forward Backward Flex/Extension			
Right Shoulder-Abduction	175.0	160.0	-8.6%
Right Shoulder-External Rotation			
Right Shoulder-Internal Rotation			
Right Shoulder-Forward Flexion			
Left Shoulder-Abduction	170.0	165.0	-2.9%
Left Shoulder-External Rotation			
Left Shoulder-Internal Rotation			
Left Shoulder-Forward Flexion			
Right Elbow-Combined Flexion/Extension			
Left Elbow-Combined Flexion/Extension			
Right Wrist-Combined Flexion/Extension			
Left Wrist-Combined Flexion/Extension			
LS Spine Forward Flexion(uncorrected)	80.0	80.0	0.0%
Right Hip-Combined Internal/External Rotation			
Left Hip-Combined Internal/External Rotation			
Right Knee-Combined Flexion/Extension			
Left Knee-Combined Flexion/Extension			
Right Ankle-Combined Dorsi/Plantar Flexion			
Left Ankle-Combined Dorsi/Plantar Flexion			
Straight Leg Raising-Right ,Lying			
Straight Leg Raising-Left , Lying			
Deep Knee Bend(squat)-0 degrees vertical thigh	55.0	90.0	63.6%
Grip Right Hand (in pounds)	54	58	7.4%
Grip Left Hand(in pounds)	69	62	-10.1%
Pinch Right Hand(in pounds)			
Pinch Left Hand(in pounds)			

Total Count Changes of Case ROM	Total Case Percent Change Degrees ROM	Average Percent Case ROM Change
5.0	79.4%	15.9%

MFM Medical Clinic
Offfice: 5140 N. Teutonia Avenue Mailing: PO Box 090498
Milwaukee, WI 53209
414-535-0072 fax 414-535-0450

Invoice Number: 0211676 NM **10/10/2002**

Accident Code 0211676 **DOB** 8/7/1972 **Date of Injury** 7/26/2002

Patient Number 10405 **SSN** 396-78-2531

THERESA WILLIAMS **Type of Injury** SLIP AND FALL

4669 n 20th street

MILWAUKEE, WI 53209 **WC** No

Billed To: 80015 **Contact Patient Number**

Barry Cymerman,JD
610 South 5th Street **Insurance Company Patient Number**
Milwaukee, WI 53204

Non-Medical Case Expenses

Payment Due Upon Receipt

Service Description	Date	Hourly Rate	Hours	Total Fee
Fee For Medical Records				$19.25
Postage Shipping Handling Fee				$2.75
Special Fee Medical Records Handling				
Fee For Final or Initial Narrative	Initial:		Final:	
Fee For Custom Narrartive				
Fee For Deposition With Case Review		$300.00		
Minimum Fee Deposition With Case Review $500.00				
Fee For Court Appearance/Case Review		$375.00		
Minimum Fee Court Appearance $750.00				
Fee For Conference Call Meeting		$175.00		
Minimum Fee Conference Call Meeting $100.00				
Fee For Independent Medical Examination		$325.00		
Minimum Fee Independent Medical Examination $500.00				

Total NonMedical Fees	$22.00
Total Nonmedical Payments	
Nonmedical Payment Writeoff	
Balance Due Nonmedical Payments	$22.00

Comments:

MFM Medical Clinic
Offfice: 5140 N. Teutonia Avenue Mailing: PO Box 090498
Milwaukee, WI 53209
414-535-0072 fax 414-535-0450

Invoice Number: 0211676 NM **10/10/2002**

Accident Code 0211676 **DOB** 8/7/1972 **Date of Injury** 7/26/2002

Patient Number 10405 **SSN** 396-78-2531

THERESA WILLIAMS **Type of Injury**

4669 n 20th street SLIP AND FALL

MILWAUKEE, WI 53209 WC No

To: BARRY CYMERMAN,JD **Balance Due** **$1431.00**

MFM Billing and Collecting Policy

MFM Medical Clinic is committed to serving the residents of the central city of Milwaukee. Our clinic has developed practice protocols and management procedures that allows us to provide first rate services in the area of personal injury and workman's compensation. To remain competitive and grow, we must receive fair and timely reimbursement for our services. Additionally, the AMA and other medical societies have certain ethical standards for physician billing and collection of fees-these require that we collect fees for services rendered independent of settlements. Our fees are fair and consistent with area fees as determined by the many worker's compensation data bases. We insure that all of our services are medically necessary for the injuries sustained.

With the above in mind, the policies of MFM regarding personal injury and worker's compensation billing and collections are as follows:

1) MFM **does not accept any contingency of fees** as a percent of settled cases;
2) MFM **expects full payment of our fees at 100%** of our charges;
3) MFM **does not accept any partial or percentage payment less than the greatest percent of charges paid to any other health provider**; this includes hospitals, emergency rooms, and other primary or specialty physicians;
4) If full fees are not paid via the attorney or insurance company, MFM reserves the right to collect the balance from the patient or other insurance company. MFM reserves the **right to bill any other insurance immediately** and expects the patient and representative to provide the proper information to do so;
5) MFM **recognizes that all patients cannot afford medical care** and would either forgo treatment or suffer significantly financially if forced to pay. Please see the 'Payment of Fees Waiver' form that is included;
6) If the MFM charges **cannot be paid in full, our office should be contacted** to discuss the individual particulars of the fee payment;
7) Since the personal injury business is unique in health care, MFM asks that each negotiating **attorney agree to make reimbursement as soon as funds are obtained.** In no instance, unless our office is contacted, **should this exceed more than 14 days** from the time the patient receives the settlement. If a payment is made to your client, and our fees are not paid within 14 days, then we will make our complete bill due immediately and will procede to collections. We reserve the right to make contacts with your office and the patient to protect our fees;
8) In any instance in which our **fees cannot be properly paid from the insurance settlement**, we ask that you and the patient **provide us with any insurance** that we may bill to collect our fees;
9) **Non-medical Case Expenses are due within 30** days of billing;
10) Any **deposition, court appearance or other non-medical services charges** are expected to be **paid in full within 30 days** of billing and are **not contingent on the case outcome;**
11) MFM will defer direct collections from the patient until the case 'settles' as long as the above are being met.

If you have any questions, please contact myself.

Janice Moreland, Clinic Director

MFM Medical Clinic
Offfice: 5140 N. Teutonia Avenue Mailing: PO Box 090498
Milwaukee, WI 53209
414-535-0072 fax 414-535-0450

Invoice Number: 0211676 NM **10/10/2002**

Accident Code 0211676 **DOB** 8/7/1972 **Date of Injury** 7/26/2002

Patient Number 10405 **SSN** 396-78-2531

THERESA WILLIAMS **Type of Injury** SLIP AND FALL

4669 n 20th street WC No

MILWAUKEE, WI 53209

Payment of Fees Waiver

Balance Due **$1431.00**

This form is to be completed and returned only if the payment of MFM's medical fees is not at 100% of charges.

The **AMA requires that physicians bill and collect fees** based on services rendered and **not on any contingency** arrangements of any type. MFM has set **fees that are consistent with area charges** and MFM makes sure **all services rendered are medically necessary**. Therefore, MFM **expects payment at 100%** of all fees billed. Additionally, MFM is committed to serving the residents of its geographic area. The reality is that all individuals in this area cannot afford medical care and would forego it if required to pay. It is the **policy of MFM to forego fees in those situations where patient payment would result in undue hardships**, the forfeiture of basic requirements of life, food/shelter/clothing/etc, or the forfeiture of needed medical care. MFM only asks that the patient and the attorney affirm this is the case by signing and returning this form to our office. If this form is not returned, then we assume the patient can afford to pay that portion not covered by insurance and will be billed accordingly.

I, Theresa A Williams or my legal guardian as signed below, do attest to to the following as correct and true(check **all the true** responses):

☐ **I can afford to pay the balance** not paid by insurance and will pay as follows
- ○ the full remaining balance immediately
- ○ I have other insurance I want you to bill first and will provide the information
- ○ $20.00 per month on the balance until paid
- ○ $50.00 per month on the balance until paid
- ○ $100.00 per month on the balance until paid
- ○ $ per month on the balance until paid

☐ **I cannot afford to pay the balance** not paid by insurance because to do so would have caused or will cause the following or is true (check all that apply)
- ○ I would have to forgo essentials such as rent/food/basic clothing
- ○ I would not have received the medical treatment due to no funds
- ○ I would be forced into bankruptcy
- ○ I have no source of income
- ○ My income is at or below the poverty level or am disabled
- ○ Other:_____

Signature Patient or Guardian:_____ Date:_____

Signature Attorney/Representative:_____

MFM Medical Clinic
Offfice: 5140 N. Teutonia Avenue Mailing: PO Box 090498
Milwaukee, WI 53209
414-535-0072 fax 414-535-0450

Please Use Our Records Efficiently

Accident Code	**0211676**
Patient Number	**10405**
Patient Name	**THERESA A WILLIAMS**
Date of Birth	8/7/1972

Date of Injury **7/26/2002** **All Dates of Service:** **7/30/2002** **to** **10/10/2002**

The records for the above patient are comprehensive and contains a huge amount of useful information. It is not possible to explain all the information that is to be found in the records on a single sheet of paper. We have prepared a comprehensive explanation of the MFM records and how to use them. So, you may better serve your client, patient, insured or other, we sincerely suggest you review the the booklet on MFM records entitled, "***Description of Personal Injury/Worker's Compensation Medical Records", 55 pages.*** If you do not have a copy of this and want to understand the MFM record system, then call or write or fax us for a copy. There is no charge.

Thank you.

Janice Moreland, Clinic Director

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.** 22

PART D-Final Visit

Date: 10-10-02

(IX) **Doctor only dictate the summaries from the reports**

EMERGENGY/CLINIC(PHMS,MDM): ___NONE X PLEASE REVIEW THE ACTUAL REPORTS
DIAGNOSTIC RESULTS(PMSH,HPI,MDM: ___NONE X PLEASE REVIEW THE ACTUAL REPORTS
CONSULTS(PMSH,HPI, MDM): ___NONE X PLEASE REVIEW THE ACTUAL REPORTS

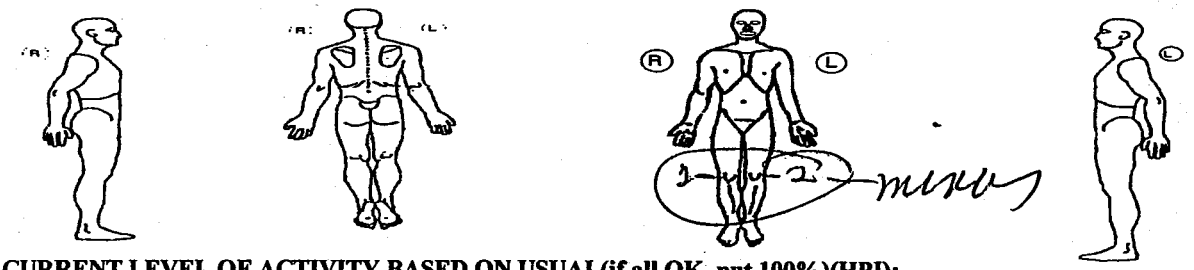
(X) **Doctor dictate the therapy modalities the patient received and review all interim visits.**

(XI) **Doctor dictate the summary days off from work and school** some work/OK missed no days

WORK(HPI) and SCHOOL TIME OFF:
PLEASE REFER TO THE INDIVIDUAL VISIT SHEETS FOR ADDITIONAL TIME OFF AND TO THE INDIVIDUAL WORK/SCHOOL PRESCRIPTIONS

(XII)CC: some knee pains/.

Patient's Residual Pain(HPI)? Rate each residual area from 0-10 if permanency (See page26) **No Pains/No Problems**



CURRENT LEVEL OF ACTIVITY BASED ON USUAL(if all OK, put 100%)(HPI):

As of today, I am performing 90 % of my **usual *home/child/personal cares*** without injury symptoms.
As of today, I am performing 95 % of my **usual *job/school*** without injury symptoms. ___None
As of today, I am performing 90 % of my **usual *exercise/hobbies*** without injury symptoms. ___None

(**For all below**: each refers to the extent of problems or symptoms present with activity/symptoms: **none** =no problems/symptoms; **little**=little problems/symptoms; **some**=some problems; **lot**=lots of problems)

SYMPTOM AND FUNCTIONAL RATING SCALE for Groups III and IV and Areas of Function

Symptoms/Complaints(PCS) Circle how much affected: None Little Some Lot

Check(√) Each Of The Symptoms You Are Experiencing **Due To The Accident.** O None (0)

__Concentration, Loss Of	__Dazed Sensation	__Disorientation	__Dizzy/Lightheaded
__Ears, Ringing In	__Faint Sensations	__Lights, Avoid Bright	__Memory Lapses
__Spinning Sensation	__Sounds, Avoid Loud	__Thinking, Difficulty	

Symptoms/Complaints(PTS) Circle how much affected: None Little Some Lot

Check(√) Each Of The Symptoms You Are Experiencing **Due To The Accident.** ___None (0)

__Anxious/Afraid In Similar Situations	__Avoid Accident Conditions (e.g., cars)	__Avoid Accident Scene
__Down and Out, More Than Usual	__Dreams, Bad	__Dying, Had Fear Of During Acc.
__Helpless/Horror, Feeling Of	__Hyperactivity, New or Increased	__Irritability, New or Increased
__Jumpy/On Edge, New or Increased	__Nightmares	__Startles More Easily
√Talks Lot About Accident	__Thoughts of Accident Stay In Head	__Wetting, Bed New or Increased
__Wetting, On Clothes, New or Increased		

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

AREAS OF FUNCTION(Circle the word that most closely describes how this accident is affecting you.)

Note: Check how this accident is affecting you now and not how you may have been affected before or at beginning of this accident.

DRIVING(Circle none if you do not drive)	None	Little	Some	Lot
EXERCISE(not just work or usual walking, regular true exercise which you were doing)	None	Little	Some	Lot
HOBBIES/RECREAT.(eg, sewing, gardening, fishing, pool, cards, bingo, music, dancing, skating, bowling, video games, computer, etc)(Circle none if no hobbies/recreation)	None	Little	Some	Lot
HOME CARES(eg, cleaning house/apartment, grocery shopping, washing dishes, child care, laundry)	None	Little	Some	Lot
LIFTING/CARRY (based on whatever you would usually do at home or work)	None	Little	Some	Lot
PERSONAL CARE(eg, taking a bath/shower, combing hair, dressing, etc)	None	Little	Some	Lot
SEX LIFE(Circle none if not sexually active)	None	Little	Some	Lot
SITTING	None	Little	Some	Lot
SLEEPING-(based on your usual sleeping pattern before the accident)	None	Little	Some	Lot
SOCIAL LIFE(eg, going to church, movies, activities with family or friends, etc)	None	Little	Some	Lot
STANDING/BENDING	None	Little	Some	Lot
TRAVELLING(eg, to work or school, or vacations or holidays, to friends/relatives)	None	Little	Some	Lot
WALKING/CLIMBING (based on your usual walking/climbing habits)	None	Little	Some	Lot
WORK/SCHOOL(circle none if not working and not in school)	None	Little	Some	Lot

Total: 44 out of 100

Comments(HPI): Pt doing OK. Back to usual activities. Neuros, knee pains at times. When stand a lot.

PT(HPI,MDM): Please refer to the **Therapy and Exercise** Sheets For Response/Outcomes.

EXERCISE(HPI,MDM): Please refer to the **Therapy and Exercise** Sheets For Status/Outcomes.

HOME TX(HPI): ___NONE ___HELP ___NOT HELP

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

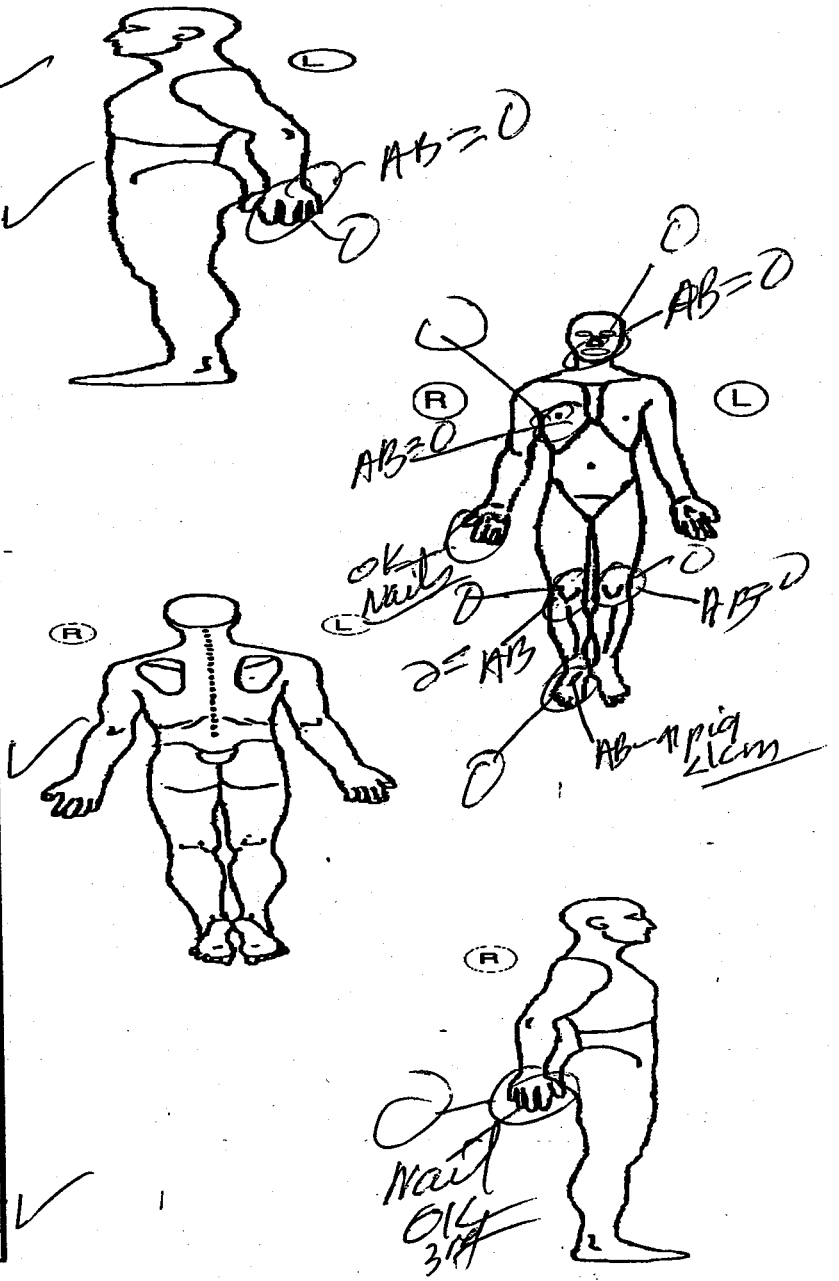
(XII)PHYSICAL EXAMINATION: **Pain Rating**: BL=Baseline; Pain 0 =None, *=Minimal/Minor (1,2) **=Mild (3,4,5) ***=Moderate (6,7,8) ****=Severe (9,10); AB=abrasions, BR=Bruise, LA=Laceration, SP=spasm, STR=soft tissue restrictions, SW=swelling, TP=trigger points (0=none, +1 to +3)

Vitals: BP: _____/_____ **P:** _____ R IR **R:** _____ L UL **T:** _____ ^{0}F

Weight: 192 Pounds **General Appearance:** __Posture OK __Well Nourish __Dressed OK

Gait: ___**normal** ___**Abnormal**_____ **Obvious Distress:** ___**No** ___**Yes**_____

Location	Average/Pathological	Final R	Final L
Neck: (Evans, p.17+)	Rotation R L(>80°, <60°)	70	70
	Bend R L(>45°, <30°)		
	Forward(>80°, <40°)		
	Backward(>70°, <50°)		
Shoulder (Evans, p. 79+)	Abduct R L(180°, <160°)	160	165
	Ext Rot R L(90°, <60°)		
	Int Rot R L(90°, <60°)		
	For Flex R L(180°, < 160°)		
Elbow: (Evans, p.142)	Flex R L(140-150°, <130°)		
	Ext.R L(0 to -10°, >-10 of 0°)		
	Supination R L(90°, <60°)		
	Pronation R L(80-90°, <70°)		
Wrist: (Evans, p. 164)	Rad. Dev R L(15°, <15°)		
	Ulnar Dev R L(30-45°, <25°)		
	Flexion R L(80-90°, <50°)		
	Exten. R L(70-90°, <35°)		
Fingers (Evans, p. 165)	Flex MCP R L # (85-90°, <80°)		
	Flex PIP R L # (100-15°, <90°)		
	Flex DIP R L # (80-90°, <60°)		
	Ext MCP R L #(30-45°, <10°)		
	Ext PIP R L #(0°, xxx°)		
	Ext DIP R L #(20°, xxx°)		
LS Spine: (Evans, p. 251)	For Flex(80°, <60°)	80	
	Back Ext(35°, <20°)		
	Bend R L(25°, <20°)		
Hip (Evans, p. 387)	Extension R L(30-40°, <20°)		
	Flexion R L(120°, <90°)		
	Abduction R L(40-5°, <30°)		
	Adduction R L(20-30°, xxx°)		
	Ext Rot R L(45°, <40 °)		
	Int Rot R L(40°, <30°)		
Knee: (p. 428)	Flex. R L(130-50°, <140°)		
	Ext. R L(0-15°, >10° flex)		
Ankle: (p. 479)	Dorsiflex. R L(20°, <10°)		
	Plantarflex. R L(40°, <30°)		
Foot: (p.480)	Inversion R L(30°, <20°)		
	Eversion R L(20°, <10°)		
Grip	Grip strength in pounds	58	62
Pinch	Thumb/Index in pounds		



(Evans RC, *Illustrated Essentials in Orthopedic Physical Assessment*, 1994, Mosby, St. Louis)↑=Increased ;↓=decreased.

St. Leg Lying: R _____ **L** _____ **Squatting :** 90

DOCTOR: See p.12 and reexamine all affected areas and measurements found on that page. Update all abnormal findings on p.11.

(Assistant to perform all ROM's/Other done on the initial visit by the physician as on page 12)

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.** 25

DOCTOR:1) Update the final diagnoses and codes found on page 14. Give final status code and date to each one.

(XIII) MECHANISM OF INJURY (HPI,MDM): For complete details, see the initial evaluation on page 14 or pages 2, 3, 4 and 5.

STATEMENT OF HEALING PLATEAU (MDM): The patient has reached a healing plateau: X YES ___NO
___The patient chooses to complete treatment at this time.

ASSESSMENT(MDM): DOCTOR: Use information found on p.14

Statement of Final Status of Initial Injuries and Problems: (Check all that apply)

___Complete Resolution of All Initial Injuries and Problems

X Complete Resolution of All Initial Injuries and Problems Except Those Noted Below

___ A Return to Baseline For the Following Problems_____

X Patient Will Have Continued Minor Symptoms Expected to Resolve Within 9 to 12 months If No New Injury.

For these problems (give the residual from 1-10) Knee (1)

Permanency Determination: (Check all that apply)

X The patient has no new permanency

___Patient Will Have Permanency Due To These Injuries Beyond Any Preexisting Permanency

Injuries/Diagnoses of Permanency:_____

Because Of Persistent (___Pain ___Loss Of Motion ___Dysfunction ___Deformity ___Scar),

And ___No PPD is being determined or ___Patient has a PPD of _____%

___Permanency determination is not being made at this time:_____

(XIV) PLANS(MDM): Discharge patient with status as determined above.

Permanent Restrictions (complete if permanency given): X None.

Prosthetics/Orthotics (complete if permanency given): X None.

Future Medical Care (complete if permanency given): X None.

Estimated Cost of Future Medical Care Per Year (complete if permanency given): ___None.

Continue Home Exercise Program: X No ___Yes ___At Discretion of Patient

Continue Home Therapy Program: X No ___Yes ___At Discretion of Patient

Further Formal Evaluations/Treatment Suggested (complete if permanency given): X No ___Yes

(XV) Are All Statements/Conclusions Made To Reasonable Medical Probability? X Yes ___No

11 - OV-FINAL (DETAIL) 12 - OV-FINAL (COMPREHENSIVE) 13 - OV –FINAL (COMPLEX

Patient (Parent/Guardian) Signature or Initials:_____

Physician Signature or Initials:_____ **DATE:** 10/10/02

Revisions: 11/7/01

MFM MEDICAL CLINIC

PART C-Follow-up Visit

Date: 9-10-02

Subjective(statement by patient of on-going problems): doing better, no major pains walking good OK

Update of Active Diagnoses(use page 14 and refer to it for details-comment on all **non-resolved** diagnoses)

rest OK

Work/School Status: X none on layoff __disabled/retired __at work/school/FT/NR/OK _____

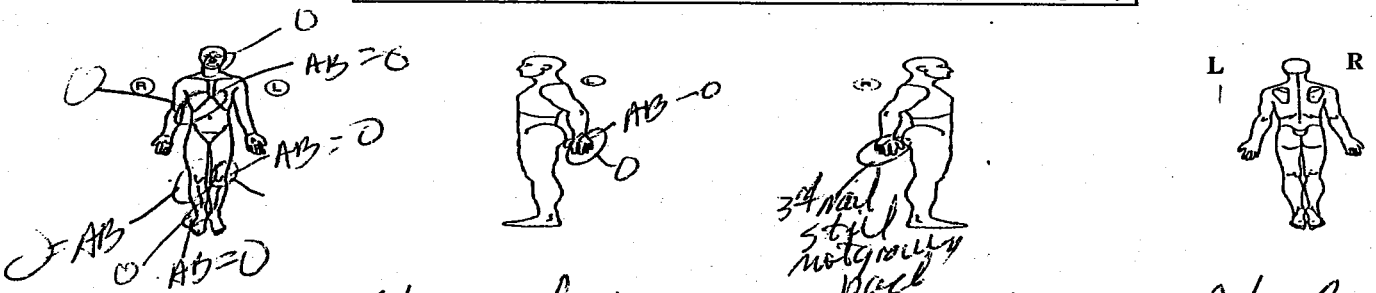
PT/Exer/In Clinic: __none X help lot __helping some __help little __not helping _____

Home/PT/Exer/Tx: __none __meds __HP/soaks X stretch/exer _____

Records Reviewed: X none __not back _____

Objective/Physical Exam: **BP** **P** **Other:**

Doctor: (Refer to page 12 and update all active areas of complaints on p. 14)



Assessment: ft good OK, no major pain, good back to usual activity

Plans: 1) **Therapy:** 0 /wk for 0 wks **Modalities (see p.19):** CP EM HILL HP IR MT MASS PB TENS TR-B TR-N US UT VB WP **EXERCISE:** __None __Same __Decrease X Increase extend

2) **RTC** 1 2 3 4 5 6 weeks 3) __See Work/School Prescription 4) Final do regular activity

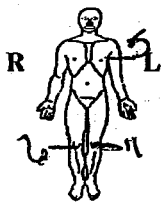
Physician Signature: _____ **Patient Initials:** TW

Charges: 7-Brief 8-Extensive 9-Intermediate 10-Comprehensive

Patient Name: _____ DOI: _____

MS THERESA A WILLIAMS
DOB: 8/7/1972 SSN: 396-78-2531
ACC NO: 0211676 DOI: 7/26/2002
Type: Slip and Fall 10405 WC No

MFM MEDICAL CLINIC
THERAPY AND EXERCISE ORDERS PERFORMED



Service Date: 8-29-02 Procedures Done: 303 304 _____ _____ Entered: J

Area(s) Treated: (L) Chest Both Knees

Exercise: _____ Exercise: _____

Reps: _____ Sets: _____ Load: _____ Reps: _____ Sets: _____ Load: _____

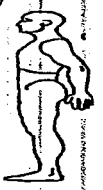
Pain: Y N Fatigue: Y N Effort: U S Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: ___Aerobic(light mod stren) _____ _____

PATIENT(I received the above treatments): X TW **PT/MD/DO(I gave the above treatments):** X

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: Tolerated Rx well. No A noted in (L) chest.



Service Date: 9-3-02 Procedures Done: 313 303 304 _____ Entered: J

Area(s) Treated: (B) Knees _____ _____

Exercise: Stepper Exercise: _____

Reps: Swings Sets: 1 Load: _____ Reps: _____ Sets: _____ Load: _____

Pain: Y N Fatigue: Y N Effort: U S Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: ___Aerobic(light mod stren) (B) Knees _____

PATIENT(I received the above treatments): X TW **PT/MD/DO:(I gave the above treatments):** X

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: Some pain discomfort Ued from heat.

Service Date: _____ Procedures Done: _____ _____ _____ _____ Entered _____

Area(s) Treated: _____ _____ _____

Exercise: _____ Exercise: _____

Reps: _____ Sets: _____ Load: _____ Reps: _____ Sets: _____ Load: _____

Pain: Y N Fatigue: Y N Effort: U S Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: ___Aerobic(light mod stren) _____ _____

PATIENT(I received the above treatments): X ____ **PT/MD/DO(I gave the above treatments):** ____

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: _____

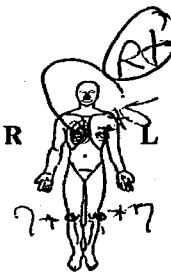
MS THERESA A WILLIAMS
DOB: 8/7/1972 SSN: 396-78-2531
ACC NO: 0211676 DOI: 7/26/2002
Type: Slip and Fall 10405 WC No

301-Soft Tissue Massage
302-Vibration Therapy
304-Hot Packs
305-Mechanical Massage(Hill)
306-Infrared Therapy
307-Paraffin Bath
308-Cold Packs
303-Mechanical Massage Mat
modified 6/9/99

309-Ultrasound
310-US/Elec Stim
311-Electric Stim-Manual
312-Traction/Manual
313-Therapeutic Exercise
314-Tens Unit
316-Whirlpool/Dry
342-Magnathermy Deep Heat

318-Iontophoresis/Ph
319-Air Compression/now plus
321-Ultratone (2-8 leads)
323-Biofeedback
324-Electrical Stimulation
325 - Crutches
326- Cane
330 - Rehabilitation

PITNI CLINICS
THERAPY AND EXERCISE ORDERS PERFORMED



Service Date: 8/16/02 Procedures Done: 313 316 ____ ____ Entered: L

Area(s) Treated: (3) Knees

Exercise: Stepper

Reps: 5 min Sets: 1 Load: #3

Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: Aerobic(light mod stren)

Exercise: ____

Reps: ____ Sets: ____ Load: ____

Pain: Y N Fatigue: Y N Effort: U S

(B) Knees

PATIENT(I received the above treatments): X **PT/MD/DO(I gave the above treatments):**

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: Tolerated procedures well

Service Date: 8/20/02 Procedures Done: 313 342 303 ____ Entered

Area(s) Treated: Both Knees

Exercise: Windbike/Stepper

Reps: 10 mins Sets: 1 Load: ____

Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: Aerobic(light mod stren)

Exercise: ____

Reps: ____ Sets: ____ Load: ____

Pain: Y N Fatigue: Y N Effort: U S

(B) Knees

PATIENT(I received the above treatments): X **PT/MD/DO:(I gave the above treatments):**

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: Chest pain ted. (B) Knees causing some discomfort.

Service Date: 8/23/02 Procedures Done: 303 304 ____ ____ Entered

Area(s) Treated: (B) Knees

Exercise: ____

Reps: ____ Sets: ____ Load: ____

Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: Aerobic(light mod stren)

Exercise: ____

Reps: ____ Sets: ____ Load: ____

Pain: Y N Fatigue: Y N Effort: U S

PATIENT(I received the above treatments): X **PT/MD/DO(I gave the above treatments):**

Patient Assessment of Therapy(check one): ___Helping ___Not Helping(***please speak to therapist***)

COMMENTS: Tolerated well

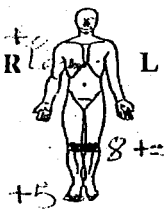
301-Soft Tissue Massage
302-Vibration Therapy
304-Hot Packs
305-Mechanical Massage(Hill)
306-Infrared Therapy
307-Paraffin Bath
308-Cold Packs
303-Mechanical Massage Mat
modified 6/9/99

309-Ultrasound
310-US/Elec Stim
311-Electric Stim-Manual
312-Traction/Manual
313-Therapeutic Exercise
314-Tens Unit
316-Whirlpool/Dry
342-Magnathermy Deep Heat

318-Iontophoresis/Phonopheresis
319-Air Compression/flow plus/vasopneumatic
321-Ultratone (2-8 leads)
323-Biofeedback
324-Electrical Stimulation
325 - Crutches
326- Cane
330 - Rehabilitation

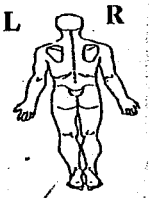
MS THERESA A WILLIAMS
DOB: 8/7/1972 SSN: 396-78-2531
ACC NO: 0211676 DOI: 7/26/2002
Type: Slip and Fall 10405 WC No

PITNI CLINICS
THERAPY AND EXERCISE ORDERS PERFORMED



Service Date: 8-2-02 Procedures Done: 303 304 ____ ____ Entered: ____

Area(s) Treated: Both Knees (1st Chest (Rt Foot



Exercise: ____ Exercise: ____

Reps: ____ Sets: ____ Load: ____ Reps: ____ Sets: ____ Load: ____

Pain: Y N Fatigue: Y N Effort: U S Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: Aerobic(light mod stren) ____ ____

PATIENT(I received the above treatments): TW PT/MD/DO(I gave the above treatments): ____

Patient Assessment of Therapy(check one): ✓ Helping ____ Not Helping(*please speak to therapist*)

COMMENTS: Will assess further next visit.

Service Date: 8-8-02 Procedures Done: 313 303 342 ____ Entered ____

Area(s) Treated: (R) Knee ____ ____

Exercise: Stepper Exercise: ____

Reps: 5 mins Sets: 1 Load: #3 Reps: ____ Sets: ____ Load: ____

Pain: (Y) N Fatigue: (Y) N Effort: U (S) Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: ✓ Aerobic(light) mod stren) (R) Knee ____

PATIENT(I received the above treatments): TW PT/MD/DO:(I gave the above treatments): ____

Patient Assessment of Therapy(check one): ✓ Helping ____ Not Helping(*please speak to therapist*)

COMMENTS: Some fatigue and pain while exercising. Overall pain has decreased since first visit.

Service Date: 8-13-02 Procedures Done: 313 303 304 ____ Entered ____

Area(s) Treated: (R) Knee ____ ____

Exercise: Bike Exercise: ____

Reps: 10 mins Sets: 1 Load: HP (strength) Reps: ____ Sets: ____ Load: ____

Pain: Y (N) Fatigue: Y (N) Effort: U (S) Pain: Y N Fatigue: Y N Effort: U S

Area(s) Exercised: ✓ Aerobic(light mod stren) (B) Knees ____

PATIENT(I received the above treatments): TW PT/MD/DO(I gave the above treatments): ____

Patient Assessment of Therapy(check one): ____ Helping ____ Not Helping(*please speak to therapist*)

COMMENTS: (B) Knees soreness and tightness.

301-Soft Tissue Massage
302-Vibration Therapy
304-Hot Packs
305-Mechanical Massage(Hill)
306-Infrared Therapy
307-Paraffin Bath
308-Cold Packs
303-Mechanical Massage Mat
modified 6/9/99

309-Ultrasound
310-US/Elec Stim
311-Electric Stim-Manual
312-Traction/Manual
313-Therapeutic Exercise
314-Tens Unit
316-Whirlpool/Dry
342-Magnathermy Deep Heat

318-Iontophoresis/Phonopheresis
319-Air Compression/flow plus/vasopneumatic
321-Ultratone (2-8 leads)
323-Biofeedback
324-Electrical Stimulation
325 - Crutches
326- Cane
330 - Rehabilitation

MS THERESA A WILLIAMS
DOB: 8/7/1972 SSN: 396-78-2531
ACC NO: 0211676 DOI: 7/26/2002
Type: Slip and Fall 10405 WC No

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

PITNI

COMPREHENSIVE MEDICAL EVALUATION WORKSHEET-ALL ACCIDENTS

PATIENT: Please complete all sections with the solid line down the left side of the page: [redacted]

TODAYS DATE: 7/30/02 **DATE OF INJURY:** 7/26/02 DAY: M Tu W Th (F) Sa Su

PRIMARY PROVIDER NUMBER:_____ **ACCIDENT CASE NUMBER:**_____

Part A-Initial Evaluation of Injury

I.A) INTRODUCTION-PATIENT INFORMATION

Mr. (Mrs.) Ms. Dr. Rev. Pastor (Circle one)

Williams	A.	Theresa	8-7-72
LAST NAME	MI	FIRST NAME	DATE OF BIRTH

Minor Child (Check All That Apply): ____Yes X No ____Mother ____Father ____Relative ____Guardian

I.B-INTRODUCTION-CONTACT PERSON: ___NONE

WORKSITE/EMPLOYER:_____

INSURANCE COMPANY/OTHER:_____

I.C-DID THIS ACCIDENT OCCUR DURING YOUR WORK TIME?: ___Yes X No

PLEASE READ CAREFULLY AND SIGN ONLY IF A WORKERS COMPENSATION ACCIDENT

The Workers Compensation System is meant to provide you with proper medical care and compensation for lost income as the result of an injury or occupational illness sustained while you were employed. This system is like no other form of health care delivery system. I have attempted to make myself as knowledgeable about the system as possible and I am willing to stand by you throughout your dealings with the system, your employer and the insurance companies. Get it out of your head that this is some pot of gold at the end of the rainbow-it is not like other accidents and injuries. It only provides you basic compensation and coverage for the injuries you have sustained. You have the right to two choices of a physician. If you proceed to complete this form and choose my office as one of your first two choices, you must insure me of the following. That you will provide me with the truth and nothing but the truth as best as you can determine it about your injury and any prior medical conditions or problems. That you will be honest and as accurate as possible in providing me with the details that I request. That you will follow my suggestions to the letter, understanding that if you are not satisfied with my handling of your injury that you may choose another provider if I am your first choice. That you understand that I am obligated to return you to work as soon as is medically safe with appropriate medical restrictions. That if I discover you are not fully honest with me, or if you do not follow my treatment plans and suggestions, I will discharge you from the clinic. Generally, you do not need a lawyer if everything goes smoothly. I will inform you if you should find one, then it is up to you to do so. If you accept the above and will follow them, then sign below (you will also be given some additional instructions and rules). If you cannot follow the above, then I suggest you see another doctor before proceeding.

Check One:

____I was injured during one specific incident at work (CC). _____

____I suffered injuries/problems over a period of time due to my job and can't recall one specific day/incident (CC).

____I suffered injuries/problems over a period of time due to my job and can't recall one specific day/incident(CC).

____I remember being aware of the problem beginning about_____(CC).

For this injury (or at some time in past), did your employer/supervisor:

1) Advise you that you could receive medical care for your injury/problem when you first asked/injured? ____yes ____no

2) Did your employer/supervisor advise you that you could have your own choice of doctor? ____yes ____no

3) Did your employer/supervisor only provide you with their clinic doctor/clinic for your condition? ____yes ____no

4) Has your employer/insurance company had you evaluated by an IME or have you been notified of such? ____yes ____no

5) Has your employer/insurance company stopped your benefits in any way? ____yes ____no

6) Have you been fired by your employer? ____yes ____no

Signed:_____ Dated:_____ DAY: M Tu W Th F Sa Su TIME:_____ AM PM

The information on this form is necessa. or proper documentation and han lling of yo. njuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

I.D-INTRODUCTION-TYPE OF INJURY (CC)

___Assault/Battery	___Machine Related	___Vehicle Related, Bicycle/Other
___Bite, Dog/Animal	___Pedestrian/Vehicle	___Vehicle Related, Bus-County
___Bite, Human	___Repetitive Motion	___Vehicle Related, Bus-Other
___Collapse of Structure	X Slip and Fall	___Vehicle Related, Bus-School
___Eaten/Drank Something		___Vehicle Related, Commercial (Airplane, Ship
___Emotional Distress		ubway, Train, Other)
___Falling Objects	___Vehicle Related-Auto (MVA)	___Vehicle Related, Motorcycle
___Gas/Fumes Exposure	___Vehicle Related-Boat	___Work Accident

X Other Accident: tl fell and foot went into hole.

I.E-WAS A POLICE REPORT FILED? ___No ___By Police ___By Myself ___By Other:___

I.F-WAS AN INCIDENT REPORT FILED? ___No ___Yes By___

Location of accident:___

Comment:___

II.A) Describe How Accident Happened And How You Were Injured In This Accident.

tl Theresa Williams was walking and I did not see the hole that is in the ground on the cross area, My right foot went into the hole and I fell down on both of my knees, my left chest area which is my breast, when I tried to catch myself my middle finger on my left hand and my finger nail took completely off, I was in severe pain from the fall and from my finger nail being torn off.

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

IIB) Do not write in this section-DOCTORS COMMENTS ON ACCIDENT AND INJURIES

Doctor: Use on page 14 for 'Mech', and page 15 for thresholds of MVA

(?=don't know): Time of Day: evening **hours am pm** **not a MVA/vehicle** **inside**

Lighting/Road Conditions: X daylight __night __dusk __dawn Street Lights: __on __off

__dry __wet __icy __snow __rain __hi wind __fog __sleet __hail __flat __up hill __down hill __on curve __off road

Location of Patient: **Driver** **Passenger:** __front seat __rear pass __rear middle __rear driver

Other location in vehicle description:_____

Driver Seat adjust/position relative to dash/seat in front: __up close __average distance __far back __not driver

Seat Belts: __Lap Only __Shoulder Only __Lap/Shoulder __None Avail/Seen __Poor Condition_____

Head Relation To Head Rest: __head above To Head: __less than 3 inches __more than 3 inches

Seat Back Angle: __straight up __small tilt back __mod tilt back __very tilt back __unknown

Seat Back/Cushion: __loose/flimsy __firm __hard/very stiff __fixed to wall __rods/ridge in seat back __unknown

#1-Vehicle Patient In: Year_____ ? Model/Make/Color_____ ? Air Bags Y N F S Out ?

Driver Details: M F ? Teens 20's 30's 40-50's 60-70's 80+ ?

Vehicle Was: __unknown __left __driven away __pushed/pulled away __towed _____

Visible Damage: ? __none __little __some __moderate __lot __totaled Dollar Damage: $_____ __unknown

Description of Damage to Vehicle: Location (show 1=first hit, 2=second hit, etc.):

____ front end: bumper (__drivers __middle __passenger __all) __grill/radiator __hood __windshield

____ drivers side: __front __front door/only door __middle rear door/sliding __rear __windows __all

____ passengers side: __front __front door/only door __middle rear door/sliding __rear __windows __all

____ rear end: bumper(__drivers __middle __passenger __all) __trunk __rear hatch/door __rear end window

____ other: __roof __underneath _____

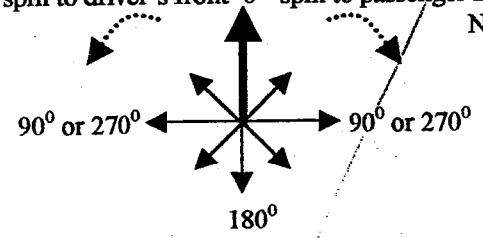
Other Motions/Damage to Car #1:

Spinning and Distance Moved: __no spinning __not pushed/moved any distance by impact

(show direction of **spin** by circling **dot** arrow; show final position by circling one of the arrows shown or draw in appropriate final position arrow)

Original front direction

spin to driver's front 0^0 spin to passenger front



Number of Complete (360^0) Spins

0 1 2 3+

Distance knocked/pushed (approximates)

Feet est.:	1-5'	6-10'	10-15'	15'+
Car Length:		(1/2+)	(3/4+)	(1+)
Ahead				
Backwards				
To Driver Side				
To Pass. Side				

Other: __none __hit same vehicle again_____ __hit other vehicles_____

__hit stationary object(_____) __off of road onto(_____)

__tipped onto wheels(_____) __rolled/flip over(_____)

__lifted off ground(_____) __other(_____)

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

For All Injuries:

Loss of Consciousness (LOC): X**none** __LOC for _____ mins dazed/dizzy X minor __some __lot (shock/upset/mad)

__saw stars/lights __went dark/black __didn't know self/location/day/what happened __nausea __vomiting

Confused: X minor __some __lot took 1 mins to clear head __unable to answer/understand right away

Visible Signs: ___None X abrasions/scratch X black/blue X bleeding __laceration __reddened X swelling/knot

chest lines knees chest knuckles up lip

Ambulation and symptoms at scene: __**none at scene** __removed/helped by paramedics/police/fire/other

X out/up after 1-2 mins pain onset: __none X at scene __later day/night __next day __next few days/week

__standing/upright and had to sit down after _____

Others Injured: none **Number in patient's vehicle:** _____ **others injured?** Y N ?

Number in other vehicle: _____ **other injured?** Y N ?

III) MEDICAL EVALUATION/TREATMENT SINCE THE ACCIDENT/SYMPTOMS(HPI)

III.A-EMERGENCY ROOMS, CLINICS OR DOCTORS HAVE YOU SEEN SINCE THE ACCIDENT? X NONE

_____

_____

_____

_____

_____

III.B-WHAT TREATMENTS DID YOU USE TO HELP/TREAT YOURSELF? _____None _____Happened Today

NON-PRESCRIPTION	PRESCRIPTION	SELF-TREATMENTS	ASSISTIVE DEVICES
__Advil/Nuprin/etc.	__Darvocet/ Wygesic	__Elevation of Arm/Leg	X Ace Wrap (R) ankle
__Aspirin/Anacin	__Ibuprofen (Motrin)	__Ice/Cold Packs	__Back Brace
__Alleve	__Muscle Relaxers	__Heating Pads/Towels	__Cane
__Ben-Gay/Rub-ons	__Vicodin (hydrocod)	__Massage/Rub Downs	__Crutches
__Epsom Salts	__Tylenol & Codeine	X Less Active Than Usual	__Knee Brace
__Liniments	__Others:	__Sleeping On Floor	__Neck Collar
__Orudis/Actron	_____	__Sitz Baths	__Pillows
__Rubbing Alcohol	_____	__Warm Baths	__Sling
__ Tylenol	_____	H2O2 / Neosporin cream	__Splints
_____	_____	_____	__ Wheelchair

Followed The Doctor's Advice: X None Given ____Emergency Room ____Private Doctor ____Other

WHAT PARTS OF YOUR BODY WERE YOU TREATING: __Abdomen __Arms R L __Back

__Chest __Headaches X Legs (R L) __Pelvis chest, _____

These Treatments Have Helped: ___None Done

_____Not At All _____A Little X Some _____A Lot _____Temporary

III.C-IF MORE THAN ONE WEEK HAS ELAPSED BEFORE YOU SAW ANY DOCTOR, PLEASE EXPLAIN:

__Commitments, Other	__Appointment, Difficult to Get	__Child Care, None
__Doctors Advice, Following	__Doctor, Couldn't Afford One	__Insurance, None
__Pains, Worsened Over Time	__Job, Fear of Losing	__Transportation, None
__Thought It Would Get Better	__Treating Self As Above	__ _____

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

SYMPTOMS/PROBLEMS DUE TO INJURIES FROM ACCIDENT(ROS)

Please Check (√) All That Apply(You May Place Two Or More Checks By The Most Severe Ones)

********Check (√) Only If The Symptoms Are A Result Of This Accident********

DO NOT CIRCLE THE LETTERS

DOCTOR: Use these to determine diagnoses found on page 14.

III.D-Group I Symptoms/Complaints (PS)

Head and Face Symptoms
__Facial/Nose Pain R L
__Jaw/Chew Problem/Pain R L
__Ear Problems R L
__Headaches R L F B Temp Top
__Eye Problems R L
__Teeth Pain R L U L

Torso (Trunk or Middle Body)
__Abdominal/Stomach Pain U M L R L
__Back Pain U M L R L
__Neck Pain R L A P Sides
X Chest Pain U L (R) L
__Pelvis/Butt/Groin R L A P

Arms (Upper Extremities)
__Forearm Pain R L A P
__Thumb Pain R L
__Elbow Pain R L A P
__Hand Pain P D R L
__Wrist Pain R L A P
X Fingers 2 (3) 4 5 (R) L
__Shoulder/Up Arm R L A P

Legs (Lower Extremities)
X Foot Pain (R) L S D
__Thigh/Hip Pain R L A P
X Ankle Pain (R) L Me La
X Knee Pain R L Me La A P
__Toe Pain 1 2 3 4 5 R L
__Calf Pain R L
__Shin Pain R L

Skin X Abrasions X
__Lacerations
X Bruises X
X Swelling X
__Burns

Other Head/Face Symptoms
X Nose, Bleeding
__Vision, Double
__Ears, Ringing
__Nose, Clear Drainage
__Hoarseness
__Swallowing, Difficulty

Lungs/Chest/Heart Symptoms
__Coughing, Bloody
__Hearts, Rapid Rate
__Breathing, Difficulty
__Coughing, General
X Chest Pressure/Pain
__Heart, Fluttering Beats

Bowel/Urinary Symptoms
__Nausea/Vomiting
__Bowel Movements, Bloody
__Urine, Bloody
__Constipation
__Urinating, Difficulty
__Diarrhea

Other Physical Symptoms
__Allergy Reaction
__Bleeding
__Burning Sensations
__Numbness/Tingling/Weakness In Arms R L A P Dist Prox
X Numbness/Tingling/Weakness In Legs R L A P Dist Prox

III.E-Group II Symptoms/Complaints (CS)

Check(√) Each Of The Symptoms You Are **Experiencing Since The Accident.** __None

__Appetite/Eating, Change In
__Appetite, Loss Of
X Body Aches, General
__Cold, Feel Too
__Hot, Feel Too
__Fatigue
__Fever
__Sex Drive, Loss Of
X Sleep, Disturbed
X Sleep, Painful
X Weakness, General Body
__

III.F-Group III Symptoms/Complaints(PCS)

Circle how much affected: (None) Little Some Lot

Check(√) Each Of The Symptoms You Are Experiencing **Due To The Accident.** ___None (0)

__Concentration, Loss Of
__Dazed Sensation
__Disorientation
__Dizzy/Lightheaded
__Ears, Ringing In
__Faint Sensations
__Lights, Avoid Bright
__Memory Lapses
__Spinning Sensation
__Sounds, Avoid Loud
__Thinking, Difficulty

III.G-Group IV Symptoms/Complaints(PTS)

Circle how much affected: None Little Some Lot

Check(√) Each Of The Symptoms You Are Experiencing **Due To The Accident.** ___None (0)

__Anxious/Afraid In Similar Situations
__Avoid Accident Conditions (e.g., cars)
X Avoid Accident Scene
__Down and Out, More Than Usual
__Dreams, Bad
__Dying, Had Fear Of During Acc.
__Helpless/Horror, Feeling Of
__Hyperactivity, New or Increased
X Irritability, New or Increased
__Jumpy/On Edge, New or Increased
__Nightmares
__Startles More Easily
__Talks Lot About Accident
__Thoughts of Accident Stay In Head
__Wetting, Bed New or Increased
__Wetting, On Clothes, New or Increased

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

III.H-AREAS OF FUNCTION (Circle the word that most closely describes how this accident is affecting you.)

Note: Only check how this accident is affecting you and not how you may have been affected before this accident.

DRIVING(Circle none if you do not drive).....	(None)	Little	Some	Lot
EXERCISE(not just work or usual walking, regular true exercise which you were doing)...	None	Little	Some	(Lot)
HOBBIES/RECREAT.(eg, sewing, gardening, fishing, pool, cards, bingo, music, dancing, skating, bowling, video games, computer, etc)(Circle none if no hobbies/recreation).....	None	Little	Some	(Lot)
HOME CARES(eg, cleaning house/apartment, grocery shopping, washing dishes, child care, laundry)...	None	Little	(Some)	Lot
LIFTING/CARRY (based on whatever you would usually do at home or work).....	None	Little	(Some)	Lot
PERSONAL CARE(eg, taking a bath/shower, combing hair, dressing, etc).....	None	Little	(Some)	Lot
SEX LIFE(Circle none if not sexually active).....	None	(Little)	Some	Lot
SITTING.....	None	(Little)	Some	Lot
SLEEPING-(based on your usual sleeping pattern before the accident).....	None	(Little)	Some	Lot
SOCIAL LIFE(eg, going to church, movies, activities with family or friends, etc).....	None	(Little)	Some	Lot
STANDING/BENDING.....	None	(Little)	(Some)	Lot
TRAVELLING(eg, to work or vacations or holidays, to friends/relatives).....	None	(Little)	Some	Lot
WALKING/CLIMBING (based on your usual walking/climbing habits).....	None	(Little)	Some	Lot
WORK/SCHOOL(circle none if not working and not in school).....	None	Little	(Some)	Lot

Total: 75 out of 100

IV.A) PAST MEDICAL HISTORY(PFSH)

DOCTOR: use to determine predisposing (PD) and pre-existing (PE); note on pages 14, 15 and/or 18; especially for those in bold

(A) **Allergies:** X None List:_____

(B) **Medications:** X None List:_____

(C) **Vaccinations:** Year of Last Tetanus Shot: _____ X Less Than 10 years ___Don't Know(see Private MD)

(D) **Medical Conditions (Only Those Treated By A Doctor):** X None

General Medical: __Asthma __Cancer __Diabetes __Heart Condition __High Blood Pressure

__Liver Condition __Seizures __Stroke __Ulcers/Reflux

Musculoskeletal: __**Arthritis** _____ __**Bursitis/Tendonitis** _____

__**Back Condition** _____ __**Carpal Tunnel Syndrome**_____

__**Dislocations** _____ __**Neck Condition**_____ __ **Rotator Cuff Injury** _____

__**Sciatica** _____ __**Sprains (Severe)** __Ankle __Knee __Shoulder _____

Mental/Other: __**Anxiety** __Depression __**Headaches**_____

Assistive Devices: __Contacts __Dentures/Partials __Glasses __Hearing Aide

__**Metal Implants** _____ __ Pacemaker _____ __**Prosthesis** _____

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

Please List Other Conditions For Which You've Been Treated: _____

Please List Your Personal Doctor Or Clinic: X None _____

(E) **Family History** (Check Problems Present In Your Near Relatives): ___None

X Diabetes ___Cancer ___Heart Disease X High Blood Pressure

Other Family Conditions: _____

(F) **Smoke Cigarettes:** ___Yes X No If Yes, Patient Advised To Quit: ___Yes ___No

(G) **Operations** (**All** Operations In The Past): X None

__Appendix __C-Section(s) __Gallbladder __Heart __Hernia __Hysterectomy (Uterus) __Stomach __Tonsils __Tubal Ligation/Burn

__**Back** _____ __**Hand/Wrist** _____

X **Knee** _____ __**Neck** _____

__**Shoulder** _____

Others: X Wrist

(H) **Fractures (Broken Bones):** X None _____

(I) **Women Only:** Last Menstrual Cycle(Weeks Ago): 7/10/02

___Haven't Started Yet ___Post-Menopausal (Change Of Life)

___No Periods Are You Pregnant? ___Yes X No Due Date If Pregnant: _____

IV.B) ACCIDENTS WITH RESIDUAL SYMPTOMS OR WITHIN ONE YEAR(PFSH):

Check All That Apply Regarding Previous Accidents or Injuries

X **No accidents or no pertinent accidents with persistent problems/pains (details not requested)**

__**The following previous injuries/accidents still have symptoms/problems/treatment/disability**

_____

__**The following accidents/injuries occurred within the past 12 months and required treatment**

_____

IV.C)-DISABILITY/RESTRICTIONS PRIOR TO THIS ACCIDENT (PFSH)

X I had no disability or limitations in my work or activities before this accident

___I had the following disability before this accident: _____

_____

___I had the following limitations before this accident: _____

_____

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

IV.D) WORK OR SCHOOL STATUS(PFSH)

Check All That Apply: ___Disability ___Lay-Off ___Retired X School, Attending
___School, Too Young ___Vacation ___Working, At Work ___Working, Fired Due To Accident
___Working, Leave Unrelated ___Working, None X Working, Off Due to Injury
___ Other:_____

School Attending: ___None Name: Carson Academy (computer class) Grade Level:_____
Are You In Gym/Sports?: X No ___Yes

Place Of Employment #1: Name: Private Duty
Number Of Years Employed: 3 Years ___Months Temporary Job Service? X No ___Yes
Job Title/Description: Home Health Aide
Check Job Level: ___Sedentary(lift 0-10 lbs max, occas walk) ___Light(lift 20 lbs max and freq lift/carry up to10 lbs)
___Medium(lift 50 lbs max and freq lift/carry up to 25 lbs) X Heavy(lift 100 lbs max and freq lift/carry up to 50 lbs)

Place Of Employment #2: Name: Intellistaff (MPS) Milw Public Schools 8/ for summer
Number Of Years Employed: ___Years ___Months Temporary Job Service? X No ___Yes
Job Title/Description: Handicapped Children's Asst / Teacher Asst.
Check Job Level: ___Sedentary(lift 0-10 lbs max, occas walk) X Light(lift 20 lbs max and freq lift/carry up to10 lbs)
___Medium(lift 50 lbs max and freq lift/carry up to 25 lbs) ___Heavy(lift 100 lbs max and freq lift/carry up to 50 lbs)

Complete the following only if this is a workers compensation accident(___#1 ___#2)

Contact Person at Work Site:_____

Insurance Company/Other:_____

Workers Compensation Claim Number:_____

Contact Person at Insurance Company:_____

Date First Received Time Off/Compensation For Injury/Problem:_____ ___None

Date First Reported Injury At Work:_____ (Name:_____) ___None

Who Is Your Immediate Supervisor?_____

What Is Your Usual Work Schedule? _____Hours/Day _____Days Per Week M Tu W Th F Sa Su

Time Work: From _____am/pm to _____am/pm OvertimeOther/Work:_____

Number Of Days Missed From Work or School: **DOCTOR: Please complete a Work/School Prescription if needed**

Work #1: ___None X Off Since Accident Happened Days Missed:_____
Returned to Work On:_____ Problems at work due to accident: ___Yes ___No

Work #2 ___None ___Off Since Accident Happened Days Missed:_____
Returned to Work On: out for summer Problems at work due to accident: ___Yes ___No

School: ___None X Off Since Accident Happened Days Missed:_____
Returned to School On:_____ Problems at school due to accident: ___Yes ___No

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.** 10

Stop- give to receptionist

STOP!!!!

STOP!!!!

STOP!!!!

Patient Name: Accident Code: 10

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

V.A) PHYSICAL EXAMINATION (Initial Evaluation)

Patient Is: ___Don't Know (X)Left Handed ___Right Handed ___Ambidextrous

Vitals: BP:_____/_____ **P:**_____ R IR **R:**_____ L UL **T:**_____ °F

Height: 5 Feet 1 Inches **Weight:** 162 Pounds

(Clothes: X On ___Off Shoes: X On X Off)

Size Of Person, And Muscle Mass, Compared To Average Adult Hybrid Dummy (H=height=70 ins, W=weight=170 lbs Assume 3.5" and 35lbs as approximately one standard deviation):

___much smaller(H W) ___smaller(H W) ___about same(H W) ___larger(H W) ___much larger(H W)

Posture/Sym:(+1=Min,+2 =Mod,+3= Sev) ___ Normal Center Of Gravity Properly Aligned: ___Yes ___No

Cervical Lordosis: ___Nml ___Decr ___Incr Kyphotic Hump C7/T1: ___No ___Yes

Lumbar Lordosis ___Nml ___Decr ___Incr Thoracic Kyphosis: ___Nml ___Decr. ___Incr

Scoliosis: ___No ___Yes:_____ Weight bearing: ___even ___right ___left

Head Forward:_____Inches From External Meatus To C7(avg.=0). Max Head Circumference (in):_____ (avg 21-23")

Distance C7 to mid-head (eyeline)(in):_____(avg = 5-7) Shoulders Level: ___No ___Yes_____

Pelvis Level (Axis): ___No ___Yes_____ Scapula Level: ___No ___Yes_____

___Antalgic: ___No ___Yes _____

Gait: ___Normal Antalgic: X No ___Yes_____

Stiff/Restricted X No ___Minimal ___Minor ___Mild ___Moderate ___Severe

Limping: ___No ___LLE X RLE

X Minimal ___Minor ___Mild ___Moderate ___Severe

Assistive Devices Using: X None

__Ace Wrap On _____ __Back Brace __Brace On _____ __Cane

__Cast On _____ __Contacts __Crutches __Dentures U L __Dressing On _____

__Glasses __Hearing Aide R L __Pacemaker __Neck Collar __Prosthetic Device _____

__Sling On _____ __Splint On _____ __Sutures In/On _____

__Wheelchair _____

Level Of Distress:

At Rest: X None ___Minor ___Mild ___Moderate ___Severe

Describe:_____

During Exam/Movement: ___None ___Minor X Mild ___Moderate ___Severe

Describe:_____

Mental Status/Mood/Other General Appearance:

X Alert	___Anxious	X Consistent
X Appropriate	___Depressed/Sad	___Grooming, Good
___Confused	___Friendly	___Grooming, Poor
___Inappropriate	___Hyperactive	___Inconsistent
X Oriented x3	___Irritable	___Nourishment, Good

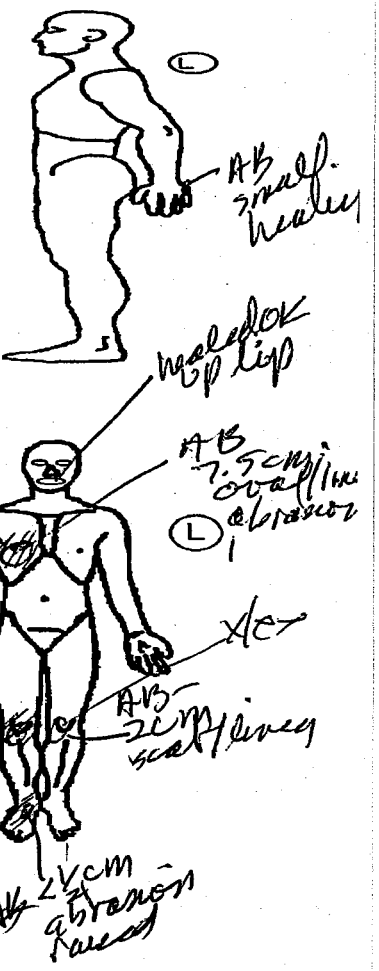
Other Comments:_____

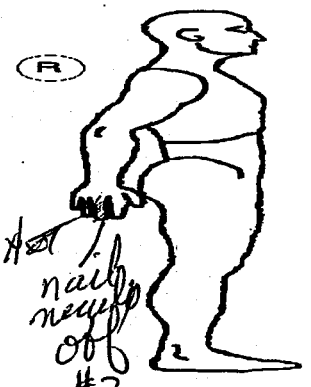
The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

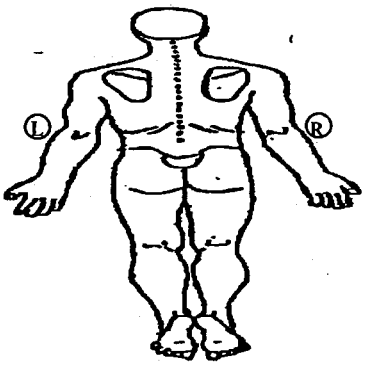
PHYSICAL EXAMINATION (Continued): **Pain Rating**: BL=Baseline; 0 =None, *=Minimal/Minor (1,2) **=Mild (3,4,5) ***=Moderate (6,7,8) ****=Severe (9,10) **Palpation Findings**: CR=crepitus, EF=effusion, LA=laxity, MS=mass, PO=popping, STR=soft tissue restriction, SP=spasm, SL=subluxation, SW=swelling, TP=trigger point **Visual Findings-Skin**: AB=abrasion, BR=bruise, BU=burn, ES=eschar, MO=mole, NO=nodule, , RA=rash, SC=Scar, TA=Tattoo, UL =ulcer **Visual Findings-Other**: AM=abnormal movement, AP=amputation, AS=asymmetry, AT=atrophy, DF=deformity, DL=dislocation, FL=flaccid, FC=flexion contracture, MA=malalignment, PL=paralysis (Rate all except pain as 0=none, +1=minor/mild, +2=mild/mod, +3=mod/severe)

Location	Average/Pathological	R	L
Neck: (Evans, p.17+)	Rotation R L(>80°, <60°)	55	55
	Bend R L(>45°, <30°)		
	Forward(>80°, <40°)		
	Backward(>70°, <50°)		
Shoulder (Evans, p. 79+)	Abduct R L(180°, <160°)	175	170
	Ext Rot R L(90°, <60°)		
	Int Rot R L(90°, <60°)		
	For Flex R L(180°, < 160°)		
Elbow: (Evans, p.142)	Flex R L(140-150°, <130°)		
	Ext.R L(0 to -10°, >-10 of 0°)		
	Supination R L(90°, <60°)		
	Pronation R L(80-90°, <70°)		
Wrist: (Evans, p. 164)	Rad. Dev R L(15°, <15°)		
	Ulnar Dev R L(30-45°, <25°)		
	Flexion R L(80-90°, <50°)		
	Exten. R L(70-90°, <35°)		
Fingers (Evans, p. 165)	Flex MCP R L # (85-90°, <80°)		
	Flex PIP R L # (100-15°, <90°)		
	Flex DIP R L # (80-90°, <60°)		
	Ext MCP R L #(30-45°, <10°)		
	Ext PIP R L #(0°, xxx°)		
	Ext DIP R L #(20°, xxx°)		
LS Spine: (Evans, p. 251)	For Flex(80°, <60°)	80° knees	
	Back Ext(35°, <20°)		
	Bend R L(25°, <20°)		
Hip (Evans, p. 387)	Extension R L(30-40°, <20°)		
	Flexion R L(120°, <90°)		
	Abduction R L(40-5°, <30°)		
	Adduction R L(20-30°, xxx°)		
	Ext Rot R L(45°, <40 °)		
	Int Rot R L(40°, <30°)		
Knee: (p. 428)	Flex. R L(130-50°, <140°)		
	Ext. R L(0-15°, >10° flex)		
Ankle: (p. 479)	Dorsiflex. R L(20°, <10°)		
	Plantarflex. R L(40°, <30°)		
Foot: (p.480)	Inversion R L(30°, <20°)		
	Eversion R L(20°, <10°)		
Grip	Hand Grip in pounds	54	69
Pinch	Thumb/index pinch in pounds		

Examined	Finding OK	Finding Abnl
Head and Face		✓
Eyes	✓	
ENT,Mouth		✓
TMJ		✓
Neck	✓	
Thoracic Area	✓	
Lumbosacral Area	✓	
Chest and Ribs		✓
LUE		✓
RUE		✓
Abdomen	✓	
Pelvis/Hips	✓	
LLE		✓
RLE		✓
Lungs	✓	
Heart	✓	
Skin		✓
Perih Edema	✓	







(Evans RC, ***Illustrated Essentials in Orthopedic Physical Assessment***, 1994, Mosby, St. Louis)↑=Increased ;↓=decreased.

St. Leg Lying-Sitting: ___Normal Or _____°R _____°L

Squatting: 55 Degrees (measured on thigh with pleurimeter) ok knees

Pinprick: ✓Intact X4 Extremities **Light Touch**: ✓Intact X4 Extremities

Motor: ✓OK Prox/Dist Up ✓OK Prox/Dist Low Muscle Waste: ✓N __Y

Cerebellar: ✓Coord Intact ✓No Tremors ✓RAM Intact ✓Romberg Intact

DTR's: ✓Symmet Up ✓Symmet Low **Pronator Drift**: __Pos ✓Neg

CN II-XII Intact: Y N **Blood Behind TM's**: Y (N)

Coon's Eyes: Y (N) **Battle Sign**: Y (N)

Patient Name: Accident Code:

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

VI.A) ASSESSMENT/DIAGNOSIS(MDM)-Initial and Final Evaluation Sheet

'CODE' FOR OBJECTIVITY OF INJURIES/DISCOMFORT

CODE	PALPATION EXAM	OBJECTIVE FINDING-S, STR, TP,BR,AB,L,BU, SW
0	NO RESPONSE TO EXAM/NORMAL	NONE
1	VERBAL RESPONSE ONLY	NONE
2 - 4	MOVES TO AVOID TOUCH	1
5 - 6	MOVES TO REPEL TOUCH	1 OR 2
7 - 8	"VIOLENT" VERBAL OR MOVEMENT	2 OR 3
9 - 10	UNABLE TO PALPATE EXCEPT LIGHTLY	3

Subjective findings are those that the patient expresses to the physician during the history-taking portion. **Objective findings** are those determined by the physician during the physical exam of the patient. Bates (***A Guide To Physical Examination and History Taking*, 5th Edition**, Lippincott, 1987) on page 119, notes how the physical examination is performed by the physician: "*By listening, looking, touch, or smell, the skillful clinician examines each body part and at the same time senses the whole patient, notes the wince or worried glance, and calms, explains and reassures.*" Continuing on page 123, "*Observe the general state of health, stature and habitus, and sexual development. Weigh the patient, if possible. Note posture, motor activity, and gait; dress, grooming, and personal hygiene; and any odors of body or breath. Watch the patient's facial expressions and note manner, affect, and reactions to the persons and things in the environment. Listen to the patient's speech and note state of awareness and level of consciousness.*" All of these observations constitute objective examination of the patient. Magee (***Orthopedic Physical Assessment*, 3rd Edition,** Saunders, 1997) notes on pages 38-39 that the palpation examination, an objective evaluation, allows determination of tissue tension (eg, spasm), tissue thickness and texture (eg, soft tissue restrictions), swelling, temperature variation and grading of tenderness. Magee's scale of tenderness is: Grade I-Patients complains of pain, Grade II-Patient complains of pain and winces, Grade III-Patient winces and withdraws the joint (or part), Grade IV-Patient will not allow palpation of the joint (part). In **our scale used** above, a 1 means purely subjective complaints only. As the ratings go from 2 through 10, there is a progressive increase in the objectivity as determined by physical examination of the physician. Ratings 2-4 are borderline subjective/objective. Ratings of 5 of more are primarily objective. The physician has determined if the movements, withdrawals, facial expressions are genuine or not. The final rating reflects only physical, objective, findings that in the experience of the physician are genuine.

Basic Diagnosis List

Office Code	ICDM-9 Code	Description of Code
51	V71.4	Accident-Observation Following
52	V71.3	Accident-Work, Observation Fol.
53	995.3	Allergy
54	308.0	Anxiety/depression due to stress
55	719.4	Arthralgia
56	715.0	Arthritis
57	716.1	Arthropathy, Traumatic
58	949.0	Burn
59	727.3	Bursitis
62	726.1	Bursitis/tendinits-shoulder
60	726.3	Bursitis/tendinitis-elbow
61	726.5	Bursitis/tendinitis hip
63	354.0	Carpal tunnel syndrome
64	850.9	Concussion
65	920.9	Contusion-Face/Scalp/Neck
66	924.9	Contusion-lower limb
67	922.9	Contusion-trunk
68	923.9	Contusion-upper limb
130	370.00	Corneal abrasion/ulcer
69	309.0	Depressive reaction-brief
136	832.00	Dislocation of elbow
127	831.00	Dislocation of shoulder
70	780.4	Dizziness/vertigo
71	307.6	Enuresis
129	726.32	Epicondylitis lateral elbow
155	726.31	Epicondylitis, medial elbow
72	784.7	Epistaxis
73	783.3	Feeding problem
74	005.9	Food poisoning
133	728.82	Foreign body soft tissue
75	829.0	Fracture bone-closed
76	829.1	Fracture bone-open
134	873.63	Fracture of tooth
77	781.2	Gait disturbance
78	558.9	Gastroenteritis
150	346.90	Headache-migraine
79	307.8	Headache-tension
80	784.0	Headache/facial pain
151	722.0	Herniated disc-cervical
152	722.1	Herniated disc-lumbar
128	553.20	Hernia,ventral
81	929.9	Injury, crush
84	919.8	Injury superficial w/o infection
82	908.9	Injury-late effects
83	959.9	Injury-NOS
85	717.9	Knee-internal derangement
86	780.7	Malaisse/fatigue
126	836.1	Meniscus tear-lateral
87	729.1	Myalgia/myositis
88	787.0	Nausea/vomiting
89	799.2	Nervousness
132	269.9	Nutritional deficiency, NOS
90	729.5	Pain in an extremity
91	724.2	Pain in low back
92	723.1	Pain in neck
93	724.1	Pain in thoracic spine
50	E812.1	Passenger in vehicle collided with
95	309.8	Post trauma emot. Distur.prolong
96	293.9	Post trauma organo mental disord
97	308.3	Post trauma stress disord. Acute
94	310.2	Post-concussion syndrome
98	729.2	Radiculitis, neural, neuritis-NOS
99	723.4	Radiculitis-neck and arm
100	724.4	Radiculitis-thorax/back/leg
101	840.4	Rotator cuff tear
102	726.0	Rotator cuff tendinitis
125	353.0	Scalenus anticus syndrome
103	724.3	Sciatica
104	780.6	Sleep disturbance
105	845.0	Sprain-Ankle
106	847.9	Sprain-Back
153	848.40	Sprain-Chest
107	842.1	Sprain-finger
108	845.1	Sprain-foot
109	842.2	Sprain-hand
110	843.9	Sprain-hip/thigh
111	844.9	Sprain-knee/leg
112	847.0	Sprain-neck
114	848.1	Sprain-TMJ
115	842.0	Sprain-wrist
116	905.7	Sprain/strain late effects
117	308.9	Stress reaction-acute
118	388.3	Tinnitis
154		Tooth-contusion
156	873.73	Tooth-fracture
119	995.2	Toxic effects-drug/medicin
121	987.9	Toxic effects-gas/fume/vap
120	988.9	Toxic effect-substance eat
135	783.1	Weight Gain, Abnormal
131	783.2	Weight Loss, Abnormal
122	V62.1	Work environment advers
123	958.2	Wound infect-post trauma
124	879.8	Wound w/o complications
113	840.9	Sprain-Shoulder/Arm

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

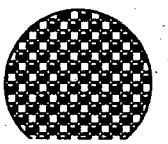
VIB-Patient Initial Diagnoses and Status, Mechanism of Injury, Progress and Final Status

DOCTOR: Use this as a progress flow sheet for all phases of patient visits. Use page 6 for diagnoses.

For 'mech' of injury(use pages 3,4): AD=accel/decel, CH=chemical, CD=cold, CR=crush/compression, DT=direct trauma, EE=electrical, HE=heat/fire, JA=jam, JE=jerk, RA=radiation, RM=repetitive motion, SE=sudden and unexpected, TG=toxic ingestion, TI=toxic inhalation, TN=Tension, TW=twist, VB=vibration; **'Code's** are found on the prior page (use page 12). **DX**=shows diagnosis is present; **PD**=predisposing condition present (see p.7/8 &15/18); **PE**=preexisting condition present (see p. 7/8 & 15/18); **OC**=office code for the diagnosis.

Dx	PD	PE	OC	ICDM 9	Description	Comments	Mech	Init 'Code'	X	Date Resolved	Final 'Code'
			64	850.9	**Concussion (Grade 1 2 3)						
X			65	920.9	Contusion-face/scalp/neck	up lip	DT	1	X	9/10/02	D
X			66	924.9	Contusion-lower limb	R/L knee	DT	2	X	9/10/02	D1
X			67	922.9	Contusion-trunk	(R) chest	DT	2	X	9/10/02	D
X			68	923.9	Contusion-upper limb	(L) 5th Finger (R) 3rd Thumb	DT	1	X	9/10/02	D
			75	829.0	Fracture bone-closed						
			80	784.0	*Headache/facial pain						
			98	729.2	*Radiculitis, neuralgia, neuritis						
			99	723.4	*Radiculitis-neck and arm						
			100	724.4	*Radiculitis-thorax/back/leg						
X			105	845.0	Sprain-Ankle	(R)	TW	2	X	10/10/02	D
			106	847.9	Sprain-back						
			107	842.1	Sprain-finger						
			108	845.1	Sprain-foot						
			109	842.2	Sprain-hand						
			110	843.9	Sprain-hip/thigh						
			111	844.9	Sprain-knee/leg						
			112	847.0	Sprain-neck						
			113	840.9	Sprain-Shoulder/Arm						
			114	848.1	Sprain-TMJ						
			115	842.0	Sprain-Wrist						
			117	308.9	*Stress reaction-acute						
			121	987.9	*Toxic effects of gas/fumes/vapor						
			120	988.9	*Toxic effects substance eaten						
X			124	879.8	*Wound w/o complications	mult Abras	DT	2	X	9/10/02	D

*Based On A Scale Of 0(None)-10(Extreme) **Based on Grade 1=transient confusion, Grade 2=confusion with mental abnormalities , Grade 3-LOC



Patient Name: Accident Code:

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

**VII.A)ASSESSMENT/INJURY POTENTIAL MVA(MDM): ___Not assessed or not applicable

Whether this is a low speed impact or not, the following may be helpful in determining/understanding the true potential for injury of this patient other than the presence or absence of vehicular damage.

Studies (Nielsen JP, et al, ***Low Speed Rear End Impact Test Summary-Human Test Subjects***; Accident Reconstruction Journal, ARJ, Sept/Oct 1996,pp 40-41) of enclosed vehicles, mainly passenger cars and light trucks, have shown that at delta v's of less than 5-7 mph, injury is unlikely to occur in test subjects. Engineering firms have mainly conducted these studies. The crash tests mandated by the US government occur at 30 and 35 mph into a rigid barrier for a delta v of 30 to 35 mph. These crashes result in significant damage, eg, up to two feet of crush damage, but do not involve live human occupants. In a head on collision, a vehicle with air bags should have deployment of the air bag at average delta v's of 10-12 mph give or take 1-2 mph. The typical passenger car bumper is required to sustain 2.5 - 5 mph of delta v, depending on the bumper, without damage. With bumper impacts less than the bumper limit, there is little to no damage expected and the occupant only receives a small jolt. If the bumper limit is exceeded, damage increases and occupant motion increases (Watts AJ, et al, ***Low Speed Automobile Accidents***, 1996, Lawyers and Judges Publishing Co, Tucson, AZ, ***The Bumper Response***, pp 23-30) If there is a direct hit of the bumper, and there is damage, the delta v is estimated to be greater than that bumper limit. Beyond that, impact speeds may be determined by crush analysis. This does not involve complete reconstruction of the accident. Once the impact speed is known, some approximation of the delta v may be determined. In the on-line rear end car crashes conducted at low speeds, the threshold for more than transient injuries was determined to be delta v 's of 5-7mph. There is very limited data for delta v's from 7 to 11mph(ARJ sited). These tests were done with these parameters controlled and present: 1) occupant generally early to mid age male in good health (some spinal changes in Szabo TJ et al, ***Human Occupant Kinematic Response to Low Speed Rear-End Impacts***, SAE 940532 done at delta v of 5mph with no lasting injuries); 2) occupant knew vehicle was going to be rear-ended(some frontal collisions); 3) occupant had properly fitting seat belt(shoulder and lap) in good condition; 4) occupant in firm seat with head rest status variable but generally properly fitted; 5) crash was an in line collision with bumper to bumper impacts; 6) occupant was sitting straight up with head and neck both facing ahead; 7) occupant rarely, if ever, sustained direct impact with vehicle interior; and 8) occupant typically in the drivers position. Many of the conditions of real accidents have yet to be studied. Extrapolation beyond the limits of the studies must be done with extreme caution. Variations from these ideal test scenarios may lower the threshold of injury based on delta v. It is estimated that the threshold to injury may be as low as a delta v of 3mph for individuals with predisposing conditions(Watts, p. 132) **In this patient and this accident**, based on information obtained and documented above, the following factors will decrease the delta v injury threshold. This means this patient may have injuries at lower speeds than expected or that the injuries at a given speed are greater than expected:

Factors Known To Decrease Threshold For Injury	**Present**				**DOCTOR**
	No	**Yes**			**Page Of**
+1=slight/minor +2=mild/mod +3=severe/extreme/significant		**+1**	**+2**	**+3**	**Form**
1) Older Adult(over 40 YO)-known to be more fragile in impact/injuries					**1**
2) Female-more fragile in injuries/impacts					**1**
3) Small Muscle Mass-unable to protect self as well in impact/injuries					**11**
4) Very Small Person Compared to Vehicle Interior-not secured by belt/bag as well					**11**
5) Very Large Person Compared to Vehicle Interior-not secured by belt/bag as well					**11**
6) No Seat Belt/Seat Belt In Poor Condition/lap belt only/shoulder belt only					**3**
7) Not Expecting Accident To Occur (No Tensing of Muscles)					**4**
8) Not Facing Directly Ahead (ie, along line of force of impact)					**4**
9) Longer Neck Than Average(Watts, has greater possibility of whiplash)					**11**
10) Larger Head Than Average(Watts, has greater possibility of whiplash)					**11**
11) Patient ejected from seat during impact					**4**
12) Patient's seat back broken by impact					**4**
13) Patient On Opposite Side Of Impact Of Light Truck (ARJ 8(4) Jul/Aug 96,p5)					**3,4**
14) Patient On Same Side Of Impact of Car (ARJ 8(4) Jul/Aug 96,p5)					**3,4**
15) Presence Of Postural Abnormality (ies): kyphosis, kyphotic hump, incr Lordosis					**11**
16) Collision Not In Line Rear End/Frontal Collision					**3,4**
17) Sustained Direct Trauma With Vehicle Interior					**4**
18) The center of gravity of the neck/head with the spine is displaced forwards					**11**
19) Not a bumper to bumper impact					**3,4**
20) Head level above the level of the top of seat/headrest (or more than 3" from it)					**3,11**
21) Patient in a car struck by a light truck (minivan, regular van, SUV, pickup)					**3**
22) Patient in vehicle that sustained multiple impacts					**3,4**
23) Patient in vehicle that experienced torque/spinning motions					**3,4**
24) Patient in vehicle which flipped/rolled over					**3,4**
25) Patient ejected from vehicle					**3,4**
26) Patient in vehicle struck by larger vehicle					**8**
27) Patient is pregnant					**7,8**
28) Predisposing Condition(s) Present					**7,8**
29) Preexisting Condition(s) Present					
30) Other					
31) Other					

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

VII.B-FACTORS AFFECTING INJURY IN SLIPS/FALLS

__Not assessed or not applicable

+1=slight/minor +2=mild/mod +3=severe/extreme/significant	No	+1	+2	+3
1) Blind or legally blind	X			
2) Poor eyesight not legally blind				
3) Hard of hearing				
4) Neuropathy involving feet/legs				
5) Motor deficit lower extremities				
6) Motor deficit upper extremities				
7) Amputation lower extremities				
8) Amputation upper extremities				
9) Cerebellar dysfunction				
10) Arthritis of hips/knees/legs				
11) Carrying/pushing/pulling objects one or both arms/hands				
12) Unaware of conditions of surface/area of fall				X
13) Very young, less than 10				
14) Very old over 70 or fragile elderly				
15) Disabled due to:				
16) Using walker/cane/crutches				
17) In cast/splint/prosthesis/other device				
18) In wheelchair				
19) Lack of warning of abnormal status of surface				
20) Debris on surface(eg, paper, fragments of glass/wood/etc, small trash):				X
21) Objects on surface (larger than debris):				
22) Strips/attachments/carpeting irregular or out of place or broken:				
23) Foreign substance on surface decreasing friction:				
24) Foreign substance on surface increasing friction:				
25) Surface made of material with low friction:				
26) Pieces of wood/metal/other protruding out of surface abnormally				
27) Surface irregular -visible:				
28) Surface irregular-camouflaged:				
29) Surface slanted upwards in direction of initial motion				
30) Surface slanted downward in direction of initial motion				
31) Surface slanted sideways up or down to left or right				
32) Surface with holes/pieces missing - visible or not visible				
33) Steps/stairs irregular or pieces missing				
34) No hand support or railing or railing/support broken/loose				
35) Surface very hard/rough				
36) Poor surface of shoes rubber/ slip ons=				
37) Shoestrings/other untied				
38) Presence of shorts/minimal clothing				
39) Pants/shirts over shoes/onto surface				
40) Loose shoes				
41) Very cold				
42) Very windy				
43) Contact with or by others in immediate area				
44) Area poorly lit				
45) Nighttime conditions				
46) Very bright sun				
47) Other				
48) Other				

Fall Type: X Trip ___Stumble ___Slip ___Crumple

Patient Name: Accident Code:

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

VII.C-Factors Affecting Repetitive Motion Injuries

__Not assessed or not applicable

+1=slight/minor +2=mild/mod +3=severe/extreme/significant		Rating			
		No	+1	+2	+3
1)	Light sources that can be seen by worker				
2)	Reflected glare on screen				
3)	Too much contrast between screen and surroundings or documents; Workers feels relief when bright areas are shielded				
4)	Very bright ambient lighting (above 500 lux or 50fc) or shadowed Areas caused by over-illumination				
5)	Monitor closer than 40cm(16 inches)				
6)	Different view objects at different distances from eyes				
7)	Screen or documents not oriented perpendicular to line of sight				
8)	Prolonged near focusing throughout the day with few far-focus opportunities				
9)	Monitor image dim, fuzzy, flickery, small or otherwise difficult to read				
10)	Shiny, low-contrast, or small print documents				
11)	Eyestrain complaints				
12)	Exertion of considerable physical effort to complete motion (awkward postures, increase force, contact stress)				
13)	Doing same motion over and over again (awkward postures, increase force, repetitive motions, cold temperatures)				
14)	Performing motions constantly without short pauses or breaks in between (awkward postures, static postures, increase force, repetitive motions, contact stress, vibration)				
15)	Performance of tasks that involve long reaches (awkward postures, static postures, increase force)				
16)	Work surfaces too high or too low (awkward postures, static postures, increase force, repetitive motions, contact stress)				
17)	Maintaining same position or posture while performing tasks (awkward postures, static postures, increase force, contact stress)				
18)	Sitting for a long time (awkward postures, static postures, increase force, contact stress)				
19)	Using hand and power tools (awkward postures, static postures, increase force, repetitive motions, contact stress, cold temps, vibration)				
20)	Vibrating working surfaces, machinery or vehicles (increase force, cold temps, vibration)				
21)	Work station edges or objects press hard into muscles or tendons (contact stress)				
22)	Using hand as a hammer (increase force, contact stress)				
23)	Using hands or body as clamp to hold object while performing tasks (awkward postures, static postures, increase force, contact stress)				
24)	Gloves are bulky, too large or too small (increase force, contact stress)				
25)	Objects or people moved are heavy (awkward postures, static postures, increase force, repetitive motions, contact stress)				
26)	Horizontal reach is long (distance of hands from body to grasp object to be handled) (awkward postures, static postures, increase force, repetitive motions, contact stress)				
27)	Vertical reach is below knees or above the shoulders (distance of hands above the Ground when the object is grasped or released) (awkward postures, static postures, increase force, repetitive motions, contact stress)				
28)	Objects or people are moved significant distance (awkward postures, static postures, increase force, repetitive motions, contact stress)				
29)	Bending or twisting during manual handling (awkward postures, static postures, increase force, repetitive motions)				
30)	Object is slippery or has no handles (awkward postures, static postures, increase force, repetitive motions)				
31)	Floor surfaces are uneven, slippery or sloped (awkward postures, static postures, increase force, repetitive motions)				

Areas Affected: ___Headache ___Eye ___Neck ___Back ___Shoulder
___Elbow/Forearm ___Wrist/Hand/Fingers ___Hip/Thigh ___Knee ___Ankle/Foot

Patient Name: Accident Code:

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

VII.D-FACTORS AFFECTING INJURIES IN ALL ACCIDENTS(For Non-MVA)

Treated Injury Within Three Years of This Injury: ___**None** _____

_____

Preexisting Conditions(conditions which are similar to the current injury but predated it) _____**None**

_____

Predisposing conditions(conditions which are not similar to the current injury but would lower the threshold of injury, make the injury more severe and contribute to prolonged injury greater than expected) _____**None**

_____

Preparation for Injury(being unbraced/untensed increases severity of injury)

_____totally unprepared for injury
____Muscles tensed not braced
_____Muscles untensed but braced
____Fully prepared for injury

VII.E –ADDITIONAL ASSESSMENT FOR WORKERS COMPENSATION ACCIDENTS

Based on the information I have assembled above in this history and examination, I can conclude the following **to reasonable medical probability.** If additional information is present, my assessment may or may not be modified.

___I have **inadequate evidence** to conclude whether this injury is work related or not.

___I feel this injury is **not work** related at this time.

___This injury (illness) is a manifestation of a definitely preexisting condition of a progressively deteriorating nature, which became apparent during work, but is **not due to work.**

___This injury **is work related** and is due to a discreet traumatic event which occurred during work.

___This injury **is work related** and is due to an appreciable period of work place exposure.

___This injury **is work related** and is due a series of traumatic injuries which have occurred over a period of time.

___This injury **is work related** and due to repetitive motion over a period of time.

Additionally, **if the injury is a work injury,** I also conclude to a reasonable medical probability:

___I **cannot make any additional conclusions** until I have received additional information.

___The **exposure is the sole condition** resulting in the patient's injury (illness).

___The **exposure is not the sole condition** resulting in the patient's injury (illness) but is a **material causative factor** in the condition's onset and/or progression.

___There is a **definite breakage,** or letting go, described in this injury (illness) while the employee was engaged in usual or normal activity on the job.

___There is a **definite relationship between the breakage and the effort** exerted or motion involved in the injury(illness) sustained.

___This patient has a **preexisting medical condition** (_____) which was precipitated, aggravated or accelerated **beyond its normal progression** by the work activity or incident discussed.

___This patient has a **predisposing medical condition** (_____) which was precipitated, aggravated or accelerated **beyond its normal progression** by the work activity or incident discussed.

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

VII.F-Additional Comments And Assessment For All Patients ___See Prior Notes

INITIAL PATIENT STATUS(DOCTOR CHECK ONE):

X **ACUTE**: New injury with symptoms. ___**SUBACUTE**: Significant symptoms past 6 weeks.

___**CHRONIC**: Significant symptoms past 12 weeks. ___**CHRONIC/RECURRENT**: Significant symptoms of over 12-14 weeks duration which are progressive and/or episodic.

___**ACUTE ON CHRONIC**: A preexisting or predisposing condition aggravated by an acute injury.

INITIAL HEALING PHASE AND GOALS(DOCTOR CHECK ONE):

___**PHASE I.** Inflammatory; 0-72 hours. Protect, Rest, Ice, Compress, Elevate.

X **PHASE II.** Regeneration; 72 hours to 6 weeks. Stabilize affected tissues and joints; minimize scar formation.

___**PHASE III.** Remodeling; 2 to 6 months. Enhance fibroelastic tissue matrix formation through motion exercises.

___**PHASE IV.** Degenerative/static. Failure of first three phases now or previous damage/injury. Return patient to previous strength and endurance.

___**PHASE V.** Degenerative/progressive. Predisposing or preexisting condition present. Strive for pain free joint motion; reduce chance of arthritic development or tissue degeneration.

VIII) PLANS(MDM)

1) **THERAPY ORDERS** ___**No therapy needed at this time. Will reevaluate as needed.**

TREAT: __Abdomen X Ankle(R) L) __Back (U M L) __Chest __Elbow/Forearm (R L) __Foot (R L) X Hand/Wrist (R L)

__Headache __Hip/Thigh (R L) X Knee/Leg(R L) __Neck __Pelvis (R L) __Shoulder/Arm (R L) __TMJ (R L)

MODALITIES: X Cold Packs(CP) __Endomed (EM) __Hill Table(HILL) X Hot Packs(HP) X Infrared(IR) X Magnathermy(MT)

__Massage(MASS) __Paraffin Bath(PB) __TENS __Traction-Back(TR-B) __Traction Neck(TR-N) X Ultrasound(US) __Ultratone(UT)

__Vibration(VB) __Whirlpool(WP)

THERAPIST MAY FURTHER EVALUTATE/TREAT: XYES ___NO **FREQ OF TX:** 2 per week for 3 wks

___**SEE SPECIAL THERAPY ASSESSMENT ORDERS** X **DO THERAPY/EXER AT HOME**

Therapy Goals: To decrease pain in all areas shown on page 12 to baseline levels.

2) **EXERCISE ORDERS** ___**No exercise needed at this time. Will reevaluate as needed.**

MAXIMUM LEVELS OF EXERCISE EXPECTED (DOCTOR CHECK ONE):

___**LEVEL I.** Low impact activities. Short slow movements sweeping through pain free range of motion as allowed by patient's condition.

___**LEVEL II.** Low impact assisted exercises. Extend short slow range of motion to maximum range of motion with a tolerated pain threshold limited by patient.

X **LEVEL III.** Progressive resistance exercises. Slow complete range of motion at tolerated pain levels with graded resistance at variable supervised speeds for endurance.

___**LEVEL IV.** Active resistive exercises. Slow complete range of motion at tolerated pain levels with dynamic resistance uploaded for strength and endurance.

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

PHYSICIAN HOME EXERCISE ORDERS AND STRETCHING SHEETS: ___**none** ___**continue**

___**Hand/Arm/Shoulder:** ___all ___1-9(hands) ___10-17(arm/shoulder) ___strengthening exercises

___**Neck/Shoulder/Arm:** ___all ___1-7(neck) ___8-18(shoulder/arms)

___**Lower Back:** ___all ___1-10(sitting/reclining) ___11-15 and lifting(standing/squat)

___**Groin/Hip:** ___all ___1-11(sitting/reclining) ___12-20(squat/stand/lean)

X **Upper and Lower Leg:** X all ___1-8(sitting/reclining) 9-18(sit/stand/squat/lean)

___**Pregnancy Sheet:** ___all ___1-7(reclining) ___8-13(sitting) ___14-19(stand/squat/lean)

Therapist to instruct and observe proper performance: X YES ___NO

Therapist to suggest additional home exercises for patient's specific condition X YES ___NO

PATIENT TO PERFORM 1 2 3 **SETS** 1 2 3 4 5 6 7 **DAYS PER WEEK**

PHYSICIAN ORDERS FOR IN CLINIC THERAPEUTIC EXERCISES: ____**none**

Sessions Per Week: 3

Number Of Weeks: 3 **Advance all therapy and exercise as tolerated.**

Begin Minutes Per Session: 15

Warm Up/Cool Down(Mins):

Exercise Level:(light/mod/heavy) light

Areas To Exercise: ___**thigh/hip R L** ___**low back** X **legs/knee R L** ___**abdomen**

___**shoulders R L** ___**upper back** ____**chest/upper arms R L** ___**forearm/wrist R L**

___**wrist/hands R L** ___**head/neck** ___**foot/ankle R L**

Other Comments:_____

Other Orders for Therapist: ___**teach/train in proper posture/body positioning**

___**teach/train in proper lifting techniques**

Exercise Goals: To improve all abnormal range of motions on page 12 to baseline levels. To recondition and redevelop endurance to baseline patient levels.

3) **MEDICATIONS/ETC**

____NONE

X OTC ANALGESICS

____CONTINUE CURRENT MEDS ____See PMD for tetanus shot/status

___dT given in R L deltoid Company:_____ Lot:_____ Expiration Date:_____

____OTHER_____

4) **OFF WORK/SCHOOL**

WORK/SCHOOL PRESCRIPTION (WP) DONE: ____YES(PLEASE REFER TO THIS FOR DETAILS) X NO

WORK: ___NO TIME MISSED FROM WORK ___No Work ___See WP **DOCTOR: Do Work Prescription**

FROM_____ TO _____

REEVALUATE ON _____ ____AS NEEDED

RETURN TO WORK ON_____RESTRICTIONS:____NONE ___light duty ___moderate ___heavy

SCHOOL: X NO TIME MISSED FROM SCHOOL ___No School ___See WP **DOCTOR: Do School Prescription**

FROM_____ TO _____

REEVALUATE ON _____ ____AS NEEDED

RETURN TO SCHOOL ON_____ RESTRICTIONS:___NONE __NO GYM FOR __WEEKS _____

5) X **DIAGNOSTIC EVALUATION** ____NONE

PROCEDURE CONCERN

_____

_____

The information on this form is necessary for proper documentation and handling of your injuries. Please be patient and complete this as best you can. This will help the doctor diagnose and manage your injuries most effectively. The staff and doctor will be **happy to assist you** if needed. - **Thank you very much.**

6) **RELEASE INFORMATION REGARDING ACCIDENT FROM:** ____NONE

HOSPITALS: __BURLINGTON __CHILDREN'S __COLUMBIA __ELMBROOK
__FROEDERT __KENOSHA __MENOMONEE FALLS COMMUNITY __OCONOMOWOC
__RACINE-ST MARY __ST FRANCIS __ST JOSEPH (MAIN BLUEMOUND) __ST LUKES
__ST MARYS(MILWAUKEE MEQUON) __ST MICHAELS __SINAI SAMARITAN
__TRINITY __WAUKESHA MEMORIAL __WEST ALLIS MEMORIAL __WEST BEND ST JOS.
OTHER HOSPITAL:_____

LARGE CLINICS: __AURORA CLINICS _____ __BURLINGTON CLINIC
__COLUMBIA CLINIC_____ __CONCENTRA CLINIC _____
__CONVENANT CLINIC _____ __DOWNTOWN HEALTH CLINIC
__FALLS MEDICAL CLINIC _____ __GLENDALE CLINIC __HARWOOD CLINIC
__IGNACE INDIAN CLINIC __IMMEDIATE CARE CLINIC __ISSAC COGGS CLINIC __JACKSON CLINIC
__JOHNSTON CLINIC __LAKESHORE CLINIC_____ __MCW/COLUMBIA CLINIC
__MED-SURG CLINIC __MEDICAL ASSOCIATES CLINIC _____ __METCALF PARK CLINIC
__MILWAUKEE MEDICAL CLINIC_____ __MLK HERITAGE CLINIC
__ST MARY CLINIC _____ __SOUTH 16TH STREET CLINIC __WEST BEND CLINIC
__WILKINSON CLINIC OTHER LARGE CLINIC:_____

DOCTOR/SMALL CLINIC:_____

7) **SET UP CONSULTS:** ____NONE

PROVIDER	CONCERN	TO DO

8) **ASSISTIVE DEVICES** __**None**

___Cane **___Crutches** **___Ace Wrap** **___ankle brace/splint** **___Knee brace/splint**
___Wrist Splint **___Forearm support** **___Neck Collar** **___Back Brace** _____

9) **OTHER PATIENT INSTRUCTIONS:**

___treat self/dependent at home/reassured

___if not improving at home before appointment, then call clinic for therapy sessions or reevaluation

10) **RETURN TO PHYSICIAN ON/IN:** ___1 Wk ___2 Wks __X__3 Wks ___4 Wks ___6 Wks ___ 8 Wks _____Wks

___MONDAY ___TUESDAY ___WEDNESDAY ___THURSDAY ___FRIDAY ___SATURDAY ___SUNDAY

SPECIFIC DATE:_____

CHARGES:

1- OV-LIM-NEW 2-OV-INT-NEW 3-OV-EXT-NEW 4-OV-COMP-NEW 5-OV-COMP-COMPLEX

Theresa Williams
PATIENT SIGNATURE-DATE

Michelle Flowers 7-30-02
STAFF SIGNATURE-DATE

7/30/02
PHYSICIAN SIGNATURE-DATE

Initial Worksheet: MVA 2/13/93; Revised: 3/31/93; 6/15/93; 8/1/93; 11/4/93;3/31/95;6/26/97;1/2/98
Major/Other Revision: **1/1/96**; 2/1/96;10/17/96;**10/25/97**;3/13/98;5/13/98;6/1/98;7/24/98;**1/1/2000**;2/29/00; 9/1/00;**5/1/01;8/1/01;10/1/01; 1/2/02**

For PART B-Therapy And Exercise Orders see orders above and separate sheets.

For Part C-Follow-Up Visits –see separate sheets.