



# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

This report is being prepared under the guidance and direction of the IL workers compensation commission formally known as the IL industrial relations commission. Although it is not mandatory, we at the Spine Institute require proper reporting on every injured worker. This report is an initial report of findings and personal patient information which is current and for the sole purpose of the insurance co and claims examiners records. This report will also serve as an initial report that will include working diagnosis, recommended beginning treatment protocol and overall outline of the patients condition at this time and what we expect to accomplish in a reasonable time period through proven and proper treatment methods that have been tested and tried over many years. Regular written reports or progress reports will be submitted every thirty to 45 days or 10 to 12 visits of care, whichever ever comes first.

1. INSURER NAME AND ADDRESS -		CLAIM NUMBER:		PLEASE DO NOT USE THIS COLUMN	
2. EMPLOYER NAME -					
3. ADDRESS: NO. and STREET		CITY		STATE ZIP	
4. NATURE OF BUSINESS (e.g., food manufacturing, building construction, retailer of women's clothes)					County
5. PATIENT NAME (First name, middle initial, last)		6. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		7. DATE OF BIRTH: Mo Day Yr. Age	
8. ADDRESS: NO. and STREET		CITY		9. TELEPHONE NUMBER: Hazard	
10. OCCUPATION (Specific job title)				11. SOCIAL SECURITY NUMBER: Disease	
12. INJURED AT: NO. and STREET		CITY		COUNTY Hospitalization	
13. Date and hour of Injury or onset of illness		MO DAY YR		14. Date last worked Mo. Day Yr. Occupation	
02/22/07		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		03/02/07	
15. Date and hour of first examination or treatment		MO DAY YR		16. Have you (or your office) previously treated patient? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no Return Date/Code	
04/12/07		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM			

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to work comp under Illinois WC act. 17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required)

Patient works for his employer for over 6 years as a mechanic. He works M-F around 8 hours a day. On 02/22/07 patient started his usual shift at 8:00am and for couple of hours worked on cars without lifting anything heavy. Around 2:00pm, patient had a car elevated on a lift and was changing car's brakes. He lifted the first tire from the ground and felt immediate pain in his low back. He thought he pulled a muscle and continued to lifting tires. He finished his shift with pain. He had difficulty sleeping at night due to pain in his low back. The next day he worked with pain thinking it would go away. Then for the next two days (weekend 02/24/07 & 02/25/07) he rested. He worked for another week while taking over the counter pain pills and finally could not take pain anymore. He told his supervisor Chris Davenport that he was going to a doctor. Pt went to his primary care physician John Lee M.D. Pt had MRI on 03/06/07 showing herniated disks. Dr. Lee referred Pt to neurologist Dr. Chhabria. Pt went to Dr. Chhabria on 03/12/07 and was given pain medications and a hot pack. Dr. Chhabria told pt not to work for a week. Pt was scheduled for another visit to perform a nerve test but it was not authorized. Pt went an additional 2 weeks without therapy and only took pain pills. Patient continues with pain and wishes to be treated.

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required)  
 1) Low back pain bilateral sides more on the right side that is sharp, and constant. Pain is worse with sitting and laying down. He has difficulty sleeping at night due to low back pain. 2) Radiating pain into right thigh/leg to distal leg. 3) Numbness throughout right thigh/leg that is constant.

19. OBJECTIVE FINDINGS (use reverse side if more space is required)  
 A. Physical examination

**PHYSICAL EXAM:** Height 169cm, Weight 183lbs, BP 136/90 seated on right side, Pulse 86 and regular, Respirations 14.

**THORACOLUMBAR:** Range of motion in flexion 35 degrees with extreme pain, extension 10 degrees with extreme pain, R. Lateral flexion 15 degrees with pain, L. Lateral flexion 15 degrees with pain, R. Rotation 30 degrees with pain, and L. Rotation 30 degrees with pain. **INSPECTION:** No ecchymosis. No erythema. No deformity or swelling noted. Circumferential measurements within normal limits for lower extremities at this time. **PALPATION:** Trigger points with moderate spasm noted throughout bilateral paraspinal, bilateral piriformis, and bilateral gluteus medius muscles. Segmental dysfunctions throughout T6-T8 and L4-S1. Vertebrae compression severely tender at L4-S1. **SPECIAL TESTS:** (+) SLR on right at 30 degrees and SLR on left causes low back pain, (+) Braggards 25 degrees on right, (+) Kemps bilaterally, (+) Nachlas bilaterally, (+) Ely's bilaterally.

**MUSCLE STRENGTH:** Hip Flexors 5/5 for L and 4/5 for R, Knee extensors 5/5 for L and 4/5 for R, Knee flexors 5/5 for L and 3/5 for R, Foot inversion 5/5 for L and 4/5 for R.

**NEURO:** Reflexes for upper extremities +2 and lower extremities +1 and symmetrical. Pathological reflexes negative. Patient was able to walk on his heels and toes but experienced pain in his low back.

B. X-ray of lumbar spine taken with misalignments and rotations throughout. Radiologist report pending. CT scan of lumbar spine signed by Steven Nydick M.D. shows central disk protrusion at the L4-L5 level producing moderate impression upon the ventral thecal sac and upon the L5 nerve root sleeves bilaterally. Bulging disks at L1-L4 with mild impression upon the ventral thecal sac.

**DOCTOR'S FIRST REPORT**

DOI:  
RE:  
CL#:

<p>20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.)</p> <ol style="list-style-type: none"> <li>1) LUMBAR DISC INJURY/ SYNDROME - Bulges at L1-L5</li> <li>2) LUMBAR RADICULOPATHY</li> <li>3) MUSCLE WEAKNESS, Lower Extremity</li> <li>4) MUSCLE SPASM, Internal Rotatory and Paravertebral Muscles, Primary</li> <li>5) LUMBAR SPRAIN/ STRAIN - Chronic</li> <li>6) MYOFASCITIS, Lumbar Spine</li> <li>7) MULTIPLE VERTEBRAE DISPLACEMENT - Lumbar</li> <li>8) MULTIPLE VERTEBRAE DISPLACEMENT - Thoracic</li> <li>9) Lumbar Segmental Dysfunction</li> <li>10) Sacral Segmental Dysfunction</li> <li>11) Pelvic Segmental Dysfunction</li> <li>12) SWELLING and INFLAMMATION, Nerve Roots and L-Sp Soft Tissue</li> <li>13) DIFFICULTY WALKING, Prolonged Gait Alteration 2<sup>nd</sup> to L-sp Pain</li> <li>14) LUMBOSACRAL PLEXUS DISORDER</li> </ol>	<p>Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>ICD-9 Code:</p> <ol style="list-style-type: none"> <li>1) 722.10</li> <li>2) 724.4</li> <li>3) 728.87</li> <li>4) 728.85</li> <li>5) 847.2</li> <li>6) 729.1</li> <li>7) 839.20</li> <li>8) 839.21</li> <li>9) 739.3</li> <li>10) 739.4</li> <li>11) 739.5</li> <li>12) 716.95</li> <li>13) 719.7</li> <li>14) 353.1</li> </ol>
<p>21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "no," please explain.</p>	
<p>22. I there any other current conditions that will impede or delay patient's recovery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please explain.</p> <p>Patient is suffering from multiple disc bulges and secondary ligamentous disruption with probable Vertebral Segmental Translation. This is causing radicular pain, pressure on the thescal sac that is continual and worse symptomatology with positional behavior. There will be difficulties in achieving avenues of success without cooperation on certain medical intervention and authorization for medical services needed. *( see below for recommendations. )</p>	
<p>23. TREATMENT RENDERED (Use reverse side if more space is needed)</p> <p>The patient initially was given a thorough consultation and a detailed history and examination was performed in our office that consisted of neurological and orthopedic measure through AMA guidelines. He was also tested thoroughly with muscle testing in the lower extremities, range of motion of his lumbar spine along with reflexes. 5 view X-rays of his lumbar spine were taken. He was then referred to our therapy department and was scheduled for his rehabilitation and therapy sessions.</p>	
<p>24. If further treatment required, specify treatment plan / estimated duration.</p> <p>This patient will need additional treatment in the form of Physical Therapy and CMT procedures daily for the first 1-2weeks, then 3x's per week with a gradual reduction of weekly visits until such time the patient can be released as stable and static. Course of treatment will be approximately 6-8 weeks however, request leniency if indeed the time line of care goes beyond these guesstimates due to delay in care. <b>WE WILL NOT PROCEED FORWARD WITH CONTINUED CARE</b> unless the patient <b>IS SHOWING IMPROVEMENT</b> on a fairly consistent basis. Patient will begin with Physical Therapy and CMT procedures. After the first or second week, we will attempt to start patient on therapeutic exercises as tolerable and eventually start work conditioning/hardening. The rehabilitation will be comprised of specific spinal strengthening machines with Life Fitness Cardio Equipment utilized to also increase the patient's functional capacity overall and finally, range of motion exercises/ stretching of the lower extremities, hips and low back. If patient does not show adequate progress or improvement in 2 weeks, his treatment plan will be re-evaluated and changed accordingly. Since the MRI scan exhibits multiple disc problems with secondary neurologic insult, we will soon begin VAX-D decompression therapy to his low back to reduce the pressure to his lower spine and to assist the disc bulges in reducing in size and shape. This procedure must be performed on a regular basis several times per week, in conjunction with the therapy, up to 20 sessions which is what's recommended per case studies and research. The patient should be seen by our Medical Neurologist for further opinion as to other options that might be available to mitigate expense and expedite the patient's recovery. Medication choices will also be evaluated for him. We do not know at this time, whether or not this patient is a surgical candidate. We will schedule him with Dr. Jonathon Citow, Neuro-Surgeon Specialist of Lake County Neurosurgery. Re-exams will be every 30 days for improvement status or if there are changes with his recovery or further authorization is needed for other medical services. Patient is in need of Electro-diagnostic assistance and will be necessary to refer the patient accordingly for a lower NCV/EMG. We could not find in the record the study and noted that it was delayed due to authorization problems. We ask that you please authorize this at this time to be performed as well as the MD evaluation and treatment regimen recommended. The Neuro-Surgeon will want to see the study and scans during his review. Thank you for your assistance.</p>	
<p>25. If hospitalized as inpatient, give hospital name and location.</p> <p>N/A</p> <p style="text-align: right;">Admitted date: MO DAY Year Estimated Stay None</p>	
<p>26. WORK STATUS-is patient able to perform usual occupation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If "no," Date when patient can return to: Regular Work:</p> <p>Modified Work <u>Patient is TTD from 04/12/07 to 04/20/07 where restrictions may be implemented.</u></p> <p>Is permanent residual disability anticipated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown</p> <p>If "yes," to what extent:</p>	

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DOI:  
RE:  
CL#:

Doctor's Signature: _____	IL License Number 038-010349
Doctor's Name and Degree (please type) <u>Dr. Kelly G. Worth, D.C., F.A.F.I.C.C., D.A.C.A.N.</u>	IRS Number 20-2713448
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