



**SPINE
INSTITUTE
OF
WAUKEGAN**

Workers Compensation Specialists

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 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, which ever comes last. Disability issues are discussed at the bottom of this report and will be updated accordingly.

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			STATE		9. TELEPHONE NUMBER:		ZIP	
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	HOUR	14. Date last worked		Mo	Day	Yr.
					<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM					
15. Date and hour of first examination or treatment		MO	DAY	YR	HOUR	16. Have you (or your office) previously treated patient?		<input type="checkbox"/> yes	<input checked="" type="checkbox"/> no	
					<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM				Return Date/Code	
<p>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.</p> <p>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is require)</p> <p>Patient has worked at the above location for approximately eight years Monday-Friday eight hours a day. Job usually entails painting cars, lifting car parts such as doors, and auto bodywork. He began work on 05/16/07 around 8:00 a.m. Through out the day he kept bending down and swinging and twisting his body side to side to paint cars, and occasionally had to lift car doors/parts in order to paint them. Around 4:45 p.m. patient was painting a car's fender with his knees bent, and when he stood up he suddenly felt immediate severe pain in his low back. Patient sat back down to rest for couple of minutes due to his pain. He then stopped working and went to tell his boss Hector about what had just happened. Hector told the patient to go to the hospital if he had a lot of pain. Patient did not continue working and was taken home by a friend. Once at home patient laid on the floor for a couple of hours with pain. Patient continued with pain and inability to stand up due to severe pain, and therefore his wife around 9:00-9:30pm decided to call an Ambulance. Once the ambulance arrived, the paramedics gave the patient morphine. The ambulance drove patient to Victory Hospital ER where x-rays and blood work were done. Patient was admitted to the floor on 05/16/07. Patient had pain medication while admitted and had a CT scan to his low back. Patient was released from the hospital on 05/18/07 and referred to see Dr. Parreno M.D. for a follow-up. Patient rested for a few days and went to see Dr. Parreno M.D. on 05/24/07 in Waukegan. Dr. Parreno M.D. gave patient new medications and took him off work for 2 week and patient was to return on June 5, 2007. Dr. Parreno M.D. referred patient to our facility for treatment and evaluation. Patient presents with pain and evaluation.</p>										
18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required)										
<p>1) Low back pain more that is more in middle and left side of back. Pain at the moment is on/off and at times it is constant. Pain is sharp and dull at times. Sitting and walking increases the pain. 2) Radiating pain for middle of back to left gluteus muscle. 3) Difficulty walking with weakness in lower extremities.</p>										
19. OBJECTIVE FINDINGS (use reverse side if more space is required)										
A. Physical examination										
<p><u>PHYSICAL EXAM:</u> Height 74inches, Weight 288lbs, BP 135/82 seated on right side, Pulse 78 and regular, Respirations 14. Alert, awake, and oriented x 3. Postural observation shows a right head tilt, left head rotation, right elevated shoulder, and a right elevated iliac crest.</p> <p><u>THORACOLUMBAR:</u> Range of motion in flexion 30° with pain, extension 20° with pain, R. Lateral flexion 20° with pain, L. Lateral flexion 20° with pain, R. Rotation 30° with pain, and L. Rotation 30° with pain. <u>INSPECTION:</u> No ecchymosis. No erythema. No deformity. Swelling is noted in and around the lowerregions of the lower spine, particularly around the SI region bilaterally with semi hard nodules particularly on the left side. <u>PALPATION:</u> Trigger points, tenderness and spasms noted throughout bilateral lumbar paraspinal, piriformis, and gluteus medius muscles. Moderate tenderness in bilateral sacroiliac joints. Vertebrae compression moderately tender at L3-S1. <u>SPECIAL TESTS:</u> (+) SLR on left at 35 degrees and (-) on the right, (+) Kemps bilaterally, (-) Nachlas bilaterally, (-) Ely's bilaterally.</p>										

DOCTOR'S FIRST REPORT

DOI:
RE:
CL#:

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

NEURO: Reflexes for upper and lower extremities 2+ bilaterally and symmetrical. Pathological reflexes negative.

B. X-ray and laboratory results (State if none or pending.)

20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.)	Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1) Lumbar Intervertebral disc displacement, L4-S1 2) LUMBAR RADICULOPATHY 3) MUSCLE WEAKNESS, Lower Extremities 4) MUSCLE SPASM 5) Lumbar strain/sprain 6) Myofascitis 7) Lumbar Segmental Dysfunction 8) Sacral Segmental Dysfunction 9) Pelvic Segmental Dysfunction 10) Thoracic Segmental Dysfunction	ICD-9 Code: 1) 722.10 2) 724.4 3) 728.87 4) 728.85 5) 847.2 6) 729.1 7) 739.3 8) 739.4 9) 739.5 10) 739.2

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no," please explain.

22. I there any other current conditions that will impede or delay patient's recovery? Yes No If "yes," please explain.

If work restrictions are not honored or proper treatment and therapy authorized.

23. TREATMENT RENDERED (Use reverse side if more space is needed)
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.

24. If further treatment required, specify treatment plan / estimated duration.
This patient will need additional treatment in the form of Physical Therapy and CMT procedures daily for the first week, 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 should not be longer than 6-8 week however, request leniency if indeed the time line of care goes beyond these guesstimates due to complications of care. Patient will begin with passive physical therapy modalities such as e-stim, hot packs, ultrasound, manual therapy, and CMT procedures. After a few visits, we will attempt to start patient on active care such as therapeutic exercises as tolerable that will include strengthening, stretching, and range of motion as MD requested. If patient does not show adequate progress or improvement in 2 weeks, his treatment plan will be re-evaluated and changed such as adding VAX-D decompression therapy to his low back. Re-exam will be every 30 days. If patient does not improve as we expect or by his next re-exam, low back MRI and/or Electro-diagnostic assistance will be necessary. We will co-manage case with patient's primary doctor Dr. Xavier Parreno M.D.

25. If hospitalized as inpatient, give hospital name and location. Admitted date: MO DAY Year Estimated Stay
VICTORY MEMORIAL HOSPITAL 05 16 07 Half Day

26. WORK STATUS-is patient able to perform usual occupation? Yes No
If "no," Date when patient can return to: **DEFER TO DR. PARRENO, MD**
Regular Work: _____ Modified Work: _____ Specify restrictions:
Is permanent residual disability anticipated? Yes No Unkown
If "yes," to what extent:

Doctor's Signature: _____ IL License Number 038-010349
Doctor's Name and Degree (please type) **Dr. Kelly G. Worth, D.C., F.A.F.I.C.C., D.A.C.A.N.** IRS Number 20-2713488
Address 2634 Grand Avenue, Suite #100, Waukegan, IL 60085 Telephone Number (847) 775-0800