



State of Illinois
Workers' Compensation Commission
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR2)
PROGRESS REPORT UPDATE

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e. has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

Form with checkboxes for: Periodic report (required 30-45 days after last report), Change in treatment plan, Discharged, Change in Work Status, Need for referral or consultation, Info. Requested by, Change in patient's condition, Need for surgery or hospitalization, Other: NEED FOR CONTINUED CARE

Patient: *(see below) Treatment Facility: SPINE INSTITUTE of WAUKEGAN, LLC

Form with fields for: Last, First, MI, Sex, D.O.B., Address, City, State, Zip, Occupation, SS#, Phone

Form with fields for: Claims Administrator Name, Claim Number, Address, City, State, Zip, Phone, Fax

Employer Name: Employer Phone:

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Patient presents today for her first re-exam. Patient states that she still has neck complaints but she feels she has improved over 50% and is much better. She will have pain at night sometimes while sleeping and during the day while she has her neck in a flexed position. Otherwise, she feels much better. She also feels that her right shoulder, although is still in some discomfort, is much better and seems to be healing from the therapy and rehab.. She feels however pain and stiffness that is moderate, in her right brachium or upper arm just below the deltoid insertion or lateral aspect of the brachium. The left side she states is better and not as bad, but the right is not and seems to hurt every time she lifts her arm to flip off a light switch or anything that is at or above horizontal. Patient has right and left hand and wrist pain from when she went down on all four's. Her arms still are sore, right worse than left and she still is experiencing the pain in her wrists and hands along with intermittent numbness. Patient states that she cannot cook, clean teeth, clean house, do her regular ADL's and/or successfully perform her meticulous detailed work at the Dental office. She has no more complaints with her right or left knees at this time.

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Her right hand grip strength measures today at 20, 23 and 20. The left side shows 39, 37 and 35. Patient's reflexes for the right side upper are (+)1 and for the left are (+)2. Lower extremity reflexes are (+)1 for the left and "0" for the right. Compression to spinous processes are moderately tender at L3-L5, and C6-T1. Orthopedic tests for lumbar spine were negative. Cervical range of motion is slightly decreased in all directions with slight stretch in flexion and right lateral flexion. Orthopedic tests for cervical spine were (+) cervical compression, (-) left shoulder depression, (+) right shoulder depression. Lumbar range of motion is decreased in flexion, left lateral flexion with some pain, and right rotation with some pain. Shoulder range of motion, right side, is decreased in all directions but mostly in flexion with pain, abduction with pain, and internal rotation. Muscle spasm is noted in cervical and thoracic, and lumbar paraspinals. Tenderness and myospasm in lumbar spine are compensatory it would seem to the Thoracic spine although it is possible that the patient injured this when she fell down of all four's as the sEMG graph is positive in this area.

Diagnoses:

Table with 2 columns: Diagnosis description and ICD-9 code. Includes: 1. Right Rotator Cuff Injury/ Syndrome, r/o Tear (ICD-9 726.10), 2. Numbness and tingling of upper extremities bilaterally with the right dominant; r/o traumatic Median Nerve Neuropathy (ICD-9 782.0), 3. Cervical Radicular pain (ICD-9 723.4), 4. Sprain/strain of neck/thoracic spine (ICD-9 847.0, 847.1), 5. Superficial and Deep Myospasms throughout upper torso/ traps/ c-sp (ICD-9 728.85), 6. Right Knee Sp/St - Injury/ Resolving (ICD-9 844.8 - Resolving)

Treatment Plan: Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation or acupuncture) Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Patient has done well this past 4 weeks with her care and we anticipate her to continue to improve as expected. Patient will continue with her treatments. She will be seen 3x's per week for an additional four weeks at which point she will be re-examined. She has been fairly consistent with her regimen of treatment and has felt improvement with her treatments but she is still having hand pain. We will have her engage in further hand, wrist and upper extremity rehabilitation/ exercises as this seems to be helping her the most. She will receive Physical Modalities as needed for healing of the median nerve injury.

PROGRESS REPORT - PR2

EXAM DATE

DOI:

RE:

NCV results are positive for Median Nerve Damage and exhibits serious delays for the left side and slight to moderate findings on the opposite side. This patient will engage in deep myofascial release for the wrists bilaterally as well as rehabilitation exercises directly to the wrists. She may need to see our Medical Neurologist for second opinion and/or our upper extremity specialist to evaluate whether or not she is a surgical candidate. We will keep you posted with her progress.

Work Status: this patient has been instructed to:

Remain off work until: _____

Continue modified work on: 09/07/06 **WITH THE FOLLOWING RESTICTIONS:**

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.): **Restricted from lifting >25lbs. No excessive gripping with the right hand. No lifting at or above shoulder level with the upper extremities bilaterally.**

Continue at full duty: _____ with no limitations or restrictions.

Primary Treating Physician: (Original signature, do not stamp)

Date of exam: 09/07/06

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated any WCC Illinois Laws.

IL Lic. #: 038-010349

Signature: _____

Executed at: Lake County, Illinois

Date: 09/07/06

Name: Dr. Kelly G. Worth, D.C., FAFICC, DACAN, DABCI

Specialty: Chiropractic Neurology and Rehabilitation

Address: 2634 Grand Avenue, Suite #100, Waukegan, IL 60085

Phone: (847) 775-0800

WCC Form PR-2 (Rev. 8/29/05)

(Use additional pages, if necessary)