Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: "*Comments***".

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Motor Vehicle vs Motorcycle Collision** on **MM/DD/YYYY,** the injuries and clinical condition of **XXXX** as a result of accident, treatments rendered for the complaints and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	*No prior injury records available.*
Date of injury	MM/DD/YYYY
Description of injury	Patient states that he was riding his motorcycle on the freeway and was slowing down merging into traffic when he and his father were struck on the rear end by a large truck. Sadly his father passed away at the scene. Patient was thrown off of his motorcycle landing on his head and his side. There was no loss of consciousness. His motorcycle was totaled. Police and ambulance were at the scene and ambulance transported him to Sutter emergency department.
Injuries/ Diagnoses	• Post-traumatic headache, unspecified • Working diagnosis of concussion • Pain, cervical spine, with radicular symptoms • Pain, right shoulder • Pain, left shoulder • Pain, spine, thoracic • Pain, spine, lumbar • Acute stress disorder • Posttraumatic stress disorder (PTSD), acute • Major depressive disorder, single episode, moderate, without psychotic features • Memory and cognitive decline • Secondary insomnia • Dizziness and disequilibrium • Forgetfulness, poor memory • Poor concentration • Taking longer to think • Blurred vision • Light sensitivity (easily upset by bright light) • Restlessness • Headache attributed to TMD • Arthralgia • Myalgia
Treatments rendered	**Medications:** • Pain medications • Muscle relaxers • Anti-depressants **Therapy/Rehabilitation sessions:** • Psychotherapy/Cognitive behavior therapy from MM/DD/YYYY to MM/DD/YYYY at The Brain Works Neuropsychological Evaluation and Treatments • Physical therapy on MM/DD/YYYY at Select Physical Therapy **Procedures/Surgeries:** **MM/DD/YYYY:** • Stem cell infusion

	• Trigger point injection X 6 spots (3 on each side in the trapezius muscles) • Cervical interlaminar epidural steroid injection
Condition of the patient as per the last available record	As of **MM/DD/YYYY,** patient presented to XXXX at The Brain Works Neuropsychological Evaluation and Treatments to receive psychotherapy for the post-traumatic stress disorder. The patient presented with ongoing significant stress related to severe sleep disturbance, unresolved legal and financial matters, family dynamics, and grief associated with his father's death. He reported difficulty falling asleep, frequent awakenings throughout the night, vivid nocturnal sensations, and persistent daytime exhaustion. The patient attributed much of his sleep difficulty to ongoing stressors, including frustration with medical concerns and management of his father's estate. He also described feeling overwhelmed by the accumulation of responsibilities and acknowledged difficulty maintaining consistent self-care routines, including exercise, nutrition, and stress management. The patient endorsed persistent symptoms of sleep disturbance, stress, frustration, grief, depressed mood, and irritability. He described severe fatigue, poor sleep quality, and feeling emotionally and physically depleted. Grief remains active as he continues working with family members on his father's headstone and estate matters, though he described the headstone selection process as meaningful and therapeutic. He was recommended to continue psychotherapy focused on stress management, grief processing, emotional regulation, sleep improvement, and reinforcement of adaptive coping strategies. He was also encouraged to delegate estate-related responsibilities where possible.

Patient History

Past Medical History:

- The patient's past medical history is positive for hypercholesterolemia two years ago and a workers' compensation injury of the right shoulder in YYYY.
- Right ankle fracture
- (**PDF REF:** 265, 412)

Surgical History:

- Right ankle surgery, finger surgery, eye (pterygium) surgery
- The patient's past surgical history is positive for a right ankle in 1999 and a right 4th digit surgery in 1999-YYYY. (**PDF REF:** 265, 412)

Family History:
Mother: Alcoholism (**PDF REF:** 8)

Social History: The patient does not smoke. The patient reports drinking 1-2 drinks a week. (**PDF REF:** 265)

Allergy: No known drug allergies. (**PDF REF:** 8)

Detailed Summary

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Reviewer's Comment: Medical records prior to MM/DD/YYYY if any are unavailable for review.			
Summary of post injury medical records ***Date of injury: MM/DD/YYYY***			
MM/DD/YYYY	Hospital/ Provider	**Initial office visit for motor vehicle collision:** **Focused Subjective History:** The patient stated that he scheduled a visit with Medical due to unresolved pain and symptoms that started after a motor vehicle collision that occurred on or around MM/DD/YYYY. The patient stated that after the collision he tried medications and rest, which have helped, somewhat. The patient stated that since the collision he continues to have headaches as well as pain and unresolved symptoms to his neck, right shoulder, left shoulder and lower back. The patient stated he continues to experience symptoms that radiate from his neck down his left arm. **Past medical history:** The patient stated that he did have an injury to his right shoulder and lower back prior to the subject injury, he stated it was stable and the collision caused his need for additional medical care for this body part. The patient stated that he has a medical history of dyslipidemia. The patient stated that he had a right ankle surgery and right ring finger surgery. **Focused Physical Examination:** **Cervical spine:** The patient had abnormal range of motion with cervical spine flexion, and this did increase symptoms. The patient had abnormal range of motion with cervical spine extension, and this did increase symptoms. The patient had abnormal range of motion with right cervical tilt, and this did increase symptoms. The patient had abnormal range of motion with left cervical tilt, and this did increase symptoms. The patient had abnormal range of motion with right cervical rotation, and this did increase symptoms. The patient had abnormal range of motion with left cervical rotation, and this did increase symptoms. **Left upper extremity:** While performing 10 repetitions of opening and closing the hand and fingers into a fist, the patient reported that strength was not diminished compared to baseline. With repeated wrist extension, the patient reported that strength was not diminished compared to baseline. With repeated shoulder abduction, the patient reported that strength was not diminished compared to baseline. With scratching the skin overlying the palm, the patient reported that sensation was not diminished compared to baseline. With scratching the skin overlying the lateral deltoid, the patient reported that sensation was not diminished compared to baseline. **Right shoulder:** The patient had normal range of motion with shoulder abduction, and this did increase symptoms. The patient had normal range of motion with shoulder adduction, and this did increase symptoms. The patient had normal range of motion with shoulder flexion, and this did increase symptoms. The patient had normal range of motion with shoulder extension, and this did increase symptoms. The patient had normal range of motion with shoulder external rotation, and this did increase symptoms. The patient had normal range of motion with shoulder internal rotation, and this did increase symptoms.	198-201

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		Left shoulder: The patient had normal range of motion with shoulder abduction, and this did increase symptoms. The patient had normal range of motion with shoulder adduction, and this did increase symptoms. The patient had normal range of motion with shoulder flexion, and this did increase symptoms. The patient had normal range of motion with shoulder extension, and this did increase symptoms. The patient had normal range of motion with shoulder external rotation, and this did increase symptoms. The patient had normal range of motion with shoulder internal rotation, and this did increase symptoms.
		Thoracic spine: The patient had abnormal range of motion with thoracic spine flexion, and this did increase symptoms. The patient had abnormal range of motion with right thoracic rotation, and this did increase symptoms. The patient had abnormal range of motion with left thoracic rotation, and this did increase symptoms.
		Lumbar spine: The patient had abnormal range of motion with lumbar spine flexion, and this did increase symptoms. The patient had abnormal range of motion with lumbar spine extension, and this did increase symptoms. The patient had abnormal range of motion with right lumbar tilt, and this did increase symptoms. The patient had abnormal range of motion with left lumbar tilt, and this did increase symptoms.
		
		Assessment:
		• Post-traumatic headache, unspecified
		• Working diagnosis of concussion
		• Pain, cervical spine, with radicular symptoms
		• Pain, right shoulder
		• Pain, left shoulder
		• Pain, spine, thoracic
		• Pain, spine, lumbar
		
		Recommendations:
		• I recommend that the patient have consultation and treatment with a board certified neurologist.
		• I recommend that the patient undergo a course of conservative care (for instance, physical therapy, at-home exercises / tele-physical therapy, chiropractic care, etc.).
		• I recommend that the patient have a cervical spine MRI without contrast.
		• I recommend that the patient have a follow up visit to review MRI results.
		• If pain and symptoms persist after 4-6 weeks of conservative care, then I recommend:
		  ○ I recommend that the patient have a lumbar spine MRI without contrast.
		  ○ I recommend that the patient have a follow up visit to review MRI results.	

MM/DD/YYYY	Hospital/ Provider	**Video telehealth psychotherapy progress note:** **Session #:** 1 **Therapeutic Techniques Used:** Cognitive Behavior Therapy (CBT) **Current Diagnoses:** Acute Stress Disorder	3-5

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		Mental status exam: **Attitude:** Open **Affect:** Appropriate **Mood:** Depressed **Cognition:** Intact **Insight/Judgment:** Good **Comments:** Patient is in active mourning state and is struggling **Topic for today's session:** Anger Acceptance **Patient's participation:** Active Participation **Treatment summary/progress:** **Subjective:** The patient presented seeking support for acute grief and trauma following the recent and sudden death of his father, which occurred during their annual motorcycle trip. During the trip, a Caltrans truck struck and killed the patient's father; the patient was also injured in the same collision. He described witnessing the traumatic event and experiencing intense emotional distress, physical injury, and survivor's guilt. He reported feeling "out of my mind" and noted that the emotional pain is so overwhelming that it interferes with his ability to implement coping strategies. He expressed a strong internal pressure to maintain the appearance of strength for the sake of his family, which may be impeding his own grieving process. He reported significant difficulty sleeping without distraction and acknowledged that the loss has left him emotionally and mentally destabilized. The patient described his 78-year-old father as the "base" of the family — a central, grounding figure off whom "everything kind of like hung." Since the death, the family has felt "spread out" and directionless. He is close with his father's partner, who is also grieving, and voiced deep concern for his younger brother, who witnessed the accident and is reportedly coping through alcohol use and social withdrawal. The patient lives with his son and feels a heavy sense of responsibility to support others, potentially at the cost of his own emotional processing and healing. He appears to be experiencing complicated grief with symptoms indicative of trauma-related distress. **Objective:** A semi-structured clinical interview served as the primary assessment tool during this session. The interview was used to establish therapeutic rapport, provide immediate psychological first aid, and gather initial information regarding the patient's presenting concerns, including the nature of the traumatic event, current emotional symptoms (such as grief, guilt, and anger), coping strategies, and family dynamics. This approach was intentionally person-centered and supportive, rather than diagnostic, aligning with the clinician's goal of being "available as more of a clinician" in the immediate aftermath of trauma. In terms of risk assessment, the patient was determined to be at moderate risk due to the severity of his acute traumatic grief response. Although he denied current substance use and did not endorse any thoughts of self-harm or suicidal ideation, the intensity of his emotional distress, survivor's guilt, and the violent nature of the traumatic event are significant risk factors for the potential development of complicated grief or other trauma-related disorders. Therapeutic interventions employed during the session included elements of Humanistic/Person-Centered Therapy, Grief Counseling, and Supportive	

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		Therapy. Psychoeducation was provided regarding the non-linear nature of grief, emphasizing that emotions such as anger may arise and dissipate over time and that getting "stuck" in any one emotional stage can complicate healing. The clinician offered validation of the patient's survivor's guilt and emotional pain, normalizing these feelings as real and understandable reactions to traumatic loss. The session also included exploration of the patient's efforts toward meaning-making, particularly regarding a dream in which he believed his father had saved his life. This was gently framed as a potentially comforting and connecting experience. A therapeutic writing exercise—specifically writing a letter to his deceased father—was suggested as a concrete tool to facilitate emotional expression and processing of unresolved feelings. **Assessment:** XXXX was highly engaged, articulate, and receptive throughout this initial session. He demonstrated a strong capacity for introspection and was willing to share deeply personal and painful details related to the traumatic event and its emotional impact. He responded positively to the clinician's validation of his emotional experiences and appeared to find some comfort in exploring spiritual themes and early meaning-making related to his grief. XXXX actively participated in the session, reflecting thoughtfully on his grief, survivor's guilt, and family dynamics. **Follow up actions and plan:** **Treatment Recommendations:** Continue with Current Treatment Plan **Frequency:** Weekly **Next session scheduled for:** MM/DD/YYYY **Additional Comments:** Clinician will also be working with Patient's brother who was also a witness to this traumatic event.	
MM/DD/YYYY	Hospital/ Provider	**Initial psychiatric evaluation for acute stress disorder:** **Chief Complaint:** " I had a bad accident"! **History of Present Illness:** XXXX is a 55 year old male who presents for a psychiatric evaluation. Approximately two weeks ago, the patient was riding his motorbike with his brother and father on the freeway when a Caltrans truck struck the patient and the patient and his father from behind. The patient's father passed away during the accident, and he fell off his bike and landed on his head and shoulders. He did not sustain any fractures " but I had a lot of bruises and fractures". He has developed pain injuries in his shoulders, neck, and back. He complaints of forgetfulness and visual changes and feels like his vision on " the left side has been magnified". He has a meeting pending with neurology and potential imaging studies. The patient states that every time he closes his eyes to sleep, he relives the accident in the form of intrusive thoughts and flashbacks. He has had difficulties falling and staying asleep since the accident. He has been avoiding talking to people and his employees because he does not want to talk about"…what happened". He feels guilty about not having done enough or" we should have left sooner". He has been irritable towards loved ones brother and girlfriend as he has not had any patience to deal with others. He has become vigilant, scoping his surroundings while out and about- " I am worried about my son". He prefers to detach and does not have any interest to see anyone or do anything at this time. There is no history of MDE, mania/hypomania, psychosis,	7-9

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		any other anxiety spectrum disorders. There is no history of ED, O-C related disorders, or AD/HD prior to the accident/incident. There are no spontaneous/uncontrollable episodes of laughing or crying since the accident. The patient denies the excessive use of EtOH or any substances. The patient feels safe and denies any suicidal or homicidal thoughts or any intent/plan to hurt herself or anyone else at the time of this evaluation. **Mental Status Examination:** **Mood:** Bit dysphoric; affect: constricted **Diagnosis:** • Acute stress disorder **Assessment/Plan:** • Psychoeducation provided. • **Start:** o Lexapro (Escitalopram) - titrated to 10 mg qd over 9 days. o Prazosin 1 mg po qhs prn. nightmares. o I informed the patient of the medication(s)' common side effects, risks/benefits, and alternative treatment options. The patient seems to understand and agree with plan. • **Recommend:** Individual cognitive behavioral/cognitive processing therapy. • Follow-up in 4 weeks.	
MM/DD/YYYY	Hospital/ Provider	**Cognitive behavioral assessment report:** **Identifying information:** XXXX is a 55-year-old male who was injured in a motor vehicle accident (MVA) on MM/DD/YYYY. Due to his acute debilitating symptoms, XXXX was referred for a cognitive behavioral assessment to assess his current psychological functioning and guide treatment planning. **Tests administered:** • Clinical Interview • Mental Status Exam • Beck Depression Inventory-II (BDI-II) • Beck Anxiety Inventory (BAI) • Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) • PTSD Diagnostic Scale (PDS-5) • Rivermead Post Concussion Symptoms Questionnaire (RPQ) **Clinical interview:** XXXX was available on time for his evaluation session, which was conducted remotely via telehealth. XXXX was informed about the nature and purpose of the evaluation as well as limits of confidentiality. XXXX acknowledged that he understood the process and completed the necessary informed consent and HIPAA forms. XXXX presented seeking support for acute grief and trauma following the recent and sudden death of his father. The incident occurred during the family's annual motorcycle trip, when a Caltrans truck struck and killed XXXX 's father.	11-19

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		XXXX and his brother witnessed the collision, and XXXX himself was also hit and injured in the event. He is now grappling with the emotional aftermath, including physical injury, survivor's guilt, and the profound impact on his family. He reported severe emotional distress that is interfering with daily functioning, including difficulties with sleep and an inability to fully utilize coping strategies due to the overwhelming nature of his pain. A recurring theme is the pressure he feels to uphold a perception of strength for the sake of his family, which may be hindering his own grieving process. XXXX described his 78-year-old father as the 'base' of the family. His death has left the family feeling fragmented and directionless. XXXX maintains a close relationship with his father's partner, who is also deeply affected. He voiced particular concern for his younger brother, who also witnessed the accident and is now coping by drinking heavily and isolating. XXXX lives with his son and feels a strong responsibility to be emotionally stable for those around him, further contributing to a dynamic in which his own emotional needs may be suppressed. XXXX presented with multiple acute psychological symptoms. One of the primary symptoms reported is the presence of intrusive thoughts and vivid, distressing memories related to the accident. He described the experience as "so surreal" and noted that the images "get into your head and they stay," indicating a re-experiencing symptom cluster consistent with an acute stress reaction. These symptoms began immediately after the event and appear to occur daily, establishing a baseline of severe psychological impact. XXXX described feeling "out of my mind," with the emotional pain being overwhelming. These acute symptoms have persisted since the trauma, which occurred within the last few weeks, as the funeral has not yet taken place. In addition to intrusive memories, XXXX reported experiencing significant survivor's guilt. He expressed a belief that his father bore the brunt of the impact and, in doing so, saved his life. This belief is both a source of meaning and a trigger for guilt. He stated, "So he saved my life." These feelings of guilt emerged immediately after the accident and were a recurring theme throughout the session. The intensity is moderate to severe and reflects a complex emotional processing of the trauma that blends cognitive attributions of meaning with emotional distress. XXXX also endorsed experiencing intense anger, primarily directed toward the driver of the truck and the circumstances surrounding the accident. He acknowledged this anger as a central emotional focus, stating, "So I'm guilty of being angry. So that's my focus right now—trying to heal the family." He has begun to channel this anger into a desire to advocate for road safety improvements, indicating an early effort to find purpose through action. The clinician normalized this response as part of the grieving process. The anger has been present since the incident and remains a persistent and severe emotional state. These symptoms, taken together, establish a baseline for ongoing treatment and reflect the acute and multifaceted nature of XXXX 's psychological response to trauma.	

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		The current risk level is assessed as moderate. XXXX is experiencing an acute and severe traumatic grief reaction. Although he denies any current substance use and did not endorse thoughts of self-harm or suicidal ideation during the session, the intensity of his emotional pain, the presence of survivor's guilt, and the graphic nature of the trauma represent significant risk factors for the development of complicated grief, post-traumatic stress, and other mental health concerns. Additionally, there are risks present within the broader family system. Continued monitoring and support are warranted to mitigate these risks. XXXX presents with symptoms of anxiety, depression, and post-traumatic stress disorder (PTSD), all of which appear to have emerged following the tragic motorcycle accident he experienced that resulted in the sudden death of his father in September YYYY. He reports experiencing significant distress and depressive affect daily as he manages the process of planning a funeral while recovering from his own physical injuries. These episodes include intense feelings of panic, sadness, guilt, and hypervigilance, accompanied by physical symptoms such as his hands trembling, feeling dizzy and lightheaded and restlessness. XXXX also endorses significant levels of anhedonia, and sleep disturbance. These distressing symptoms occur daily. He describes the intensity of his anxiety and depression as severe, especially when it involves catastrophic thoughts such as fear of the worst happening, and fear of dying and especially when he considers his family members' safety. XXXX also endorses significant symptoms indicative of PTSD. These include re-experiencing the trauma and marked avoidance behaviors such as intentionally avoiding thinking about the trauma. He also experiences strong emotional distress and physical reactions when reminded of the trauma, along with difficulty experiencing positive emotions. These symptoms have persisted since the time of the accident and significantly impair his sleep, emotional well-being, and daily functioning, including engaging in social activities. **Clinical assessments:** **Brief mental status exam:** **Appearance:** Attractively Dressed and Groomed **Attitude:** Cooperative **Behavior:** Congruent with Content **Affect:** Emotional Distraught **Speech:** Normal Coherent, somewhat quiet **Mood:** Depressed, Frustrated **Thought Process:** No Hallucinations or Delusions Reported **Thought Content:** Denied Suicidal Ideation, Means, or Plan **Orientation:** Oriented x4 Person Place Time Situation **Memory:** Intact **Memory/Concentration:** Intact during session. Patient reported struggles with concentration **Insight/Judgment:** Intact **Beck Depression Inventory-II (BDI-II):** XXXX completed the BDI-II, and the results indicated a total score of 34 points, which placed him in the severe level	

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		of self-reported depression. XXXX reports severe manifestations of the following symptoms of depression: • I am sad all the time • I feel I am being punished • I can't get any pleasure from the things I used to enjoy • I feel guilty most of the time • I am so restless that I have to keep moving or doing something • It's hard to get interested in anything • I don't have enough energy to do very much • I sleep a lot less than usual • I am more irritable than usual • I find I can't concentrate on anything • I am too tired to do most of the things I used to do • I have lost interest in sex completely **Beck Anxiety Inventory (BAI):** XXXX completed the BAI and the results indicated a total score of 19 points, which placed him in the moderate level of self-reported anxiety. XXXX reports moderate to severe manifestations of the following symptoms of anxiety: • Unable to relax • Fear of worst happening • Dizzy /lightheaded • Indigestion • Fear of dying • Hands trembling **Primary Care Posttraumatic Disorder Screen for DSM-5 (PC-PTSD-5):** XXXX 's score is 4, indicating that further assessment for PTSD symptoms is warranted. **Posttraumatic Diagnostic Scale for DSM-5 (PDS-5):** The results indicate a raw score of 59, suggesting that XXXX may be experiencing Probable symptoms of PTSD. With respect to PTSD symptoms, XXXX reported experiencing virtually all symptoms of PTSD at least once a week. The symptoms that he experiences four or more times a week include: • Unwanted upsetting memories about the trauma • Bad dreams related to the trauma • Reliving the traumatic event • Having physical reactions when reminded of the trauma • Feeling very emotionally upset with reminded of the trauma • Trying to avoid thoughts or feelings related to the trauma • Blaming self or others for what happened • Losing interest or not participating in activities you used to do • Feeling distant or cut off from others • Having difficulty experiencing positive feelings • Having trouble concentrating	

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		• Having trouble falling or staying asleep **Rivermead Post Concussion Symptoms Questionnaire (RPQ):** XXXX 's current symptoms (He was asked to assess symptoms within the last two days): **RPQ-3:** Sum of questions 1-3 XXXX endorsed mild concerns for dizziness, headaches, and nausea. 6 Mild post-concussion symptoms **RPQ-13:** Sum of questions 4-16 XXXX endorsed severe concerns related to cognitive symptoms (i.e., forgetfulness, poor concentration). He noted moderate concerns about fatigue, impatience, taking longer to think, restlessness, light sensitivity, and blurred vision. 34 Moderate to severe post-concussion symptoms **Summary and impressions:** Consistent with the impressions garnered in the clinical interview, XXXX endorsed moderate to severe symptoms of anxiety, depression and PTSD. This was an initial intake session with XXXX , who is experiencing acute grief and trauma following the recent, violent death of his father in a motorcycle accident, which he and his brother witnessed. XXXX presented with significant emotional pain, survivor's guilt, and anger related to the event. He described his father as the central figure in their family and reported that his loss has left the family unit feeling disorganized. XXXX described the surreal and intrusive nature of the traumatic memory, the burden of feeling he must remain strong for his family, and early attempts at meaning-making, such as the belief that his father saved his life. XXXX was highly engaged and receptive throughout the session. The primary clinical risk is the potential for complicated grief and deteriorating mental health given the severity of the trauma. Two key assessment tools were utilized in the diagnostic process. First, a comprehensive clinical interview was conducted, allowing for exploration of XXXX 's history, symptom profile, psychosocial context, and functional impairments. This interview revealed pervasive anxiety, trauma-related symptoms, depressive features, and disruptions across several life domains, including academic performance, occupational functioning, and interpersonal relationships. Second, XXXX completed standardized questionnaires assessing symptoms of anxiety, depression, and PTSD. The measures indicated clinically significant elevations in all three domains, corroborating the diagnostic impressions formed during the interview. **Clinical conceptualization and Diagnostic formulation:** **Diagnostic Impression:** • Posttraumatic stress disorder (PTSD), acute XXXX meets the diagnostic criteria for Posttraumatic Stress Disorder (PTSD) following the sudden and violent death of his father in a motorcycle accident, which he witnessed and in which he was physically injured. The trauma occurred approximately one month ago, and XXXX 's symptoms have persisted since that time. The event involved actual death and serious injury and meets Criterion A	

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		of the DSM-5-TR for PTSD. XXXX directly witnessed the fatal collision and was struck during the impact, fulfilling the requirement of direct exposure to a traumatic event. He meets Criterion B (intrusion symptoms) through his report of recurrent, involuntary, and distressing memories of the accident. He described the experience as "so surreal," noting that the intrusive images "get into your head and they stay." These memories are associated with intense emotional distress. Criterion C (avoidance) is met through indications of emotional numbing and avoidance of grief-related processing, likely as a result of overwhelming affect and pressure to maintain strength for others. Criterion D (negative alterations in mood and cognition) is supported by XXXX 's persistent negative emotional state (grief, guilt, anger), distorted cognitions related to survivor's guilt ("I truly believe he saved my life"), and difficulty experiencing positive emotions. He also expressed a deep sense of family disorganization and personal disconnection since the trauma. Criterion E (marked alterations in arousal and reactivity) is evidenced by his heightened irritability, persistent anger directed at the driver and situation, and significant sleep disturbance. There is no evidence that these symptoms are due to the effects of a substance or medical condition, and XXXX has denied personal substance use. Given the persistence and severity of XXXX 's post-traumatic symptoms, including intrusion, emotional numbing, survivor's guilt, anger, and dissociation, and their impact on his daily functioning and relationships, a diagnosis of Posttraumatic Stress Disorder is clinically justified. Continued treatment and monitoring are strongly recommended to address the complexity of his trauma response and to support stabilization, emotional processing, and recovery. **Diagnostic Impression:** • Major depressive disorder, single episode, moderate, without psychotic features XXXX meets the diagnostic criteria for Major Depressive Disorder (MDD), single episode, moderate, without psychotic features, as outlined in the DSM-5-TR. His symptoms began following the sudden and traumatic death of his father in a motorcycle accident, which he witnessed and in which he was physically injured. While his presentation is clearly linked to a traumatic loss, the intensity and pervasiveness of his symptoms exceed what would be expected in normative grief and align more closely with a depressive episode. XXXX endorsed a persistently low mood, describing himself as "out of my mind" with emotional pain and despair, and reported an inability to experience comfort or peace—consistent with depressed mood and anhedonia. He also reported significant sleep disturbance, relying on distractions to fall asleep due to racing thoughts and emotional pain. His concentration appears impaired, and he struggles to implement coping strategies due to the overwhelming nature of his distress. He expressed feelings of excessive guilt, particularly survivor's guilt, believing that his father took the brunt of the impact to save his life, stating, "I truly believe he saved my life." These thoughts, while partially tied to trauma, reflect distorted guilt that contributes to depressive cognition. He is also experiencing marked fatigue and low energy, compounded by the emotional burden of having to be "the strong one" for his family. These symptoms have persisted consistently since the trauma, and appear to cause significant functional impairment, including disrupted family dynamics, sleep, and emotional regulation. While the	

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		traumatic event may initially suggest a trauma-related disorder, XXXX 's presentation includes a full depressive syndrome that stands apart from typical acute stress or bereavement. There is no indication of psychotic features, and XXXX denied substance use or suicidal ideation. Based on the symptom constellation, intensity, and duration of more than two weeks, a diagnosis of Major Depressive Disorder is clinically appropriate at this time. **Diagnosis:** • Posttraumatic stress disorder (PTSD), acute • Major depressive disorder, single episode, moderate, without psychotic features • R/o traumatic brain injury and postconcussion syndrome - based on results of Rivermead questionnaire. **Recommendations:** **Medical follow-up:** • Continue consultation with his medical team to address ongoing pain, as well as follow ups with physical and chiropractic therapy. **Psychological recs:** **General:** • Individual cognitive behavioral therapy (CBT) psychotherapy is recommended to address anxiety/PTSD symptoms and to provide close monitoring of XXXX 's psychosocial adjustment. A minimum of 12 sessions is recommended. Brain Works provides this service • To address anxiety and panic-related symptoms, XXXX may benefit from the following evidence-based interventions and techniques: ○ Cognitive reframing and mind shift techniques, strategies for emotional and physical regulation, diaphragmatic breathing exercises, and grounding exercises. ○ Grounding techniques, strategies to build awareness and regulate their physiological state and regulate their responses, somatic tracking techniques to enhance their awareness of bodily sensations associated with trauma-related arousal, imagery/visualization techniques for emotional/distress regulation, processing techniques such as breaking memories into small parts, using metaphors, and monitoring body cues. ○ XXXX will benefit from relaxation/mindfulness exercises to address somatic symptoms of anxiety and PTSD. The box breathing technique has demonstrated effectiveness in improving PTSD and anxiety symptoms. To engage in the box breathing technique, XXXX is instructed to undergo the breath cycle of inhaling, holding, exhaling, and holding each for a count of 4. This technique can be practiced during times of stress or routinely to improve concentration. Box breathing has been demonstrated clinically to support the parasympathetic nervous system, which can decrease sympathetic activity and resultantly lower cortisol levels and feelings of stress.	

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		Sleep & exercise: • XXXX should maintain a healthy sleep schedule. XXXX reports sleep disturbance, which may be impacted by his mood symptoms. Healthy sleep is also an important intervention/prevention for mental health. Some sleep hygiene techniques may include: ○ limiting naps throughout the day to shorter time frames and earlier in the day if needed, establishing a consistent nighttime routine, exercising/increase activity to promote good quality of sleep, getting exposure to the sun in the morning and throughout the day, and avoiding caffeine close to bedtime. • Engaging in physical exercise has been shown to promote dopamine regeneration, as well as improve mood and overall wellbeing. We defer to XXXX 's medical team to determine what activities are medically safe and sensible at present, we support a return to lower risk cardiovascular activities, as long as these activities do not significantly worsen symptomatology or pose any risk for re-injury. We believe a gradual transition back to normal lower risk activities would help improve mood and sleep. Again, physical activities should be approved by XXXX 's treatment team. **Psychiatry:** • XXXX should consider consulting with a psychiatrist to explore the possibility of psychopharmaceutical interventions to address his debilitating symptoms of depression and anxiety.	
MM/DD/YYYY	Hospital/ Provider	**MRI of the cervical spine without contrast:** **History:** Neck pain. **Technique:** Multiplanar multisequence MR images through the cervical spine were obtained without the administration of intravenous contrast. **Findings:** No cervical spine fracture and the vertebral body heights are normal. Diffuse disc desiccation. Endplates are intact. Craniocervical junction and atlantodental interval are anatomically aligned. Cervical spine is anatomically aligned. Anterior and middle columns are intact as well as the anterior and posterior longitudinal ligaments. No focal ligamentous disruption nor epidural fluid collection. Cervicothoracic junction is intact. Marrow signal is normal. Visualized posterior fossa and position of the cerebellar tonsils are normal. Visualized pons, medulla, and spinal cord are normal in signal and contour. No evidence of an intradural or extradural mass. **C2-3:** No significant spinal canal or neuroforaminal stenosis. **C3-4:** There is a 4 to 5 mm broad-based posterior disc bulge. There is severe bilateral neural foraminal stenosis and moderate spinal canal stenosis. **C4-5:** There is a 4 to 5 mm broad-based posterior disc bulge. There is severe bilateral neural foraminal stenosis and moderate spinal canal stenosis. **C5-6:** There is a 3 to 4 mm right paracentral disc osteophyte complex. There is severe bilateral neural foraminal stenosis with moderate spinal canal stenosis.	67-68

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		C6-7: There is a broad-based posterior disc bulge measuring 3 to 4 mm. There is severe bilateral neural foraminal stenosis with moderate spinal canal stenosis. **C7-T1:** Mild bilateral facet hypertrophy. No spinal canal or neuroforaminal stenosis. Visualized soft tissues of the neck are unremarkable. **Impression:** • Severe bilateral neural foraminal stenosis with moderate spinal canal stenosis at C3/C4, C4/C5, C5/C6, and C6/C7. • No abnormal cord signal.	
MM/DD/YYYY	Hospital/ Provider	**MRI of the lumbar spine without contrast:** **History:** Low back pain. **Technique:** Multiplanar multisequence MR images through the lumbar spine were performed without the administration of intravenous contrast. **Findings:** **General:** Conventional lumbar anatomy with 5 nonrib-bearing lumbar vertebral bodies. The last fully formed disc space is assumed to represent L5/S1. No evidence of acute fracture. No traumatic malalignment. There is mid and lower lumbar disc desiccation. There is Modic Type II marrow signal at L5/S1 Conus medullaris is at T12-L1, and visualized spinal cord and cauda equina nerve roots are normal. No evidence of an intradural or extradural mass. **T12-L1:** No disc degeneration or facet arthritis. No spinal canal or neuroforaminal stenosis. **L1-2:** No disc degeneration or facet arthritis. No spinal canal or neuroforaminal stenosis. **L2-3:** No disc degeneration or facet arthritis. No spinal canal or neuroforaminal stenosis. **L3-4:** There is a 4 mm broad-based posterior disc bulge, eccentric to the right. There is moderate to severe right neural foraminal stenosis without spinal canal or left neural foraminal stenosis. **L4-5:** There is a 5 mm broad-based posterior disc bulge with moderate bilateral facet hypertrophy. There is moderate bilateral neural foraminal stenosis without significant spinal canal stenosis. **L5-S1:** There is a 3 mm disc bulge with annular fissure. There is mild bilateral facet hypertrophy. There is severe left and mild right neural foraminal stenosis. No spinal canal stenosis. Prevertebral and paraspinal soft tissues are normal. Visualized soft tissues of the abdomen and pelvis are unremarkable. **Impression:** • Moderate to severe right neural foraminal stenosis at L3/L4. • Moderate bilateral neural foraminal stenosis at L4/L5. • Severe left and mild right neural foraminal stenosis at L5/S1.	70-71
MM/DD/YYYY	Hospital/ Provider	**Initial physical therapy evaluation for neck, bilateral shoulder and back pain:**	146-150

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		Treatment diagnosis: • Vertebrogenic low back pain • Pain in right shoulder • Pain in left shoulder • Cervicalgia **History of Injury:** Patient with chief complaint of low back pain, neck pain with numbness and tingling from the left elbow down to the hand and weakness in the **MOI:** MVA **Date of injury:** MM/DD/YYYY Location of symptoms Symptoms described as dull and occasional sharp pains Symptoms provoked with laying down on back, sitting bending Symptoms alleviated with medication, stretching **Pain:** Current: 6/10 At best: 4/10 At worst: 7/10 **Premorbid Status: Work status:** Full time **Current Status: Work status:** Full time **Physical Examination:** **Lumbosacral spine:** **Range of motion:** Extension: WNL Flexion: 30% Left rotation: WNL Right rotation: WNL Left side glide: 70% Right side glide: 70% **Joint integrity/mobility:** Central P-A: Bilaterally hypomobile/Painful Unilateral P-A: Bilaterally hypomobile/Painful **Cervical spine:** **Range of motion:** Extension (painful): 50% Flexion: WNL Left rotation(painful): WNL Right rotation(painful): WNL Left side glide: 70% Right side glide: 70% **Joint integrity/mobility:** **Thoracic:** **Central P-A:** Bilaterally normal **Cervical:** **Side bending:** Left hypomobile/painful; right hypomobile **Central P-A:** Bilaterally hypomobile/painful	

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		Palpation: Tenderness to palpation to left sided lumbar paraspinals and left QL **Range of Motion:** Shoulder elevation ROM WFL but possible positive painful arc. **Assessment:** **Presentation:** Patient presents with signs and symptoms consistent with localized low back pain, neck pain with radiating pain, and possible shoulder impingement. Current impairments include limited spinal ROM, tenderness to palpation to low back musculature, decreased mobility of lumbar and cervical spinal joint segments. These findings impact patient's ability to perform IADLs, regular exercise routine and recreational activities hiking, mountain biking). Patient will benefit from skilled PT in order to address these impairments and return to PLOF. **Recommendations: Skilled Intervention:** **Required to:** • Decrease Pain • Improve Function • Improve Motor Control • Increase Range of Motion • Increase Strength. The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program. **Plan:** **Amount, Frequency and Duration: Frequency and Duration:** It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 6 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified. **Therapeutic Contents:** • Client Education • Home Exercise Program • Joint Mobilization Techniques • Manual Therapy Techniques • Manual Range of Motion Activities • Neural Mobilization Techniques • Neuromuscular Re-education. **Therapeutic Contents:** Modalities: As Needed. **Therapeutic Contents:** • Proprioceptive/Closed Kinetic Chain Activities • Therapeutic Exercise • Therapeutic Activities.	

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		Reviewer's Comment: Further physical therapy records are unavailable for review.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for stress:** **Subjective:** The patient reports starting and stopping the SSRI therapy after one week and has not been consistent with taking it. He has had a difficult time being present and dealing with father's funeral. No more nightmares on Prazosin 1 mg po qhs- some grogginess but sleeping better; appetite-> "ok"; no XS EtOH or any substance use. **Assessment/Plan:** • I encouraged the patient to redstart Escitalopram 5 mg po qd x 4 days, then 10 mg po qd thereafter • Continue with Prazosin 1 mg po qhs prn nightmares. • Follow-up 6 weeks.	37
MM/DD/YYYY	Hospital/ Provider	**Neurosurgical consultation for neck and back pain:** **Reason for Appointment:** Initial Neurosurgical Evaluation **History of Present Illness:** **History:** Patient comes in today for evaluation following a motorcycle accident that occurred on September 24, YYYY. Patient states that he was riding his motorcycle on the freeway and was slowing down merging into traffic when he and his father were struck on the rear end by a large truck. Sadly his father passed away at the scene. Patient was thrown off of his motorcycle landing on his head and his side. There was no loss of consciousness. His motorcycle was totaled. Police and ambulance were at the scene and ambulance transported him to Sutter emergency department. *(*Reviewer's Comment: Mentioned police, ambulance report and emergency room records from Sutter Emergency Department are unavailable for review.*)* Patient had neck pain back pain headache shoulder pain left ankle and left elbow pain. Patient also reports numbness and tingling into left elbow down to the hand. He reports weakness of his grip, dropping objects and difficulty with his balance. Patient has undergone physical therapy without much relief of symptoms. Patient denies any history of the symptoms prior to this accident. **Physical Examination:** **Cervical Spine Range of Motion:** Flexion: 40 (Normal 60 degrees) Extension: 20 (Normal 60 degrees) Positive Spurling's with radiation into the left shoulder Right Rotation: 60 (Normal 80 degrees) Left Rotation: 60 (Normal 80 degrees) **Motor:** **Upper extremity motor- RUE:** Grip 5/5, Wrist extension 5/5, Biceps 4/5, Triceps 5/5,deltoid 5/5. Light touch intact in all major dermatomes on right upper **LUE:** Grip 5/5, Wrist extension 5/5, Biceps 5/5, Triceps 5/5, deltoid 5-/5	253-255, 256-259

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		Lumbar Spine Range of Motion: Flexion: 50 (Normal 90 degrees) Extension: 30 (Normal 30 degrees) Right Rotation: 30 (Normal 30 degrees) Left Rotation: 30 (Normal 30 degrees) Tenderness to palpation LBP **Motor:** **Lower extremity motor RLE:** Iliopsoas 4/5, Quad 5/5, Hamstring 5/5, Dorsiflexion 5/5 **LLE:** Iliopsoas 4/5, Quad 5/5, Hamstring 5/5, Dorsiflexion 5/5 Patellar reflex Hyperreflexia at 3+ Straight leg raise Causes low back pain. **Assessments:** • Cervical disc disorder with myelopathy, unspecified cervical region • Low back pain, unspecified **Treatment:** **Cervical disc disorder with myelopathy, unspecified cervical region:** **Notes:** **Imaging:** Was able to personally review the MRI of the cervical spine dated through NorCal imaging MM/DD/YYYY. At C3-4 there is a 5 mm broad-based disc bulge with severe bilateral foraminal stenosis as well as moderate central stenosis. At C4-5 there is a 5 mm broad-based disc bulge with severe bilateral foraminal stenosis. At C5-6 there is a 4 mm right sided disc osteophyte complex with severe foraminal stenosis and moderate central stenosis. At C6-7 there is a 4 mm disc bulge with severe bilateral foraminal stenosis. **Treatment plan:** • Unfortunately patient has significant central stenosis with clinical findings of myelopathy as well as severe foraminal stenosis at C4 causing neck pain, at C5 causing shoulder pain at see 6 causing right sided biceps weakness and at C7 causing numbness and tingling on the left hand as well as weakness in the grip. Due to the severity of his spinal canal compression as well as weakness associated with his radicular complaints I do not feel he is a good candidate for nonsurgical therapies. I also informed the patient that he should not do any activity that puts him at risk for further whiplash type injury as this may result in a permanent spinal cord injury. I discussed with the patient the procedures available for decompression and fusion to include an anterior 4 level discectomy and fusion versus a posterior laminectomy and fusion. Procedures were discussed in detail, and patient prefers the anterior 4 level fusion and reconstruction we did discuss the possibility of nonunion due to the multi segment fusion. • Will order flexion-extension X-rays as well as place surgical case request. Risks and benefits of the procedure were discussed. All questions were answered. • Referral to Pain Medicine for low back pain • Referral to Surgery for C3-4, C4-5, C5-6, C6-7 ACDF, hard collar, bone	

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		stimulator **Low back pain, unspecified:** **Notes:** **Imaging:** Was personally reviewed and findings pleated at NorCal imaging on MM/DD/YYYY. At L3-4 there is a 4 mm broad-based disc bulge with foraminal stenosis. At L4-5 and 5 mm broad-based disc bulge with foraminal stenosis and at L5-S1 3 mm disc bulge with annular fissure. **Treatment plan:** • The patient is instructed to begin with chiropractic/physiotherapy treatments as tolerated. A consistent home exercise program was also recommended to help improve muscle strength, joint stability, range of motion, and active reconditioning. Will send referral for consideration for initiating injections/ pain management therapies are indicated. • Follow-up with me in 2 months regarding nonsurgical therapies on lumbar spine. Follow up in 2 months.	
MM/DD/YYYY	Hospital/ Provider	**Telemedicine neurological consultation for traumatic brain injury:** XXXX is a 55 year old who was referred for evaluation of symptoms resulting from an accident on MM/DD/YYYY. **History of Present Illness:** The patient reports that he was struck from behind by a truck while riding his motorcycle. He was violently thrown off of it and struck his head on the pavement. He experienced dazedness, confusion, and disorientation and was transported to the hospital via ambulance. His father was killed in the accident. The patient reports experiencing headaches. He describes them as dull and throbbing, lasting 1–2 hours per episode and occurring daily. Headaches are localized to the temples, mainly the left side of the head, with photophobia but no phonophobia. Tylenol and Ibuprofen provide relief when taken. Headaches do not worsen with movement but have worsened since the accident. He reports pain throughout his body, primarily in the neck, upper and lower back, left and right shoulders, left arm, and left knee. Pain worsens with movement. He is following up with pain management and physical therapy and has undergone imaging. Surgery for the neck and back has been discussed but he is hesitant to proceed and would like to purse conservative measures first. He does not report constipation or urinary retention and has not been receiving chiropractic care. The patient reports short- and long-term memory difficulties, including misplacing objects, forgetting same-day events as well as events in the past, trouble remembering appointments, and difficulty recalling names and phone numbers. He occasionally experiences word-finding difficulty but does not report stammering or slurred speech. These cognitive issues have significantly worsened since the accident.	263-274

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		His level of physical activity has decreased; he is currently not exercising compared with approximately five times per week prior to the accident resulting in loss of muscle mass. He is a retired military officer and works in real estate sales but has found it challenging to focus on tasks and manage social interactions at the office. The patient reports impaired sleep, averaging four hours per night compared with eight hours prior to the accident. Sleep is disrupted by anxiety, nightmares, and PTSD-related symptoms. He has difficulty initiating and maintaining sleep, does not feel rested upon waking, and experiences daytime fatigue, sometimes requiring naps. Sleep quality has worsened since the accident. He reports mood disturbances including increased depression, irritability, emotional reactivity, low energy, and decreased interest in activities. He denies thoughts of self-harm or harm to others. Anxiety levels have increased, and he is currently under psychiatric care with medication prescribed but has not started the regimen yet. The patient reports vision changes, with the left eye magnifying the visual field compared to the right. He does not experience difficulty navigating or bumping into objects. Vision disturbances are constant and have worsened since the accident. He reports intermittent tinnitus in the left ear which he has found to be disruptive. There is no subjective hearing loss. The patient reports attention and concentration difficulties, including brain fog, trouble focusing, frequent zoning out, incomplete task completion, and slowed problem-solving abilities. These cognitive issues have significantly worsened since the accident. **Review of Systems:** **Neurologic:** Reports headaches, musculoskeletal pain, memory loss, sleep disturbance, mood changes, vision changes, hearing changes, and executive dysfunction **Psychiatric:** Reports feelings of depression, irritability, anxiety **Physical Examination:** **Motor Testing:** Had difficulty lifting bilateral lower extremity against gravity for more than 5 seconds without drift **PHQ-9 Score:** 21 **Assessment:** • Traumatic brain injury • Chronic post-traumatic pain • Memory and cognitive decline • Secondary insomnia • Mood disorder due to known physiologic condition	

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		• Post traumatic vision syndrome • Frontal lobe and executive function deficit **Causation:** The patient has headaches, musculoskeletal pain, memory loss, sleep disturbance, mood changes, vision changes, hearing changes, and executive dysfunction in the setting of an accident. In the context of the patient's clinical history, physical exam, and symptoms, I believe that the findings are consistent with a diagnosis of traumatic brain injury. **Future Risks:** **Dementia:** Traumatic brain injury is associated with a twofold increased risk in patients with dementia and can rise even higher than fourfold depending on the severity of traumatic brain injury. **Endocrine:** Traumatic brain injury is associated with neuroendocrine dysfunction and hormonal disturbances. These changes can result in long term cognitive, behavioral, physical and psychological dysfunction and delayed recovery. **Psychiatric:** Traumatic brain injury is associated with an increased risk for a wide variety of psychiatric and mood disorders such as dysphoria, depression, anxiety, and agitation. Psychosis, mania and obsessive compulsive disorder can be seen in traumatic brain injury as well. **Management and Further Plan of Care:** **Neurologic:** • They will need regular follow up with a neurologist every 12 months or as needed for the duration of their lives to screen for dementia and manage other neurologic dysfunction. • They will need an MRI of the brain with both DTI and volumetrics. • The patient will need supplementation with Magnesium Oxide 500mg every night, Riboflavin 200mg daily, and Coenzyme Q10 300mg daily for chronic migraine management. • Recommend starting at 400 mg of Ibuprofen as needed for headaches, may increase to a maximum dosing of 800 mg three times daily (no more than 2400 mg in 24 hours). Can also alternate the ibuprofen dose with Tylenol 500-1,000mg as needed (max 4 g/day). **Additional Therapy Required:** • They will need physical therapy of their neck, upper back, lower back, left shoulder, right shoulder, left arm and left knee for three times a week for a period of, at minimum, 3 months. They may require more physical therapy depending on the degree of their improvement as well as their response. • The patient will need cognitive rehabilitation therapy once a week for 6 months. They may require additional cognitive rehabilitation therapy depending on their improvement. **Additional Consultation Required:** • They will need to follow up with a pain management specialist for additional management of post traumatic pain; I will defer the duration and frequency of these appointments to the specialist.	

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		• The patient will need to follow up with a sleep specialist for their sleep dysfunction; they may require a sleep study for further assessment of their dysfunction. • The patient will need to follow up with a psychiatrist for mood dysfunction at minimum twice a year indefinitely. They will likely require cognitive behavioral therapy, the duration and frequency of which I will defer to the psychiatrist. • They will need a vision evaluation by preferably a neuro-ophthalmologist or an ophthalmologist for visual dysfunction. They will likely require follow up with an optometrist as well as a visual therapist; the duration and frequency of which I will defer to the specialist. • They will require follow up with either a neuroendocrinologist or an endocrinologist twice at minimum over the span of their lifetime. They also will likely need testing for endocrine dysfunction including ACTH, TSH, Prolactin, AM Cortisol, GH level • The patient will need an evaluation by an audiologist for tinnitus. Please reschedule an appointment on completion of testing or as needed based on the patient's symptoms. This was a complex neurologic evaluation. It entailed a detailed history and decision making of high complexity.	
MM/DD/YYYY	Hospital/ Provider	**Telemedicine visit for headaches and pain in the neck and lower back:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **History of Present Illness:** XXXX is a 55 year old gentleman presenting with a chief complaint of neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck which occurred on MM/DD/YYYY. Upon impact, the patient was ejected and thrown backwards, landing on his head, hitting the back of his head against the pavement, and hitting the left side of his body against the pavement. He did not lose consciousness, but he was severely dazed and dizzy. The patient was wearing a helmet. He experienced extensive road rash and a severe whiplash sensation to the neck at the time of the accident. The paramedics arrived at the scene of the accident, and he was transferred to the emergency room. He states X-rays and CTs were performed which did not reveal any fractures or an acute head bleed. The patient was discharged as there was no evidence of life-threatening injuries and his condition seemed to be stable at that time. **Reviewer's Comment: Mentioned EMS report, emergency room records, X-ray and CT scan reports are unavailable for review.** He states he has completed chiropractic and physical therapy treatments however he continues to experience the painful symptoms. He states he has also been examined by a pain management physician who has performed steroid injections	222-223

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		which have not been helpful managing his neck pain and lower back pain. Later on, it was recommended for him to see a neurosurgeon who recommended surgical interventions in regard to his neck and lower back pain. **Reviewer's Comment: Mentioned physical therapy, chiropractic therapy and pain management physician consultation and steroid injection procedure report are unavailable for review.** The neck pain is constant, and the pain is achy in nature. The pain is mainly located on the left side of the neck. The pain can be as high as 6/10 on the intensity scale. The pain is worse with turning the head from side to side and with flexion and extension of the neck. There is radiation of pain and weakness into the right upper extremity all the way into the right hand. There is radiation of numbness into the left upper extremity all the way into the left hand. The pain wakes him up multiple times during the night as he is unable to find a comfortable position without experiencing severe neck pain. The headaches are present on a daily basis and are continuous. The pain is achy in nature. The pain can be as high as 7/10 on the intensity scale. The pain is mainly located in the left temple but in general, he has holocranial head pain accordingly. There is nausea and light sensitivity associated with the headaches. There is a severe sensation of imbalance and depth perception present. He also has severe memory problem in the form of recall of especially recent events and also has difficulty finding words and attending to complex tasks. He also suffers from extreme irritability and feels very withdrawn from daily activities as a result of this accident as well. He denies history of seizures, aura, or ringing in the ears. He denies any changes in the sense of smell or taste. The lower back pain is constant, and the pain is achy in nature. The pain is mainly located on the left side of the lower back. The pain can be as high as 7/10 on the intensity scale. The pain is worse with ambulation and bending forward. There is radiation of pain into the proximal aspect of the lower extremities with only occasional radiation of numbness and tingling into the lower extremities. He denies history of kidney stones. He states he has history of suffering from anxiety which has worsened drastically after this accident. He states he did not experience any of these aches or pains prior to the accident. The pain impacts the patient's ability to perform activities of daily living severely. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI). • R/o post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy.	

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		• Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain • R/o lumbar radiculopathy MRI of cervical and lumbar spine dated MM/DD/YYYY were reviewed. **Plan:** I will review the results of the images with the patient and physically examine the patient in the upcoming follow up appointment. Further recommendations will follow. All risks and benefits explained, and patient fully understands and agrees.	
MM/DD/YYYY	Hospital/ Provider	**Referral report:** **Diagnosis:** • Tinnitus **Plan:** Referral to audiology Full audiogram Tympanogram Tinnitus evaluation	280
MM/DD/YYYY	Hospital/ Provider	**Initial orthopaedic surgery telemedicine consultation for bilateral shoulder and left knee pain:** **To Whom It May Concern:** Mr. XXXX is a 55-year-old right hand dominant male, who presents has had a telemedicine consultation on 12/01/YYYY for an orthopaedic evaluation. **Chief Complaint:** • Bilateral shoulder pain. • Left knee pain. **History of Present Illness:** The patient reports that on MM/DD/YYYY, he was driving a motorcycle when he was rear-ended by a vehicle. He felt dazed and has lost consciousness. The patient reports that an ambulance responded to the scene of the accident. He was then treated and brought to the emergency room of a hospital where he was examined by an emergency room doctor. He was later discharged home with no medications given. The patient reports that after the accident, he began to have immediate neck, lower back, bilateral shoulder, left knee and left ankle pain. **Current complaints:** The patient complains of moderate in intensity, intermittent sharp bilateral shoulder pain which bothers him daily. The pain is worse with overhead activity and stretching and it is relieved by icing and with medication (Motrin over the counter). The patient also complains of intermittent sharp bilateral knee pain which bothers him daily. The pain is worse with bending, stairs, kneeling and squatting and it is relieved by icing and with medication (Motrin over the counter).	411-413

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		Assessment: • Right shoulder pain. • Left shoulder pain. • Right knee pain. • Left knee pain. **Discussion and plan:** I have discussed with the patient today his diagnoses and physical examination findings. At this time, my recommendations are as follows: • Due to persistence of the patient's symptoms in the region of the right shoulder, despite conservative treatment modalities, as well as based on the physical exam findings today, I now recommend an MRI of the right shoulder without contrast. I am giving the patient a prescription for this study today. • The patient should start a bilateral shoulder home exercise program. I am giving the patient a guide of the appropriate exercises. The patient should attempt to do all the exercises in this guide on a daily basis. • The patient should start a home icing program. I would like the patient to apply ice to the bilateral shoulder and left knee for twenty minutes before going to bed on a daily basis. • I will see the patient back in my office in four weeks for follow-up evaluation. The history was obtained by Delmy Paz, medical historian, and was reviewed with the patient by the undersigned. **Causation:** Based on the history provided to me by the patient, based on review of the available medical records including medical imaging studies, and based on my initial orthopaedic musculoskeletal evaluation of the patient on today's visit, it is my opinion that the patient's above-stated musculoskeletal diagnoses is causally related to the above-mentioned accident.	
MM/DD/YYYY	Hospital/ Provider	**Neurology consultation for TBI:** **Description of accident:** The patient tells me that on the date of injury, he was riding motorcycles with father and brother when a CalTrans truck collided with their group. His father died in crash; he does not appear to have had a loss of consciousness. He was taken to emergency department at Roseville where he stayed for 4 hours was evaluated and then sent home. He later contacted an attorney, who is a family. **Present complaints:** • Cervical pain • Lumbar pain • Photophobia • Significant headaches, 5-8/10 in severity • Poor recall • Difficulty multi-tasking • Pain throughout the left side of his body where he was hit • Trouble sleeping	417-420

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		Review of Systems: **Constitutional:** Insomnia/fatigue **Physical Examination:** **Neurological examination:** MRI Brain, cervical and lumbar, and Neuropsych Neck pain on palpation. **Gait:** Slightly positive Romberg, loses balance to either side, cannot do tandem without falling to either side **Initial recommendations:** This patient more likely than not suffered a traumatic brain injury (TBI) secondary to being hit while on his motorcycle on MM/DD/YYYY. I recommend that he undergo a 3T MRI of the brain with DTI, SWI, ASL and Neuroquant to better evaluate for any intracranial pathology. I also recommend a 3T MRI of the cervical spine due to his persistent neck pain. This patient should also undergo an evaluation with a board certified Neuropsychologist to better evaluate any areas of impairment, and to recommend any possible treatments or therapies accordingly. Final report and opinions will be submitted on review of recommended imaging, in office EEG testing, and review of available medical records.	
MM/DD/YYYY	Hospital/ Provider	**Neuropraxis evaluation report:** **Diagnosis:** Cervical disc disorder with myelopathy, unspecified cervical region **Date of Injury:** MM/DD/YYYY **Medical History:** Mr. XXXX is a 55-year-old male who was involved in a motorcycle accident on MM/DD/YYYY. The following medical records were reviewed as part of the evaluation. Mr. XXXX was injured in a motor vehicle accident on MM/DD/YYYY, when he was riding his motorcycle with his brother and father on the freeway when a Caltrans truck struck him and his father from behind. Mr. XXXX 's father passed away during the accident, and Mr. XXXX fell off his bike and landed on his head and shoulders. **Mr. XXXX was seen for a Cognitive Behavioral Assessment by XXXX., Clinical Psychologist, on 10/09/YYYY, and the following was noted: HPI:** Mr. XXXX is a 55-year-old male who was injured in a motor vehicle accident (MVA) on MM/DD/YYYY. Due to his acute debilitating symptoms, Mr. XXXX was referred for a cognitive behavioral assessment to assess his current psychological functioning and to guide treatment planning. **As per Dr. Karjoo's report the following was noted: Diagnosis:** 1) Post-traumatic stress disorder. 2) Major depressive disorder. 3) Rule out Traumatic brain injury S06.2X9D and post-concussion syndrome F07.81 based on the results of Rivermead questionnaire - RPQ -3: Sum of questions 1-3. Mr. XXXX endorsed mild concerns for dizziness, headaches, and nausea (score 6) = Mild post-concussion symptoms. RPQ-13: Sum of questions 4-16. Mr. XXXX endorsed severe concerns related to cognitive symptoms (i.e., forgetfulness, poor concentration). He noted moderate concerns about fatigue, impatience, taking longer to think, restlessness, light sensitivity, and blurred vision (score 34) = Moderate to severe post-concussion symptoms.	162-171

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		As per Dr. Karjoo's report, the following recommendations were made: **General:** • Individual cognitive behavioral therapy (CBT), psychotherapy is recommended to address anxiety/PTSD symptoms and to provide close monitoring of Mr. XXXX 's psychosocial adjustment. A minimum of 12 sessions is recommended. • To address anxiety and panic-related symptoms, Mr. XXXX may benefit from the following evidence-based interventions and techniques: o Cognitive reframing and Mindshift techniques, strategies for emotional and physical regulation, diaphragmatic breathing exercises, and grounding exercises. o Grounding techniques, strategies to build awareness and regulate their physiological state and regulate their responses, somatic tracking techniques to enhance their awareness of bodily sensations associated with trauma-related arousal, imagery/visualization techniques for emotional/distress regulation, processing techniques such as breaking memories into small parts, using metaphors, and monitoring body cues. o Mr. XXXX will benefit from relaxation/mindfulness exercises to address somatic symptoms of anxiety and PTSD. **As per Dr. Karjoo's medical report:** **Sleep and exercise:** • Mr. XXXX should maintain a healthy sleep schedule. He reports sleep disturbance, which may be impacted by his mood symptoms. Healthy sleep is also an important intervention/prevention for mental health. • Engaging in physical exercise has been shown to promote dopamine regeneration, as well as improve mood and overall wellbeing. We defer to Mr. XXXX 's medical team to determine what activities are medically safe and sensible at present. **Psychiatry:** Mr. XXXX should consider consulting with a psychiatrist to explore the possibility of psychopharmaceutical interventions to address his debilitating symptoms of depression and anxiety. Mr. XXXX had a neurosurgical consultation on MM/DD/YYYY with Dr. James Silverthorn. As per Dr. Silverthorn's report, the following was noted: Assessment: 1) Cervical disc disorder with myelopathy, unspecified cervical region. 2) Low back pain, unspecified M 54.50. Treatment: 1) Cervical disc disorder with myelopathy, unspecified cervical region. Imaging: I was able to personally review the MRI of the cervical spine dated through NorCal Imaging 1/15/YYYY. At C3-C4 there is a 5 mm broad-based disc bulge with severe bilateral foraminal stenosis. At C5-C6 there is a 4 mm disc bulge with severe bilateral foraminal stenosis. Treatment plan: 1) Unfortunately, patient has significant central stenosis with clinical findings of myelopathy as well as severe foraminal stenosis at C4 causing neck pain, at C5 causing shoulder pain, at C6 causing right side biceps weakness, and at C7 causing numbness and tingling on the left hand as well as weakness in the grip. Due to the severity of his spinal canal compression as well as weakness associated with his radicular complaints, I do not feel he is a good candidate for nonsurgical therapies. I also informed the	

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		patient that he should not do any activity that puts him at risk for further whiplash type injury as this may result in a permanent spinal cord injury. I discussed with the patient the procedures available for decompression and fusion to include an anterior 4 level discectomy and fusion versus a posterior laminectomy and fusion. Procedures were discussed in detail, and patient prefers the anterior 4 level fusion and reconstruction. We discussed the possibility of nonunion due to the multi segment fusion. 2) Will order flexion-extension X-rays as well as place surgical case request. Risks and benefits of the procedure were discussed. All questions were answered.
		
		Imaging Studies:
		MRI of the cervical spine without contrast, NorCal Imaging Concord on MM/DD/YYYY, per Dr. Michael Modica's report, the following was noted:
		Impression: Severe bilateral neural foraminal stenosis with moderate spinal canal stenosis at C3/C4, C4/C5, C5/C6, and C6/C7. No abnormal cord signal.
		MRI of the lumbar spine without contrast, at NorCal Imaging Concord on MM/DD/YYYY, per Dr. Michael Modica's report, the following was noted:
		Impression: 1) Moderate to severe right neural foraminal stenosis at L3/L4. 2) Moderate bilateral neural foraminal stenosis at L4/L5. 3) Severe left and mild right neural foraminal stenosis at L5/S1.
		
		Primary and Secondary Diagnoses:
		• Cervical disc disorder with myelopathy, unspecified cervical region
		• Low back pain, unspecified
		• Posttraumatic stress disorder (PTSD)
		• Major depression disorder
		
		Current Level of Independence: Mr. XXXX 's current level of functioning was based on a video call evaluation allowing for an accurate, real-time visual assessment of the client on 12/02/YYYY. Please refer to Addendum A for a reference of reports reviewed.
		Medical:
		• **Sleep:** He used to sleep 8 hours at night before the accident. Currently, he has difficulty falling asleep and staying asleep due to recurrent dreams of the accident, neck, and left shoulder pain. He repositions and struggles with going back to sleep. This happens nightly, and he is averaging 4 hours of sleep. He feels exhausted during the day and takes a daily 15-to-30-minute nap. He states that he is dozing off while he is doing work on his computer.
		• **Nutrition:** Prior to his accident, he had a regimented meal schedule and prepared healthy meals daily. Since the accident, he is not motivated to prepare meals, he is snacking throughout the day, and he is not eating healthy snacks. He orders prepared healthy fresh meals, but he states that he lacks the motivation to microwave and eat the meals on a daily basis.
		• **Pain:**
		  ○ **Headache:** Constant dull pain that varies from 4/10 to 8/10 in intensity.
		  ○ **Cervical spine:** Constant dull/sharp 6/10 to 7/10.	

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		○ **Lumbar spine:** Constant 5/10 to 6/10 dull/sharp pain. ○ **Mid back:** Intermittent spasming. ○ **Left knee:** Constant dull 4/10 pain, which intensifies with weight bearing to 6/10. ○ **Left elbow:** Constant dull 4/10 to 5/10 pain. ○ **Left hand:** Intermittent numbness throughout the day. ○ **Pain triggers:** Bending, sitting, or standing for an extended period of time, and lifting objects. He takes Tylenol or Motrin as needed for pain management. • Client height - 5 feet, 10 inches. • Client weight - 197 pounds. **Activities of Daily Living and Higher Independent Living Skills:** • **Showering:** He requires increased time to complete bathing due to neck and back pain when bending to wash lower body. This was not a problem prior to the accident. • **Dressing:** He requires increased time to complete lower body dressing due to neck and back pain when donning socks and shoes. This was not a problem prior to the accident. • **Meal Preparation:** He reports that since the accident; he has not been motivated to prepare meals. He used to have a healthy meal schedule planned for the week and prepared his own healthy meals daily. • **Grocery Shopping:** Mr. XXXX son assists with the grocery shopping. Mr. XXXX is not able to carry heavy grocery bags now due to his injuries. The neurosurgeon recommended that he avoids carrying any heavy items due to the severity of his cervical spine injury. • **Household Tasks:** He has a house cleaner come weekly, who was working for him before the accident. His son now assists with laundry, since Mr. XXXX is unable to carry the laundry basket. This was not a problem prior to the accident. • **Money Management/Budgeting/Bill Paying:** He uses a spreadsheet to manage his private bills and the bills for his real estate business. He is struggling with structuring his day to manage his personal and business affairs such as paying the invoices. Prior to the accident, this was not an issue. • **Driving:** He only drives short distances due to his vision deficit in the left eye. He reports that he has had 1 episode of a sudden onset of anxiety while driving since the accident, and he had to pull over into the "slow lane" while trying to manage his anxiety. His attorney is currently arranging transportation for his medical appointments. This was not an issue prior to the accident. **Physical:** • **Balance/Vestibular:** Mr. XXXX reports that he feels off-balance due to his vision problem. He will deviate to the right side, but he is able to self-correct his loss of balance. This happens 1-2 times a day. • **Strength:** The neurosurgeon has recommended that he does not participate in any high impact sports or exercise due to the severity of the injury to his cervical spine. Hence, he is unable to follow his exercise gym routine and running, and he feels that he has lost strength in	

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		bilateral upper and lower extremities. Prior to the accident, he successfully followed an exercise routine. • **Endurance:** He feels exhausted due to lack of sleep, which affects his ability to engage in basic daily activities such as cooking meals and taking his dog for walks. This was not an issue prior to the accident. • **Range of Motion:** Cervical and lumbar spine ROM limitations due to pain. He reports that he is performing a daily range of motion/stretching exercises program that he was trained on by a physical therapist after his accident. This provides minimal pain relief. **Cognition and Speech:** • **Attention/Concentration/Multi-Tasking:** He has decreased ability to concentrate on tasks related to his business that need to be addressed. Mr. XXXX states that he cannot get motivated to complete tasks, and some of these tasks have deadlines. He is concerned whether he has the ability to continue managing his business at this point due to his cognitive deficits. This was not a problem prior to his injury. • **Communication:** Prior to the accident, he would prepare training materials and train real estate agents. He states that he recently spoke with an agent and he got lost in the conversation. He has wordfinding difficulty, and he is worried if he will be able to present verbally in front of a crowd. This was not an issue prior to his injury. • **Memory:** Mr. XXXX is concerned about an increase in his forgetfulness. He cannot remember where he put items in his home. This happens on a daily basis and was not an issue prior to his injury. This evaluator noted during the evaluation that Mr. XXXX deviated from the subject and required redirection and having the question repeated. This occurred 5-7 times. Staying on topic was not an issue prior to his injury. • **Comprehension:** He comprehends conversations, but he frequently gets lost in the conversations and does not recall the full content. He reports that he often asks to have the person repeat the information. This happens 2-4 times during the week when he speaks with business contacts. This was not an issue prior to the accident. • **Following Directions:** He is able to follow directions, and he takes notes if the directions are lengthy to assure that he remembers. This was not a problem prior to his accident. • **Sequencing:** He gets easily distracted and states that he is not motivated. He believes that is the reason why office tasks are not being completed. He realizes later that he missed a deadline. He is not able to quantify how often this is happening. • **Problem Solving:** Mr. XXXX verbalized that he is able to problem solve, but he does need extra time to come to a solution. This was not a problem prior to his injury. • **Processing Speed:** He reports that his ability to process efficiently has slowed compared to prior to his injury. This is of great concern to him since he is supposed to begin the training of real estate agents in the beginning of YYYY. He is concerned that he will not be able to recall and deliver the teaching material as efficiently as he used to prior to his accident.	

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		• **Decision Making:** He states that he is "second guessing" a lot. He feels undecisive regarding decision making with regards to his business. This was not a problem prior to the accident. • **Learning:** He requires increased time to learn new information and often has to read the information twice to retain. This was not a problem prior to his injury. • **Cognitive Flexibility:** He struggles with his current schedule since he is not able to structure and plan his day. He verbalized that he used to have his days structured and planned throughout the week, and this is currently not happening due to his struggles with lack of motivation and overall ability to organize his day. This was not a problem prior to his injury. • **Planning/Organization:** Mr. XXXX states that his planning and organization is improving. He still reports that he struggles to "keep things together" and his day is often "falling apart." He has difficulty managing all aspects of his business. • **Time Management:** Mr. XXXX forgets appointments. This evaluator called to remind him of the evaluation. He stated he forgot about it. He used to be extremely organized prior to his accident. His attorney is currently reminding him of his medical appointments via phone calls and text. • **Reading:** He is able to read small print using his reading glasses. He sometimes has to read the information twice to comprehend. This was not an issue prior to his accident. **Sensory and Perception:** • **Acuity:** Mr. XXXX reports that his vision in his left eye has changed since the accident. He states that his vision is "magnified' on the left eye compared to his right eye. He has an ophthalmology appointment scheduled. He cannot recall the date. • **Saccades:** Yes. His eyes fatigue as the day progresses. • **Uses Glasses:** Reading glasses. • **Light Sensitive:** He has light sensitivity with fluorescent lighting. He is unable to drive at night secondary to the lights/glare from oncoming traffic. • **Tinnitus:** Mild tinnitus in bilateral ears. He has had tinnitus since he was in the military. **Behavior:** • **Mood:** He gets easily irritable when around people, and he occasionally lashes out at people close to him. He has terminated several employees of his company due to getting upset and angry. He did not use to be an angry person, and he is unable to state what triggers this behavior. He feels sad due to the loss of his father and also being worried about his family. • **Initiation/Motivation:** Mr. XXXX states that he struggles daily with initiating tasks and also feels that he is not motivated. He is trying to establish a routine and is also finding "the new me." This was not an issue prior to his injury. • **Self-Esteem:** Prior to the accident 5/5, after the accident 1/5 due to his	

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		current inability to manage his basic day-to-day activities and cope with the loss of his father. • **Self-Advocacy:** His attorney is assisting Mr. Casto with scheduling his medical appointments, providing transportation, and forwarding reminders for his appointments. He was able to manage his own appointments prior to the accident. • **Stress Causes:** He worries about the well-being of his family, if he will be able to manage his business, not being able to fly as a pilot due to his current medical condition, which is one of his favorite leisure activities. **Vocational:** • **Leisure Interest:** He is currently not able to ride his motorcycle, be a pilot, go to the gym or run, due to his current medical condition. He is taking his dog out on short walks. • **Level of Education:** Bachelor's in Aeronautics. • **Current Employment:** Self-employed. He owns a real estate business. • Mr. XXXX is currently available Monday through Sunday. He works part-time and has a flexible schedule. • **Mr. XXXX therapy goals:** Being able to return to work full-time and manage his business. Decrease pain, improve his cognition, and being able to return to leisure activities. • Language preference for therapy sessions - English. • The client is available for in-person therapy and telehealth. • He can receive either a phone call or a text. **Home Environment:** • Mr. XXXX lives with his son in a 2-story home. He has a large German Shephard dog. • **Current Schedule:** He is home during the week. **Personality Changes:** • He used to be confident, successful, and things were going well for him prior to his accident. Since the accident, he feels unsure about the future, he has become an angry person, and he is trying to find a new identity. **Proposed Plan of Care:** At NeuroPraxis, our mission is to deliver a personalized and comprehensive brain injury rehabilitation program right in the client's home. Our community-oriented approach combines careful assessment, treatment planning, rehabilitation, support, and advocacy to achieve optimal results. Mr. XXXX is an excellent candidate for NeuroPraxis and will benefit from continued rehabilitation in al structured in-home and community day treatment level for 3 days a week/4-5 months to improve overall independence in higher independent living skills, cognition, community, avocational engagement, overall health and well-being, set-up of community activities to improve overall strength and endurance and; follow through of use of strategies and program. Additional support to the rehabilitation services will include access to technology and wellness coaching. Some services may be delivered via tele-health following the core guidelines of the American Telemedicine Association.	

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		Mr. XXXX will receive a comprehensive and individualized evaluation and team treatment plan to improve his overall independence, higher independent living skills, functional mobility, safety in the home and community settings, and set-up of meaningful avocational activities. Upon start of services, an evaluation of the home environment, set-up of recommended strategies and identification of a functional routine would be arranged to ease transition of care. It is recommended that the initial program may include: • Occupational Therapy • Physical Therapy • Vestibular Therapy • Cognitive Therapy • Speech Therapy • Case Management • Psychotherapy • Therapeutic Specialist • RebuildU Program The plan of care will be re-evaluated after the initial 30 days and every 30 days thereafter. The proposed plan of care includes the mentioned services but does not include medical services except those specified above, translation services, medications, medical supplies, laboratory testing and services, adaptive and durable medical equipment, personal items, fees for recreational activities, and transportation. **Recommendation:** NeuroPraxis will provide the structure, support, and therapy needed to meet Mr. XXXX 's individualized requirements while working toward maximizing his functional potential. Please be advised that this is a proposed plan of care, which has been provided to determine the appropriateness of this candidate for home and community rehabilitation services. The proposed plan of care is subject to revision and increased specificity following the completion of the intake process. Regarding Home and Community-Based Rehabilitation, the California MTUS states the following: Outpatient home and community-based rehabilitation is selectively recommended for TBI patients. The indications are for sufficient residual symptoms and/or signs of post TBI to necessitate ongoing treatment, be it medical, physical therapy, occupational therapy, or other. These programs are generally more helpful for those with greater numbers and magnitudes of mismatch between current abilities and job cognitive and physical demands. There may be select cases with mild TBI with ongoing symptoms who may be candidates. In this case, there is evidence that the patient is deemed to be an appropriate candidate with functional deficits and goals to warrant certifying the request for	

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		authorization. If there are any questions regarding the content of this report, I invite you to contact me directly at (888) 266-8921. NeuroPraxis appreciates the opportunity to evaluate Mr. XXXX 's rehabilitation needs towards a life of purpose, social connection and optimism.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for headaches and pain in the neck and lower back:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **History of Present Illness:** Patient is here today for a follow up to reassess his symptoms in regard to his complaint of neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. The patient states he continues to experience the neck pain, headaches, lower back pain, memory dysfunction, brain fog, and mood changes since the previous encounter. The headaches are present on a daily basis and are continuous. The pain is achy in nature. He states he has been experiencing a change in the depth perception in his left eye as well. He was examined by an ophthalmologist who determined that there were not abnormal findings accordingly. The neck pain is worse with turning the head from side to side and with flexion and extension of the neck. There is radiation of pain and weakness into the right upper extremity all the way into the right hand, and he has troubling holding objects with his right hand. There is radiation of numbness into the left upper extremity all the way into the left hand. The pain wakes him up multiple times during the night as he is unable to find a comfortable position without experiencing severe neck pain. The lower back pain is worse with ambulation and bending forward. There is radiation of pain into the proximal aspect of the lower extremities with only occasional radiation of numbness and tingling into the lower extremities. A CT scan of the head that was performed did not reveal any acute intracranial bleed accordingly. *(*Reviewer's Comment: Mentioned CT scan of head is unavailable for review.*)* The pain interferes with his ability to attend to the activities of daily living severely. **Physical Examination:** **Examination of the head and neck:** Area corresponding to the supraorbital nerves is tender upon deep palpation. Area corresponding to the supratrochlear nerves is tender upon deep palpation. Area corresponding to the occipital nerves is tender upon deep palpation. There is no stiffness in the neck. Tenderness is elicited upon deep palpation of the area corresponding to the cervical facet joints bilaterally. Cervical facet loading and Spurling's tests are positive bilaterally. Three trigger points in the trapezius muscles bilaterally, each measuring about 1 x 2 cm. There are no cerebellar or autonomic signs or symptoms. Conjugate eye movement is normal. Gross visual field testing is within normal limits and there is no nystagmus. **Examination of the lower back:** Tenderness upon deep palpation of the areas overlying the lower paravertebral gutters corresponding to the lumbar facet	225-226

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		joints. No tenderness upon deep palpation of the sacroiliac joint. Straight leg raising tests are positive on the left side. Patrick's test is negative bilaterally. Two trigger points in the lower lumbar paravertebral muscles bilaterally, each measuring about 3 x 2 cm. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI). • Post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. • Myofascial pain syndrome with trigger points. **Plan:** • I recommend a cervical epidural steroid injection (ESI) and a lumbar epidural steroid injection (LESI) and trigger point injections. He may benefit from bilateral occipital nerve blocks. If he continues to experience the neck pain with headaches and lower back pain, he may be a candidate for double diagnostic cervical and lumbar medial branch blocks to assess the contribution of the cervical and lumbar facet joints in his head, neck, and lower back pain symptomatology. • In regard to the presence of TBI symptoms, memory dysfunction and brain fog after the head trauma, I recommend stem cell infusions with 6 mL of minimally manipulated umbilical cord blood stem cells performed intravenously every 2 weeks during 3 sessions. • If he continues to experience the mood changes, he may be a candidate for a series (4-6 sessions) of IV Ketamine infusions. He an upcoming appointment with neurologist for further evaluation. • All risks and benefits explained, and patient fully understands and agrees.	
MM/DD/YYYY	Hospital/ Provider	**Dental consultation for jaw pain:** **History of Present Illness:** 55 year old male here for evaluation of jaw status post motorcycle crash ~3 months ago. Patient has no history of TMJ or headaches prior to accident. He complains of migraines and jaw tension mainly on the left side which is worse in the morning but can be constant throughout the day. He has noticed wear on his teeth from recent clenching/grinding of teeth and a few chipped teeth as well from the accident. He is not having trouble chewing. Has some other neck/back issues being treated by other practitioners. **Physical Examination:**	375-376

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		Oral: ASA 1 Airway Class 2 Fractured enamel #26 occlusal edge Wear on #8 occlusal Point tenderness to left TMJ, temporalis and masseter- both masseter insertion and origin **Radiologic:** CBCT created today: 12/11/25 No jaw fractures visualized TMJ appears normal No gross fractured teeth or dental abnormalities visualized **Diagnosis:** • Left TMJ muscle pain, myofascial pain **Counseling Note:** **TMJ Counseling Note:** Counseled patient concerning the nature of TMJ/MPD disease. The discomfort here is muscle in origin. Will recommend hard splint therapy for grinding and muscle pain relief. In addition, Aleve BID x 2 weeks, moist heat, soft non chew diet x 2 weeks. Also recommend botox 100units to bilateral TMJ for clenching/grinding relief. Counseling was performed using the patient's own radiographs. **Plan:** Follow-up for bite splint delivery and TMJ botox in about 1 month.	
MM/DD/YYYY	Hospital/ Provider .	**Neuro-ophthalmic consultation for eye problem:** **History of Present Illness**: Patient is here for a neuro-ophthalmic evaluation. The patient reports that MM/DD/YYYY he was riding a motorcycle on the highway with his father on the back of the vehicle as they were passing into a construction zone. As the lanes merged into one and the patient slowed the motorcycle, the patient and his father were rear ended by a Caltrans truck. Upon impact, the patient was flung onto the road after spinning numerous times and landing on the back left of his head. He was wearing a helmet and denies subsequent facial fractures or bruising, but reports severe road rash on his left shoulder, elbow, hip, knee, and ankle. His father passed away due to the motor vehicle incident. He reports an initial adrenaline rush after being flung to the ground, though reports eventually collapsing onto the road. He was transported via ambulance to a nearby medical center where a CT Head was completed, along with MRI imaging of his neck and back. CT Head was negative for cranial hemorrhaging and, though the patient is unsure exactly of results of MRI imaging of his neck and back, reports being told about slipped discs and pinched nerves in the aforementioned areas. In the time since the incident, the patient has struggled with daily, severe headaches, attacking mainly his left temple and extending back throughout the left side of his head. In terms of visual changes, he reports that his vision OS looks magnified relative to OD which has resulted in mild imbalance issues. Motion sickness while riding in a motor vehicle has also increased, and the patient reports an increase in floaters OS. He reports new pain in his right arm, as well as chipping teeth during the incident. **Assessment/plan:**	100-106

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		Other motorcycle passenger injured in collision with heavy transport vehicle or busin traffic accident, initial encounter 55M here for a neuro-ophthalmic evaluation. The patient reports that MM/DD/YYYY he was riding a motorcycle on the highway with his father on the back of the vehicle as they were passing into a construction zone. As the lanes merged into one and the patient slowed the motorcycle, the patient and his father were rear ended by a Caltrans truck. Upon impact, the patient was flung onto the road after spinning numerous times and landing on the back left of his head. He was wearing a helmet and denies subsequent facial fractures or bruising, but reports severe road rash on his left shoulder, elbow, hip, knee, and ankle. His father passed away due to the motor vehicle incident. He reports an initial adrenaline rush after being flung to the ground, though reports eventually collapsing onto the road. He was transported via ambulance to a nearby medical center where a CT Head was completed, along with MRI imaging of his neck and back. CT Head was negative for cranial hemorrhaging and, though the patient is unsure exactly of results of MRI imaging of his neck and back, reports being told about slipped discs and pinched nerves in the aforementioned areas. In the time since the incident, the patient has struggled with daily, severe headaches, attacking mainly his left temple and extending back throughout the left side of his head. In terms of visual changes, he reports that his vision OS looks magnified relative to OD which has resulted in mild imbalance issues. Motion sickness while riding in a motor vehicle has also increased, and the patient reports an increase in floaters OS. He reports new pain in his right arm, as well as chipping teeth during the incident. **12/12/YYYY:** Central VA is 20/20 OU; color vision is 11/11 OU. There is no APD on pupillary examination. IOP is 19 mmHg OU. On sensorimotor examination, the patient is ortho in all gazes with full EOMs. VF shows a superior scotoma OD, otherwise full OU. Fundus photos obtained OU + OCT MAC shows a moderate ERM OS + OCT ON shows an RNFL thickness of 102 microns OD and 101 microns OS. DFE shows pink and healthy appearing optic nerves and retinae OU; there are no signs of retinal holes, tears, or detachments. I mentioned to the patient that while there is an association between trauma and a macular ERM, I am unable to determine if the ERM is secondary to trauma sustained during the incident or if there was another cause as ERMs are common and can result from a multitude of reasons. Since his visual acuity OS is still 20/20, I do not recommend surgical intervention at this time but mentioned it is something to consider in the future if his VAsc diminishes secondary to ERM worsening. Membrane peeling is a more invasive surgery, so I advised him to continue keeping vascular risk factors minimized so as not to worsen ERM. I recommended he obtain photos from his optometrist prior to the incident to see if his ERM OS is visible prior to the accident. I explained the ERM can explain the aniseikonia he is experiencing. **Epiretinal membrane; left eye:** OS OCT MAC shows ERM OS, confirmed by DFE. See treatment plan as above. **Subjective visual disturbances:** **Aniseikonia:** The patient reports that his vision OS looks magnified (macropsia) relative to OD which has resulted in mild imbalance issues. He has developed	

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		ERM OS. Aniseikonia is a vision condition where the brain receives images from each eye that differs in size or shape. The reason is photoreceptors in the eye with ERM get closer together, the image stimulates more receptors for the same objects.	
MM/DD/YYYY	Hospital/ Provider	**Neurosurgery consultation for TBI:** **History:** XXXX is a 55M who is status post a motor vehicle accident on MM/DD/YYYY, as a helmeted motorcyclist who struck from behind by a truck on a freeway. This impact resulted in a fall off his motorcycle where he struck the occiput and left side of his body on the pavement. His father, who was on another motorcycle, was killed in the accident. He notes gaps in his memory concerning for a brief loss of consciousness. After the accident, the patient developed a constellation of complaints, of which include a constant left temporal headache, rated 4-10/10, described as dull/throbbing, and lasting 1-2 hours per day. He also notes symptoms of photophobia, memory issues, word-finding difficulties, insomnia, nightmares, mood disturbances, depression, emotional lability, concentration issues, and a general brain fog. These complaints have severely impacted his ability to work in real estate. He is also unable to maintain a consistent exercise regimen. The patient also notes a constant neck pain, rated 7/10, with radiation to the left greater than right arm aches, with numbness/tingling from the left elbow to left thumb/index finger. He notes a weakness in the right arm in the shoulder and grip, and is dropping things. This has resulted in an increased use of his left hand, despite being right-handed. He notes a constant low back pain, rated 8/10, without complaints of leg pain. The low back pain is worse with bending forward and activity. The patient denies bowel/bladder issues or gait instability. The patient has undergone conservative therapies consisting of PT/OT without relief. He is currently being evaluated by a neurologist for work-up of a traumatic brain injury (TBI). **Physical Examination:** On palpation of the neck, there is minimal tenderness. Some minimal pain with neck rotation. On palpation of the low back, there is minimal tenderness with otherwise a full range of motion. Motor: Right delt/bi 4+, right grip 4+. Otherwise power is 5/5 throughout with normal bulk and tone. **Gait:** Normal gait. Unstable with tandem gait. **Questionnaires:** Mini-Mental Status Exam (MMSE) results are 30/30 The MRI of the cervical and lumbar spine dated MM/DD/YYYY was reviewed. **Assessment:** • Chronic post-traumatic pain • Traumatic brain injury • Mood disorder due to known physiologic condition • Memory and cognitive decline • Secondary insomnia • Dizziness and disequilibrium • Cervicalgia	247-250

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		• Cervical spine strain/sprain • Cervical degenerative disc disease • Cervical radiculopathy • Lumbago • Lumbar spine strain/sprain • Lumbar degenerative disc disease **Causation:** XXXX presents for evaluation of a constellation of complaints that include photophobia, memory issues, word-finding difficulties, insomnia, nightmares, mood disturbances, depression, emotional lability, concentration issues, and a general brain fog most consistent with a traumatic brain injury. He also complains of neck pain with arm pain and weakness most consistent with a C5 and C6 radiculopathy. He notes a new low back pain after the accident. These symptoms were not present prior to the car accident. **Future risks:** • Chronic neck pain • Chronic low back pain • Radiculopathy • Myelopathy • Bowel/bladder dysfunction • Gait instability • Dementia • Memory loss and Concentration Deficits • Endocrine dysfunction • Anxiety Disorder **Plan of care:** At this juncture, I have recommended further evaluation with: • EMG of the bilateral upper extremities • Flexion/extension X-ray of the cervical and lumbar spine • Pain Management Referral • Cognitive Rehabilitative therapy • Vestibulonystagmography • Psychiatry • Neuro-ophthalmology • Endocrine labs I have also requested the electronic medical records from the initial emergency visit. Follow-up afterwards. I have addressed all questions with the patient.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for acute stress:** **Subjective:** The patient reports “doing ok”; not sure if he feels a lot from the SSRI- no SE; Prazosin helpful but feels groggy the next am; psychotherapy-> “going okay with getting things off my chest”; sleep- better; appetite-> “ok”; no XS EtOH or any substance use. **Objective/MSE:** Euthymic, affect: bit constricted	108

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		Assessment/Plan: • Increase Lexapro dose to: 15 mg qd x 6 days, then 20 mg qd thereafter. Prazosin 1 mg po qhs prn • Follow-up in 4-6 weeks.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up orthopedic evaluation for the pain in the neck and back:** To Whom It May Concern: Mr. XXXX presents to my North Hollywood office today on 12/15/YYYY for follow-up orthopaedic evaluation of his bilateral shoulder and left knee pain. **Interim history:** The patient reports that since his last visit to my office, he has been attending physical and chiropractic therapy of his bilateral shoulder and left knee once a week. He denies new injuries and has not seen other doctor since the last visit. He has been taking Meloxicam and states that he has not had any problems with the medication. Today, the patient complains of mild to moderate in intensity, constant sharp bilateral shoulder pain. He states that any overhead activity worsens his pain and it is relieved with little to no movement. He has been icing his bilateral shoulder four times a week. The patient also complains of moderate in intensity, constant sharp left knee pain. He states that standing worsens his pain and it is relieved by resting. He has been icing his left knee four times a week. **Physical Examination:** The physical examination of the patient's bilateral shoulder today reveals tenderness to palpation over the acromioclavicular joint and the right biceps tendon. There is also tenderness to palpation over the lateral/middle portion of the rotator cuff. Range in motion in forward flexion is 150 degree with pain on the right and 180 degree on the left, abduction is 150 degree with pain on the right and 175 degree with pain on the left, external rotation is 85 degree with pain on the right and 90 degree with pain on the left and internal rotation is 55 degree with pain on the right and 75 degree with pain on the left. Muscle testing reveals 4+/5 strength in right forward flexion and abduction. Muscle testing reveals bilaterally strong biceps, triceps, external and internal rotation. Speed's and Hawkin's tests are positive bilaterally. Neer's test is positive on the right. Lateral Jobe, Lift off, Belly press and Cross Arms tests are negative. Upper Extremity Circumferences in the upper arm is 13 inches bilaterally and forearm is 10 1/2 on the right and 11 inches on the left. The physical examination of the patient's left knee today reveals patient is observed ambulating normally with his left knee. There is no swelling or effusion noted upon gross inspection. He has cubitus normal alignment on bilateral knees. His gait is normal on bilateral knees. There is patellar tenderness noted over the medial facet and inferior pole of the patella. There is posteromedial joint line tenderness noted. Range in motion in flexion is 130 degree, and extension is 0 degree bilaterally. Muscle testing reveals bilaterally strong quadriceps and hamstrings. **Lower Extremity Circumferences:** 6" above patella Right 19; Left 19 3" above patella Right 18; Left 18 ½	461-464

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		At the patella Right 16"; Left 16 **Assessment:** • Right shoulder pain. • Left shoulder pain. • Bilateral shoulder acromioclavicular joint osteoarthritis. • Right shoulder tendinitis/rotator cuff syndrome. • Left shoulder tendinitis/rotator cuff syndrome. • Right shoulder biceps tendinitis. • Right shoulder impingement syndrome. • Left shoulder impingement syndrome. • Left knee pain. • Left knee patellofemoral syndrome. **Discussion and plan:** I have discussed with the patient today his diagnoses and physical examination findings. At this time, my recommendations are as follows: • Due to persistence of the patient's symptoms in the region of the right shoulder, despite conservative treatment modalities, as well as based on the physical exam findings today, I now continue recommending an MRI of the bilateral shoulders. I am giving the patient a prescription for this study today. • I would like to recommend weight bearing X-ray of the patient's left knee. • I would like to recommend an intra-articular steroid injection of the left knee to the patient. This injection cost $650.00. • The patient should start a bilateral shoulder home exercise program. I am giving the patient a guide of the appropriate exercises. The patient should attempt to do all the exercises in this guide on a daily basis. • The patient should start a left patellofemoral syndrome home exercise program. I am giving the patient a guide of the appropriate exercises. The patient should attempt to do all the exercises in this guide on a daily basis. • The patient should continue his home icing program. I would like the patient to apply ice to the bilateral shoulder and left knee for twenty minutes before going to bed on a daily basis. • I will see the patient back in my office one week after the above-mentioned MRI and X-ray for review of the results and discussion of further treatment plan.	
MM/DD/YYYY	Hospital/ Provider	**Correspondence letter to Dr. Kayem regarding left ear tinnitus:** Dear Dr. XXXX, XXXX stated that on September 24, YYYY, he was involved in a motorcycle accident with his father and brother on individual motorcycles; he reported a truck had struck his father first and then him from the back. He reported he was thrown off the motorcycle and spun backwards and fell headfirst onto the pavement. He does not think there was a loss of consciousness; he recalls hitting his head as well as his jaw and cracking his teeth. Mr. XXXX went to the Emergency Room; he reported that follow-up testing after the emergency room were suggestive of a concussion. Shortly after the accident, he perceived intermittent ringing in the left ear that is brief in duration, lasting up to thirty	449-451

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		seconds at a time and occurring a few times a week. The patient perceives the sound 20% of his waking time. He rated the loudness of the sound a 3 on a 0-10 visual analog scale. The tinnitus does not interfere with his sleep. He feels that occasionally, the ringing will cause a plugged sensation in his left ear. The patient endorsed dizziness as well as vision issues following the accident; the patient reported that his equilibrium is off. He has had a balance assessment. There is a history of noise exposure from being in the Air Force, with the use of hearing protection. **Results:** Otoscopy revealed clear ear canals and normal tympanic membranes for both ears. Tympanometry showed a Type A configuration, consistent with normal tympanic membrane compliance, ear canal volume, and middle ear pressure, bilaterally. Ipsilateral Acoustic Reflexes were present from 0.5-4 kHz in the right ear and present from 0.5-4 kHz in the left ear. Acoustic Reflex Decay was negative at 0.5 and 1 kHz bilaterally. Pure Tone Audiometry was performed. Testing revealed normal hearing sensitivity in the right ear and normal hearing sensitivity in the left ear. The Speech Reception Threshold (SRT) was 5 dB HL in the right ear and 5 dB HL in the left ear. The SRT was in good agreement with the Pure Tone Average (PTA) for both ears. Word recognition was 100% correct at 45 dB HL in the right ear and 100% correct at 45 dB HL in the left ear. Masking was utilized where appropriate. Test reliability was good. Distortion Product Otoacoustic Emissions (Diagnostic) were performed. DPOAEs are an objective measurement of outer hair cell function within the cochlea. DPOAEs were tested from 0.75-10 kHz. DPOAEs were present from 1.3-5 kHz in the right ear and 0.75-5 kHz in the left ear. All other frequencies were reduced or absent for both ears. This indicates cochlear damage that is not evident in the audiogram. Tinnitus Evaluation was not performed, as tinnitus was not present at time of testing. Tinnitus Functional Index (TFI) was performed. This subjective tool evaluates the effect of tinnitus on daily activities. Studies show that the TFI is sensitive and reliable in evaluating different aspects of tinnitus. It is also sensitive to improvement as a result of treatment modalities. It evaluates the strength, persistence, effect on concentration, thinking, resting, sleep, annoyance, coping, and social activities. His score was 31.6, suggesting a small problem with daily activities as a result of having tinnitus. Tinnitus Handicap Inventory (THI) was performed. The THI is a psychometrically valid test that evaluates the patient's subjective handicap as a result of tinnitus perception. His score was 14, suggestive of slight subjective handicap as a result of tinnitus. **Counseling:** Mr. XXXX was counseled regarding the anatomy and physiology of the ear and hearing, central auditory processing and its function, and the relationship between tinnitus and cochlear damage. The limbic system, its effect on the central auditory nervous system, and the vicious cycle were explored. The	

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		notion of central gain as the reason for tinnitus was discussed. **Discussion:** Mr. XXXX has intermittent left subjective tinnitus, normal hearing sensitivity in both ears, and dizziness. DPOAEs objectively showed cochlear damage in both ears that indicates damage that is not evident in the audiogram. Currently, there is no cure for tinnitus. The patient needs to add environmental sounds whenever the tinnitus is present. Use of the Widex Zen Application may be needed if daily environmental sounds are not adequate to cover the tinnitus. This level of tinnitus does not require further treatment. **Impressions:** • Intermittent subjective tinnitus, left ear • Normal hearing sensitivity, bilateral • Cochlear damage, bilateral • Dizziness **Recommendations:** • Review of results and clinical correlation by Dr. Kayem. • Utilize strategies for coping with and habituating to tinnitus. • Audiogram in 6 months, or whenever deemed medically necessary.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for TBI:** **To Whom It May Concern:** I had the opportunity to evaluate XXXX on 12/15/YYYY. XXXX is a 55-year-old male who was involved in a motor vehicle collision on or about MM/DD/YYYY. He was riding on his motorcycle on the highway, with his dad on the motorcycle behind him. A Caltrans truck his dad first, then hit him. His dad died in this injury. XXXX recalls hitting his helmeted head on the concrete. He does not recall a loss of consciousness but has limited recall to details of the injury. He noted severe pains in his left elbow, back and left knee and ankle. He also noted problems with his balance at the scene. Paramedics came and evaluated him. They recommended he be transported to the hospital, but he was more concerned about lifesaving maneuvers being performed on his dad. However, he ended up falling to his knees and side and paramedics put him on a gurney. He was taken to Sutter Trauma Center in Roseville, CA. There, he had medical and radiological evaluations and was released home later that day. His balance issues persist. These can often be exacerbated by the pain in his back and left leg. He continues to feel that his equilibrium is off, and he will often find himself bumping into objects around him. He has noted that closing one eye can help during an acute episode. He describes the dizziness as the feeling one has with too much wine (he gets this without having any alcohol). This is constant and does not come in bouts. He will note it more if he does any sudden movements (getting up from bed or from a couch). He also noted left tinnitus at the time of the impact. This persists and can come and go, though it has not been keeping him up at night. The tinnitus occurs a few times a week, and lasts from 30 seconds to a minute. He has not noted a change in his hearing. Prior to the injury, he had no complaints of any issues with his balance, tinnitus or hearing loss. He was in the air force for 26 years and always	457-460

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		wore hearing protection if exposed to loud noises. He has also noted significant issues with his memory and concentration since the injury. He has difficulty finding words in a conversation, now commonly misplaces objects and can repeat a task that he forgot he already did. He has also had issues with his mood and increased irritability. He also noted issues with his vision, feeling that objects appear larger in his left eye than his right eye. He has also had constant left-sided headaches, for which he has been followed by a neurologist. He has no known allergies to medication. His past medical history is insignificant and non-contributory to the present problems. He denies diabetes, thyroid problems, hypertension, and heart or lung problems. His past surgical history is insignificant and non-contributory to the present problem. He does not take medications other than a statin for cholesterol and occasional pain medication (Ibuprofen). **Physical Examination:** EOMs normal without nystagmus. **Romberg:** Borderline, with compensated unsteadiness with eyes closed. **Sensitized Romberg:** Abnormal, falling to the left repeatedly with left-foot forward and with right-foot-forward both with eyes open and (worse) with eyes closed. **Impression:** Motor vehicle collision on MM/DD/YYYY. • Balance dysfunction secondary to MVC above. • Tinnitus secondary to MVC above. • Memory and concentration issues secondary to MVC above. • Vision problems secondary to MVC above. • Back issues secondary to MVC above. **Plan:** • VNG for balance testing. • Tinnitus evaluation. • Neurocognitive testing. • Follow up with eye specialist. • Follow up with appropriate specialists. Follow-up is planned after the above tests have been performed. Please feel free to call if you have any questions.	
MM/DD/YYYY	Hospital/ Provider	**Videonystagmography/platform report:** **<u>Rotational Testing:</u>** • Within normal limits. • Limited dataset points. **<u>Oculomotor Battery:</u>** **Smooth Pursuit (tracking):** Abnormal. • Hypermetria. • Gain - 231 (normal gain is between 70-140). **Saccades:** Abnormal.	431-448

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		• Saccadic intrusions. • Latency of .350 (normal is < .350). **Optokinetic:** Abnormal (normal is > 6 deg/ sec and < 30% asymmetry) • Asymmetric OPK Leftward. **Gaze & Spontaneous Nystagmus:** Within normal limits **Torsion Swing:** Within normal limits **Dix - Hallpike:** (normal 0-3 deg/sec) • Scattered square waves Dix-Hallpike Right and Left. **Positional Testing:** (normal 0-3 deg/sec) • Scattered vertical square waves Supine Head Right, Head Left and Head Center. **Caloric Testing:** (normal velocity is > 20° per second for all four irrigations) • Within normal limits **Platform:** Abnormal - Greater than 3 Standard deviations out of norm in all platforms tested: EOSS, ECSS, EOFS, and ECFS. **Predominant findings:** **Central vestibulopathy:** Indicated by abnormal Smooth Pursuit, Saccades, OPK Dix-Hallpike and Positional Testing. These findings are supportive of a diagnosis of a TBI (traumatic brain injury) leading to balance dysfunction. **Care considerations:** (Care choices to be based upon physical exam, history and test results) • A full course vestibular rehabilitation (Vestibular Compensation and Recuperation- VCR) • Safety assessment of living quarters if needed. • Enrollment in falls prevention program.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for stem cell infusion procedure:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **History of Present Illness:** Patient is here today for proceed with the first round of intravenous stem cell infusions (6 mL of minimally manipulated umbilical cord blood stem cells) based on the guidelines for traumatic brain injury (TBI) provided by TBI Analytics. Patient was informed that this protocol is based on the investigational clinical use of minimally manipulated umbilical cord blood stem cells for the treatment of patients diagnosed with symptoms of TBI. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI).	473-474

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		• R/o post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. **Plan:** Today we will proceed with the first round of stem cell infusions (6 mL of minimally manipulated umbilical cord blood stem cells) in regard to the TBI symptoms. All risks and benefits explained, and patient fully understands and agrees. Informed consent signed. Next infusion in 2 weeks. **Procedure note:** **Procedure Performed:** • Stem cell infusion After obtaining consent having explained all the risks and benefits of the procedure, a gauge 22 angiocath was placed in the right antecubital area to gain access to the venous circulation. The port was flushed with 3 mL of Heparin lock flush (standard concentration) immediately prior to administration of stem cells. Then 6 mL of minimally manipulated umbilical cord blood stem cells was infused over one minute with monitoring of the patient's vital signs using pulse oximetry and NIPB. Patient tolerated the procedure well with no evidence of any alteration in the hemodynamics and the vital signs and no adverse effects. The intravenous line was removed after 15 minutes of observation and patient was provided with all the post infusion instructions. The patient was discharged in stable condition and follow up appointment was provided.	
MM/DD/YYYY	Hospital/ Provider.	**Follow-up visit for trigger point injections:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **Subjective:** Patient is here today for trigger point injections (ESI) in regard to his complaint of neck pain with headaches after a motorcycle accident where he was rear-ended by a commercial truck. **Physical Examination:** **Examination of the head and neck:** Three trigger points in the trapezius muscles bilaterally, each measuring about 1 X 2 cm. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck.	475-476

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		• Traumatic brain injury (TBI). • Post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. • Myofascial pain syndrome with trigger points. **Plan:** Today we will proceed with TPIs. All risks and benefits explained, and patient fully understands and agrees. Informed consent signed. Follow-up in 1-3 weeks. Patient will receive six bottles of MiGuard, the all-natural headache nutritional supplement. **Procedure note:** **Procedure performed:** • Trigger point injection X 6 spots (3 on each side in the trapezius muscles) **Needle Guidance:** None **Sedation:** None **Details:** Signed consent in chart. I explained the above procedure to the patient and reviewed its possible benefits, complications, and risks. Alternatives to the procedure were also mentioned and explained to the patient. Patient was given the opportunity to ask questions before an informed consent was obtained. A time-out was completed verifying correct patient, procedure, site, positioning prior to starting the procedure. The benefits, complications, risks, and limitations associated, as well as possible alternatives were explained. Patient was monitored with pulse oximetry Using G#27, 1.5" needle, TPI was performed after Betadine prep. Injectate includes 1ml of Lidocaine 1% MPF, 1ml Marcaine 0.5% MPF per location. No apparent complications. No sensory/motor deficits. Patient was observed and monitored after the procedure by anesthesia and nursing staff until recovered. The patient tolerated the procedure well without complications. Patient was discharged awake and oriented with stable vital signs accompanied by a responsible adult and given written discharge instruction sheet with phone numbers to call in case of emergency.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for cervical epidural steroid injections:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **Subjective:** Patient is here today for a cervical epidural steroid injection (ESI) in regard to his complaint of neck pain with headaches after a motorcycle accident	477-478

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		where he was rear-ended by a commercial truck. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI). • Post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. • Myofascial pain syndrome with trigger points. **Plan:** Today we will proceed with cervical ESI. All risks and benefits explained, and patient fully understands and agrees. Informed consent signed. Follow-up in 1-3 weeks. **Procedure note:** **Procedure performed:** • Cervical interlaminar epidural steroid injection **Needle Guidance:** Fluoroscopic guidance **Sedation:** Monitored Anesthesia Care **Details:** Signed consent in chart. I explained the above procedure to the patient and reviewed its possible benefits, complications, and risks. Alternatives to the procedure were also mentioned and explained to the patient. Patient was given the opportunity to ask questions before an informed consent was obtained. A time-out was completed verifying correct patient, procedure, site, positioning prior to starting the procedure. The procedure was done under MAC. The patient was informed of and agreed to the above procedure to be done with the administration of MAC. The benefits, complications, risks, and limitations associated, as well as possible alternatives were explained. Patient was monitored with pulse oximetry, blood pressure monitor, and EKG tracing. Supplemental oxygen was provided via nasal cannula. The patient was positioned prone on the fluoroscopy table and MAC anesthesia was provided. With use of AP fluoroscopy view the interlaminar space of C7-T1 was identified and the skin over this area was prepared and draped in the usual and sterile fashion. The skin and the overlying subcutaneous tissue were anesthetized with 1% Lidocaine 5ml. With intermittent AP and lateral fluoroscopic imaging an G 20, 3.5 inch Tuohy needle was then advanced using LOR technique toward the interlaminar space (first touching the superior border of the lamina of TI). No CSF, blood or paresthesia was elicited. After negative	

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		aspiration, Isovue 200, 1 ml was injected revealing a perfect epidurogram in AP and lateral/contralateral views. Total of 1 ml of 1% Lidocaine MPF and 80 mg of Depomedrol was injected slowly with no complications. The needle was removed and band aid was applied. Fluoroscopy time was 3 seconds. Patient was observed and monitored after the procedure by anesthesia and nursing staff until recovered. The patient tolerated the procedure well without complications. Patient was discharged awake and oriented with stable vital signs accompanied by a responsible adult and given written discharge instruction sheet with phone numbers to call in case of emergency.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for headaches and pain in the neck and back:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **Subjective:** Patient has been contacted today for a follow up after undergoing a cervical epidural steroid injection (ESI), the first stem cell infusion, and trigger point injections (TPI) in regard to his complaint of neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. The patient states he has not experienced a significant amount of gradual relief of the neck pain following the cervical ESI and TPIs. He denies experiencing any adverse effects following the procedures. He states that there is still some discomfort at the injection site for the cervical ESI, however there is no warmth, redness and no drainage and the injection site has healed properly. He still continues experiencing the LBP. The lower back pain is constant, and the pain is achy in nature. The pain is mainly located on the left side of the lower back. The pain can be as high as 7/10 on the intensity scale. The pain is worse with ambulation and bending forward. There is radiation of pain into the proximal aspect of the lower extremities with only occasional radiation of numbness and tingling into the lower extremities. The pain impacts the patient's ability to perform activities of daily living severely. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI). • Post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. • Myofascial pain syndrome with trigger points.	479-480

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		Plan: • I recommend for the patient to proceed with the second stem cell infusion. • I will meet with the patient in the upcoming follow up appointment for further examination. He may benefit from a repeat cervical ESI and a lumbar ESI. • All risks and benefits explained, and patient fully understands and agrees.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for stress:** **Subjective:** The patient reports doing ok- continues to feel heavy and has thoughts of the accident; sleep- better, much less nightmares; appetite-> "ok"; no XS EtOH or any substance use. Able to work better; meeting with psychotherapist weekly for the past several weeks. **Assessment/Plan:** • Continue with Lexapro 20 mg po qd and Prazosin 1 mg po qhs prn • Follow-up in 2 months.	194
MM/DD/YYYY	Hospital/ Provider.	**Follow-up visit for TBI:** **To Whom It May Concern:** I had the opportunity to evaluate XXXX via telemedicine follow up call on 02/17/YYYY. XXXX is a 55-year-old male who was involved in a motor vehicle collision (motorcycle VS. auto) on or about MM/DD/YYYY, which killed his father who was riding his motorcycle behind him. XXXX recalls hitting his helmeted head on the concrete. He does not recall a loss of consciousness but has limited recall to details of the injury. He has been followed in our office for issues with his balance and tinnitus that resulted from this injury. Prior to this injury, he had no issues with his balance or any tinnitus. **Balance:** This continues to be an issue for him. He feels off balance when he stands up or when being active. He has been less active than usual because of his other injuries, and feels that when he does move, his balance is off. He also feels his vision remains off and that this has been contributing to the issue. He feels his balance is much worse when his eyes are closed. He VNG testing on 12/15/YYYY, which revealed a central vestibular pathology compatible with a mild traumatic brain injury (mTBI). **Tinnitus:** This can come and go. He notes this more often in quiet environments. This has been tolerable and has not kept him up at night but remains noticeable any time he is in a quiet environment. He underwent audio testing on 12/15/YYYY, which revealed hearing within normal range. However, DOEs revealed cochlear damage that was not evident on the audiogram. The tinnitus was not present at the time of testing. **Memory and concentration:** This remains challenging for him. He continues to have issues with his recall and feeling that his thought process if much slower. He has been getting cognitive therapy with his speech therapist. He underwent neurocognitive testing on 12/15/YYYY, which revealed the likely present of cognitive impairment in the field of Delayed Recognition Memory and possible impairment in Executive Function. **Impression:** Motor vehicle collision on MM/DD/YYYY. • Balance dysfunction secondary to MVC above.	533-535

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		• Tinnitus secondary to MVC above. • Memory and concentration issues secondary to MVC above. • Vision problems secondary to MVC above. • Back issues secondary to MVC above. **Plan:** • Recommend a full course of vestibular rehabilitation (Vestibular Compensation and Recuperation- VCR). o Recommended Length of Therapy: ▪ An intensive plan of Vestibular Compensation and Rehabilitation (VCR) therapy of 16-24 weeks duration. Treatment plan will be 2-5 sessions per week, based on patient's treatment tolerance, for a total of 80-100 hour-sessions @ $500/hr.-session, inclusive of in-office, and/or Zoom call. Treatment package cost: $40,000 - $50,000. ▪ Daily at-home exercises, to include x1 and x2 viewing three times daily. ▪ Walking exercises to be increased as progress gained through outpatient sessions. o Follow-Up Upon Therapy Completion: ▪ Consider repeating VNG to reassess initial abnormalities to document improvement. ▪ Long-term maintenance of balance strongly recommended. ▪ Return to VCR/VRT as needed for residual unsteadiness or balance issues. o Annual Maintenance VCR therapy ~ ½ the time of initial course- 40-50 hrs. inclusive of in-office, and/or Zoom, and/or at-home (Annual Maintenance Therapy package cost - $20,000 - $25,000). o Annual balance testing (VNG/CDP) to monitor for changes and to alter therapy as necessary. • Clinical follow up. Consider tinnitus retraining therapy (TRT) if this is bothersome. • Recommend full neuropsychological testing if not yet done. • Follow up with eye specialist. • Follow up with appropriate specialists. Follow-up is planned after he has completed the first 10 sessions of VCR vestibular therapy.	
MM/DD/YYYY	Hospital/ Provider	**Follow-up visit for headaches and pain in neck and back:** **Chief Complaint:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. **Subjective:** Patient has been contacted today for a follow up to reassess his symptoms in regard to his complaint of neck pain with headaches, lower back	542-543

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		pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. The patient states he continues to experience the neck pain, headaches, lower back pain, memory dysfunction, brain fog, and mood changes since the previous encounter. He states that the cervical ESI that was already performed has been helpful, but he feels that the relief is gradually decreasing. The neck pain is present most of the time and the pain is achy in nature. The pain is mainly located on the left side of the neck. The pain is worse with turning the head from side to side and with flexion and extension of the neck. There is radiation of pain and weakness into the right upper extremity all the way into the right hand. There is radiation of numbness into the left upper extremity all the way into the left hand. The pain wakes him up multiple times during the night as he is unable to find a comfortable position without experiencing severe neck pain. The headaches are present on a daily basis and are continuous. The pain is achy in nature. The pain can be as high as 7/10 on the intensity scale. The pain is mainly located in the left temple but in general, he has holocranial head pain accordingly. There is nausea and light sensitivity associated with the headaches. There is a severe sensation of imbalance and depth perception present. He also has severe memory problem in the form of recall of especially recent events and also has difficulty finding words and attending to complex tasks. He also suffers from extreme irritability and feels very withdrawn from daily activities as a result of this accident as well. He denies history of seizures, aura, or ringing in the ears. He denies any changes in the sense of smell or taste. The lower back pain is constant, and the pain is achy in nature. The pain is mainly located on the left side of the lower back. The pain can be as high as 7/10 on the intensity scale. The pain is worse with ambulation and bending forward. There is radiation of pain into the proximal aspect of the lower extremities with only occasional radiation of numbness and tingling into the lower extremities. The pain interferes with her ability to attend to the activities of daily living severely. **Assessment:** Neck pain with headaches, lower back pain, severe memory dysfunction, brain fog, and mood changes after a motorcycle accident where he was rear-ended by a commercial truck. • Traumatic brain injury (TBI). • Post concussive syndrome. • R/o occipital neuralgia. • Headaches may be cervicogenic in nature due to cervical facet joint arthropathy. • Whiplash injury to the cervical spine due to the accident. • Axial neck pain possibly due to referral from the cervical facet joints. • R/o cervical radiculopathy. • Axial back pain possibly due to referral from the lumbar facet joints or the sacroiliac joints. • R/o discogenic low back pain. • R/o lumbar radiculopathy. • Myofascial pain syndrome with trigger points.	

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		Plan: • I recommend a repeat cervical epidural steroid injection (ESI) and a lumbar epidural steroid injection (LESI) followed by PRP vs stem cell injections and trigger point injections. He may benefit from bilateral occipital nerve blocks. If he continues to experience the neck pain with headaches and lower back pain, he may be a candidate for double diagnostic cervical and lumbar medial branch blocks to assess the contribution of the cervical and lumbar facet joints in his head, neck, and lower back pain symptomatology. • In regard to the presence of TBI symptoms, memory dysfunction and brain fog after the head trauma, I recommend stem cell infusions with 6 mL of minimally manipulated umbilical cord blood stem cells performed intravenously every 2 weeks during 3 sessions. • If he continues to experience the mood changes, he may be a candidate for a series (4-6 sessions) of IV Ketamine infusions. All risks and benefits explained, and patient fully understands and agrees.	
MM/DD/YYYY	Hospital/ Provider	**Preadmission evaluation report:** **Program Recommendation:** Participation is recommended in a specialized, post-acute, comprehensive, day treatment brain injury neurorehabilitation program at CNS. Although prior treatment has been partially successful in reducing pain symptoms a three-to-four-month day treatment program may be necessary, following initial, intensive, discipline-specific evaluations to effect meaningful change, but program duration and frequency will be determined by therapeutic progress. **Primary/Secondary Diagnoses:** • Left TMJ muscle pain • Myofascial pain • Acute stress disorder • Post-traumatic stress disorder (PTSD) • Major depressive disorder (MDD), single episode, moderate, without psychotic features **Reasons for Specialty Program:** XXXX requires medically necessary, specialized, unique diagnostic, and therapeutic neurorehabilitation services in this setting and cannot be treated at a lower level of care due to the following: • Persistent signs and symptoms following reported impact to the head, and which are commonly associated with brain injury, suggest candidacy for treatment in an integrated brain injury rehabilitation program. • History of falls, placing him at risk for falls and re-injury; skilled intervention required to address balance disturbances. • Significant vision issues, including impaired convergence and oculomotor function, increasing the risk of falls and re-injury, and necessitating vision therapy. • An ongoing need for supervision and re-training for completion of self-care and instrumental activities of daily living (IADLs).	550-570

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		• Skilled therapy intervention is needed to address ongoing pain issues, balance impairments, and decreased endurance; past outpatient physical therapy (PT) has not been adequate in remediating his current deficits. • No therapy has been provided to address cognitive impairments; cognitive-linguistic deficits, including poor memory and attention, slow processing speed, and expressive and receptive language deficits impact communication of wants and needs and place safety at risk, especially in emergencies. • Persistent anxiety, anger, irritability, decreased frustration tolerance, and PTSD issues all require ongoing psychotherapy treatment. • Limited family support in local area. • He shows potential for further progress, if provided a highly structured rehabilitative approach to relearning of tasks. • This is not an exhaustive list for this patient and may require modification as issues arise during treatment. **History of Present Injury:** According to a report from an initial psychiatric evaluation on October 6, YYYY, Rod Amiri, MD, reported that XXXX was a 55-year-old male injured approximately two weeks prior. XXXX was riding his motorbike on the freeway with his brother and father when a Caltrans truck struck him and his father from behind. XXXX 's father was killed and XXXX fell off his bike and landed on his head and shoulders. XXXX stated, " had a lot of bruises and fractures". Dr. Amiri reported XXXX had developed "pain injuries" in his shoulders, neck, and back. He complained of forgetfulness and visual changes and his vision on the left side had been "magnified." XXXX had difficulty falling and staying asleep since the accident and experienced intrusive thoughts and flashbacks every time he closed his eyes to sleep. He was avoiding talking to others to avoid discussing "what happened" and felt guilty, saying "we should have left sooner." XXXX was irritable and impatient toward loved ones and had become vigilant, surveying his surroundings in the community. He was isolating himself and denied interest in seeing anyone or doing anything at the time of the visit with Dr. Amiri. XXXXfelt safe and denied any suicidal or homicidal thoughts or any intent/plan to hurt himself or anyone else. In a mental status examination, XXXX was alert and oriented to person, place, time, and situation. He was in no acute distress and was cooperative during the evaluation. His mood was somewhat dysphoric and his affect was constricted. Thought processes were goal-directed. He denied suicidal or homicidal ideation and did not experience any perceptual disturbances or delusions. His insight and judgment were fair. XXXX had a neurology visit and potential imaging studies pending. Dr. Amiri conferred a diagnosis of acute stress disorder. His plan included the following: • Psychoeducation • Start Lexapro (Escitalopram) - titrated to 10 mg qd over 9 days • Start Prazosin 1 mg po qhs prn, nightmares • Recommend individual cognitive behavioral/cognitive processing therapy	

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		According to a cognitive behavioral assessment report dated October 9, YYYY, Diana Karjoo, PhD, of The Brain Works reported that due to his acute, debilitating symptoms, XXXX was referred for a cognitive behavioral assessment by Telehealth to assess his current psychological functioning and guide treatment planning. XXXX presented seeking support for acute grief and trauma following the sudden, violent death of his father. XXXX and his brother witnessed the collision, and XXXX himself was also hit and injured in the event. He was struggling with physical injury, emotional pain, anger, survivor's guilt, and the profound impact on his family. He reported severe emotional distress interfering with daily functioning, and an inability to fully utilize coping strategies due to the overwhelming nature of his pain. A recurring theme was feeling pressure to uphold an impression of strength for his family, which appeared to hinder his grieving process. XXXX endorsed moderate to severe symptoms of anxiety, depression, and PTSD. He reported heightened irritability, persistent anger directed at the driver and situation, significant sleep disturbance, and a persistently low mood. He reported an inability to experience comfort or peace with depressed mood and anhedonia. He also reported significant sleep disturbance, relying on distractions to fall asleep due to racing thoughts and emotional pain. His concentration appeared impaired and he struggled to implement coping strategies due to the overwhelming nature of his distress. In the assessment, which incorporated formal testing and an interview, XXXX met the diagnostic criteria for PTSD and for MDD, single-episode, moderate, without psychotic features. Dr. Karjoo identified the primary clinical risk as the potential for complicated grief and deteriorating mental health, given the severity of the trauma. Dr. Karjoo's recommendations included the following: • Continue consultation with his medical team to address ongoing pain, as well as follow-ups with PT and chiropractic therapy • Individual cognitive behavioral therapy (CBT) and psychotherapy • Maintain a healthy sleep schedule • Engage in physical exercise • Consider consulting with a psychiatrist to explore the possibility of psychopharmaceutical interventions to address his debilitating symptoms of depression and anxiety According to records dated October 15, YYYY, Michael Modica, MD, of NorCal Imaging reported that of MRI of the cervical spine without contrast that day produced these impressions: • Severe bilateral neural foraminal stenosis with moderate spinal canal stenosis at C3/C4, C4/C5, C5/C6, and C6/C7 • No abnormal cord signal According to a progress note dated November 3, YYYY, Dr. Amiri noted XXXX reported starting the SSRI therapy, but had not taken it consistently and had stopped after one week. XXXX had difficulty being present and dealing with his father's funeral. No more nightmares were noted on Prazosin 1 mg po qhs. XXXX endorsed some grogginess, but was sleeping better and his appetite was	

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		"ok." No excessive alcohol use or any substance use was noted. Objectively, XXXX was cooperative and exhibited a euthymic mood with an appropriate affect. His thought processes were goal-directed, and he had no suicidal or homicidal ideation. Dr. Amiri detailed the following plan: • Encouraged to redstart Escitalopram 5 mg po qd X 4 days, then 10 mg po qd thereafter • Continue with Prazosin 1 mg po qhs prn nightmares • Follow up in six weeks According to a report from a neurosurgical consultation dated November 4, YYYY, James Silverthorn, MD, reported that XXXX presented for evaluation following a motorcycle accident that occurred on September DD, YYYY. XXXX stated that he was riding his motorcycle on the freeway with his father on the bike and was slowing down to merge into traffic when he and his father were struck from behind by a large truck. His father died at the scene. XXXX was thrown off his motorcycle, landing on his head and side, but did not lose consciousness. His motorcycle was totaled, and police and ambulance responded, with the ambulance transporting him to Sutter Emergency Department. XXXX experienced neck pain; back pain; headache; shoulder pain; left ankle and left elbow pain; as well as numbness and tingling from his left elbow to his hand. XXXX reported weakness of his grip, dropping objects, and difficulty with balance. He had undergone PT, but did not experience significant relief. He denied any history of these symptoms before the accident. Physical examination showed positive Spurling's with radiation into the left shoulder and left Hoffman's reflexes. Lumbar spine range of motion showed flexion at 50 degrees, where normal was 90 degrees. He exhibited tenderness to palpation in the lower back. Motor examination of the lower extremities revealed iliopsoas strength at 4/5 bilaterally with quadriceps, hamstrings, and dorsiflexion at 5/5 on both sides. Light touch was intact in all major dermatomes on both the right and left. Patellar reflex demonstrated hyperreflexia at 3+. Straight leg raise caused low back pain. Dr. Silverthorn assessed the following: • Cervical disc disorder with myelopathy, unspecified cervical region (Primary) • Low back pain, unspecified Dr. Silverthorn commented XXXX had significant central stenosis with clinical findings of myelopathy as well as severe foraminal stenosis at C4 causing neck pain; at C5 causing shoulder pain; at C6 causing right-sided biceps weakness; and at C7 causing numbness and tingling on the left hand as well as weakness in the grip. Due to the severity of his spinal canal compression, as well as weakness associated with his radicular complaints, he was not a good candidate for non-surgical therapy. Dr. Silverthorn discussed procedures for decompression and fusion to include an anterior 4 level discectomy and fusion versus a posterior laminectomy and fusion, and XXXX preferred the anterior 4 level fusion and reconstruction. The doctor's plan included these items: • Order flexion-extension X-rays as well as place surgical case request • Referral to pain medicine • Referral to surgery	

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		• Begin chiropractic/physiotherapy treatments as tolerated • Home exercise program to improve muscle strength, joint stability, range of motion, and active reconditioning • Referral for consideration for initiating injections/ pain management therapies • Follow up in two months regarding nonsurgical therapies on lumbar spine According to a history and examination document dated December 11, YYYY, Brittany Sonnichsen, DMD, reported XXXX presented for evaluation of jaw, status-post motorcycle crash three months before. He had no history of TMJ or headaches prior to the accident. XXXX complained of migraines and jaw tension, mainly on the left side, worse in the morning, but at times constant throughout the day. He noticed wear on his teeth from recent clenching/grinding of teeth and a few chipped teeth from the accident. He was not having trouble chewing. Examination was notable for fractured enamel #26 occlusal edge and wear on #8 occlusal. Point tenderness was noted to left TMJ, temporalis, and masseter, both masseter insertion and origin. CBCT taken that day showed the following: • No jaw fractures visualized • TMJ appeared normal • No gross fractured teeth or dental abnormalities visualized Dr. Sonnichsen conferred a diagnosis of left TMJ muscle pain, myofascial pain. She commented on TMJ/MPD disease, noting the discomfort was muscular in origin. Her plan included the following: • Recommend hard splint therapy for grinding and muscle pain relief • Aleve BID X 2 weeks, moist heat • Soft non chew diet X 2 weeks • Recommend Botox 100 units to bilateral TMJ for clenching/grinding relief • Follow up for bite splint delivery and TMJ Botox in approximately one month During the CNS evaluation, XXXX reported that he was wearing a full-face motorcycle helmet when the accident occurred. He stated he was thrown from his motorcycle and "I hit my head and then my body just compressed," adding that the impact "took a chunk out of my helmet." XXXX reported he had seen a neurologist, but did not recall what was discussed. He had also had an "ear test" and "they said it was fine." He confirmed he had undergone vestibular testing, which "was definitely a complete fail" and added, "there's definitely something going on" in the area of balance. XXXX reported he participated in five sessions of Telehealth vestibular therapy, but had been advised to discontinue with anticipation to switch in-person vestibular therapy instead. Records for these services were not available for review at the time of the CNS evaluation. *(*Reviewer's Comment: Mentioned telehealth vestibular therapy records are unavailable for review.*)*	

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		XXXX was also receiving chiropractic care and home health PT. He felt PY was helpful; however, he commented that, overall, the level of care he was receiving for the sum effects of the accident did not meet his needs. *(*Reviewer's Comment: Mentioned chiropractic therapy and home health PT records are unavailable for review.*)* **Post-injury Medical Status/General Health:** • Weight loss following injury • Continent of bladder only; several incidences of incontinence of bowel • **Diet:** o Regular textures o Thin liquids o Decreased appetite; "I snack" but "I really don't eat" o "I just don't feel that hungry" • **Food allergies:** None reported • **Swallow function:** Concern for dysphagia o Coughing on food and liquids "quite often" o Clinical correlation advised • **Sleep:** o Stated sleep was "terrible" o Difficulty endorsed attaining and maintaining sleep o Went to bed late and got up approximately once an hour o Slept up to four hours a night o Sleep disturbed by rumination; "I have to have the TV on to go to sleep" o Disrupted due to pain o Hot flashes at night; "I'll have to open my window" o Endorsed nightmares "from the crash" o Daytime napping denied; "then, I won't sleep"; endorsed falling asleep on couch o Endorsed "choking" sensation while sleeping; "I've woken myself up not breathing" o "I think that I am snoring;" however, no one else was nearby to observe o "Sore throat" on waking in mornings o A sleep study is recommended • **Implantable devices:** Not present **Known Comorbidities or Other Health Issues:** • **Endocrinology:** Clustered symptoms raise concern for endocrine function o Poor sleep o Hot flashes at night; "I'll have to open my window" o Skin changes: persistently red, raised patch on right-side face between nose and eye; "it scabs up;" denied itching o Itchy, discolored bumps on left arm and knee; he attributed these to road rash o Reduced libido; sex was "not a primary drive like it used to be"	

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		○ Changes in appetite; "I just don't feel that hungry" ○ Weight loss ○ Consultation with an endocrinologist is recommended • **Cardiology:** High cholesterol • **Gastroenterology:** ○ Frequent coughing on food and liquids ○ "Sore throat" in mornings ○ "Heartburn" sensation in upper chest ○ "I feel bloated without eating" • **Infections:** Not vaccinated against SARS-CoV-2 • **Musculoskeletal:** ○ Headaches ○ Neck pain; "sharp pain" with rotation ○ Right shoulder pain and weakness ○ Muscle spasms in back; "it's just terrible" ○ Endorsed loss of muscle mass ○ Felt "everything's compressed" throughout his body • **Neurological:** ○ Multiple persisting signs and symptoms often associated with brain injury, with onset following reported impact to the head ○ Rivermead Post Concussion Symptoms Questionnaire (RPQ) scores of 8/12 (RPQ-3) and 50/52 (RPQ-13) ○ Symptoms included dizziness, poor sleep, vision changes, headaches, reduced libido, and cognitive changes ○ Consultation with a neurologist is recommended regarding concern for traumatic brain injury • **Psychiatric:** Was receiving Telehealth psychotherapy services with Dr. Diana Karjoo **Post-injury Functional Status and Updates:** **Sensory:** • Smell: Intact • Taste: Intact • Hearing: Impaired • Vision: Impaired • Proprioception and cutaneous sensation: Impaired • Vestibular: Impaired **Hearing:** • History of exposure to loud noise • Suspected diminished hearing • Difficulty understanding speech in group conversations • "I have to have focus on the • person I'm talking to" • "It just takes me a few seconds to process what they said" • "I hear it; it's just not processing" • Endorsed occasional bothersome tinnitus since injury onset • Hypersensitive to sound, worse with migraines	

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		• Irritated by loud television • Passed an informal hearing screening during the CNS evaluation • A full audiological assessment is recommended to rule out auditory processing disorder **Vision:** • Used reading glasses prior to injury, farsighted • Endorsed changes in visual acuity: blurred vision, and hypersensitive to fluorescent light • Blurred distance vision "that's definitely new" • Perception that "everything is magnified" in left eye vision, while "right eye is clear" • Told the CNS evaluator "you look larger in my left eye than my right eye" • Irritated by headlights at night; bright lights in Costco "hurt my eyes" • Sensitive to lit screens; wearing tinted glasses to use computer • "I don't know what's going on with my eyes;" "something's going on" • Intact peripheral visual fields • Convergence appeared impaired, with blurred vision reported when attempting to focus on an object at 12 inches; double vision reported at six inches; right eye observed abducting at three to four inches • Nystagmus observed with saccades; reported task "felt a little difficult to do" • Left eye watering with pursuits; reported "strain pull" • Consultation with a neuro optometrist is recommended **Proprioception and cutaneous sensation:** Reported tingling and numbness in the left hand **Vestibular:** • Dizziness • Vertigo • Described sensation "like the floor was off balance" or a "tipping feeling, like if you're on a boat" • Occasional nausea • Symptoms provoked by head movement, sit-to-stand transfers, supine-to-sit transfers, bending or crouching • Endorsed "running into the walls and corners" • Felt "off balance" when shampooing his hair, while tipping head with eyes closed **Physical Impairments:** • Neck: Impaired • Trunk: Impaired • Upper Extremity: Impaired • Lower Extremity: Impaired • Endurance: Impaired • Balance: Impaired **Neck/Trunk:** • Neck range of motion impaired	

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		• Reduced rotation, flexion, and extension; "it's just really tight" • "Sharp pain" with neck rotation • Trunk range of motion potentially affected by back pain **Upper Extremity:** • Tone intact bilaterally • Lifted bilateral arms above shoulders, but below normal range • Impaired grip strength on the right; endorsed "weak grip" • Frequently dropped items • Right hand observed shaking when lifting coffee cup • Compensated by carrying heavier items with left hand • Impaired coordination bilaterally • Coordinated reciprocal hand movements • Coordinated finger-thumb opposition • Groping for nose bilaterally with eyes closed **Lower Extremity:** • Tone and coordination intact bilaterally • Range of motion impaired bilaterally • Lifted bilateral legs below knee during heel-to-shin slides; reported pain on right • Increased pain when seated or bending • Right ankle "feels like it needs a snap" • Strength impaired bilaterally; attributed to inactivity **Endurance:** • Evidence of cognitive and physical fatigue • "I'm exhausted all the time" • Required frequent rest breaks • Walked up to four blocks • Lightheadedness with ambulation • Stopped running for exercise, which he had enjoyed premorbidly **Balance:** • Maintained upright sitting unsupported • While seated, observed to reach outside of base of support, in all directions, without a loss of balance • Upright standing balance maintained with wide base of support • Positive Romberg with loss of balance after 19 seconds; broke stance and opened eyes • "I felt like I was a little off balance" • Impaired dynamic standing balance • Loss of balance with sudden movement or changes of movement • Lower extremity weakness • Fall risk • Fell in home; stood up from bed, lost balance, and fell onto lit gas fireplace, burning his arm • "I guess I was just up too quick" • Reached for walls and furniture to prevent falls • "I'm gonna fall through the shower one of these days"	

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		Functional Limitations:
		• Bed Mobility: Impaired
		• Transfers: Impaired
		• Locomotion – Household: Impaired
		• Locomotion – Community: Impaired
		• Basic ADLs: Impaired
		• Instrumental ADLs: Impaired
		Bed Mobility:
		• No assistive device; affected by dizziness; required upper extremity support
		• Independent
		• Able to roll and scoot without external assistance or support
		• Transition from supine to/from sitting required increased time to perform
		Transfers:
		• No assistive device; affected by dizziness
		• **Bed-to-chair transfers:** Supervision/touch assistance, required upper extremity support
		  ○ Questionable safety awareness
		  ○ Had fallen when getting up from bed
		• **Sit-to-stand transfers:** Independent, required upper extremity support
		• **Toilet transfers:** Independent, required upper extremity support
		• **Tub/Shower transfers:** Supervision/touch assistance, required upper extremity support
		• **Car transfers:** Independent, required upper extremity support
		Locomotion:
		• No assistive device
		• Ambulated household distances with modified independence
		  ○ Apparent gait deviations include but not limited to: questionable environmental scanning, decreased cadence
		• Able to ascend/descend stairs using a step-to pattern and handrail support
		• "I can see the imbalance sometimes"
		• Community distances accomplished via ambulation with supervision
		  ○ Ability to negotiate uneven terrain requires further assessment
		  ○ "Sometimes, cause it's uneven ground, I'll lose my footing"
		Basic ADLs:
		• May require additional time to complete basic ADLs with independent status, due to dizziness, balance issues, and diminished executive function skills and cognitive processing speed
		• **Grooming/hygiene:** Independent
		• **Upper body dressing:** Supervision/Touch assistance
		  ○ Affected by shoulder pain
		  ○ "I take a little bit to get my right arm through"
		• **Lower body dressing:** Supervision/Touch assistance
		  ○ Did not dress for work; attended meetings by video from home
		• **Bathing/showering:** Supervision/Touch assistance	

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		○ Affected by dizziness ○ Felt "off balance" when shampooing his hair or bending to wash feet ○ Leaned on built-in bench in shower for balance • **Toileting:** Independent • **Eating:** Supervision/Touch assistance ○ Supervision suggested to ensure adequate calorie intake, given reduced appetite **Instrumental ADLs:** • May require additional time to complete instrumental ADLs with independent status, due to dizziness, balance issues, and diminished executive function skills and cognitive processing speed • **Simple meal prep:** Independent • **Complex meal preparation:** Not applicable/did not perform prior to injury/illness • **Grocery Shopping:** Dependent ○ Bright lights in Costco "hurt my eyes" ○ Unable to carry heavy boxes or packages due to right hand weakness ○ 22-year-old son had taken responsibility for shopping • **Laundry:** Supervision/Touch assistance ○ Forgot wet clothes in washing machine; had to re-wash them • **Household cleaning:** Substantial/Maximal assistance ○ "I can't really do a whole lot" • **Money management:** Supervision/Touch assistance ○ Had not started income taxes, although "I usually have them done by now" ○ "I don't have the energy for it" ○ Paid property taxes late and was charged a penalty; "I did forget about that" • **Transportation needs:** Unrestricted • **Driving:** Resumed driving, but would avoid driving at night ○ Vision issues while driving ○ Sensitive to headlights at night ○ Fatigue while driving ○ Anxious while driving on freeway ○ Car smog check was three months overdue; had not completed it ○ An adaptive driving evaluation is recommended • Evaluation of the home for safety and fall risk hazards is recommended **Cognition:** • Attention: Impaired • Memory: Impaired • Safety/Awareness of Deficits: Impaired • Initiation: Impaired • Problem-Solving: Impaired • Processing Speed: Impaired	

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		• Receptive Language: Impaired
		• Expressive Language: Impaired
		• Pragmatics: Intact
		• Speech Intelligibility/Oral Motor Control: Intact
		Attention/Concentration:
		• Sustained attention noted to be impaired
		• Endorsed a "short attention span;" "what was the question again?"
		• Restlessness; poor task persistence
		• Struggled with sales work at his business due to impatience with clients
		• Alternating attention noted to be impaired
		• Lost attention when performing alternating mental math operations; "am I adding three now?"
		• Optimal attention observed in quiet settings
		Memory:
		• Oriented to person, place, and situation
		• Responded correctly to 5/6 orientation questions
		• Did not recall current date; stated "seventh" although the date was the sixth
		• Impaired short-term memory
		  ○ Registered 4/5 items immediately by spontaneously using a mnemonic strategy
		  ○ Recalled 5/5 items after 5-minute delay
		• Impaired auditory working memory
		  ○ Revealed intact ability for information consisting of up to six digits; decreased accuracy emerged when progressed to seven digits, indicating impaired ability to recall and manage short strings of information
		  ○ Relied on chunking strategy to recall digits
		  ○ "I kind of got lost there;" "did I miss one somewhere?"
		  ○ Normal range = 7 digits without repetition
		• Impaired long-term memory
		  ○ Did not recall the name of his cholesterol medication; had to produce the bottle
		  ○ "It's a statin - I don't remember what it was"
		  ○ Poor recall of an over-the-counter supplement he took; "something for my headaches"
		  ○ Did not recall his therapist's or chiropractor's names; "I forgot his name"
		  ○ Did not recall his PT provider; "I forgot what company;" "Neuro Practice, I think [sic]"
		  ○ Noted he recalled names quickly before injury
		• Impaired functional memory
		  ○ "I forget if I locked the door or not;" returned home to check
		  ○ Frequently lost keys; resorted to placing all keys in one drawer in order to find them
		• Impaired prospective memory
		  ○ Initiated a task after a ten-minute delay by using an alarm, but	

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		needed cues to recall its content o Admitted "I've missed a couple doses" of medications o Forgot to pay his property taxes and incurred a penalty **Safety / Awareness of Deficits:** • Fair perception of deficits • Aware of physical pain issues, mobility impairments, and strength deficits • Emerging awareness of cognitive deficits and psychological changes following injury • Unaware of need for supervision • At risk for making poor decisions or committing unsafe actions • Had returned to driving, despite anxiety, dizziness, and vision issues • Had fallen onto gas fireplace in home and burned his arm **Initiation:** • Able to initiate basic activities of daily living (ADLs) • Questionable ability to follow a medication administration schedule • Reduced initiation of IADLs • May require a written checklist for activities **Problem-Solving:** • Diminished problem-solving skills • Able to perform serial seven subtractions; produced 9/10 differences correctly • "46, I think _" • Non Rule-Governed learning style evident during card sorting activity; suggests potential for difficulty in novel or complex situations • Registered 2/4 patterns during card sorting activity, improved to 3/4 with cues • Impaired functional problem solving • Coworkers commented he was "not as sharp as I used to be" • Reduced executive functioning • Poor emotional regulation • Fired his assistant and a manager out of anger after the accident • Further assessment of executive functions recommended **Processing Speed:** • Delays evident during structured tasks • Greater time needed to integrate complex information • Struggled to process rapid speech on air traffic controller channel; "the processing speed's not there" **Receptive Language:** • Able to follow multi-step verbal commands consistently • Poor auditory comprehension • "I hear it; it's just not processing;" "maybe it's too much data coming in" • Attempted to listen to an air traffic control channel at home, but struggled to understand rapid speech • "I would have an issue with [following controller instructions] right now" • Impairments may be compounded with potentially affected auditory	

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		processing; consultation with an audiologist is recommended **Expressive Language:** • No overt evidence of impaired conversational wordfinding • Decreased thought organization • "I even talk slower" • Impaired word fluency: Produced nine words in both a concrete and an abstract category, respectively, during a timed task **Pragmatics:** • Appropriate eye contact, turn-taking and topic maintenance • Adequate basic communication skills; likely to struggle in distracting or complex situations • Pragmatics affected by attention and memory problems **Standardized Screenings:** **Rivermead Post-Concussion Symptoms Questionnaire:** RPQ-3 = 8/12 RPQ-13 = 50/52 Higher scores reflect greater severity of post concussive symptoms The total score for RPQ-3 items is associated with early symptom clusters of post-concussive symptoms. A higher score on the RPQ-3 indicates need for earlier reassessment and closer monitoring. The RPQ-13 items are associated with a later cluster of symptoms, although the RPQ-3 symptoms of headaches, dizziness and nausea may also be present. **XXXX rated the following as severe problems:** • Headaches • Sleep disturbance • Fatigue, tiring more easily • Being irritable, easily angered • Feeling depressed or tearful • Feeling frustrated or impatient • Forgetfulness, poor memory • Poor concentration • Taking longer to think • Blurred vision • Light sensitivity (easily upset by bright light) • Restlessness **Preliminary recommendations/treatment plan:** **Discharge Disposition:** • Continue to reside at home with family support as needed while completing a day treatment neurorehabilitation program at Centre for Neuro Skills®.(CNS) **Patient Retraining and Family Education:** • Increase independence with ADLs/self-care. • Increase independence with IADLs/home management. • Money management. • Balance training.	

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		• Strength and endurance training.
		• Gait training.
		• Stairs.
		• Home safety.
		• Safety awareness.
		• Visual perceptual training.
		• Neuromuscular reeducation.
		• Educate XXXX and his family regarding the importance of establishing and maintaining a daily structured routine and teach how to incorporate structure into daily life.
		• Education for XXXX and his family related to brain injury and common subsequent medical complications.
		• Bowel training to maintain continence without relying on assistance from others.
		• Medication administration training.
		• Provide education regarding sleep hygiene.
		• Teach XXXX and family strategies for assisting with activity endurance, safe physical activity, and all ADLs to optimize progress and independence at home and in the community.
		• Provide education related to strategies for treating communication/cognitive/language deficits.
		• Strategies for XXXX and his family to develop and encourage coping skills, adjustment to disability, insight, and to combat depression while progressing through the rehabilitation process.
		• Instruction for family if agitated or inappropriate behaviors arise to provide appropriate guidelines for interactions and redirection.
		
		Recommendations:
		• XXXX should participate in a multi-disciplinary day treatment neurorehabilitation program at CNS for the continued medical management of cognitive, linguistic, and physical deficits related to his injuries and subsequent decline in functional abilities. This includes deficits in the areas of mobility; balance; vestibular function; basic and instrumental ADL performance; initiation; attention; concentration; memory; problem solving and expressive/receptive language. Neuroplasticity occurs optimally in the setting of intensive, aggressive and repetitive treatment. CNS utilizes neurodevelopmental sequence approaches in all areas to maximize improvement. These services cannot be easily duplicated in the home setting.
		• Although prior treatment has been partially successful in reducing pain symptoms a three-to-four-month day treatment program may be necessary, following initial, intensive, discipline-specific evaluations to effect meaningful change, but program duration and frequency will be determined by therapeutic progress.
		• Clinically, areas of deficit will be addressed by the following disciplines:
		  ○ Physical Therapy
		  ○ Occupational Therapy	

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		○ Speech Therapy ○ Counseling ○ Clinical Case Management • Continue to consult with established physicians familiar with XXXX 's case and care needs. • Consultation should be arranged with other medical specialties including, but not limited to, the following: ○ Audiology ○ Endocrinology ○ Gastroenterology ○ Neurology ○ Neuro-Optometry ○ Physical Medicine and Rehabilitation ○ Sleep medicine • Consultations should be conducted with the Neurologist and Physiatrist, who possess expertise in the field of brain injury for medical management during his day treatment stay. • Consultation with neuro optometry to assess for possible oculomotor dysfunction and visual perceptual difficulties. • Conduct endocrine testing with referral to Endocrinology in relation to his brain injury, which increases risk for hypothalamic/pituitary axis damage/dysfunction as a common result of such injury and possible impediment to recovery. CNS has been conducting testing on patients and discovered that over 70% of patients have endocrine deficits impacting skills. • Obtain and review pertinent medical records from otolaryngology to assist in care plan development. • Obtain a formal sleep study. • Exploration of an adapted driving evaluation if vehicular operation continues, to better ensure safety for XXXX and others. • Transportation should be arranged to allow XXXX to travel between the CNS clinic and his home residence in Fairfield to receive therapy services. Thank you for the opportunity to review this case. If there are any questions, please do not hesitate to contact me through Ashley Banks, Admissions Coordinator, with Centre for Neuro Skills®.	
MM/DD/YYYY	Hospital/ Provider	**Referral report:** **Signs and symptoms:** Bilateral shoulder pain and bilateral knee pain after a motorcycle accident where he was rear-ended by a commercial truck. **Plan:** MRI of the shoulders and knees bilaterally without contrast.	613
MM/DD/YYYY	Hospital/ Provider	**Referral report:** **Signs and symptoms:** Bilateral shoulder pain and bilateral knee pain after a motorcycle accident where he was rear-ended by a commercial truck. **Plan:** MRI of the shoulders and knees bilaterally without contrast.	616
MM/DD/YYYY	Hospital/	**MRI of the left knee:**	202-203

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	Provider	**Clinical History:** Pain. Injury. **Technique:** Multiplanar, multisequence MRI of the knee was performed without contrast. Sequences were obtained in sagittal, coronal and axial planes. **Limitation of the study:** The presence of motion-related artifact on multiple pulse sequences decreases the sensitivity and specificity of the study. **Findings:** **Alignment:** Unremarkable femorotibial alignment. **Medial compartment:** **Medial femoral condyle cartilage:** Preserved. **Medial tibial plateau cartilage:** Preserved. **Medial compartment joint:** Preserved. **Medial meniscus:** Horizontal tear involving the body and posterior horn of the medial meniscus. **Medial collateral ligament:** Intact. **Lateral compartment:** **Lateral femoral condyle cartilage:** Preserved. **Lateral tibial plateau cartilage:** Preserved. **Lateral compartment joint:** Preserved. **Lateral meniscus:** Horizontal tear involving the anterior horn and posterior horn of the lateral meniscus. **Lateral collateral ligament:** Intact. **Patello-Femoral compartment and Extensor Mechanism:** **Patellotrochlear alignment:** Normal. **Patellar cartilage:** Normal. **Trochlear cartilage:** Normal. **Joint space:** Normal. **Patellar retinaculum:** Intact. **Quadriceps tendon:** Normal. **Patellar tendon:** Patellar tendon strain vs partial tear. **Intercondylar compartment/Cruciate Ligaments:** **Anterior cruciate ligament:** Increased signal of the anterior cruciate ligament which may reflect sprain. **Posterior cruciate ligament:** Intact. **Muscles:** Unremarkable. **Vascular:** Normal. **Nerves:** Unremarkable. **Other findings:** **Hoffas Fat Pad:** Unremarkable. **Fluid:** Small knee joint effusion. **Miscellaneous:** Small Bakers cyst. **Impression:** • Horizontal tear involving the body and posterior horn of the medial meniscus. • Horizontal tear involving the anterior horn and posterior horn of the lateral meniscus.	

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		• Patellar tendon strain vs partial tear. • Increased signal of the anterior cruciate ligament which may reflect sprain. • Small knee joint effusion. • Small Bakers cyst.	
MM/DD/YYYY	Hospital/ Provider	**MRI of the right knee:** **Clinical History:** Pain. Injury. **Technique:** Multiplanar, multisequence MRI of the knee was performed without contrast. Sequences were obtained in sagittal, coronal and axial planes. **Limitation of the study:** The presence of motion-related artifact on multiple pulse sequences decreases the sensitivity and specificity of the study. **Findings:** **Alignment:** Unremarkable femorotibial alignment. **Medial compartment:** **Medial femoral condyle cartilage:** Preserved. **Medial tibial plateau cartilage:** Preserved. **Medial compartment joint:** Preserved. **Medial meniscus:** Horizontal tear involving the body and posterior horn of the medial meniscus. **Medial collateral ligament:** Intact. **Lateral compartment:** **Lateral femoral condyle cartilage:** Preserved. **Lateral tibial plateau cartilage:** Preserved. **Lateral compartment joint:** Preserved. **Lateral meniscus:** Increased signal in the anterior horn and posterior horn of the lateral meniscus which likely reflects internal degeneration. **Lateral collateral ligament:** Intact. **Patello- Femoral compartment and Extensor Mechanism:** **Patellotrochlear alignment:** Normal. **Patellar cartilage:** Normal. **Trochlear cartilage:** Normal. **Joint space:** Normal. **Patellar retinaculum:** Intact. **Quadriceps tendon:** Normal. **Other findings:** There is mild bone marrow edema or contusion at the subchondral aspect of the patella. **Intercondylar compartment/Cruciate Ligaments:** **Anterior cruciate ligament:** Increased signal of the anterior cruciate ligament which may reflect sprain. **Posterior cruciate ligament:** Intact. **Muscles:** Unremarkable. **Vascular:** Normal. **Nerves:** Unremarkable. **Other findings:** **Hoffas Fat Pad:** Unremarkable. **Fluid:** Small knee joint effusion.	206-207

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		Miscellaneous: Small Bakers cyst. **Impression:** • Horizontal tear involving the body and posterior horn of the medial meniscus. • Increased signal in the anterior horn and posterior horn of the lateral meniscus which likely reflects internal degeneration. • There is mild bone marrow edema or contusion at the subchondral aspect of the patella. • Increased signal of the anterior cruciate ligament which may reflect sprain. • Small knee joint effusion. • Small Bakers cyst.	
MM/DD/YYYY	Hospital/ Provider	**MRI of the left shoulder:** **Clinical history:** None provided. **Technique:** Multiplanar multisequence MRI of the shoulder was performed without contrast. Sequences were obtained in sagittal, coronal and axial planes and submitted for interpretation. **Findings:** **Coraco- acromial Arch:** **Acromion:** Hooked and anteriorly downsloping acromion. This results in mild narrowing of the supraspinatus outlet which may predispose to impingement. **Acromioclavicular joint:** Mild acromioclavicular joint osteoarthritis is seen. **Os acromiale:** Absent. **Coraco- acromial Ligament:** Unremarkable. **Coracohumeral distance:** Normal. **Rotator Interval:** Normal. **Rotator cuff:** **Supraspinatus:** Mild supraspinatus tendinosis. **Infraspinatus:** Mild infraspinatus tendinosis. **Subscapularis:** Mild subscapularis tendinosis. **Teres Minor:** Unremarkable. **Long Head of the Biceps Tendon:** Intact. **Glenoid Labrum:** Posterior superior glenoid labral tear with paralabral cysts. **Joint Capsule and Glenohumeral Ligaments:** Thickened middle glenohumeral ligament is seen. **Glenohumeral Joint:** **Alignment:** Cephalad subluxation of the humeral head relative to the glenoid. **Articular Cartilage:** Unremarkable. **Synovium:** Physiologic fluid. **Bone and bone marrow:** Normal. **Muscles(other than rotator cuff):** Unremarkable. **Bursal fluid/bursitis:** None. **Vascular:** Unremarkable. **Nerves:** Unremarkable.	204-205

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: • Hooked and anteriorly downsloping acromion. This results in mild narrowing of the supraspinatus outlet which may predispose to impingement. • Mild acromioclavicular joint osteoarthritis is seen. • Mild supraspinatus tendinosis. • Mild infraspinatus tendinosis. • Mild subscapularis tendinosis. • Posterior superior glenoid labral tear with paralabral cysts. • Thickened middle glenohumeral ligament is seen. • Cephalad subluxation of the humeral head relative to the glenoid.	
MM/DD/YYYY	Hospital/ Provider	**MRI of the right shoulder:** **Clinical history:** None provided. **Technique:** Multiplanar multisequence MRI of the shoulder was performed without contrast. Sequences were obtained in sagittal, coronal and axial planes and submitted for interpretation. **Findings:** **Coraco- acromial Arch:** **Acromion:** Curved and anteriorly downsloping acromion. **Acromioclavicular joint:** Moderate acromioclavicular joint osteoarthritis is seen. **Os acromiale:** Absent. **Coraco- acromial Ligament:** Unremarkable. **Coracohumeral distance:** Normal. **Rotator Interval:** Normal. **Rotator cuff:** **Supraspinatus:** Moderate supraspinatus tendinosis. **Infraspinatus:** Mild infraspinatus tendinosis. **Subscapularis:** Mild subscapularis tendinosis. **Teres Minor:** Unremarkable. **Long Head of the Biceps Tendon:** Intact. **Glenoid Labrum:** Focus of increased signal involving the anterior and inferior glenoid labrum which may reflect degenerative change; however a tear is not excluded. **Joint Capsule and Glenohumeral Ligaments:** Increased signal of the inferior glenohumeral ligament is noted which likely reflects sprain however a tear is not excluded. **Glenohumeral Joint:** **Alignment:** Normal. **Articular Cartilage:** Unremarkable. **Synovium:** Physiologic fluid. **Bone and bone marrow:** Normal. **Muscles (other than rotator cuff):** Unremarkable. **Bursal fluid / bursitis:** None. **Vascular:** Unremarkable. **Nerves:** Unremarkable.	208-209

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: • Curved and anteriorly downsloping acromion. • Moderate acromioclavicular joint osteoarthritis is seen. • Moderate supraspinatus tendinosis. • Mild infraspinatus tendinosis. • Mild subscapularis tendinosis. • Focus of increased signal involving the anterior and inferior glenoid labrum which may reflect degenerative change; however a tear is not excluded. • Increased signal of the inferior glenohumeral ligament is noted which likely reflects sprain however a tear is not excluded.	
MM/DD/YYYY	Hospital/ Provider	**Temporomandibular Disorder (TMD) Forensic Examination (for mediation purpose only):** **DOI:** MM/DD/YYYY **Mechanism of Injury:** Rear ended by a truck while riding a motorcycle at highway speed. **History of Subject Injury:** Mr. XXXX states that on September 24, YYYY, he was traveling eastbound on Interstate 80 near the Crystal Springs Road exit in Alta, California, riding his motorcycle with his brother to his right and his father riding behind him, when traffic slowed for roadwork and a Caltrans Ford pickup struck his father from behind and then struck him. He fell backwards and first landed on his head onto the highway pavement. His father was nearly decapitated from the rear impact by the truck and later passed away from his injuries. **Reported Injury, Symptoms and Functional Limitations:** Following the subject motorcycle collision, he developed jaw pain, dental discomfort, increased bruxism (teeth clenching and grinding), and frequent headaches. He states that these jaw-related symptoms were not immediately recognized in the immediate post-traumatic period, as his attention was initially focused on the severity of his headaches and other acute injuries; however, he began noticing progressive jaw and dental symptoms within several days to approximately one week after the incident. He reports significant nocturnal bruxism, as well as clenching and grinding when he first wakes up in the morning. Since the incident, he has experienced bilateral jaw muscle pain involving both sides of the face, accompanied by morning jaw fatigue, soreness, and tightness. He rates his average jaw pain at 6/10, with exacerbations reaching 7 to 8/10, particularly when associated with a “snap.” He describes the pain as dull and aching in quality and states that it occurs several times per week. He reports that yawning, clenching, and grinding aggravate the pain, while resting the jaw provides some relief. Mr. XXXX has post-traumatic jaw joint symptoms including intermittent clicking, as well as cracking and “snapping”, particularly during yawning. He states that these joint noises began after the collision. Although the clicking is not always painful, snapping episodes is often associated with increased discomfort. He localizes much of his pain to the bilateral temporal regions and reports that his teeth no longer feel “normal” since the incident. He further states	352-370

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		that his anterior teeth rub together excessively, feel increasingly rough, and appear to be wearing in an unusual manner, raising concern for ongoing parafunctional loading and altered occlusal function. He also reports persistent daily headaches beginning immediately after the collision, typically rated at 7 to 8/10 in severity. He states that these headaches are primarily located in the temporal regions and may radiate toward the left side of his forehead. In addition, he reports mild tinnitus, more frequent and pronounced in the left ear than the right, as well as dizziness and imbalance, for which he is currently undergoing evaluation by an ENT specialist. Beyond his craniofacial complaints, Mr. XXXX reports weakness in the right hand and ongoing pain involving the lower back, shoulder, and neck. He states that the severity of his pain has been substantial, particularly given what he describes as a generally high tolerance for pain. Mr. XXXX suffers from significant post-traumatic sleep disturbance. He states that he typically sleeps only 3 to 4 hours per night, has difficulty both falling asleep and staying asleep, and does not feel rested when he wakes up. He wakes up with headaches approximately five times per week. He has been diagnosed with depression and PTSD and is currently receiving counseling and therapy. He believes that the psychological stress and trauma-related sequelae following the collision have contributed to worsening headaches and increased clenching and grinding. Functionally, Mr. XXXX reports ongoing difficulty due to persistent pain, headaches, poor sleep, jaw soreness, and morning facial tightness. His symptoms are aggravated by routine jaw function, including yawning, clenching, and grinding, and have negatively affected his overall comfort and day-to-day functioning. He denies any prior diagnosis or treatment for chronic pain condition before the subject incident. For symptomatic relief, he reports the use of over-the-counter Ibuprofen and Acetaminophen (Tylenol). **Relevant Prior Dental History:** Mr. XXXX denies any history of temporomandibular joint disorder, prior TMJ treatment, bite instability, or occlusal changes before the incidence on MM/DD/YYYY. His last routine checkup and teeth cleaning was over a year ago. He had orthodontic care with Invisalign and reports he is wearing through his retainer material quickly due to his excessive teeth grinding. **Dental Findings:** Patient has a class I occlusion, with 3mm of overjet and 4mm of overbite. He has excessive tooth wear especially in the anterior region. The objective findings are consistent to patient's reporting of highly elevated teeth grinding activity since the subject incident. **Work Status and Psychosocial Impact, per Report:** Mr. XXXX 's jaw pain and headaches have had a substantial adverse effect on his daily functioning, which he rates at 8/10 compared to his pre-incident baseline, with 10/10 representing the maximum level of impact. These symptoms interfere with his work responsibilities and routine daily activities. The incident has negatively affected his ability to eat a normal diet, which he rates at approximately 4 to 5/10 in severity. The incident has left a profound negative effect on his mood and	

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overall sense of well-being, which he rates at 10/10. He states that he has reduced his social activities, missed work, and he increasingly avoids social situations, despite describing himself as highly social person prior to the subject incident. He further reports that he no longer rides his motorcycle or flies as a pilot. In his words, "this thing changed everything!"

Examination Methods (DC/TMD Protocol):

- **Palpation:** Temporalis & masseter at 1.0 kg; TMJ lateral pole/around at 0.5 kg; 2-5 seconds per site. Assess pain, familiar pain, referred pain.
- **Range of Motion:** Pain-free opening, maximum unassisted opening (incl. overbite), maximum assisted opening (incl. overbite), lateral excursions (L/R), protrusion (mm). Record deviation/deflection.
- **Joint Sounds:** Reproducibility across 3 trials; crepitus noted when present.

Mandibular range of motion:
Lateral excursion – right: Pain level 5/10 bilaterally
Overbite: Right Angle's class I; Left Angle's class I

Joint sounds:
Click on opening: Left present

Muscle palpation:

Muscle/Site	Right pain	Right familiar	Left pain	Left familiar	Pain intensity
Temporalis - Anterior					
Temporalis – Middle	Yes	Yes	Yes	Yes	Right: 4/10 Left: 6/10
Temporalis – Posterior					
Masseter – Origin (zygomatic arch)	Yes	Yes	Yes	Yes	Right: 2/10 Left: 3/10
Masseter – Body	Yes	Yes	Yes	Yes	Right: 5/10 Left: 6/10
Masseter – Insertion (angle)	Yes	Yes	Yes	Yes	Right: 4/10 Left: 5/10

TMJ palpation:

Site	Right pain	Left pain	Familiar	Pain intensity
Lateral pole	Yes	Yes	Yes	Right 3/10

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				Left 4/10
Around lateral pole	Yes	Yes	Yes	Right 4/10 Left 5/10

TMJ load test (Leaf Guage):

Site	Right pain	Left pain	Familiar	Pain intensity
Around lateral pole	Yes	Yes	Yes	Right 2/10 Left 4/10

Axis I - Diagnostic Impression:

- Myofascial pain
- Headache attributed to TMD
- Arthralgia
- Myalgia

Note: Future evaluation should include presence or development of degenerative joint disease (DJD) or osteoarthrosis.

Assessment & Treatment Plan:

- Education, self-care, and habit modification, including avoidance of aggravating factors such as prolonged open-jaw posture, clenching, gum chewing, and extreme mandibular excursions; jaw rest, soft diet during symptomatic periods, and heat/ice as needed.
- Pharmacologic management for symptom control, including NSAIDs and/or Acetaminophen as appropriate, with consideration of a short-term muscle relaxant if clinically indicated.
- Physical therapy directed to cervical and mandibular biomechanics.
- Fabrication of a hard full-arch occlusal stabilization appliance, with periodic monitoring and adjustment.
- Adjunctive supportive therapies, including laser therapy and/or TENS therapy to help with myofascial symptoms
- Referral to appropriate medical and/or behavioral health providers as needed for associated psychosocial or sleep-related factors that may exacerbate TMD symptoms.
- Advanced imaging as clinically indicated, including MRI of the TMJs in open- and closed-mouth positions when internal derangement or persistent soft-tissue/joint symptoms are suspected, and CBCT when osseous pathology or degenerative joint change is suspected during future evaluations.
- Re-evaluation within approximately 6 to 8 weeks initially, with continued follow-up thereafter; longer-term reassessment at 6 months depending on clinical response.

Causation (within a reasonable degree of dental probability): It is my opinion that Mr. XXXX 's current jaw pain, temporomandibular symptoms, and bruxism are causally related to the subject motorcycle collision of September 24, YYYY. The mechanism of trauma, the lack of a reported prior TMJ condition, the post-incident onset of jaw pain, temporal pain, headaches, joint symptoms,

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		sleep disturbance, and clenching/grinding, together with the clinical findings documented on examination, support a direct and medically plausible causal relationship. Published literature supports that traumatic injury is associated with subsequent onset of painful TMD, and that painful TMD commonly coexists with headache, sleep disturbance, tinnitus, and psychosocial distress. It is further my opinion that the collision, together with its resulting pain, sleep disturbance, PTSD, persistent headaches, tooth wear, and other post-traumatic effects, more likely than not precipitated and/or substantially aggravated Mr. XXXX 's bruxism behavior. His reported post-traumatic grinding and clenching are further supported by clinical tooth wear, morning jaw soreness and fatigue, and masticatory muscle symptoms. Taken together, these findings are consistent with trauma-related onset or significant aggravation of parafunctional jaw activity following the subject incident. **Future care need:** From a dental standpoint, Mr. XXXX will likely require ongoing evaluation and treatment for his posttraumatic jaw pain, masticatory muscle pain, TMJ arthralgia, headache symptoms associated with TMD, and parafunctional clenching/grinding behavior. Future dental care should be directed toward symptom reduction, protection of the dentition, improvement in jaw function, and monitoring for progression of joint or occlusal changes. In my opinion, the appropriate initial approach is conservative and reversible. Reasonable future dental treatment would include periodic follow-up examinations to monitor pain levels, jaw function, range of motion, joint symptoms, occlusion, and progression of tooth wear. He would also reasonably benefit from fabrication and adjustment of a hard full-arch occlusal stabilization appliance/night guard intended to reduce parafunctional loading, protect the teeth from further wear, and decrease strain on the masticatory system, provided it is monitored and adjusted as needed. NIDCR notes that stabilization splints may be used as a short-term conservative measure and should not create permanent bite changes. He would also reasonably require behavioral and self-management instruction, including counseling regarding daytime clenching awareness, jaw rest position, avoidance of parafunctional habits, temporary soft diet as needed during flare-ups, limitation of extreme opening, and use of homebased conservative measures such as moist heat, ice, and jaw stretching or relaxation exercises. These measures are consistent with standard conservative TMD management goals of reducing aggravating factors, improving function, and decreasing pain. Because his presentation includes persistent pain, morning jaw soreness, headache symptoms, and parafunctional activity, further orofacial pain/TMD evaluation would also be reasonable if symptoms persist despite initial conservative care. Depending on his course, co-management with physical therapy familiar with TMD/cervicogenic dysfunction will be appropriate, particularly given the overlap between jaw symptoms, head/neck pain, and post-traumatic cervical strain. Given his reported tooth wear and abnormal anterior tooth contact, he will likely require future restorative dental treatment if attrition, fracture risk, sensitivity, or occlusal deterioration progresses. That may include monitoring, smoothing/polishing of roughened surfaces where appropriate, bonded restorations, buildups, or other restorative care depending on the degree of	

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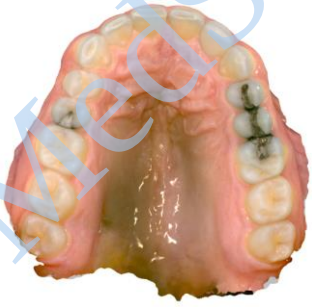
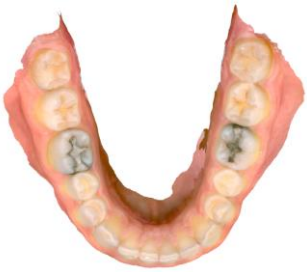
		structural breakdown over time. The need and timing of such treatment would depend on the progression of wear and clinical symptoms documented on serial examinations. The report should make clear that this portion of future care is conditional and based on progression rather than guaranteed immediate reconstruction. If joint symptoms worsen, or when locking develops, or opening becomes more restricted, or if pain fails to respond to conservative care, then additional diagnostic workup may be indicated, including TMJ imaging such as MRI to evaluate internal derangement/disc pathology and CBCT when bony joint changes are suspected. Conservative treatment remains first-line, but persistent or worsening symptoms will justify additional evaluation and imaging. Because his bruxism appears to be intertwined with poor sleep, PTSD/stress symptoms, and headaches, it is my recommendation to continue interdisciplinary care with his existing medical and mental health providers. As a dental expert, I would not independently treat PTSD or sleep disorders, but those conditions are relevant because they may perpetuate clenching/grinding and painful TMD symptoms **Imaging:** • iTero Intraoral Scan (Full Mouth) – Attached • Intra oral and extra oral photography –Attached • CBCT– Completed • FMX – Attached **<u>Intraoral scans (iTero):</u>** Figure 3. Maxillary occlusal view (intraoral scan image).  Figure 4. Mandibular occlusal view (intraoral scan image)  Figure 5. Left lateral occlusal view (intraoral scan image	

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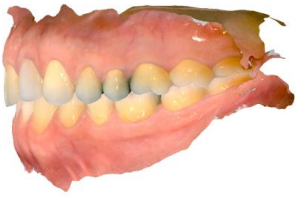
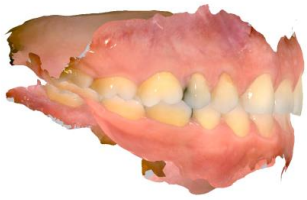
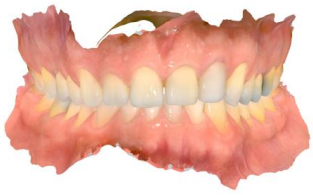
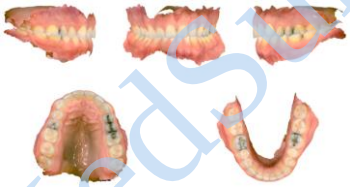
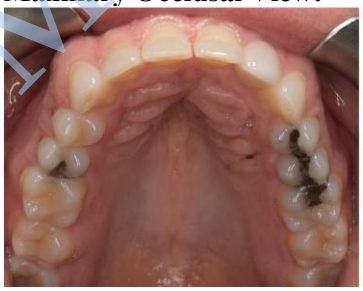
		 Figure 6. Right lateral occlusal view (intraoral scan image).  Figure 7. Frontal occlusal view (intraoral scan image).  Figure 8. Composite gallery view (intraoral scan images).  **Maxillary Occlusal View:**  **Mandibular Occlusal View:**	

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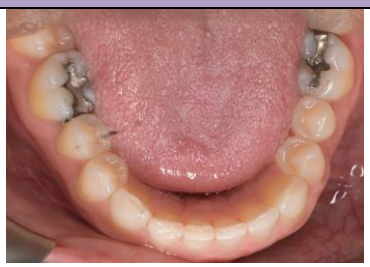
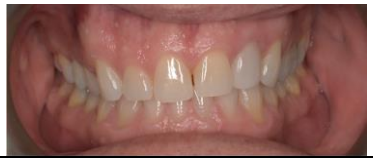
		 **Frontal Close:** 	
MM/DD/YYYY	Hospital/ Provider	**Summary of multiple interim psychotherapy and cognitive behavior therapy visits for PTSD:** **Treatment diagnosis:** • Post traumatic stress disorder -acute **Treatment modalities:** • Psychotherapy • Cognitive behavior therapy **Treatment dates:** MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, MM/DD/YYYY, **Total visits:** 16 visits **Summary:** **MM/DD/YYYY:** The patient presents with acute grief and trauma following the recent death of his father, reporting intensified emotional and physical symptoms. He describes persistent re-experiencing of the traumatic motorcycle accident, particularly at night, when his mind becomes preoccupied with hypothetical scenarios and self-questioning about what could have been done differently. This intrusive cognitive rumination disrupts his sleep and emotional equilibrium, contributing to irritability, physical tension, and overall distress. The patient reports new physical complaints, including pain in his hips and elbow, light sensitivity, and hand tremors, which appear to be stress-related somatic manifestations. He expresses growing frustration and irritability, noting that these symptoms have strained his relationships and caused him to distance himself from others, including colleagues and staff. His motivation in his professional role as a coach and trainer has diminished, impacting his ability to engage and inspire others. He remains heavily involved in managing the logistical and emotional demands of funeral planning, describing this responsibility as both overwhelming and isolating. Despite feeling burdened, he continues to suppress his own grief to fulfill his perceived role as the family "rock," expressing guilt for not grieving as openly as others. Family relationships	21-24, 26-29, 39-41, 43-45, 173-174, 185-186, 191-192, 329-330, 514-515, 516-518, 522-523, 530-532, 536-537, 538-539, 546-547, 614-615

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		remain central to his experience; he maintains a positive connection with his son through shared activities but expresses concern about his brother's continued heavy alcohol use as a coping mechanism. He reports efforts to model healthier behavior and to find new ways to bond with his brother following the loss of motorcycling as their primary shared activity. The patient also voiced uncertainty regarding the effectiveness and potential side effects of his prescribed medications for sleep and anxiety. Overall, he appears emotionally burdened, fatigued, and preoccupied with reliving the traumatic loss, which continues to interfere with his rest, concentration, and emotional stability. **MM/DD/YYYY:** The patient presented for a follow-up session, expressing continued struggle with acute grief following his father's death, reporting feeling 'very heavy' and overwhelmed by 'everything. ' He is experiencing difficulty getting 'back on track' with daily functioning, work, and self-care, despite the funeral milestone. Concerns were raised about potential self-neglect (nutrition, exercise) and the risk of deeper depression. Interventions focused on validating his pain, encouraging self-care (meditation, 10-minute cardio, planned nutrition), exploring grief expression (visiting resting place, writing), and discussing the temporary use of medication for acute stress. The patient was receptive to suggestions for self-care and open to the transfer of care to a long-term clinician. The risk level remains moderate due to self-neglect and the potential for worsening depression. Treatment direction involves continued grief support, emphasis on basic self-care, and transition to ongoing therapy with another clinician. The patient's chief complaint centers on pervasive feelings of being overwhelmed and emotionally burdened following the recent death of his father. He described struggling to return to normal functioning and experiencing a pervasive sense of heaviness affecting "everything." This emotional distress has led to difficulties with self-care, including poor nutrition, lack of exercise, and disrupted sleep patterns, all of which have negatively impacted his ability to be fully present and effective at work. As a result, he reports "going through the motions" but not feeling truly engaged, which raises concern for a potential deepening of depressive symptoms. The patient is experiencing significant functional impairment, particularly in his occupational and personal life. His ongoing self-neglect contributes to a worsening sense of emotional fatigue and overwhelm, further diminishing his overall well-being. As a coach, he finds it increasingly difficult to motivate others while internally struggling with grief and low mood. Family dynamics remain an important area of focus; his relationship with his brother has been strained by their father's passing, as their father previously served as the "conduit" between them. The clinician encouraged intentional efforts to strengthen this bond. The patient expressed concern for his brother's well-being and continues to play a supportive role within his family system. Psychologically, the patient is exhibiting symptoms consistent with generalized acute grief and emotional overwhelm, manifesting as an inability to regain stability and maintain daily functioning. He reports self-neglect in areas of nutrition, exercise, and sleep, along with a persistent sense of emotional heaviness and distress. These symptoms began acutely following his father's death several weeks ago and have persisted with high intensity. The overall presentation reflects severe emotional distress and profound grief with a risk for progression into a major depressive episode if unmitigated.	

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		MM/DD/YYYY: The patient mentions that he is "trying to stay busy" and "do my best" as a means of coping with his father's death in the accident. He reports being away from home for the last six months and coming back for the "boy's yearly motorcycle trip to Reno." He describes the accident and mentions that he wishes "that maybe a few seconds would have made a difference." The patient mentions that he currently lives with his 22 year old son. He mentions that since the accident, "we have started playing video games together and going for drives." The patient mentions that he is "trying to get back into normal life again but it's so hard." He reports difficulty sleeping and not being able to eat. He has been prescribed sleeping aids but mentions that he prefers not to take them as he says, "I don't like taking medicine." He currently tries to "sleep with the TV on" and finds relief in watching videos or near death experiences on YouTube. The patient takes comfort in believing that his father is with his grandfather. The patient goes for short walks daily with his dog. He is currently experiencing pain and fatigue from his own spinal injuries and has been recommended to get spinal surgery but is still contemplating it. He mentions that his overwhelmed with "everything happening." The patient reports that it has become difficult for him to work as he did before. His enthusiasm for coaching and mentoring others "has become difficult" since the accident. He adds that he "would not like people at work to see me like this." The patient mentions that his brother lives across the street from him and he mentions that they meet often and have a good relationship. The patient expresses concern over his brother's wellbeing, his drinking, and the way his brother is dealing with his father's passing and he says, "I'm really worried about him because I really think he needs someone to talk to." He describes feeling that "I have to be strong for my family." The patient mentions that he visits the cemetery and speaks to his father. **MM/DD/YYYY:** The patient reports persistent acute grief following his father's recent death, describing a significant disconnect between his intellectual understanding of coping strategies and his ability to implement them. He experiences profound survivor's guilt, emotional disorientation, and physical strain, all of which are intensified by the approach of family holidays. He anticipates Thanksgiving will be particularly difficult as he continues planning family gatherings while navigating shared grief. He also notes ongoing concern for his brother, whose progress in managing alcohol use and beginning medication was discussed, reflecting the interconnected nature of their family's grieving process. The patient's grief remains pervasive and severe, with constant emotional distress characterized by a high-intensity sense of guilt and difficulty putting coping concepts into practice. He reports a slight improvement in anger but continues to struggle with translating cognitive insight into action, stating, "It's just a guilt that I deal with." **MM/DD/YYYY:** The patient reports persistent acute grief following his father's recent death. He continues to experience profound guilt. He also notes ongoing concern for his brother, whose progress in managing alcohol use and beginning medication was discussed, reflecting the interconnected nature of their family's grieving process. The patient's grief remains pervasive and severe, with constant emotional distress characterized by a high-intensity sense of guilt and difficulty	

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		putting coping concepts into practice. The patient reports efforts towards better sleep hygiene and consistent nutrition though he continues to struggle in these areas. **MM/DD/YYYY:** The patient presented much the same as prior sessions. He continues to struggle though he is doing what is needed to improve. The patient reports persistent acute grief. He experiences profound guilt, cognitive dissonance and physical pain. The patient reports little to no improvement in pain management and he is frustrated with the limited physical movement/activity he can have. The patient's grief remains pervasive and severe, with constant emotional distress characterized by a high-intensity sense of guilt and difficulty putting coping concepts into practice. He continues to report feeling angry though he is better able to manage it. **MM/DD/YYYY:** The patient presents with ongoing acute grief following his father's death, reporting persistent emotional distress marked by pervasive guilt related to financial matters and his ability to move forward with his own life. He describes feeling emotionally "in a weird place" and reports difficulty translating intellectual insight about coping strategies into meaningful emotional relief. Family dynamics have become increasingly strained since the loss of their father, who previously served as a central stabilizing figure in their relationship. The patient reports a recent argument with his brother related to discussions about their father's accident, highlighting differing grief-processing styles and unresolved tension. He also notes his brother's emotional withdrawal and reluctance to engage in shared activities, often isolating in his garage. The patient acknowledges a tendency to internalize guilt and worry rather than express emotions directly, which interferes with self-care and open family communication. **MM/DD/YYYY:** The patient reports a persistent sense of "heaviness" and not feeling himself in the context of ongoing grief following his father's death, accompanied by frequent worry about his brother's well-being, particularly related to alcohol use and their strained relationship. He describes feeling emotionally drained by these concerns, compounded by the ongoing legal process surrounding his father's death, which keeps his grief acute. He also notes increased irritability in his professional role as a motivational coach, attributing this to feeling at full emotional capacity while managing significant life decisions, including a potential move for flight training. Sleep remains disrupted with no reported improvement. **MM/DD/YYYY:** The patient reports significant emotional distress related to his ex-partner's continued involvement in his life, including financial exploitation, attempts to re-establish a romantic relationship, and legal complications surrounding eviction. He states, "I just don't need this right now. Additional stressors include concern about his brother's alcohol use and financial instability, prompting consideration of a substantial loan. These stressors interfere with his ability to grieve his father's death, simplify his life, and emotionally recover. He reports increasing irritability and emotional exhaustion in his coaching role and is contemplating retirement. Symptoms endorsed include persistent grief,	

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		excessive worry, sleep disturbance with nighttime rumination and stress-related perceptual experiences, and irritability affecting professional functioning. **MM/DD/YYYY:** The patient reports feeling profoundly overwhelmed and mentally exhausted by the cumulative demands of ongoing legal proceedings and numerous therapy appointments, stating, "It's entirely too much. Too much." He describes significant emotional distress and mental fatigue that interfere with his ability to focus on personal well-being. In response to this overwhelm, he expresses a strong desire to escape his current circumstances by pursuing a long-term aircraft program in another location, which he views as a potential "last hope" for his future, while simultaneously feeling conflicted by family obligations and unresolved emotional ties to his ex-partner. He reports persistent lethargy and diminished motivation, particularly with respect to maintaining a gym routine, which he notes has been ongoing since starting Lexapro. Grief related to his father's death remains present and continues to influence his emotional state, life decisions, and desire to spend time with loved ones. Family dynamics contribute to his distress, as he feels a strong sense of responsibility toward his mother and brother, expresses concern about his brother's emotional and financial well-being. He also voices concern for his son's future and contemplates work opportunities that would allow him to support and remain connected to him. **MM/DD/YYYY:** The patient reports significant emotional distress and frustration related to the overwhelming volume of medical and legal appointments, which he experiences as inefficient and emotionally desensitizing. These stressors, combined with ongoing grief following his father's death and concern regarding his brother's alcohol use and memory difficulties, have impaired his ability to prioritize self-care and manage daily functioning. He describes increased irritability, disrupted sleep, lethargy, and reduced exercise, along with subjective working-memory difficulties and a persistent sense of cognitive "fog," which he attributes to cumulative stress and emotional burden. The patient continues to feel a strong sense of responsibility toward his family, including his brother and son, which further complicates his efforts to focus on his own recovery and well-being. **MM/DD/YYYY:** The patient presented with ongoing emotional distress primarily related to concern about his brother's escalating alcohol use, self-sabotaging behaviors, and financial mismanagement, stating, "It's concerning." He described feeling a strong sense of responsibility as the older sibling, often assuming a parental role within a longstanding family dynamic in which his brother is viewed as "the one who gets in trouble" and he as "the boy scout." This dynamic, compounded by unresolved grief following his father's death, contributes to persistent worry, moderate distress, and difficulty focusing on his own growth and self-care. He also reflected on the lingering emotional impact of a past relationship, noting a pattern of "one step forward, three steps back," and expressed concern about the possibility of his ex-partner developing alcoholism, which he wishes to avoid re-engaging with. Overall, family trauma history, ongoing grief, and boundary challenges continue to influence his emotional landscape and maintain moderate, persistent symptoms of distress.	

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		MM/DD/YYYY: The patient presents with significant stress and frustration related to ongoing legal proceedings surrounding his father's estate, particularly a settlement dispute and concerns about his brother's financial situation. Physical pain and limitations, combined with persistent grief over his father's death, have contributed to severe stress, moderate frustration, and ongoing emotional distress over the past several weeks. He reports difficulty maintaining boundaries with his brother and mother, feeling obligated to help despite resentment and financial strain. The cumulative impact of legal conflict, family role strain, and unresolved grief is negatively affecting his emotional well-being, sense of identity, and ability to prioritize self-care. **MM/DD/YYYY:** The patient presents with severe and persistent stress related to the ongoing legal case surrounding his father's death, compounded by his brother's financial circumstance and entrenched family conflict. He reports feeling overwhelmed, frustrated, and increasingly hopeless, expressing concern that his personal goals-such as flying, traveling, and long-term life plans-are now on hold or "gone" due to external burdens and lack of control. He perceives himself as the responsible sibling, carrying disproportionate financial and emotional weight, which has led to resentment and difficulty setting boundaries. Grief remains active and intertwined with his pursuit of justice in the legal matter, and he described feeling conflicted about moving forward in ways he believes his father "wouldn't want." Symptoms include severe stress, moderate-to-severe frustration, persistent grief, significant emotional distress, and emerging depressed mood over several weeks, all of which are negatively impacting his sense of stability, motivation, and future orientation. **MM/DD/YYYY:** The patient presents with severe and persistent stress related to the ongoing legal case surrounding his father's death. The patient indicated increased frustration surrounding cognitive and physical limitations since the accident. He was hopeful that the therapies (chiro, OT, PT, Speech) would prove effective in improving his abilities. However, work performance, relationship struggles, low frustration tolerance all point to continued weakness in executive function and cognitive resilience. The patient ended a long-term relationship after the accident and has not been able to manage/regulate his emotions and pursue reconciliation. He reports feeling overwhelmed, frustrated, and increasingly hopeless, expressing concern that his personal goals-such as flying, traveling, and long-term life plans-are now on hold or "gone" due to external burdens and lack of control. Grief remains active and combined with the physiological deficits experienced since the accident, the patient reported increased signs of depression. **Reviewer's Comment: Visit number 17 (Scheduled date MM/DD/YYYY) is unavailable for review.** **MM/DD/YYYY:** The patient's presentation this session is similar to prior overall though he expressed more than usual distress and frustration regarding working memory deficits and limited cognitive capacity. The patient presented with significant physical pain and emotional exhaustion, compounded by financial	

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		strain from ongoing medical treatments and unresolved grief related to his father's death. The reality of possible long-term, even lifelong debilitation is daunting. The patient reported multiple occasions of deep depression when confronted with this possibility. Therapies are progressing though slower than he would prefer. Physical pain including head, neck and shoulder are persistent and often disrupt sleep. These symptoms are also distracting. The patient reported feeling distracted and not able to focus on tasks as long as he used to. The pain he feels is an ever-present thought on his mind. Overall, the patient described persistent stress, frustration, grief, and emotional depletion over the past several weeks, which are negatively impacting his mood, motivation, professional functioning, and overall sense of well-being. *Reviewer's Comment: Interim psychotherapy and CBT therapy visits are summarized with significant information.*	
MM/DD/YYYY	Hospital/ Provider	**Final psychotherapy progress note for PTSD:** **Session #:** 24 *Reviewer's Comment: Psychotherapy visit number 19 to 23 are unavailable for review.* **Therapeutic Techniques Used:** Cognitive Behavior Therapy (CBT) **Current Diagnoses:** Post traumatic stress disorder **Noteworthy Changes Since Last Report:** Insomnia continues to be debilitating **Mental status exam:** **Attitude:** Open **Affect:** Appropriate **Mood:** Appropriate **Cognition:** Intact **Insight/Judgment:** Appropriate **Topic for today's session:** Cognitive Control Acceptance Insomnia **Patient's participation:** Active Participation **Treatment summary/progress:** **Subjective:** The patient presented with ongoing significant stress related to severe sleep disturbance, unresolved legal and financial matters, family dynamics, and grief associated with his father's death. He reported difficulty falling asleep, frequent awakenings throughout the night, vivid nocturnal sensations, and persistent daytime exhaustion. The patient attributed much of his sleep difficulty to ongoing stressors, including frustration with medical concerns and management of his father's estate. He also described feeling overwhelmed by the accumulation of responsibilities and acknowledged difficulty maintaining consistent self-care routines, including exercise, nutrition, and stress management. The patient endorsed persistent symptoms of sleep disturbance, stress, frustration, grief, depressed mood, and irritability. He described severe fatigue, poor sleep quality, and feeling emotionally and physically depleted. Grief remains active as he continues working with family members on his father's headstone and estate matters, though he described the headstone selection process as meaningful and therapeutic. Additionally, the patient	617-619

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		reported increased irritability and reduced emotional bandwidth. Despite these challenges, he expressed motivation to improve routines, reduce alcohol use, and prepare for future goals, including flight school. **Objective:** The session consisted of a clinical interview focused on evaluating the patient's current emotional functioning, stressors, coping strategies, grief processing, and behavioral patterns contributing to sleep disturbance and irritability. Risk level was assessed as moderate due to severe sleep disruption, heightened stress, emotional irritability, and ongoing external stressors. However, the patient demonstrated insight, engagement in treatment, and proactive problem-solving efforts, which mitigate immediate safety concerns. Interventions utilized during the session included Humanistic/Person-Centered Therapy, Psychoeducation, and Cognitive Behavioral Therapy-informed strategies. The clinician validated the patient's feelings of frustration, exhaustion, and emotional overwhelm while reinforcing his insight into the relationship between stress, alcohol use, and sleep quality. Psychoeducation was provided regarding the impact of chronic stress and alcohol on emotional regulation and restorative sleep. CBT-informed interventions focused on re-establishing healthy routines, improving sleep hygiene, reducing avoidance behaviors, and reframing stressors into manageable tasks. **Assessment:** The patient demonstrated continued engagement in treatment and increasing insight into the relationship between stress, grief, lifestyle habits, and emotional functioning. He showed motivation to re-establish healthier routines, including improving diet, returning to exercise, reducing alcohol consumption, and organizing financial and legal tasks. His positive experience selecting his father's headstone reflects ongoing progress in grief processing and emotional acceptance. The patient was receptive to therapeutic recommendations, including journaling, routine-building, and delegation of responsibilities, and demonstrated willingness to implement coping strategies discussed during session. Despite these areas of progress, the patient continues to experience significant impairment related to severe sleep disturbance, ongoing stress, irritability, and emotional fatigue. Overall, the patient continues to present with symptoms consistent with trauma-related stress, grief-related distress, and emotional dysregulation, though he remains motivated toward recovery and future planning. **Plan:** The patient will continue psychotherapy focused on stress management, grief processing, emotional regulation, sleep improvement, and reinforcement of adaptive coping strategies. Homework assignments include re-establishing a consistent exercise routine, improving nutritional habits through meal planning, completing financial tasks such as taxes, journaling before bedtime, and reducing alcohol use with the goal of temporary abstinence. The patient was also encouraged to delegate estate-related responsibilities where possible. **Treatment Recommendations:** Continue with Current Treatment Plan **Frequency:** Weekly **Comment:** The patient has requested continued psychotherapy. This was his last authorized session. We are requesting 12 additional sessions.	

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		Next session scheduled for: 05/27/YYYY in person at The Brain Works. **Reviewer's Comment: Further psychotherapy visits are unavailable for review.**	

Other Records:

Patient information, medical bills, cover sheets, authorization, blank pages, consent, duplicate records

PDF Ref: 1-2, 6, 10, 20, 25, 30, 36, 38, 429-430, 188, 334, 289-291, 456, 276-279, 465-472, 215-216, 218-219, 232-233, 228-229, 481-486, 326-327, 503-511, 519-521, 524-529, 540-541, 544-545, 548-549, 378-398, 571-612

***Reviewer's Comment:** All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.**