Medical Chronology/Summary

Confidential and privileged information

Usage guideline/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 **Personal Injury (Dropped on her head)** on **09/17/YYYY**, the injuries and clinical condition of **Jane Doe** as a result of injury, 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 history of musculoskeletal injuries*
Date of injury	09/17/YYYY.
Description of injury	Patient stated that around 2145 hours someone did a "stage dive" into crowd and landed on top of her head where she was in 3rd row back from stage when ~ 240lb individual jumped forward off stage and his stomach/full body weight landed directly on top of her head.
Injuries/ Diagnoses	Occipital fracture with non-union Closed Anderson-Montesano type I fracture of right occipital condyle. Cervicalgia. Closed head injury Leukocytosis Acute traumatic pain Right vertebral artery irregularity Concussion without loss of consciousness Post-concussion headache Fracture of orbit Injury of other cranial nerves, left side
Treatments rendered	Pain medications 09/19/YYYY: Received physical therapy at XX Clinic 12/18/YYYY-03/28/YYYY: Received physical therapy at XX Physical Therapy Institute 05/15/YYYY-07/15/YYYY: Received physical therapy at XX Physical Therapy Institute
Condition of the patient as per the last available record	As per 07/15/YYYY, she attended a total of 14 physical therapy sessions following an initial evaluation for a right occipital fracture. Her treatment focused on managing moderate to severe pain, dizziness, and occasional headaches. She primarily reported pain in the cervical spine, more intense on the right side, described as sharp and shooting, and worse in the mornings, evenings, and during activity. The pain was aggravated by neck motion and work-related activities, though rest and heat offered some relief. Over the past month, the patient noted minimal improvement, with persistent jabs of pain when looking up and frequent headaches occurring two to three times per month. Functional outcomes, measured by the Neck Pain Disability Index and Dizziness Handicap Inventory, showed mild disability with a functional score of 6 and 8, respectively, and pain scores of 2 in each category. Range of motion assessments revealed limitations, especially in extension, rotation, and side bending, with associated pain. Observations of posture included forward head positioning and rounded shoulders, and testing was positive for smooth pursuit and various vestibulo-ocular reflex (VOR) movements. Despite ongoing limitations impacting activities of daily living (ADLs) and quality of life (QOL), her progress reached a plateau, and skilled physical therapy was no longer deemed necessary. She was discharged with a fair prognosis and instructions to continue her home exercise program independently.

Patient History

Past Medical History: Denies significant past medical history. (PDF REF: 169).

Surgical History: Wisdom tooth extraction. (PDF REF: 296).

Family History: Mother had hypertension. Sister had hypertension. Maternal grandmother had diabetes (PDF REF: 296).

Social History: Former smoker (E-cigarettes). Quit vaping on 01/01/2022 (Nicotine, flavoring) and consumption of alcohol rarely (PDF REF: 296-297).

Allergy: No known drug allergies. (PDF REF: 297).

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Personal Injury (Dropped on her head) – 09/17/YYYY	
09/17/YYYY	XX Clinic XXX, PAC XXX, M.D.	**2346 hours ER visit**: **History**: Patient presents with neck injury: Patient states she was at a concert, and someone did a stage dive and landed on top of her causing her neck to go rapidly to right side. Patient states she heard a crack. Patient was able to get up and move around after the incident. States able to feel all extremities. Equal sensation noted in triage. Patient states pain is on the left side of her neck radiating into her left deltoid and up into her head. Patient in a Cervical collar. X years female to ED for concern for neck injury sustained at concert x2 hours ago. Says around 9:45pm this evening someone did a "stage dive" into crowd and landed on top of her head. Says she was in 3rd row back from stage when ~ 240lb individual jumped forward off stage and his stomach/full body weight landed directly on top of her head. Says with impact her head tiled to left and she felt and heard "crack" with subsequent pain to back of neck. Says she stumbled after hit but caught herself and never fell to the ground. No loss of consciousness (LOC). Not anticoagulated. Says entire back of neck hurts,7/10 pain dull pain with sharp pain that radiates to occipital scalp, to both sides of jaw, to front of neck and top of both shoulders. Worse with rotation movement of neck initially but has been in C-collar since triaged in ED Hasn't taken anything yet for the pain. Denies numbness, tingling or weakness to extremities. Says had one alcoholic drink around 7:30pm—patient AAOx3, answering all questions appropriately, following all commands. Recalls entire event and all events prior. No history of previous head/neck injuries or surgery. Feels nauseous but no vomiting. Finance at bedside--never had any confusion, change in mental status or focal numbness/tingling/weakness. **Review of system (ROS**): Gastrointestinal: Positive for nausea.	169-174

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Musculoskeletal: Positive for neck pain. Neurological: Positive for headaches. **Exam**: General: Patient crying, tearful. Wearing cervical collar. Neck: Tender along cervical paraspinal muscles bilaterally. Mouth: Exhibits some trismus, says pain to posterior scalp when she opens and closes her jaw. Musculoskeletal: Moving all extremities without or deformity, able to actively elevate both arms above head but this reproduces her tenderness to her neck and trapezius. **ED medications**: IV contrast (radiology procedure) has no administration in time range. Acetaminophen 1000 mg tabs oral given 09/18/YYYY 0019). NaCL 0.9% 1000 ml IV bolus (1000 ml intravenous new bag/syringe/bottle 09/18/YYYY 0102). **Assessment/plan:** CT neck shows acute fracture of the right occipital condyle with mild posterior medial displacement. Hypoplastic right intradural vertebral artery without definitive dissection. See radiologist read above. Strength and sensation to all extremities intact without evidence of spinal cord compromise while in ED. Trauma team and purple team evaluated patient in ED. 2:15 AM patient sitting up comfortably, pain controlled at this time. Repeat exam benign. Strength and sensation to all extremity intact. 2:27 AM discussed with trauma team. 2:56 AM Discussed with Will with purple team will follow, advises admit to trauma with nonemergent MRI in morning. Neurosurgery to follow. **Clinical impressions**: Occipital condyle closed fracture Neck pain. Closed head injury Leukocytosis	
09/18/YYYY	XX Clinic/XX Hospital XX, M.D.	**0100 hours: Trauma history and physical note**: **Subjective:** This is a X-year-old white female. GCS at Scene was 15. Patient was at a concert earlier this evening when a "large man" jumped off the stage and fell on her head, causing her head to abruptly tilt to the left. Patient reports hearing a "crack" followed by severe pain. She denies falling, hitting her head, or LOC. Patient also denies any blurry vision, hearing changes, numbness, tingling, weakness, or imbalance. Not on any blood thinners. **CC**: Person fell on top of her at concert. **Brief description of injuries:** Acute fracture in the right occipital condyle.	158-162

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Revised trauma score: 12 Midface stable to palpation **ROS:** Posterior head pain. Aggravating factors: Palpation, lying down. **Exam**: Circulation: PT/DP palpable 2+ bilaterally, radials palpable 2+ bilaterally. Posterior head/occipital tender to palpation. Neck: Tenderness to palpation in C1-C3. **Prior to arrival:** Cervical collar **Diagnoses**: Right occipital condyle fracture. **VTE Prophylaxis:** Needs to be revised - SubQ Hep 5000u BID. **Treatment/Evaluation plans:** Cervical collar. -No indication for acute surgical intervention. -Admit to Trauma. -Neurosurgery consulted, appreciate recs: -Maintain Cervical-spine precautions. -Maintain Cervical-Collar with plans to transition to XX J collar. -MRI Cervical spine without IV contrast. **ED Disposition:** To RNF. **Final injuries:** No new injuries were identified after physical examination and review of final radiological reading(s) of all studies. Plan of care discussed with Staff Trauma Surgeon: Dr. XX at (time) 5:15 AM **Attending note:** Appreciate neuro-surgery input. Awaiting MRI/XX, M.D.	
09/18/YYYY	XX Clinic/XX Hospital XX, M.D.	**0130 hours: CT of the neck/brain/cervical spine/facial bone/ mandibular/ head with/without contrast:** **Clinical indication:** Neck pain, acute no red flags, head trauma, moderate-severe, spine fracture, cervical traumatic TMJ pain or limited movement, neck trauma. Dissection rule out vascular injury s/p head/neck trauma. Other rule out vascular injury after neck trauma-another person fell from height onto. **Impression**: Head CT:	65-80

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		No acute intracranial hemorrhage or calvarial fracture. Facial bone CT: No acute facial bone fracture. Cervical spine CT: Mildly displaced acute fracture in the right occipital condyle. Head CTA: Severely hypoplastic right intradural vertebral artery. No definite evidence to suggest a dissection, however an MRA neck dissection protocol would be helpful for adequate evaluation. No aneurysm vessel occlusion or high grade stenosis. Neck CTA: No aneurysm, dissection, vessel occlusion or high-grade stenosis. Arterial blood flow was measured to detect acute large vessel occlusion by computer aided detection software. Not performed. Concordance between software and imaging review. Not applicable. Anatomic variant: Small bilateral cervical ribs. Assume 7 cervical vertebrae with counting from the cranio-cervical junction.	
09/18/YYYY	XX Clinic/XX Hospital XX, APRN	**0324 hours: Neurosurgery consultation note:** Consultation requested by XX XXX, PA-C for an opinion regarding "occipital condyle fracture". My final recommendations will be communicated back to the requesting clinician by way of shared medical record or letter to requesting clinician via US mail. **Subjective** Patient is a X-year-old female who presents for C/O neck pain. Per patient she was at a concert when a large male did a stage dive. The male was ~ 240 lbs & landed with his full stomach/body weight on top PF her head. Patient's head tilted to the left & she heard a crack followed by severe pain. The pain is 7/10 & sharp radiating to occipital scalp, BL jaw, front of neck, & BL shoulders. Patient stumbled, but did not fall. Patient denies LOC, numbness, tingling, or weakness. Patient was brought to FV ED where imaging showed right occipital condyle fracture. NSGY consulted regarding this issue. **ROS**: Pain assessment: Currently having pain. Musculoskeletal: Neck pain. **Impression/recommendations:** Acute mildly displaced right occipital condyle fracture. **Assessment:** C/O neck pain. Per patient she was at a concert when a large male did a stage dive.	154-157

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The male was ~ 240 lbs & landed with his full stomach/body weight on top pf her head. Patient's head tilted to the left & she heard a crack followed by severe pain. The pain is 7/10 & sharp radiating to occipital scalp, BL jaw, front of neck, & BL shoulders. Patient stumbled, but did not fall. Patient denies LOC, numbness, tingling, or weakness. Patient was brought to FV ED where imaging showed right occipital condyle fracture. NSGY consulted regarding this issue. **Plan**: Maintain current collar pending fitting for XX. MRI cervical spine without IV contrast. Maintain cervical spine precautions. Further recommendations TBD after evaluation in AM by neurosurgeon.	
09/18/YYYY	XX Clinic/XX Hospital XX , M.D.	**0908 hours: X-ray of the cervical spine**: **Clinical indication:** Trauma. **Result:** Straightening of the cervical lordosis is noted with slight disc degenerative narrowing at C4-5 and C5-6. Prevertebral soft tissues within normal limits. No acute fractures seen. Upper airway appears patent **Impression**: Mild degenerative change.	64
09/18/YYYY	XX Clinic/XX Hospital XX , M.D. XX , APRN	**0900 hours: Neurosurgery progress note:** **Interval HPI:** Patient reports she is feeling okay, she is resting in bed appearing comfortable and in no apparent distress. She states the back of her neck and occipital area of her head feel very sore. She does not presently have any headache. She denies paraesthesia's, denies weakness in upper extremities. Denies bowel/ bladder dysfunction. **Assessment/plan:** Principal problem**:** Occipital fracture with non-union Closed Anderson-Montesano type I fracture of right occipital condyle -No acute neurosurgical intervention at this time. -Cervical-collar PRN, does not need to wear at all times but can wear if she feels more comfortable in it. -XR Cervical spine standing with open mouth view, already ordered. -MRI Cervical spine to assess for any ligamentous injury, already ordered. -If concern for vertebral artery dissection given results of CTA neck would recommend neurology consult. -Pain control per primary team -Final recommendations after MRI and XR results. **Attestation:**	147-150

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		MRI c-spine to evaluation for ligamentous injury. XX j when out of bed	
09/18/YYYY	XX Clinic/XX Hospital XX , M.D.	**1001 hours: X-ray of the chest**: **Clinical indication**: Shortness of breath. **Impression**: No acute radiographic abnormality.	62-63
09/18/YYYY	XX Clinic XX , APRN	**1030 hours: Trauma tertiary survey note:** **Subjective:** Patient is a healthy X-year-old female who was at a concert on 9/17 when a man who was crowd surfing landed directly on her head. She felt and heard her neck snap. She did not fall to the ground or sustain any other injuries. She does not take any blood thinners. Upon review of all imaging of physical exam of the patient, she was noted to have: Right occipital condyle fracture. Questionable right vertebral artery dissection (needs MRA to further evaluate). Admitted to RNF under trauma service for MRI/MRA neck, NSGY consult, PT/OT and pain control. Tertiary exam completed; no additional injuries noted. **Exam:** Neck: Cervical spine tender. Extraction collar in place. The AUDIT C score: Patient's score: 3. **Assessment/plan:** Closed Anderson-Montesano type I fracture of right occipital condyle. Occipital fracture with non-union. 1) Acute traumatic pain: -MM pain control. 2) Closed Anderson-Montesano type I fracture of right occipital condyle (HCC): -Neurosurgery consulted-Non op management -Brace: XX J when OOB. -MRI cervical spine pending to r/o ligamentous injury. -CTA showing hypoplastic right vertebral artery, MRA neck ordered to further evaluation for vertebral artery dissection. -PT/OT pending -MM pain control. **VTE Prophylaxis:** VTE prophylaxis appropriate. Lovenox. **Diet:** regular. **PT/OT:** pending. **Disposition:** RNF.	180-191

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/18/YYYY	XX Clinic/XX Hospital XX , APRN	**1231 hours: Nursing note:** **Related problem:** Closed Anderson-Montesano type I fracture of right occipital condyle -Neurosurgery consulted. -Non op management. -Brace XX J When out of bed (OOB). -MRI of cervical spine pending to r/o ligamentous injury. -CTA showing hypoplastic right vertebral artery, MRA neck ordered to further evaluation for vertebral artery dissection. -PT/OT pending. -MM pain control.	143
09/18/YYYY	XX Clinic XX , RN XX , RN	**Nurse notes:** **0545 hours:** Per Dr. XXX, awaiting inpatient admission from trauma team. States ok to wait for MRI on floor **1009 hours:** Patient called for pain control. Patient was found to have taken Cervical collar off. Patient educated on continued use of cervical collar due to possible neck injury. Patient agreed and put cervical collar back on. No other concerns at this time. **1449 hours:** Pt has removed her C-collar due to the pain. LIP notified	166
09/18/YYYY	XX Clinic XX , LSW	**1535 hours: Social work progress note**: **Caregiver assessment:** Caregiver is ready, willing and able to meet the patient's needs as recommended by the inter-professional team: No Caregiver needed. **Post-acute discharge plan:** ED assessed at bedside. Patient presents to ED with a neck injury at a concert. Patient lives at home with her Fiance, XX. IPTA, drives, employed and does not utilize DME. Patient denies financial barriers. Patient is not active with home care or community programs. Patient denies any MH or substance abuse issues at this time. Admitted to trauma with nonemergent MRI in morning. Neurosurgery to follow. CM/SW following to assist with discharge planning.	144-145
09/19/YYYY	XX Clinic XX , RN	**0119 hours: Transfer note**: 0055 Patient transferred from ED into room/unit pk214 in stable condition. Actions taken: Patient oriented to room and call light, tele applied, will continue to monitor and check with patient. Patient belongings with patient 0124 Page sent out to general surgery: XX, pt new admit can you please place tele order? thank you, Tele order declined by XX MD, on secure chat: " sorry, she doesn't need telemetry for this injury	175
09/19/YYYY	XX Clinic	**1037 hours: Attending note:**	167-168

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	XXX, M.D.	X-year-old female past medical history as documented presenting for evaluation of neck pain and injury. At a concert earlier today when somebody performed a stage diving to the ground landed on top of the patient. She describes this individual is a large about 240 pounds and landed directly on top of her head. She states that she felt a crack at that time and had subsequent pain to the back of the neck. She states that she has had pain since then that radiates to the shoulders and is worse with rotation. She denies any numbness, weakness to the extremities. No blood thinners. No loss of consciousness. No mental status changes. On exam resting overall nontoxic appearing. Alert and oriented x3 answering questions appropriately. There is tenderness in the paravertebral cervical-spine area with no midline tenderness. She is in a cervical collar currently. Slight tachycardia otherwise regular rhythm. No carotid bruits or thrills. Clear to auscultation bilaterally no respiratory distress. No other evidence of trauma to the extremities nor deformities. No focal or lateralizing neurologic deficits. Given the mechanism of her injury do believe it would be reasonable to obtain non contrasted CTs of the head and neck as well as contrasted to evaluate for possible blunt cerebrovascular injury. These were obtained and did not show any acute intracranial hemorrhage nor facial bone fracture but did show a mildly displaced acute fracture of the right occipital condyle with severely hypoplastic right intradural vertebral artery with no evidence to suggest a dissection though they did suggest an MRA of the neck. Given this, trauma as well as neurosurgery was consulted with anticipation of admission to trauma service. Neurosurgery did not recommend any acute neurosurgical intervention at this time but did recommend the MRI and admission to the hospital for further observation and management. The studies were ordered and ultimately after trauma evaluation recommended admission to their service as well. She was serially re-evaluated while in the emergency department and did not have any new or lateralizing focal neurologic deficits and remained in hemodynamically stable condition that did need multiple instances of pain medication for her injury. Awaiting admission in hemodynamically stable condition.	
09/19/YYYY	XX Clinic XX , M.D.	**1100 hours: MRA carotid without contrast:** **Clinical indication**: Vertebral artery dissection. Known prior right occipital condyle fracture. **Comparison**: CTA of head and neck 09/18/YYYY. **Impression**: Cervical spine shows abnormal signal of the right occipital condyle which corresponds to the known fracture. Detail is displayed to better advantage on the recent CT exam. Otherwise, cord signal is normal. Canal and foramina are patent throughout the cervical and upper thoracic spine within the field-of-view which extends to mid T5.	56-58

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hypoplastic and diminutive appearance of the right vertebral artery, which appears to terminate in right PICA. The left vertebral artery is patent without focal occlusion or stenosis, supplying a majority of the basilar artery. On the fat-suppressed T1-weighted scan, there is no clear evidence for abnormal vessel wall signal involving the cervical great vessels. There is typical signal corresponding to the paravertebral venous plexus which surrounds the vertebral arteries bilaterally.	
09/19/YYYY	XX Clinic XX , M.D.	**1100 hours: MRI of the cervical spine without contrast:** **Clinical indication**: Spine fracture, cervical, traumatic. Concern for vertebral artery dissection. Known prior right occipital condyle fracture. **Comparison**: CTA of head and neck 09/18/YYYY. **Impression**: Cervical spine shows abnormal signal of the right occipital condyle which corresponds to the known fracture. Detail is displayed to better advantage on the recent CT exam. Otherwise, cord signal is normal. Canal and foramina are patent throughout the cervical and upper thoracic spine within the field-of-view which extends to mid T5. Hypoplastic and diminutive appearance of the right vertebral artery, which appears to terminate in right PICA. The left vertebral artery is patent without focal occlusion or stenosis, supplying a majority of the basilar artery. On the fat-suppressed T1-weighted scan, there is no clear evidence for abnormal vessel wall signal involving the cervical great vessels. There is typical signal corresponding to the paravertebral venous plexus which surrounds the vertebral arteries bilaterally.	59-61
09/19/YYYY	XX Clinic XX , APRN	**1156 hours: Trauma progress note**: **Subjective:** History (last 24 hours): No acute events overnight. MRI cervical spine and MRA neck completed this morning, reads pending. Needs evals by PT and OT today. Once final spine plan determined, anticipate DC home today or tomorrow. **Exam**: Neck: Cervical spine tender. Extraction collar in place. **Assessment/plan:** Closed Anderson-Montesano Type I Fracture of Right Occipital Condyle (HCC). Acute traumatic pain.	178-180

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/plan: Acute traumatic pain: -MM pain control Closed Anderson-Montesano type I fracture of right occipital condyle (HCC**):** -Neurosurgery consulted -Non op management -XX: XX J when OOB. -MRI C spine pending to r/o ligamentous injury. -CTA showing hypoplastic right vertebral artery, MRA neck ordered to further eval for vertebral artery dissection: -PT/OT pending -MM pain control. **VTE Prophylaxis:** VTE prophylaxis appropriate. Lovenox. **Diet:** Regular **PT/OT:** pending **Dispo:** RNF.	
09/19/YYYY	XX Clinic XX , PT	**1201 hours: Physical therapy evaluation:** **Recommended Discharge Disposition**: Outpatient Physical Therapy. **Recommended Discharge Disposition Comments**: Outpatient PT for cervical spine rehab once cleared for activity by neurosurgery. PT 6 Clicks Score: 24. **Current hospital Course**: Right occipital condyle fracture. **Reason for hospital admission**: Trauma 2 with neck injury. Response to therapy interventions: Good participation in activities, Pain. **Assessment comments:** Patient mobilizing well independently without AD and C-collar while OOB. Patient presenting with significant left side radiating pain from upper trapezius/sub occipitals around side of skull and to left eye. Patient educated on spine precautions and need for future outpatient PT for management of cervical muscle guarding and ROM once cleared for activity by neurosurgery. Patient has no further acute skilled PT needs and will be discontinued from PT services. Treatment interventions: Education, functional mobility training, pain management. Patient will be discontinued from Physical Therapy when no further skilled needs are identified in this setting. Home Environment Patient Lives with: Significant Other Assistance Available: PRN	192-195

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Entry to Home: Stairs, Without Rail Number of Stairs into Home: 1 Number of Stairs to Bed/Bath: 6 Stairs to Bed/Bath with: Unilateral Rail Tub/Shower Type: tub shower Laundry: bottom floor of tri-level home, fiancé can complete Prior Functional Level: Within Functional Limits Prior Functional Level Comments: Patient reports previous independence with ADLs/IADLs, ambulates without AD, drives and works as an ultrasound tech **Subjective:** Patient pleasant and agreeable to PT evaluation Balance: Static Sitting, Dynamic Sitting, Static Standing, Dynamic Standing Static Sitting Balance: Good Patient able to maintain balance without handhold support, limited postural sway Dynamic Sitting Balance: Good Patient accepts moderate challenge, able to maintain balance while picking up object off floor Static Standing Balance: Good Patient able to maintain balance without handhold support, limited postural sway Dynamic Standing Balance: Good Patient accepts moderate challenge, able to maintain balance while picking up object off floor Activity Tolerance: Standing Activity Standing Activity: sit to stand, gait, Romberg and sharpened Romberg test Standing Activity Tolerance (in minutes): 4 JH-HLM: 7: Walk 25 feet or more Patient will be discontinued from Physical Therapy when no further skilled needs are identified in this setting **Plan:** PT frequency: Discontinue therapy services. Reasons therapy services discontinued: Independent in all functional mobility, No skilled needs. Plan of Care developed with: Patient. **Treatment interventions:** Therapy Diagnosis: No Skilled Need. Interventions Provided: Evaluation, Therapeutic Activity. Evaluation-Low. Therapeutic Activity. Therapeutic Activity. PT provided education on importance of in hospital mobility, current functional level, plan of care and possible discharge recommendation. PT provided written handout for cervical spine precautions and educated patient on future outpatient PT plan of care.	
09/19/YYYY	XX Clinic XX , M.D.	**1506 hours: Neurology consult note:** **Reason for consult**: Abnormal CTA. **HPI**: Patient is a X-year-old female, who presents with CT angiogram findings. The	151-154

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		patient was in her usual state of health, yesterday she was with her boyfriend watching a concert and somebody jumped up from the states and landed on her neck. She started having a headache neck pain. She was brought to the hospital a CT angiogram showed severe hypoplastic of the right intradural vertebral artery, no definite evidence to suggest a dissection and recommended an MRA neck dissection protocol. Protocol was performed showing a diminutive appearance of the right vertebral artery which appears to terminate in the right PICA the left vertebral artery is patent without focal occlusion supplying the majority of the basilar artery. On fat-suppressed scans no clear evidence for abnormal vessel wall signal involving the great vessels. Neurosurgery/trauma team has been consulted or the CT scan finding of mild acute fracture of the right occipital condyle. Neurology was called to evaluate this patient. **Assessment:** Patient is a X-year-old female who presents with CTA findings. Possible vertebral artery dissection seen on CT angiogram which fails to be seen on MRA protocol. No dissection seen. **Plan:** Start a baby Aspirin 81 mg daily for 3 months and then discontinue.	
09/19/YYYY	XX Clinic XX , APRN	**1526 hours: Neurosurgery plan of care**: Patient is a X-year-old female with right occipital condyle fracture. MRI cervical spine without ligamentous injury. Ok for discharge from NSGY standpoint. Follow up in 6 weeks, appointment requested. XX J collar when out of bed. Updated patient and family, all questions answered. NSGY to sign off, please call with questions. Discussed with Dr XX .	177
09/19/YYYY	XX Clinic XX , RN	**1703 hours: Nurse note:** 0945: Assessment completed, see NPR. 1000: Trauma NP at bedside. 1100: Pt off the floor for MRI. 1145: Pt returned to floor. 1440: Neuro at bedside. 1515: Discharge orders placed. 1645: Went over discharge instructions with patient, all aspects of care discussed, all questions and concerns addressed. 1700: Pt left the floor via wheelchair in no signs of distress.	175
09/19/YYYY	XX Clinic XX, M.D. XX , APRN	**Discharge summary**: **Date of admission:** 09/17/YYYY. **Reason for admission:** Neck fracture from blunt head trauma. **Trauma diagnoses:**	163-165

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Right occipital condyle fracture. **Hospital course:** Patient is a X-year-old female with no significant PMH who was at a concert when a crowd surfer was dropped directly onto her head. She was noted to have the above-mentioned traumatic injuries. Her right occipital condyle fracture was managed conservatively by NSGY with a XX J collar when out of bed. MRI was negative for ligamentous injury. CTA of the neck showed right vertebral artery irregularity concerning for dissection. MRA of the neck was done to follow up, which showed hypoplastic right vertebral artery. Neurology was consulted, and felt this may very likely be congenital. They recommended 2 months of baby ASA daily with no further follow up needed. The patient is medically cleared for DC home with outpatient PT today. **Condition upon discharge:** Stable. **Disposition:** Home. **Discharge meds**: Start Acetaminophen 325 mg, Aspirin 81 mg, Cyclobenzaprine 5 mg, Ketorolac 10 mg, Lidoderm 5%, Oxycodone IR 5 mg, Senna Docusate 8.6-50 mg.	
09/27/YYYY	XX Clinic XX , APRN	**Trauma clinic note**: **Mechanism:** Dropped on her head. **Injuries:** 1. Right occipital condyle fracture. 2. Right vertebral artery irregularity - concern for dissection. **Course:** Seen in clinic today after recent discharge 9/17 from FV hospital s/p right occipital condyle fracture with questionable right vertebral artery dissection. Since discharge, patient reports that her neck pain has been worsening - although is improved with PRN pain medications prescribed at discharge. Notably, she has been experiencing post concussive symptoms since discharge including intractable headaches, ringing in her ears, and 'lightning bolt head/ear pains.' Occasionally experiences tingling on the top of her head. These symptoms are only improved with ice packs and lying down in a cool, dark room. She has had no other dizziness, nausea, or vertigo. Patient needs to be seen by the CCF Concussion Clinic for significant post concussive symptoms consistent with post concussive syndrome. She has been provided with the information for this clinic. PT referral has been placed. Spine clinic 6-week f/u appointment has personally been requested by me today. In the meantime, we will prescribe a Medrol dose pack and low-dose PRN Gabapentin to see if these help with her headaches. **Exam**: Neck: Cervical spine pain, paraspinal neck pain right greater than left. XX J collar in place.	207-208

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment: Disposition plan: Follow up spine 6 weeks, PT, CCF concussion clinic.	
10/10/YYYY	XXXX, Inc XX, D.O.	**Office visit:** **HPI**: Cervical spine: Patient in today for concussion. Patient states she was at a rock concert, and somebody jumped on her head on 09/17/YYYY. Patient had been treated at CC but was having a hard time with her insurance getting things covered due to having XX Health Insurance through the hospital she works at. Patient was told she needed to follow up with a concussion specialist and neurology. **History:** X-year-old female presents for a concussion evaluation. On 9/17/YYYY, she was at a rock concert when someone jumped off the stage and landed on her head. No loss of consciousness. She developed a significant headache on the left side of her head. The following day, she went to XX Clinic and had imaging done including a CT, CTA, MRI and MRA. She was admitted overnight for a cervical spine fracture and was told to follow-up with a spinal surgeon, a concussion specialist and a neurologist. She states over the last few weeks, her head aches have improved. She still gets headaches daily, but they are much more manageable, and she has not had to take any medication. No dizziness, light-headedness, double or blurry vision. She has a good appetite, no nausea or vomiting. No previous history of concussion or headaches. **Assessment**: Concussion without loss of consciousness **Impression/plan:** I discussed with the patient that I do believe she has a concussion although she appears to be healing well clinically. I recommended a course of vestibular therapy over the next few weeks. I discussed physical rest with her and she is remaining out of work for the next few weeks. I will see her back in 2 weeks if she continues to have symptoms. She will also follow-up with a spinal surgeon and a neurologist for her cervical spine. PT: Refer to physical therapy.	224-225
10/11/YYYY	XX Health XX, D.O.	**Office visit**: **HPI**: Patient presents today to establish care. Previous PCP was Dr. XX. The patient complains of pain in her neck. She states that she has no pain at rest. She states when she turns or rolls, pain goes up to 5-6 out of 10. Pain is aching in nature. She is wearing a cervical collar today. Patient states that she fractured her neck on 09/17/YYYY. She was at a concert and someone dove off the stage and landed on her. She states that he landed on the left side of her neck and she heard a crack. She left the concert and went to the ED. She was	296-300

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		diagnosed with a fractured occipital condyle. She is currently in a brace for 6 weeks. She stated that she saw a sports medicine doctor to discuss concussions. She stated that she has been getting debilitating headaches. She states pain was on the left side of her head and she would get sharp volts of pain in her ear, behind her eye, or on the top of her head. She stated that she continued to have the pain intermittently. She states that they were happy with the direction things are heading. She stated that she is going to be seeing a spine specialist at the same office. She has not been scheduled for physical therapy yet but is going to be starting twice a week for 6 weeks. **ROS**: Constitutional: +headaches. Gastroenterology: +nausea. Musculoskeletal: +neck pain. **Exam**: Musculoskeletal: Cervical back: Decreased range of motion. **Assessment/plan**: Patient was seen today for new patient. Diagnoses and all orders for this visit. Encounter for medical examination to establish care. Closed Anderson-Montesano type I fracture of right occipital condyle with routine healing -XX, M.D. neurosurgery, XX Referral ordered. Call or go to ED immediately if symptoms worsen or persist. No follow ups on file, or sooner if necessary.	
10/24/YYYY	XX Health XX, PAC	**Follow-up visit**: **Subjective**: Patient presenting to the office today to establish care for right occipital condyle fracture. Patient states she was at a concert 09/17/YYYY when a person dove off stage onto her. She admits to hearing a “crunch” in her neck and immediately felt pain in her head/neck. Patient was evaluated at XX Clinic where she was found to have suffered an acute right occipital condyle fracture. She was placed in a XX J collar. Pain in her neck has improved. She continued to have headache but does feel that improving also. Denise loss of bowel or bladder, saddle anesthesia, pain down the legs, numbness, tingling, loss of dexterity, abnormal gait, fever, chills, N/V, SOB, or chest pain. **ROS**: Musculoskeletal: Positive for neck pain. Neurological: Positive for headaches. **Exam**: Neck: In XX J collar. **Assessment**: Patient presenting to establish follow up care for acute right occipital condyle	341-351

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		fracture. **Plan**: -No surgical intervention needed. -Continue collar for 6-7 more weeks. -No lifting more than 15 lbs. -Fioricet sent to pharmacy. -Follow up in neurosurgery clinic in 6-7 week with head CT scan with visualization of occipital condyles. -Will wait for PT for 3 months after injury. -Call/return sooner if symptoms worsen or new issues arise in the interim. -OARRS report reviewed.	
12/05/YYYY	XX Health XX, PAC	**Follow-up visit:** **Subjective**: Patient initially presented to the office 10/24 to establish care for right occipital condyle fracture. Patient states she was at a concert 09/17/YYYY when a person dove off stage onto her. She admits to hearing a "crunch" in her neck and immediately felt pain in her head/neck. Patient was evaluated at XX Clinic where she was found to have suffered an acute right occipital condyle fracture. She was placed in a XX J collar. Pain in her neck has improved. She continues to have headaches but does feel they are improving. Fioricet was ordered at last office visit. She presents to the office today for a 3 month follow up. Patients states the Fioricet was working until about 2 weeks ago. Admits to stiffness in her neck and feels like her head is heavy. Collar compliance. Denies loss of bowel or bladder, saddle anesthesia, pain down the legs, numbness, tingling, loss of dexterity, abnormal gait, fever, chills, N/V, SOB, or chest pain. **Assessment**: Patient presenting for a follow up for right occipital condyle fracture. Stable. **Plan**: -Pain control and expectations discussed. -CT head reviewed and discussed with patient in detail. -Okay to D/c collar. -Referral given for PT. -Letter written to go back to work. No restrictions. -Referral for neurology placed for headache management. -OARRS report reviewed. -Follow up in neurosurgery clinic PRN. -Call or return to neurosurgery office sooner if symptoms worsen or if new issues arise in the interim.	312-321
12/05/YYYY	XX Health XX, M.D.	**CT of the head without contrast:** **Clinical indication**: Closed Anderson-Montesano type I fracture of right occipital condyle	322-340

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: No acute intracranial abnormality. Right occipital condyle fracture.	
12/18/YYYY	XX Physical Therapy Institute XX, PT	**Physical therapy initial evaluation**: **Diagnosis**: Cervicalgia. Type I occipital condyle fracture, right side with routine healing Headache **Subjective**: Patient presents to therapy today for evaluation of neck. The patient was referred by XX, PAC. MOI was on 09/17/YYYY. Patient was at a concert, and someone jumped off the stage, landing on the patient, fracturing the patients skull. Went to XX Clinic in XX and was there 3 days for imaging and monitoring. Fracture of right occipital condyle, but imaging came back negative at the neck. Patient was on restrictions at first for lifting and work, as well as wearing a neck cast. On 12/05/YYYY, patient was cleared to return to work. **Presenting problems**: The patient reports headaches, moderate to severe. Loss of motion-pain, moderate pain location: bilateral neck pain, without radiation. Patient also reported constant headaches without known triggers: 4-5/10. Headaches usually on left side and at the top of the head. Pain description: Aching and hot pain. Current pain level: 4/10. Pain worst: 7/10. Pain at best: 4-5/10. 30 drives and pain worse with driving, can't support head and lateral side bending. Flexion and extension will increase pain too. The patient reports today's pain a 4/10. NDI: 32 **Objective**: Cervical evaluation: ROM: Cervical AROM: Flexion 60 mild, extension 40 painful, right rotation 55 feels stuck, left rotation 50 painful, right side and left side bend 20 painful. Upper extremity AROM: Right shoulder flexion 170 slight pain, left shoulder flexion 170 slight pain. Manual muscle test: Shoulder flexion and shoulder abduction (C5) with slight pain, elbow flexion (C6), elbow extension (C7), wrist extension (C6), wrist flexion (C7) and thumb extension (C8):5. MMT testing held for now due to patient being in increased pain with AROM. **Palpation**: Maximum tenderness to palpation BUT, bilateral cervical PS, and SO. TTP bilateral occiput Right>Left. Muscle palpation: Tenderness moderate bilaterally. Upper limb nerve tension	360-364

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		test positive right side, right side m ore painful, upper limb nerve tension tests positive left side, right side more painful, felt at tricep. Special testing challenging due to increased pain/muscle guarding. With traction, pain reduced but patient reported more of a "pulling pain" also tenderness at occiput challenged doing much traction. Joint mobility: C1-C2, C2-C3, C3-C4, C4-C5, C5-C6, C6-C7 hypomobile/painful. Joint play challenged due to increased pain and muscle guarding. **Activity comments**: Patient educated on sitting posture and POC. Patient also educated KT taping. For HEP, patient was given cervical retractions within nonpainful ROM. **Assessment**: Patient presents with signs and symptoms that are consistent with bilateral neck pain, subsequent encounter, right occipital fracture. Possible cervical disc derangement. Special testing challenged due to increased muscle guarding and pain. The current impairments identified include, decreased cervical and GH ROM, and decreased cervical ROM/strength. The functional deficits are as follows, headaches, decreased tolerance to sitting, driving, lifting/carrying objects OH. Skilled intervention is required to address the listed impairments and functional limitations to meet the patient's set goals. The patient's rehab potential is good. Medical and Therapy History: 1-2 personal factors and/or comorbidities that impact the plan of care. Patient Examination: Examination of body systems was completed using standardized tests and measures addressing 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions. Clinical Presentation: Evolving clinical presentation with changing characteristics. Clinical Decision Making: Moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome **Plan**: The patient's treatment will include E-stim unattended, manual therapy, dry needling 1 or 2 muscles, dry needling 3 or more muscles, neuromuscular reeducation, E stim unattended, hot/cold pack, PT reevaluation, therapeutic exercise, procedure, therapeutic activity, mechanical traction and PT evaluation moderate complexity. Planned services will focus on decreasing pain, improving cervical and GH ROM, cervical and GH strength to improve patients' tolerance to sitting, driving, and performing ADLs. The patient will be seen 2 times per week for 6 weeks, for a total of 12 visits. Follow up on patient response to HEP consisting of cervical retractions within non painful ROM. Also follow up on KT taping. Patient/caregiver of patient has consented to treatment and understands the diagnosis, prognosis and treatment goals associated with this plan of care.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
12/20/YYYY	XX Health XX, D.O.	**Follow-up visit:** **CC**: Patient presents with headache. **HPI**: Patient is here for follow up of headache. Patient complaints of post-concussion headache. She was cleared by neurosurgery to go back to work. She is starting physical therapy. She stated that she still has pain in her neck. She states that the pain is a stiffness in nature. She stated that she is having constant headaches. Pain is in the left forehead region. Pain in her head is sharp and hot in nature. Pain is 4-6/10. She states it is manageable but there are multiple moments it gets to an 8 or 9/10. Alleviating factors nothing. She was prescribed Fioricet which worked at first and then stopped working a few weeks later. Exacerbating factors, she is trying to determine her triggers, but she states that they can change. She has noticed driving at night, makes it worse. She denies nausea, vomiting. She did have dizziness a few weeks ago. She stated that she will use ice and lay down to try to help symptoms. She was referred to neurology but has not been scheduled. She was also on Neurontin which worked for a few weeks and then stopped just like the Fioricet. **ROS**: Constitutional: +Headaches. Musculoskeletal: +Neck pain. **Assessment/plan**: Patient was seen today for headache. Diagnoses and all orders for this visit: Migraine with status migrainosus, not intractable unspecified migraine type: -Inderal 20 mg, will start Propranolol, side effects reviewed. Was referred to neurology but not scheduled yet. Continue Fioricet as needed. Follow up in 2 weeks. Call or go to ED immediately if symptoms worsen or persist. Return in about 2 weeks (around 01/03/YYYY) for migraines, or sooner if necessary.	272-290
01/03/YYYY	XX Health XX, D.O.	**Follow-up visit**: **Subjective**: Headache: Patient is here with complaints of headache. This is a recent problem. This has been going on for 3 months. Pain is located left side of head. Pain is sharp and aching in nature. 5/10 exacerbating factors include nothing. Alleviating factors include Propranolol and Fioricet. Pain is not radiating. Associated signs and symptoms include light sensitivity. There is not an associated aura. Patient does not have a family history of headache. Imaging to date includes CT. She stated that twice, the left side of her face has gone numb and she slurs her words. She stated that she is unsure if it is from the Propranolol or from physical therapy but she states both times, she has taken it, it has happened about 1 hour after taking Propranolol. She states that she has	252-271

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		trouble focusing, she has blurred vision. She was referred to neurology but has not been scheduled yet. She has had dizziness also since starting the Propranolol. **ROS**: Constitutional: + Headaches. **Assessment/plan**: Patient was seen today for migraine and numbness. Diagnoses and all orders for this visit: Migraine with status migrainosus, not intractable unspecified migraine type: -Topamax 25 mg, Butalbital-APAP caffeine 50-300-40 mg, take 1 capsule by mouth every 6 hours as needed for headaches. Will stop Propranolol due to side effects. Will add Topamax, side effects reviewed. Continue Fioricet, side effects reviewed. Call or go to ED immediately if symptoms worsen or persist. Return in about 4 weeks (around 01/31/YYYY) for headache, or sooner if necessary.	
02/07/YYYY	XX Health XX, D.O.	**Follow-up visit**: **Subjective**: Headache: Patient is here with complaints of headache. This is a recent problem. This has been going on for 4 months. Pain is located left side of head. Pain is currently none in nature. 0/10 exacerbating factors include nothing. Alleviating factors include Fioricet and physical therapy. Pain is not radiating. Associated signs and symptoms include dizziness, blurred vision and light sensitivity. There is not an associated aura. Patient does not have a family history of headache. Imaging to date includes CT head done. She stated that the last 2 weeks of January were really good. She states that she is in physical therapy twice a week. She stated that she has been having issues with blurred vision and is scheduled to see optometry next Tuesday. She states that blurred vision is much worse at night. She has not taken Topamax. She was referred to neurology in December but has not been contacted. She states that she has an issue with her big toe on her right foot. She denies any pain. She states that she is unsure if it is getting infected or if she dropped something on it. **ROS**: Constitutional: + Headaches. **Assessment/plan**: Patient was seen today for migraine. Diagnoses and all orders for this visit: Migraine with status migrainosus, not intractable unspecified migraine type:	235-251

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		-Mercy-XX, CNC neurology, Boardman. Improving but still occurring. Will refer to neurology. She was referred by neurosurgery to neurology but has not been called to schedule. Will await additional recommendations. Onychomycosis: Penlac 8% solution, apply topically nightly. Call or go to ED immediately if symptoms worsen or persist. Return in about 3 months (around 05/07/YYYY), or sooner if necessary.	
12/21/YYYY-03/26/YYYY	XX Physical Therapy Institute Multiple providers	**Summary of multiple physical therapy visits:** **Diagnosis:** Cervicalgia. Type I occipital condyle fracture, right side with routine healing. Headache. **Date of treatment**: 12/21/YYYY, 12/28/YYYY, 01/02/YYYY, 01/04/YYYY, 01/09/YYYY, 01/11/YYYY, 01/16/YYYY, 01/18/YYYY, 01/23/YYYY, 01/25/YYYY, 01/29/YYYY, 02/01/YYYY, 02/06/YYYY, 02/08/YYYY, 02/13/YYYY, 02/15/YYYY, 02/20/YYYY, 02/22/YYYY, 02/27/YYYY, 02/29/YYYY, 03/05/YYYY, 03/07/YYYY, 03/11/YYYY, 03/14/YYYY, 03/19/YYYY, 03/26/YYYY. **Treatment rendered:** E-stim unattended, manual therapy, dry needling 1 or 2 muscles, dry needling 3 or more muscles, neuromuscular reeducation, E stim unattended, hot/cold pack, PT reevaluation, therapeutic exercise, procedure, therapeutic activity, mechanical traction	365-466
03/28/YYYY	XX Physical Therapy Institute XX, PT	**Physical therapy end of care:** **Diagnosis:** Cervicalgia. Type I occipital condyle fracture, right side, subsequent encounter for fracture with routine healing. Headache. **Subjective:** Patient has attended a total of 28 treatment sessions following evaluation of neck. Treatment has focused on the patient chief complaints of headaches, minimal, loss of motion pain, moderate. **Presenting problems**: The patient reports today's pain a 3 out of 10. Patient continued to experience bilateral neck pain, but reports that it has improved in the last month. Pain increases most with retraction motion of the neck. Patient experiences mild to moderate headaches, intermittently, that are mainly in the upper left portion of her head but have recently been referring around left ear and hairline. Current pain level: 3/10. Pain worst: 4/10. Pain at best: 0/10.	467-470

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Activities of daily living 75% limitations. 03/28/YYYY: Patient reports increase in dizziness symptoms; she feels worse today than she has in 2 weeks. Patient reports upcoming neurology appointment in April. Neck pain disability index (NDI) MIPS. Functional score 16. Pain score 5. **Objective**: Activity comments: Patient education on discharge and HEP. **Assessment**: The patient's discharge prognosis is good. Patient discharge due to plateu in progress with recent decline in past week. Patient to benefit from neurologist consult. Patient independent in HEP to address deficits. **Plan**: Reason for concluding the current episode of care: Medical referral to another provider. Patient is independent with HEP. Patient progress plateau.	
05/15/YYYY	XX Physical Therapy Institute XX, PT	**Physical therapy initial evaluation**: **Diagnosis**: Concussion with loss of consciousness status unknown. Fracture of orbit with routine healing. Injury of other cranial nerves, left side Cervicalgia. **Subjective**: Patient presents to therapy today for evaluation of s/p right occipital fracture. The patient was referred by XX, APRN. Patient previously attended PT following occipital fracture. On 09/17/YYYY, patient was at a Concert when someone jumped off the stage and landed on patient's skull. She went to XX Clinic where she had imaging that revealed a fracture of the right occipital condyle. She remained in the hospital for 3 days. Imaging was negative for fracture of the cervical spine. She attends PT for a few weeks however discharged in March. She had made progress, however continued to have deficits. She started to experience headaches again and continues to have pain in the neck. She recently had a follow up with her neurologist at the end of April. Patient reports at times she feels the left side of her tongue does not function properly. At the neurology follow up, he tested taste and face sensation. Left side of face has decreased sensation. Per patient, doctor believes symptoms are from cranial nerves starting to heal. **Presenting problems**: The patient reports pain, moderate to severe. Dizziness moderate. Headaches,	482-486

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		minimal. Location bilateral cervical spine right > left. Pain type/description: sharp, shooting. Pattern: worse AM.PM, worse with activity. Current 4/10, worst 8/100, and best 4/10. Aggravating factors: neck motion, work related activities, relieving factors, not moving, minimal changes in heat. Functional outcomes record: Neck pain disability index (NDI)-MIPS: Functional score: 20. Pain score 5. Dizziness handicap inventory (DHI)-MIP: Functional score: 26. Pain score: 5. **Objective**: ROM: Cervical AROM: Flexion 40, extension 55 pain when going down into position, right rotation 58, left rotation 60 pain on right side, right side bending 25 with pain, left side bending 30 with minimal pain. Smooth pursuit positive, VOR slow movement, VOR fast movement and VOR cancellation positive. IE-mobility testing, general hypomobility and pain throughout cervical and thoracic spine. Goal decrease hypomobility. Activity comments: IE patient education included POC, prognosis, diagnosis, HEP, rationale for exercise, therapy expectations, and pain modulation. **Assessment**: Patient presents with signs and symptoms that are consistent with vestibular dysfunction s/p right occipital fracture, concussion, headaches, and cervicalgia. The current impairments identified include decreased cervical mobility, decreased VOR response, decreased ROM. The functional deficits are as follows decreased tolerance to work activities, difficulty driving, difficulty sleeping. Skilled intervention is required to address the listed impairments and functional limitations to meet the patient set goals. The patient rehab potential is good. She is aware of her diagnosis. The plans and goals have been developed and discussed with the patient. Patient consents to treatment plan and goals and gives verbal informed consent. **Plan**: The patient's treatment will include E stim unattended, group therapy, hot/cold pack, manual therapy, neuromuscular reeducation, PT reevaluation, therapeutic exercise, procedure, therapeutic activity, mechanical traction and PT evaluation moderate complexity. The patient will be seen 2 times per week for 6 weeks, for total of 12 visits. Commence plan of care and follow up on tolerance to IE and compliance with Hep. Patient/caregiver of patient has consented to treatment and understands the diagnosis, prognosis and treatment goals associated with this plan of care.	
05/20/YYYY-07/11/YYYY	XX Physical Therapy Institute XX, PT	**Summary of multiple physical therapy visits:** **Diagnosis:** Concussion with loss of consciousness status unknown. Fracture of orbit with routine healing. Injury of other cranial nerves, left side Cervicalgia.	487-528

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Date of treatments: 05/20/YYYY, 05/22/YYYY, 06/03/YYYY, 06/06/YYYY, 06/10/YYYY, 06/13/YYYY, 06/20/YYYY, 06/24/YYYY, 06/27/YYYY, 07/01/YYYY, 07/09/YYYY, 07/11/YYYY. **Treatment rendered**: E stim unattended, group therapy, hot/cold pack, manual therapy, neuromuscular reeducation, PT reevaluation, therapeutic exercise, procedure, therapeutic activity, mechanical traction	
07/15/YYYY	XX Physical Therapy Institute XX, PT	**Physical therapy end of care:** **Diagnosis:** Concussion with loss of consciousness status unknown. Fracture of orbit with routine healing. Injury of other cranial nerves, left side Cervicalgia. **Subjective**: Patient has attended a total of 14 treatment sessions following evaluation of s/p right occipital fracture. Treatment has focused on the patient chief complaints of Pain, moderate to severe. Dizziness moderate. Headaches, minimal. **Presenting problems:** Location bilateral cervical spine right > left. Pain type/description: sharp, shooting. Pattern: worse AM.PM, worse with activity. Current 0/10, worst 4/10, and best 0/10. Aggravating factors: neck motion, work related activities, relieving factors, not moving, minimal changes in heat. Patient reports little changes over the past month. She continued to get jabs of pain with looking up. She has frequent headaches 2/3 per month. Functional outcomes record: Neck pain disability index (NDI)-MIPS: Functional score 6, pain score 2. Functional outcomes record: Dizziness handicap inventory (DHI) MIP: Functional score 8. Pain score 2. **Objective**: ROM: Flexion 65, extension 60 pain when going down into position, right rotation 55, left rotation 55 pain on right side, right side bending with pain, left side bending 40 with pain. The patient posture was observed as forward head and rounded shoulders. IE guarded positioning. Goal: Improve postural awareness. Positive smooth pursuit, VOR slow movement, VOR fast movement and VOR cancellation. Activity comments: Patient education on discharge rationale. **Assessment**: The patients discharge prognosis is fair. At this time, skilled PT is no longer required due to plateu in progress. Patient continued to have limitations	529-533

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		subjectively and objectively impacting ADLs and QOL. **Plan**: Reason for concluding the current episode of care: 1. Patient is independent with HEP. 2. Patient progress plateau.	
		Other records: Patient acknowledgment and consent form, ED care flow sheet and orders, telemetry and rhythm strips. **PDF Ref:** 2-55, 85-140,196-197. **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.*	