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| CLIENT: | Robert JONES |
| ATTORNEY: | David Smith, Esq. |
| OBSERVER: | Karen Magarian, D.C. |
| EXAMINING PHYSICIAN: | William Brown, M.D.<br>100 Main Street, Suite A<br>Los Angeles, CA 90000 |
| DATE OF EXAMINATION: | January 3, 2005 |
| TIME OF EXAMINATION: | 1:30 PM |
| DATE OF INJURY: | May 1, 2003 |
| PRESENT SUBJECTIVE SYMPTOMS: | 1. Neck and upper back pain;<br>2. Low back pain radiating to left buttock and down left posterior leg to foot/toes;<br>3. Numbness/tingling of feet bilaterally. |

1:00 PM I arrived at the office of Dr. William Brown, informed the receptionist that I would be accompanying Robert Jones during his examination, and provided a letter of introduction from Attorney Smith's office.

1:23 PM Robert Jones arrived and checked-in with the receptionist who provided a clipboard containing numerous intake questionnaires. I informed the receptionist of Attorney Smith's request that the examinee not complete any documents in writing. Mr. Jones and I sat in the waiting room.

1:35 PM We continued to wait.

1:40 PM Robert reported pain with prolonged sitting and frequently shifted position in the chair. We continued to wait.

1:47 PM An historian (Mary Martin) escorted us into an office where she inquired as to the date of injury, Mr. Jones' age and hand dominance (right). The historian typed the responses into a computer, verified involvement of an auto accident (confirmed) and inquired about occurrence. Robert stated he was stopped on the freeway and rear ended by a truck.

The historian inquired about second impact (confirmed, pushed into vehicle in front of him). The history continued regarding body impact within the vehicle. Robert stated is head snapped forward and back, and felt very dazed.

1:50 PM The examinee confirmed that police arrived to the scene, but not paramedics, was able to drive away from the accident and sought medical treatment the following day. Mr. Jones confirmed immediate pain at the scene involving his neck and low back regions. Robert stated he went to an emergency room the following day where x-rays were taken of his neck and back, and was provided anti-inflammatory medication.

1:54 PM The history continued regarding subsequent treatment. Robert stated he was seen by a doctor a few days after the accident, and later received physical therapy to the neck and back, which did not help, and began to notice tingling in his feet.

1:58 PM Mr. Jones stated that x-rays revealed his neck was "not straight," along with evidence of herniated discs. Robert reported that the chair in which we were sitting was uncomfortable. The examinee stated an MRI of his low back demonstrated "herniation and protrusion" and surgery was suggested.

2:04 PM Mr. Jones reported that physical therapy was not helpful, adding that one of his feet was numb at the time, and now both feet are numb.

The historian inquired about past medical history, which I stated was limited to the regions in question, per Attorney Smith's request. Robert denied previous treatment, injury, diagnosis or subsequent injury to the regions in question.

2:09 PM The history continued regarding current symptoms with Robert reporting neck, upper and low back pain, ... and was about to continue when the historian interrupted him to inquire as to his legs. Robert described that the pain starts in the low back, radiates to the left buttock and down the left posterior leg.

Robert reported constant bilateral neck pain, described as an "ache," and denied associated headaches. Upon questioning about radiation, the examinee described posterior neck to the upper back region.

2:13 PM Robert reported a constant "ache" in the upper back with radiation to the mid and low back regions. The examinee reported severe low back pain, radiating to left buttock and down left posterior leg to foot and toes. The historian inquired about numbness and tingling, with Robert reporting the feet bilaterally.

2:17 PM Mr. Jones confirmed that daily activities increase his low back pain, along with prolonged standing or sitting, denied bowel or bladder dysfunction, and confirmed that he intermittently walks with a limp, which is becoming more frequent. The examinee denied use of a cane or walker, but reported that he cannot walk for prolonged periods of time.

2:19 PM The historian escorted us into an exam room where Robert stood, leaning against the exam table.

2:23 PM A medical assistant (Linda Lee) entered the room and instructed Robert to put an exam gown on. The medical assistant and I left the room while he changed.

2:26 PM I rejoined Robert in the exam room and secured the back of the exam gown. Robert sat on the doctor's cushioned stool.

2:29 PM The medical assistant reentered the exam room and instructed Robert to sit on the exam table, stating the doctor would be in shortly.

2:35 PM We continued to wait.

2:40 PM We continued to wait.

2:45 PM We continued to wait.

2:47 PM Dr. Brown entered the exam room and reviewed the medical history, verifying occurrence of the accident, subsequent events and treatment.

The doctor reviewed current symptoms and inquired as to status of neck and upper back symptoms. Robert described that he was immobile for the first two weeks following the accident, and, therefore, is better now than he was then.

Mr. Jones confirmed upper and low back pain with radiation down left leg to foot, and numbness/tingling of the feet bilaterally. The examinee was instructed to demonstrate the region of left leg pain and stood, indicating the left lumbar paraspinal musculature into the left buttock and down the left posterior leg, adding that his left knee aches. The doctor inquired about the status of his left leg symptoms, with Robert stating it is getting worse.

2:50 PM Mr. Jones was instructed to stand, walk across the room, toe and heel walk, which he completed without apparent difficulty. I observed that the exam gown reached below his knees.

The examinee was instructed to indicate region of neck pain and demonstrated approximately the cervicothoracic junction, confirming soreness upon doctor’s palpation of the proximal upper trapezius musculature.
Active cervical range of motion was assessed for extension to approximately 25 degrees, flexion to approximately 30 degrees, left rotation to approximately 15 degrees, right rotation to approximately 25 degrees, and right/left lateral flexion to approximately 10 degrees bilaterally.

Cervical compression was assessed in neutral position and assisted right/left lateral flexion, with examinee reporting a pressure sensation along the posterior neck. Mr. Jones was instructed to position his shoulders in abducted/externally rotated position, and wiggle his fingers. Robert denied numbness of his fingers while doing so.

Active lumbar range of motion was assessed for flexion (knees flexed) with examinee reporting tightness at approximately 70 degrees. Assisted lumbar range of motion was assessed for extension to approximately 10 degrees with examinee appearing startled and reported pain; assisted right/left rotation to approximately 15 degrees bilaterally; and assisted right/left lateral flexion with examinee reporting low back pain upon right lateral flexion.

The doctor briefly contacted the low back region with examinee indicating left buttock pain, confirmed upon doctor's palpation of the region.

2:52 PM Mr. Jones was instructed to sit on the exam table. Reflexes of the upper extremities were assessed bilaterally at the biceps, triceps and brachioradialis (repeated at right brachioradialis), using a reflex hammer.

Muscle strength against resistance was assessed for shoulder abduction at approximately 80 degrees, elbow extension, and opposition of first and second digits bilaterally.

A thin filament was used to assess sensation to light touch along the palmar digits and dorsal thenar webs bilaterally, without apparent sensory discrepancies. However, I observed that one side was not directly compared to the other.

Reflexes of the lower extremities were assessed bilaterally at the patella and Achilles, using a reflex hammer, and repeated multiple times at right Achilles.

Muscle strength against resistance was assessed for ankle eversion and dorsiflexion of the big toes bilaterally. The examinee was instructed to hold onto the exam table for support while passive sitting straight legs were assessed, on the left to approximately 45 degrees and right to approximately 60 degrees.

The filament was then used to assess sensation to light touch along the left dorsal web and plantar feet bilaterally, without apparent sensory discrepancies. However, I observed that one side was not directly compared to the other.

2:55 PM The doctor inquired as to what activities Robert is now unable to do. The examinee reported snow skiing, water skiing, bike riding, and fly fishing, which the doctor documented. The doctor concluded the examination, stating the nurse would return to obtain measurements, after which we would be free to leave. The doctor left the exam room and I noted he did not document any findings during the physical examination.

2:59 PM The medical assistant (Linda) entered the exam room and inquired as to examinee's height, weight and hand dominance (right). Grip strength was assessed, using a Jamar hand dynamometer, alternating from right hand to left hand, three consecutive times for a total of six trials with elbows flexed. I observed the handle was positioned on the second rung from the body.

A tape measure was used to assess muscle girth at the upper arms, elbows, forearms, wrists and hands bilaterally. However, I did not observe the use of established landmarks.

The examinee was instructed to lie supine and tape measure was used to assess leg lengths from the ASIS to the medial malleoli bilaterally. The tape measure was then used to assess approximately 4 inches above the superior aspects of the patellae, where muscle girth was assessed at the upper legs bilaterally with knees flexed. The tape measure was also used to assess muscle girth at the knees, proximal lower legs, distal lower legs, malleolus and feet bilaterally with knees flexed throughout testing, except for foot circumference.

3:05 PM The medical assistant concluded her assessments and left the room. Mr. Jones groaned in apparent discomfort while sitting up. I untied the back of the exam gown and also left the room while he got dressed.

3:09 PM We left the doctor's office.

The examiner neglected to perform the following tests which were indicated by the examinee's present subjective symptoms. These include but are not limited to:

**NECK and UPPER BACK TRAUMA EXAMINATION OMISSIONS:**

1. Inspection of shoulder girdle for atrophy and symmetry.
   **Annotation:** Atrophy can be the result of disuse or severe nerve damage. Significant asymmetry may reflect structural damage and disfigurement.

2. Cervical distraction test. (Traction test)
   **Annotation:** A decrease in pain suggests relief of nerve root compression related to herniated cervical discs or osteoarthritis which encroaches on the intervertebral foramen ("window" between vertebrae where spinal nerves exit). An increase in pain suggests damage to ligaments or adhesions in the surrounding muscles and nerves.

**LOW BACK and LOWER EXTREMITY TRAUMA EXAMINATION OMISSIONS:**

1. Observation of standing examinee for postural deviations.
   **Annotation:** Symmetry should be noted in every plane for uneven pelvis, antalgic lean, and/or scoliosis. Asymmetry or postural deviations can indicate structural damage and disfigurement.

2. Palpation of spine and paravertebral musculature for presence of tenderness and spasm.
   **Annotation:** Palpation is important to reveal structural damage, muscle spasm and trigger points (myofascitis) which may not be easily identified by orthopedic testing alone.

3. Resisted muscle testing of the lower extremities bilaterally to include hip flexion (tests psoas, nerve roots L1-L2); hip abduction (gluteus medius, L5); hip adduction (adductors, L2,3,4); knee flexion (hamstrings, S2); and knee extension (quadriceps, L3).

**Annotation:** Weakness can indicated atrophied muscles or severe nerve damage. Weakness due to pain can be associated with muscle strains, tendinitis, fractures, etc. Muscle weakness is also rateable for impairment evaluation.

4. Palpation of lower extremity pulses bilaterally to include popliteal, posterior tibial and dorsalis pedis.

**Annotation:** Poor blood supply to legs can cause pain (vascular intermittent claudication), numbness or tingling which may be confused as secondary to spinal involvement.

5. Lower extremity sensory evaluation in all dermatomes bilaterally to include a) pain testing (by pin prick or pinwheel), b) light touch testing and c) vibration sense testing.

**Annotation:** Altered sensation can indicate damage either in the peripheral nerve, nerve root, spinal cord or brain. The screening procedure is incomplete if each individual dermatome in not assessed bilaterally, providing meaningful comparison of findings; otherwise, a complete neural deficit may go undetected. For example, the examinee may be able to feel the stimulus, but sensation may be muted compared to the uninjured extremity.

I declare under penalty of perjury that the foregoing is true and correct to my own personal knowledge and if called upon to testify could competently testify thereto.

Dictated on January 3, 2005.

I am a licensed chiropractor in the State of California.

Executed at Los Angeles, California, on



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Karen Magarian, D.C.
KM/cms