

MEDICAL DOCUMENTATION : DO NOT DETACH  
New Patient Narrative



U.S. HealthWorks  
2499 S. Wilmington Ave.  
Compton CA 90220  
Ph: 310 638-1113

**Date of Service:** 02-25-2013  
**Patient Name:** Santillan, Rosario  
**Patient Account Number:** 156238753  
**Date Of Injury:** 02-22-2013 12:00  
**Date Of Birth:** 03-26-1967  
**Employer Name:** PREMIER PERSONNEL RESOURCES  
**Claim #:**  
**Chart #:** EMR/ Yb

**History Of Present Illness:**

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

**Present complaint**

**Severity:** On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies parasthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**Occupational history:** Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, kneeling or squatting, bending, stooping and overhead work, lifting, pushing, or pulling up to 50lbs.

She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impece the recovery process. Patient states no known major/recurrent illnesses/injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Non-contributory Family History.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.

**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

**Current Medications at the start of Encounter:**

No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Blanco, Bery Date: 2/22/13. Time: 16:30.

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI 23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

**FDLMNP:** 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the midhigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

**Diagnostic Tests:**

**Radiology**

**Test Name**

**Findings**

Lumbar Spine 5 Views - Standard

Preliminary interpretation of these x-rays are Abnormal - Straightening

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**Diagnoses**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

**Physician Comments:** According to the patient, the present injury/illness is related to a single specific event. Exam findings are consistent with the patient's statement.

**Treatment Plan**

Last Saved By: Admin Admin 02-25-2013 11:22:56

**Dispensed Medications:**

New: NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
 NDC:00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1  
 NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Current Medications at Close of Encounter:**

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
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 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Forst Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**WORK STATUS:**

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 02-25-2013.

**Work Restrictions:**

Limited stooping and bending  
 Limited Lift , Limited Pull and Limited Push up to 10 lbs.  
 Patient must wear back support.

**Patient Education:**

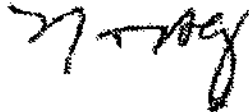
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

**Employer Contact:**

Discussed case with ----Called Marina Padilla (310) 515-2632 -Phone busy.

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2

week(s). Reasons for treatment include decreased / Impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.



Narin . Phuong, P.A.

This has been electronically signed on 02-25-2013



Marc Amush M.D.  
Supervising Provider

Next Appointment with Phuong Narin on 02-27-2013 03:30 pm.



RECEIVED  
 MAR 28 2013 A  
 OSC West

U.S. HealthWorks  
 2499 S. Wilmington Ave., Compton  
 CA 90220  
 Ph: 310 638-1113  
 Case #: 156238753

**DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

|   |   |   |                                      |        |
|---|---|---|--------------------------------------|--------|
| 1. INSURER NAME AND ADDRESS<br>YORK CLAIMS<br>P.O. BOX 619079<br>ROSEVILLE CA 95661 - 9079<br>Claim #:  |   |   | PLEASE DO NOT USE THIS COLUMN        |        |
| 2. EMPLOYER NAME<br>PREMIER PERSONNEL RESOURCES   |   |   | Case No.                             |        |
| 3. Address No. and Street<br>637 E. ALBERTONI STREET #101   | City<br>CARSON  | Zip<br>90746 - 0000                       | Industry                             |        |
| 4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)<br>EMPLOYMENT AGENCY/56  |   |   | County                               |        |
| 5. PATIENT NAME (First Name, Middle Initial, Last Name)<br>Rosario Santillan  | 6. Sex<br>Female  | 7. Date of Birth:<br>03-26-1967           | Age                                  |        |
| 8. Address: No. and Street<br>8431 Nance ave Apt P  | City:<br>Downey   | Zip:<br>90640                             | 9. Telephone Number<br>(999)999-9999 | Hazard |
| 10. Occupation (Specific Job Title)<br>Packing  |   | 11. Social Security Number<br>620-20-3894 | Disease                              |        |
| 12. Injured at: No. and Street<br>637 E. ALBERTONI STREET #101  | City:<br>CARSON   | County:<br>L.A                            | Hospitalization                      |        |
| 13. Date and hour of injury or onset of illness<br>02-22-2013 /12:00  | 14. Date last worked Mo. Day Yr.<br>02-22-2013                | Occupation                                |                                      |        |
| 15. Date and hour of first examination or treatment<br>02-25-2013/10:32 am  | 16. Have you (or your office) previously treated patient ? No | Return Date/Code                          |                                      |        |
| <p>Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure if a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.</p> <p>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)<br/>         Levantando una caja para moverla de lugar lastime la espalda.</p>  |   |   |                                      |        |
| <p>18. SUBJECTIVE COMPLAINTS (Describe Fully. Use reverse side if more space is required.)</p> <p>History Of Present Illness:<br/>         This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She said pain is localized. No foot tingling. No prior low back injury.</p> <p>Dominant hand is right.<br/>         Present complaint<br/>         Severity: On severity scale, the pain is 8 out of 10.</p> |   |   |                                      |        |

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patient states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies paresthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)**

A. A Physical Exam was performed. Any pertinent findings are noted as follows:

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 96 deg F Respiration: 16 per min.  
FDLMNP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

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

**Diagnostic Tests:**

**Radiology:**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 280)

All radiology studies are sent to Radiologist for review and confirmation.

**20. DIAGNOSES (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ( )Yes (X)No**

ICD9 Code

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2) .

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

22. Is there any other current condition that will impede or delay patient's recovery?( ) Yes (X)No If "yes", please explain.

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

Supplies:

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Priosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**Medication(s) Dispensed:**  
 NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
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 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / Impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.


**Patient Education:**  
 Patient voiced understanding of selfcare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

24. If further treatment required, specify treatment plan/estimate duration.

25. If hospitalized as Inpatient, give hospital name and location. Date Admitted :   
 Estimated stay

26. WORK STATUS - Is patient able to perform usual work? ( ) Yes (X)No

Return to work with restrictions as of : 02-25-2013 Specify restrictions: Limited stooping and bending limited lift , limited pull and Limited Push up to 10 lbs. Patient must wear back support.

|                    |   |                       |                       |
|--------------------|---|-----------------------|-----------------------|
| Doctor's Signature |  | CA License #:         | A90486                |
| Name and Degree    |   |                       |                       |
|                    | Marc Arnush M.D.  | Supervising Physician | IRS Number 95-4643269 |
| Address            | 2499 S. Wilmington Ave., Compton CA 90220   | Telephone Number      | 310 638-1113          |

FORM 5021 (rev. 4) 1992

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

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**Severity:** On severity scale, the pain is 8 out of 10.

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**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impece the recovery process. Patient states no known major/recurrent illnesses/injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Non-contributory Family History.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.



**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

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No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Blanco, Bery Date: 2/22/13. Time: 16:30.

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**Work Restrictions:**

Limited stooping and bending  
 Limited Lift , Limited Pull and Limited Push up to 10 lbs.  
 Patient must wear back support.

**Patient Education:**

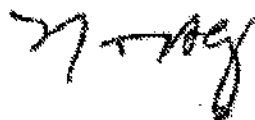
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Marc Amush M.D.  
Supervising Provider

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**Chart #:** EMR/ Yb

**History Of Present Illness:**

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

**Present complaint**

**Severity:** On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies parasthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**Occupational history:** Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, kneeling or squatting, bending, stooping and overhead work, lifting, pushing, or pulling up to 50lbs.

She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impece the recovery process. Patient states no known major/recurrent illnesses/injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Non-contributory Family History.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.

**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

**Current Medications at the start of Encounter:**

No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Blanco, Bery Date: 2/22/13. Time: 16:30.

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

FDLMNP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the midhigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg .

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

**Diagnostic Tests:****Radiology****Test Name****Findings**

Lumbar Spine 5 Views - Standard

Preliminary interpretation of these x-rays are Abnormal - Straightening

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**Diagnoses**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

**Physician Comments:** According to the patient, the present injury/illness is related to a single specific event. Exam findings are consistent with the patient's statement.

**Treatment Plan**

Last Saved By: Admin Admin 02-25-2013 11:22:56

**Dispensed Medications:****New:** NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle

NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container

NDC:00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1

NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container

NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Current Medications at Close of Encounter:**

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle

Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container

Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1

Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container

Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**WORK STATUS:**

The finding and diagnosis are consistent with patient's account of Injury or onset of illness. Return to work with restrictions as of 02-25-2013.

**Work Restrictions:**

Limited stooping and bending

Limited Lift , Limited Pull and Limited Push up to 10 lbs.

Patient must wear back support.

**Patient Education:**

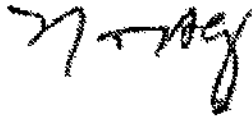
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

**Employer Contact:**

Discussed case with ----Called Marina Padilla (310) 515-2632 -Phone busy.

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2

week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.



Narin Phuong, P.A.

This has been electronically signed on 02-25-2013



Marc Arnush M.D.  
Supervising Provider

Next Appointment with Phuong Narin on 02-27-2013 03:30 pm.



U.S. HealthWorks  
 2499 S. Wilmington Ave., Compton  
 CA 90220  
 Ph: 310 638-1113  
 Case #: 156238753

**DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

|  |   |  |                                      |        |
|--|---|--|--------------------------------------|--------|
| 1. INSURER NAME AND ADDRESS<br>YORK CLAIMS<br>P.O. BOX 619079<br>ROSEVILLE CA 95661 - 9079<br>Claim #:                       |   |  | PLEASE DO NOT USE THIS COLUMN        |        |
| 2. EMPLOYER NAME<br>PREMIER PERSONNEL RESOURCES  |   |  | Case No.                             |        |
| 3. Address No. and Street<br>637 E. ALBERTONI STREET #101  | City<br>CARSON                            | Zip<br>90746 - 0000  | Industry                             |        |
| 4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)<br>EMPLOYMENT AGENCY/56 |   |  | County                               |        |
| 5. PATIENT NAME (First Name, Middle Initial, Last Name)<br>Rosario Santillan   | 6. Sex<br>Female                          | 7. Date of Birth:<br>03-26-1967                              | Age                                  |        |
| 8. Address: No. and Street<br>9431 Nance ave Apt P   | City:<br>Downey                           | Zip:<br>90640  | 9. Telephone Number<br>(999)999-9999 | Hazard |
| 10. Occupation (Specific Job Title)<br>Packing   | 11. Social Security Number<br>620-20-3894 |  | Disease                              |        |
| 12. Injured at: No. and Street<br>637 E. ALBERTONI STREET #101   | City:<br>CARSON                           | County:<br>L.A.  | Hospitalization                      |        |
| 13. Date and hour of injury or onset of illness  | Mo. Day Yr./ Hour<br>02-22-2013 /12:00    | 14. Date last worked Mo. Day Yr.<br>02-22-2013               | Occupation                           |        |
| 15. Date and hour of first examination or treatment  | Mo. Day. Yr./ Hour<br>02-25-2013/10:32 am | 16. Have you (or your office) previously treated patient? No | Return Date/Code                     |        |

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

Levantando una caja para moverla de lugar lastime la espalda.

18. SUBJECTIVE COMPLAINTS (Describe Fully. Use reverse side if more space is required.)

History Of Present Illness:

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

Dominant hand is right.

Present complaint

Severity: On severity scale, the pain is 8 out of 10.



**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patient states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies paresthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**19. OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

**A. A Physical Exam** was performed. Any pertinent findings are noted as follows:

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI: 23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.  
FDLMP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

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

**Diagnostic Tests:**

**Radiology:**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary Interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**20. DIAGNOSES** (If occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? (Y)Yes (X)No

**ICD9 Code**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

**22. Is there any other current condition that will impede or delay patient's recovery?** ( ) Yes (X)No If "yes", please explain.

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

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumelone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Nortlex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**Medication(s) Dispensed:**

NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
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 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / Impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

**Patient Education:**

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

24. If further treatment required, specify treatment plan/estimate duration.

25. If hospitalized as inpatient, give hospital name and location.

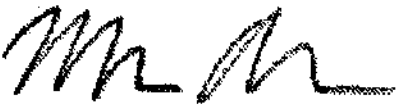
Date Admitted :

Estimated stay

26. WORK STATUS - Is patient able to perform usual work? ( ) Yes (X) No

Return to work with restrictions as of : 02-25-2013

Specify restrictions: Limited stooping and bending limited lift, limited pull and limited Push up to 10 lbs. Patient must wear back support.

|                    |   |                  |              |
|--------------------|---|------------------|--------------|
| Doctor's Signature |  | CA License #:    | A90486       |
| Name and Degree    |   |                  |              |
|                    | Marc Amush M.D.   |                  |              |
|                    | Supervising Physician   | IRS Number       | 95-4643269   |
| Address            | 2499 S. Wilmington Ave., Compton CA 90220   | Telephone Number | 310 636-1113 |

FORM 5021 (rev. 4) 1992

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.



U.S. HealthWorks  
 2499 S. Wilmington Ave., Compton  
 CA 90220  
 Ph: 310 638-1113  
 Case #: 156238753

| DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY   |                        |  |  |                                  |
|---|------------------------|--|--|----------------------------------|
| <p>Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.</p>                      |                        |  |  |                                  |
| <b>1. INSURER NAME AND ADDRESS</b><br>YORK CLAIMS<br>P.O. BOX 619079<br>ROSEVILLE CA 95661 - 9079<br>Claim #:   |                        |  |  | PLEASE DO NOT<br>USE THIS COLUMN |
| <b>2. EMPLOYER NAME</b><br>PREMIER PERSONNEL RESOURCES  |                        |  |  | Case No.                         |
| <b>3. Address No. and Street</b><br>637 E. ALBERTONI STREET #101  | <b>City</b><br>CARSON  | <b>Zip</b><br>90746 - 0000                       | Industry   |                                  |
| <b>4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)</b><br>EMPLOYMENT AGENCY/56   |                        |  |  | County                           |
| <b>5. PATIENT NAME (First Name, Middle Initial, Last Name)</b><br>Rosario Santillan   |                        | <b>6. Sex</b><br>Female                          | <b>7. Date of Birth:</b><br>03-26-1967                               | Age                              |
| <b>8. Address: No. and Street</b><br>9431 Nance ave Apt P   | <b>City:</b><br>Downey | <b>Zip:</b><br>90640                             | <b>9. Telephone Number</b><br>(999)999-9999                          | Hazard                           |
| <b>10. Occupation (Specific Job Title)</b><br>Packing   |                        | <b>11. Social Security Number</b><br>620-20-3894 |  | Disease                          |
| <b>12. Injured at: No. and Street</b><br>637 E. ALBERTONI STREET #101   |                        | <b>City:</b><br>CARSON                           | <b>County:</b><br>L.A.   | Hospitalization                  |
| <b>13. Date and hour of injury or onset of illness</b>  |                        | <b>Mo. Day. Yr./ Hour</b><br>02-22-2013 /12:00   | <b>14. Date last worked Mo. Day Yr.</b><br>02-22-2013                | Occupation                       |
| <b>15. Date and hour of first examination or treatment</b>  |                        | <b>Mo. Day. Yr./ Hour</b><br>02-25-2013/10:32 am | <b>16. Have you (or your office) previously treated patient ? No</b> | Return Date/Code                 |
| <p>Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure if a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.</p>  |                        |  |  |                                  |
| <b>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)</b><br>Levantando una caja para moverla de lugar lastime la espalda.   |                        |  |  |                                  |
| <b>18. SUBJECTIVE COMPLAINTS (Describe Fully. Use reverse side if more space is required.)</b><br><b>History Of Present Illness:</b><br>This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.<br><br>Dominant hand is right.<br><b>Present complaint</b><br><b>Severity:</b> On severity scale, the pain is 8 out of 10. |                        |  |  |                                  |

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies paresthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)**

**A. A Physical Exam was performed. Any pertinent findings are noted as follows:**

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

FDLMP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

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

**Diagnostic Tests:**

**Radiology:**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**20. DIAGNOSES (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ( )Yes (X)No**

ICD9 Code

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

22. Is there any other current condition that will impede or delay patient's recovery?( ) Yes (X)No If "yes", please explain.

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

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**Medication(s) Dispensed:**

NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle

NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, . Dispense 1 Container

NDC:00115-2011-02 Orphanadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1

NDC:85162-0617-50 Tramadol/Acel HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container

NDC:67136-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / Impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

**Patient Education:**

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

24. If further treatment required, specify treatment plan/estimate duration.

25. If hospitalized as Inpatient, give hospital name and location.


Date Admitted :

Estimated stay

26. WORK STATUS - Is patient able to perform usual work? ( ) Yes (X)No

Return to work with restrictions as of : 02-25-2013

Specify restrictions: Limited stooping and bending limited lift , limited pull and Limited Push up to 10 lbs. Patient must wear back support.

|                    |   |                       |                       |
|--------------------|---|-----------------------|-----------------------|
| Doctor's Signature |  | CA License #          | A90486                |
| Name and Degree    |   |                       |                       |
|                    | Marc Amush M.D.   | Supervising Physician | IRS Number 95-4643269 |
| Address            | 2499 S. Wilmington Ave., Compton CA 90220   | Telephone Number      | 310 638-1113          |

FORM 5021 (rev. 4) 1992

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

**MEDICAL DOCUMENTATION : DO NOT DETACH**  
**New Patient Narrative**



U.S. HealthWorks  
2499 S. Wilmington Ave.  
Compton CA 90220  
Ph: 310 638-1113

**Date of Service:** 02-25-2013  
**Patient Name:** Santillan, Rosario  
**Patient Account Number:** 156238753  
**Date Of Injury:** 02-22-2013 12:00  
**Date Of Birth:** 03-26-1967  
**Employer Name:** PREMIER PERSONNEL RESOURCES  
**Claim #:**  
**Chart #:** EMR/ Yb

**History Of Present Illness:**

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

**Present complaint**

**Severity:** On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies parasthesias . The patient states the back pain does not radiate . The patient complains of limited back motion . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**Occupational history:** Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, kneeling or squatting, bending, stooping and overhead work, lifting, pushing, or pulling up to 50lbs.

She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. Patient states no known major/recurrent illnesses/Injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Non-contributory Family History.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.

**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

**Current Medications at the start of Encounter:**

No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Blanco, Bery Date: 2/22/13. Time: 16:30.

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

**FDLMNP:** 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

**Diagnostic Tests:**

**Radiology**

**Test Name**

**Findings**

Lumbar Spine 5 Views - Standard

Preliminary interpretation of these x-rays are Abnormal - Straightening

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**Diagnoses**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

**Physician Comments:** According to the patient, the present injury/illness is related to a single specific event. Exam findings are consistent with the patient's statement.

**Treatment Plan**

Last Saved By: Admin Admin 02-25-2013 11:22:56

**Dispensed Medications:**

**New:** NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
 NDC:00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1  
 NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Current Medications at Close of Encounter:**

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1  
 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**WORK STATUS:**

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 02-25-2013.

**Work Restrictions:**

Limited stooping and bending  
 Limited Lift , Limited Pull and Limited Push up to 10 lbs.  
 Patient must wear back support.

**Patient Education:**

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

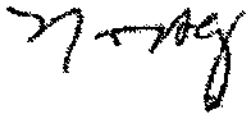
**Employer Contact:**

Discussed case with ---Called Marina Padilla (310) 515-2632 -Phone busy.

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2



week(s). Reasons for treatment include decreased / Impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.



Narin Phuong, P.A.

This has been electronically signed on 02-25-2013



Marc Amush M.D.  
Supervising Provider

Next Appointment with Phuong Narin on 02-27-2013 03:30 pm.



U.S. HealthWorks  
 2499 S. Wilmington Ave., Compton  
 CA 90220  
 Ph: 310 638-1113  
 Case #: 156238753

**DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

|  |  |                 |   |  |                  |
|--|--|-----------------|---|--|------------------|
| 1. INSURER NAME AND ADDRESS<br>YORK CLAIMS<br>P.O. BOX 619079<br>ROSEVILLE CA 95661 - 9079<br>Claim #:                       |  |                 |   | PLEASE DO NOT USE THIS COLUMN                                |                  |
| 2. EMPLOYER NAME<br>PREMIER PERSONNEL RESOURCES  |  |                 |   |  | Case No.         |
| 3. Address No. and Street<br>637 E. ALBERTONI STREET #101  |  | City<br>CARSON  | Zip<br>90746 - 0000                       | Industry   |                  |
| 4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)<br>EMPLOYMENT AGENCY/56 |  |                 |   |  | County           |
| 5. PATIENT NAME (First Name, Middle Initial, Last Name)<br>Rosario Santillan   |  |                 | 6. Sex<br>Female                          | 7. Date of Birth:<br>03-26-1967                              | Age              |
| 8. Address: No. and Street<br>9431 Nance ave Apt P   |  | City:<br>Downey | Zip:<br>90640                             | 9. Telephone Number<br>(999)999-9999                         | Hazard           |
| 10. Occupation (Specific Job Title)<br>Packing   |  |                 |   | 11. Social Security Number<br>620-20-3894                    | Disease          |
| 12. Injured at: No. and Street<br>637 E. ALBERTONI STREET #101   |  |                 | City:<br>CARSON                           | County:<br>L.A.  | Hospitalization  |
| 13. Date and hour of injury or onset of illness  |  |                 | Mo. Day. Yr./ Hour<br>02-22-2013 /12:00   | 14. Date last worked Mo. Day Yr.<br>02-22-2013               | Occupation       |
| 15. Date and hour of first examination or treatment  |  |                 | Mo. Day. Yr./ Hour<br>02-25-2013/10:32 am | 16. Have you (or your office) previously treated patient? No | Return Date/Code |

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure if a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

Levantando una caja para moverla de lugar lastime la espalda.

18. SUBJECTIVE COMPLAINTS (Describe Fully. Use reverse side if more space is required.)

History Of Present Illness:

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of parts from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

Dominant hand is right.

Present complaint

Severity: On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patient states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies paresthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)**

**A. A Physical Exam was performed. Any pertinent findings are noted as follows:**

**Physical Examination:**

**Height:** 66 inches. **Weight:** 145 lbs. **BMI:** 23 **Pulse:** 64/min. **BP:** 120/70 mmHg. **Temperature:** 98 deg F **Respiration:** 16 per min.  
**FDLMNP:** 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the midhigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

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

**Diagnostic Tests:**

**Radiology:**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**20. DIAGNOSES (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ( )Yes (X)No**

**ICD9 Code**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.B)

Pain - Back (724.2)

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

**22. Is there any other current condition that will impede or delay patient's recovery? ( ) Yes (X)No If "yes", please explain.**

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

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

Treatment Comments: Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**Medication(s) Dispensed:**

NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily, prevent upset stomach from medications, . Dispense 1 Container  
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 NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

**Patient Education:**

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

24. If further treatment required, specify treatment plan/estimate duration.

25. If hospitalized as inpatient, give hospital name and location.


Date Admitted :

Estimated stay

26. WORK STATUS - Is patient able to perform usual work? ( ) Yes (X)No

Return to work with restrictions as of : 02-25-2013

Specify restrictions: Limited stooping and bending limited lift , limited pull and Limited Push up to 10 lbs. Patient must wear back support.

|                    |   |                       |                       |
|--------------------|---|-----------------------|-----------------------|
| Doctor's Signature |  | CA License #:         | A90486                |
| Name and Degree    |   |                       |                       |
|                    | Marc Amush M.D.   | Supervising Physician | IRS Number 95-4643269 |
| Address            | 2499 S. Wilmington Ave., Compton CA 90220   | Telephone Number      | 310 638-1113          |

FORM 5021 (rev. 4) 1992

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U.S. HealthWorks  
 2499 S. Wilmington Ave., Compton  
 CA 90220  
 Ph: 310 638-1113  
 Case #: 156238753

**DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

|  |  |  |  |                                      |        |
|--|--|--|--|--------------------------------------|--------|
| 1. INSURER NAME AND ADDRESS<br>YORK CLAIMS<br>P.O. BOX 619079<br>ROSEVILLE CA 95661 - 9079<br>Claim #:   |  |  |  | PLEASE DO NOT USE THIS COLUMN        |        |
| 2. EMPLOYER NAME<br>PREMIER PERSONNEL RESOURCES  |  |  |  | Case No.                             |        |
| 3. Address No. and Street<br>637 E. ALBERTONI STREET #101  |  | City<br>CARSON                           | Zip<br>90746 - 0000  | Industry                             |        |
| 4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)<br>EMPLOYMENT AGENCY/56   |  |  |  | County                               |        |
| 5. PATIENT NAME (First Name, Middle Initial, Last Name)<br>Rosario Santillan   |  | 6. Sex<br>Female                         | 7. Date of Birth:<br>03-26-1967                              | Age                                  |        |
| 8. Address: No. and Street<br>9431 Nance ave Apt P   |  | City:<br>Downey                          | Zip:<br>90640  | 9. Telephone Number<br>(999)999-9999 | Hazard |
| 10. Occupation (Specific Job Title)<br>Packing   |  |  | 11. Social Security Number<br>620-20-3894                    | Disease                              |        |
| 12. Injured at: No. and Street<br>637 E. ALBERTONI STREET #101   |  | City:<br>CARSON                          | County:<br>L.A.  | Hospitalization                      |        |
| 13. Date and hour of injury or onset of illness  |  | Mo. Day. Yr/ Hour<br>02-22-2013 /12:00   | 14. Date last worked Mo. Day Yr.<br>02-22-2013               | Occupation                           |        |
| 15. Date and hour of first examination or treatment  |  | Mo. Day. Yr/ Hour<br>02-25-2013/10:32 am | 16. Have you (or your office) previously treated patient? No | Return Date/Code                     |        |
| Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure if a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.  |  |  |  |                                      |        |
| 17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)<br>Levantando una caja para moverla de lugar lastime la espalda.   |  |  |  |                                      |        |
| 18. SUBJECTIVE COMPLAINTS (Describe Fully. Use reverse side if more space is required.)<br>History Of Present Illness:<br>This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of parts from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.<br><br>Dominant hand is right.<br>Present complaint |  |  |  |                                      |        |

Severity: On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patient states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies paresthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)**

A. A Physical Exam was performed. Any pertinent findings are noted as follows:

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.  
FDLMNP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

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

**Diagnostic Tests:**

**Radiology:**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)  
All radiology studies are sent to Radiologist for review and confirmation.

20. **DIAGNOSES** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ( )Yes (X)No

**ICD9 Code**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

22. Is there any other current condition that will impede or delay patient's recovery? ( ) Yes (X)No If "yes", please explain.

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

| Supplies:                                  |          |            |
|--|----------|------------|
| Item Name                                  | Quantity | Hcpc / Cpt |
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |


Treatment Plan Comments: Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Frost Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

Medication(s) Dispensed:  
 NDC:66462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0156-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
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 NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 NDC:67136-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

Additional Treatment: Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week, for 2 week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

Patient Education:  
 Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis. Patient was given a Krames educational document on the injury related topic(s) of Back.

24. If further treatment required, specify treatment plan/estimate duration.  
 25. If hospitalized as Inpatient, give hospital name and location. Date Admitted : Estimated stay  
 26. WORK STATUS - Is patient able to perform usual work? ( ) Yes (X)No  
 Return to work with restrictions as of : 02-25-2013 Specify restrictions: Limited stooping and bending limited lift , limited pull and Limited Push up to 10 lbs. Patient must wear back support.

|                    |   |                  |              |
|--------------------|---|------------------|--------------|
| Doctor's Signature |  | CA License #:    | A90486       |
| Name and Degree    |   |                  |              |
|                    | Marc Amush M.D.   | IRS Number       | 95-4643269   |
|                    | Supervising Physician   | Telephone Number | 310 638-1113 |
| Address            | 2499 S. Wilmington Ave., Compton CA 90220   |                  |              |

FORM 5021 (rev. 4) 1992  
 ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

**MEDICAL DOCUMENTATION : DO NOT DETACH**  
**New Patient Narrative**



U.S. HealthWorks  
2499 S. Wilmington Ave.  
Compton CA 90220  
Ph: 310 638-1113

**Date of Service:** 02-25-2013  
**Patient Name:** Santillan, Rosario  
**Patient Account Number:** 156238753  
**Date Of Injury:** 02-22-2013 12:00  
**Date Of Birth:** 03-26-1967  
**Employer Name:** PREMIER PERSONNEL RESOURCES  
**Claim #:**  
**Chart #:** EMR/ Yb

**History Of Present Illness:**

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

**Present complaint**

**Severity:** On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies parasthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**Occupational history:** Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, kneeling or squatting, bending, stooping and overhead work, lifting, pushing, or pulling up to 50lbs.

She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. Patient states no known major/recurrent illnesses/injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Non-contributory Family History.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.



**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

**Current Medications at the start of Encounter:**

No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Bianco, Bery Date: 2/22/13. Time: 16:30.

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

FDLMNP: 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

**Psychiatric:** She is alert and oriented to person, place and time . Mood and affect appear appropriate .

**Respiratory:** There are no apparent signs of respiratory distress .

**Gastrointestinal:** Abdominal palpation is normal .

**Genitourinary:** Costovertebral angle tenderness for renal involvement is not noted .

**Lymphatic:** There is no evidence of dependent lymphedema .

**Musculoskeletal:** The patient ambulates with a normal gait, full weightbearing on both lower extremities . The patient has normal posture . There is no weakness of the lower extremities . The spine is not kyphotic . The patient does not have scoliosis . The patient has no loss of lumbosacral lordosis . The pelvis is symmetrical . There are spasms of the paravertebral musculature . There is tenderness of the paravertebral musculature - . There is no restriction of range of motion of the back. Flexion with the fingertips approximating the mid thigh . Extension 15/30 deg, lateral flexion L 20/45 deg R 20/45 deg, lateral rotation L 15/30 deg R 15/30 deg.

**Cardiovascular:** The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally.

**Neurologic:** Heel/toe ambulation is performed without difficulty . Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raising test (SLR) is negative. The back muscles display no weakness .

**Diagnostic Tests:****Radiology**

| Test Name                       | Findings  |
|---------------------------------|---|
| Lumbar Spine 5 Views - Standard | Preliminary interpretation of these x-rays are Abnormal - Straightening |

**Medical Necessity:**

Lumbar Spine 5 Views - Standard History of severe low back pain. (ACOEM pp 290)

All radiology studies are sent to Radiologist for review and confirmation.

**Diagnoses**

Sprain/Strain Lumbar (847.2)

Muscle Spasm Back (724.8)

Pain - Back (724.2)

**Physician Comments:** According to the patient, the present injury/illness is related to a single specific event. Exam findings are consistent with the patient's statement.

**Treatment Plan**

Last Saved By: Admin Admin 02-25-2013 11:22:56

**Dispensed Medications:**

**New:** NDC:68462-0359-05 Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 NDC:55111-0158-10 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
 NDC:00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1  
 NDC:65162-0617-50 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 NDC:67138-0533-15 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Current Medications at Close of Encounter:**

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle  
 Omeprazole D.R. 20mg #30 . 1 capsule daily. prevent upset stomach from medications, , Dispense 1 Container  
 Orphenadrine Citrate ER 100mg Tabs #30 . 1 at bedtime/ 1 al acostarse, Dispense 1  
 Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet every eight hours as needed for pain , Dispense 1 Container  
 Polar Frost 150ml 5oz Gel Tube 1 Twice A Day PRN , Dispense 1 Container

**Supplies:**

| Item Name                                  | Quantity | Hcpc / Cpt |
|--|----------|------------|
| Heat-Moist Heat Pad - Custom Touch 13"x13" | 1        | E0215      |

**Treatment Comments:** Nabumetone 750mg one 2 times a day for inflammation. Prilosec 20mg once daily for GI prophylaxis. Norflex 100mg one at bedtime for muscle spasm. Ultracet 37.5 mg one at bedtime for pain. Polar Forst Gel for topical pain relief. Custom Touch Heat Pack for moist heat therapy and spasm. Modified duty. Recheck in 2 days.

**WORK STATUS:**

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 02-25-2013.

**Work Restrictions:**

Limited stooping and bending  
 Limited Lift , Limited Pull and Limited Push up to 10 lbs.  
 Patient must wear back support.

**Patient Education:**

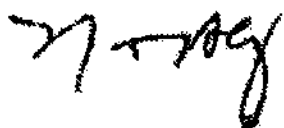
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**Employer Contact:**

Discussed case with ---Called Marina Padilla (310) 515-2632 -Phone busy.

**Additional Treatment:** Patient is referred to Chiropractic therapy for evaluation and treatment 3 times per week; for 2

week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion and functional strength deficits. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.



Narin . Phuong, P.A.

This has been electronically signed on 02-25-2013



Marc Amush M.D.  
Supervising Provider

Next Appointment with Phuong Narin on 02-27-2013 03:30 pm.

**MEDICAL DOCUMENTATION : DO NOT DETACH**  
**New Patient Narrative**



U.S. HealthWorks  
2499 S. Wilmington Ave.  
Compton CA 90220  
Ph: 310 638-1113

**Date of Service:** 02-25-2013  
**Patient Name:** Santillan, Rosario  
**Patient Account Number:** 156238753  
**Date Of Injury:** 02-22-2013 12:00  
**Date Of Birth:** 03-26-1967  
**Employer Name:** PREMIER PERSONNEL RESOURCES  
**Claim #:**  
**Chart #:** EMR/ Yb

**History Of Present Illness:**

This is a 45 y.o. female who states that at work 3 days ago, and as she was bending over to pick up a heavy box of pants from the floor to put to different area, sustaining pain to her low back. She states pain never went away. She sid pain is localized. No foot tingling. No prior low back injury.

**Present complaint**

**Severity:** On severity scale, the pain is 8 out of 10.

**Back Complaints / Symptoms**

**Complaint:** Patient's complaint at this time is as follows: pain - low back. Patient describes the symptom(s) as dull. She says it is mild. She reports having symptoms for 3 days. The frequency is intermittent.

**Associated Symptoms:** The patient denies dysuria . The patient denies polyuria . The patients states there is no hematuria . The patient denies fever, chills, and sweats . The patient denies parasthesias . The patient states the back pain does not radiate . The patient complains of limited back motion - . The patient denies any leg weakness . The patient states there is no numbness or tingling of the lower extremities . The patient denies any changes in bowel habits . The patient denies any bladder or bowel dysfunction .

**Occupational history:** Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, kneeling or squatting, bending, stooping and overhead work, lifting, pushing, or pulling up to 50lbs.

She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

**Chemical Exposure:** No chemical or toxic exposure was reported.

**Surgeries:** No Known Surgical History

**Medical History:**

Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. Patient states no known major/recurrent illnesses/injuries.

**Tetanus History:**

Last tetanus - unk.

**Family History:** Diabetes in relatives.

**Social History: Alcohol or Tobacco use:** She does not use tobacco. Denies alcohol use. Patient does not participate in any sports or does not have any hobbies.

**Review Of Systems:**

A complete review of systems was performed and was found to be negative unless otherwise noted below.

**Constitutional Symptoms:** Recent weight change - .

**Women Only:** Menstrual Irregularities. .

**Current Medications at the start of Encounter:**

No known current medication.

**Allergies:**

No Known Drug Allergies.

**Patient Report Of Injury**

**Injury Details:** Patient states injury or condition was caused at work. Injury was reported to: Blanco, Bery Date: 2/22/13. Time: 16:30.

**Physical Examination:**

Height: 66 inches. Weight: 145 lbs. BMI:23 Pulse: 64/min. BP: 120/70 mmHg. Temperature: 98 deg F Respiration: 16 per min.

**FDLMNP:** 2/13.

**Constitutional:** The patient is a well-developed, well-nourished female.

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**Radiology**

**Test Name**

**Findings**

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Last Saved By: Admin Admin 02-25-2013 11:22:56

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| Item Name                                  | Quantity | Hcpc / Cpt |
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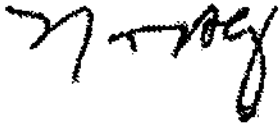
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Narin . Phuong, P.A.

This has been electronically signed on 02-26-2013



Marc Arnush M.D.  
Supervising Provider

Next Appointment with Phuong Narin on 02-27-2013 03:30 pm.