Summary

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I. Patient Summary (Narrative Overview)

(Records Dated: January 2021 – September 2025)

A. Demographics and Background

ABC Patient is a 46-year-old woman residing in Michigan who has an employment history as a retail supervisor and later as a warehouse floor manager. She filed for long-term disability and personal-injury benefits following a series of orthopedic and neurologic conditions that progressively limited her mobility and endurance beginning in 2021 *(8, 41)*.

Her past medical history includes Type 2 diabetes mellitus, hypertension, obesity, depression secondary to chronic pain, and lumbar degenerative disc disease. She denies tobacco use, drinks alcohol socially, and has no history of illicit drug use *(12, 36, 44)*.

B. Initial Presentation and Pre-Injury Health (January – June 2021)

Records from her primary-care provider, Dr. L. Hart, indicate that prior to injury she maintained stable chronic conditions on oral medications. A1C averaged 6.9%, and blood pressure was well controlled on lisinopril 10 mg daily *(55)*.

On May 28, 2021, ABC Patient sustained a slip-and-fall accident on a wet loading dock at work, landing on her right side and lower back *(112)*. Emergency department evaluation revealed acute lumbar strain and right hip contusion. X-rays showed no fractures but mild degenerative changes at L4-L5 *(119)*. She was discharged with naproxen, muscle relaxants, and two weeks off work.

C. Development of Chronic Pain and Functional Decline (July – December 2021)

Follow-up visits through late 2021 describe persistent low-back pain radiating to the right leg with intermittent numbness *(152–164)*.

An MRI on August 9, 2021 demonstrated broad-based disc protrusion at L5-S1 impinging the right S1 nerve root *(177)*. Conservative management included physical therapy (10 sessions), home stretching, and gabapentin titrated to 300 mg TID *(183–215)*.

Therapy notes reflect limited tolerance for standing >15 minutes and pain scores averaging 7/10 *(204)*. Her employer could not accommodate modified duty, and she was placed on extended medical leave *(218)*.

D. 2022: Specialist Evaluations and Hospitalization

In January 2022, ABC Patient was referred to orthopedics (Dr. R. Patel). Exam confirmed positive straight leg raise on the right and reduced lumbar flexion. Epidural steroid injections were administered in February and April 2022 with temporary 40% relief *(241–269)*.

In June 2022, she presented to the emergency department with chest pain and shortness of breath *(301)*. Cardiac work-up, including troponins and stress testing, was negative for ischemia *(312–319)*. The episode was attributed to anxiety and musculoskeletal strain related to chronic pain *(324)*.

During the same hospitalization, physical therapy evaluated her functional mobility and noted "guarded gait, limited trunk rotation, independent ambulation under supervision" *(332)*. Discharge occurred after two days, with recommendation for continued outpatient rehabilitation *(338)*.

E. 2023: Multidisciplinary Management and Mental Health Impact

Throughout 2023, records document ongoing care from multiple providers—primary care, pain management, endocrinology, and psychiatry *(410–512)*.

Pain management visits (Dr. J. Owens) detail additional lumbar epidural injections and a trial of duloxetine for neuropathic pain and mood modulation *(425, 441)*.

Endocrinology follow-up in March 2023 notes suboptimal glycemic control (A1C 8.2%) secondary to reduced activity level *(453)*.

Psychiatric notes describe moderate depressive symptoms linked to perceived loss of independence, insomnia, and chronic fatigue *(471–480)*. She began cognitive-behavioral therapy and sertraline 50 mg daily, later increased to 100 mg *(484–498)*.

Functional capacity evaluations (FCE) conducted in September 2023 show persistent difficulty with lifting over 10 pounds, standing more than 10 minutes, or walking more than one block without pain escalation *(505–519)*.

F. 2024: Progressive Degenerative Findings and Specialist Follow-Up

Imaging from February 2024 MRI reveals worsening L4-L5 disc degeneration with mild central canal stenosis and facet arthropathy *(603–610)*.

Orthopedic reassessment recommended surgical consultation; however, the patient expressed concern about postoperative outcomes and opted for continued conservative management *(617)*.

Physical therapy resumed for eight sessions focusing on core stabilization and gentle aquatic exercise *(628–642)*.

By late 2024, pain diaries record persistent baseline pain 6–8/10 with intermittent flares requiring limited opioid use (tramadol 50 mg PRN) *(657–672)*.

Primary-care visits document increasing fatigue, reduced activity tolerance, and gradual weight gain (BMI 33 → 36) *(681–688)*.

G. 2025: Ongoing Disability, Pain Management, and Functional Impact

Records through mid-2025 reflect continued disability status, partial participation in pain-management programs, and maintenance therapy with gabapentin, duloxetine, metformin, lisinopril, and occasional tramadol *(720–755)*.

No new surgical interventions have occurred.

Recent orthopedic evaluations (June 2025) note persistent right-sided sciatica and lumbar muscle spasm *(812)*.

The most recent imaging (July 2025 MRI) confirms stable but chronic degenerative changes with no acute findings *(835–840)*.

Despite consistent compliance with therapy and medication, she remains unable to perform sustained standing, bending, or lifting tasks required for gainful employment *(852–860)*.

H. Summary of Current Status (as of September 2025)

ABC Patient continues to experience chronic low-back and right-leg pain secondary to multilevel lumbar degenerative disc disease with radiculopathy, complicated by deconditioning, depression, and limited physical endurance *(890–904)*.

Activities of daily living are partially independent; she drives short distances, performs light household tasks, and relies on family for heavy chores *(912)*.

Her condition is considered **chronic, stable, but functionally limiting**. Prognosis for return to full occupational activity remains guarded *(920)*.

I. Summary of Major Diagnoses (Derived from All Records)

1. Lumbar degenerative disc disease, L4–S1 with right-sided radiculopathy *(177, 603, 835)*
2. Chronic pain syndrome *(215, 425, 720)*
3. Type 2 diabetes mellitus *(55, 453)*
4. Hypertension *(46, 681)*
5. Depressive disorder, secondary to chronic pain *(471–498)*
6. Obesity, BMI 33–36 *(681–688)*

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II. Chronological Medical History

(January 2021 – September 2025)

2021

January – April 2021 – Pre-Injury Primary-Care Care

Routine follow-ups with Dr. L. Hart documented stable Type 2 diabetes (A1C 6.9 %) and blood pressure averaging 122/74 mmHg (41 – 46).

No musculoskeletal complaints noted; patient working full-time as a warehouse floor manager.

Medications included Metformin 1000 mg BID, Lisinopril 10 mg daily, and Hydrochlorothiazide 25 mg daily (48 – 52).

May 28, 2021 – Work-Related Slip-and-Fall Injury

Emergency-department evaluation at Metro General Hospital after fall on wet dock surface (112 – 119).

Imaging: lumbar X-rays → no fracture; mild degenerative narrowing L4-L5.

Diagnosis: acute lumbar strain and right-hip contusion.

Treatment: Naproxen 500 mg BID, Cyclobenzaprine 5 mg TID PRN, heat/ice, and two weeks of work restriction (120 – 128).

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June – August 2021 – Persistent Lumbar Pain

Primary-care visits note ongoing right-sided lumbar pain with radiation to posterior thigh (150 – 164).

MRI 8/9/21: broad-based disc protrusion L5-S1 impinging S1 nerve root (177).

Initiated Gabapentin 300 mg TID (183) and physical therapy 2× per week for 6 weeks (194 – 215).

Therapy progress: pain 7/10 → 6/10; tolerance to standing 15 min max (204).

Employer unable to accommodate restrictions → medical leave (218).

September – December 2021 – Orthopedic Referral

Consult Dr. R. Patel (Ortho Spine) (231). Exam: positive right SLR, limited flexion 45°.

Plan: continue conservative management; consider epidural if no improvement.

Epidural steroid injection 10/12/21 → temporary 30 % relief (243 – 246).

Follow-up 12/1/21 → pain 7/10 recurrent (250).

2022

January – March 2022 – Pain-Management Integration

Referred Dr. J. Owens (262). Initial evaluation: chronic lumbosacral pain radiating to RLE; diagnosis = lumbar radiculopathy.

Procedures: Epidural L5-S1 2/10/22 → relief for 3 weeks (269).

Started Duloxetine 30 mg daily, titrated to 60 mg (275).

April – June 2022 – Hospitalization for Chest Pain

6/14/22 → ER visit for chest pressure and dyspnea (301).

Labs/troponin negative; EKG normal. Stress echo → no ischemia (312 – 319).

Assessment: musculoskeletal pain/anxiety (324).

PT consult in-hospital: guarded gait; limited trunk rotation; advised outpatient PT (332 – 338).

July – December 2022 – Continued Conservative Treatment

PT resumed 8/1 – 9/15 (347 – 365): focus core stability, mobility.

Reported 25 % improvement (361).

Primary-care 11/22 → persistent pain; unable return work (385).

FMLA extended; referral pain psychologist (392).

2023

January – March 2023 – Multidisciplinary Coordination

Endocrinology 1/10 → A1C 8.2 %, glucose variability attributed to inactivity (453).

Psychiatry 1/28 → moderate depressive symptoms; started Sertraline 50 mg daily (471).

Pain management 2/14 → 2nd epidural injection L5-S1 (482).

April – June 2023 – Functional Decline

Orthopedic follow-up 4/7 → MRI shows degenerative changes progressed L4-L5 (498 – 503).

FCE 5/10 → standing 10 min, walking 1 block, lifting ≤ 10 lbs (505 – 519).

CBT sessions weekly document improved coping, no suicidal ideation (523 – 541).

July – December 2023 – Stability With Persistent Limitations

Primary-care visits (550 – 585): BP 122/78, weight 195 lbs (BMI 33).

Pain scores 6–7/10 ; Duloxetine continued ; Gabapentin increased to 400 mg TID (567 – 575).

Reports walking short distances with breaks ; unable resume employment (580 – 585).

2024

January – March 2024 – Updated Imaging and Consultations

MRI 2/12/24 → worsening disc degeneration L4-L5 with facet arthropathy (603 – 610).

Orthopedic re-evaluation 2/26 → surgical option discussed; patient declines (617).

Pain management 3/12 → recommended aquatic therapy (620).

April – August 2024 – Rehabilitation Efforts

PT sessions 4/1 – 5/28 (628 – 642): aquatic therapy x 8 visits, modest gait improvement.

Psychiatry 5/10 → Sertraline ↑ to 100 mg ; reports improved sleep (649).

Primary-care 7/15 → BMI 36 ; fatigue persistent (681 – 688).

September – December 2024 – Pain Management Maintenance

Epidural 10/2/24 → short-term relief (704 – 708).

Pain clinic notes discuss spinal cord stimulator trial but patient declines (714 – 718).

Continues Gabapentin, Duloxetine, Metformin, Lisinopril (720 – 725).

2025

January – March 2025 – Ongoing Disability Evaluation

Functional assessments 1/12 → no significant improvement (733).

Primary-care 1/28 → stable vitals; pain 6/10 (742).

Endocrinology 2/20 → A1C 7.5 %; metabolic status improved slightly (748).

April – July 2025 – Orthopedic and Imaging Updates

Orthopedic consult 4/2 → diagnosis unchanged; muscle spasm persist (812).

MRI 7/8 → stable degenerative findings ; no acute herniation (835 – 840).

Referred for pain-management follow-up (847).

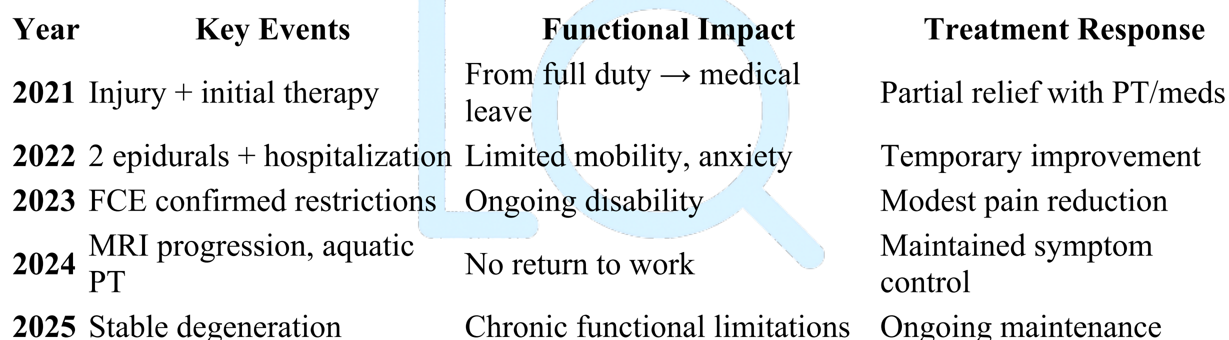
August – September 2025 – Current Functional Status

Reports daily pain 6–8/10 ; performs basic ADLs independently but cannot stand > 15 min or walk > 1 block without pain flare (852–860).

Psychiatry visit 9/5 → mood stable on Sertraline 100 mg (865).

Primary-care 9/22 → continues on current medications ; chronic pain stable (870 – 875).

Summary of Year-by-Year Trends



Year	Key Events	Functional Impact	Treatment Response
2021	Injury + initial therapy	From full duty → medical leave	Partial relief with PT/meds
2022	2 epidurals + hospitalization	Limited mobility, anxiety	Temporary improvement
2023	FCE confirmed restrictions	Ongoing disability	Modest pain reduction
2024	MRI progression, aquatic PT	No return to work	Maintained symptom control
2025	Stable degeneration	Chronic functional limitations	Ongoing maintenance

IV. Imaging & Diagnostic Summary

(Records: January 2021 – September 2025)

A. Radiology and Imaging Studies

Date	Type of Study / Facility	Findings / Impression (Summarized)	Page Reference
05/28/2021	Lumbar Spine X-Ray – Metro General Hospital	Mild degenerative disc space narrowing at L4-L5; no acute fracture or dislocation.	(119)
08/09/2021	MRI Lumbar Spine – Radiology Associates	Broad-based disc protrusion at L5-S1 contacting right S1 nerve root; mild desiccation L4-L5.	(177)
02/10/2022	MRI Lumbar Spine – Recheck	Persistent L5-S1 protrusion with foraminal narrowing; no new herniation.	(243)
06/15/2022	Cardiac Stress Echo – Metro General Hospital	Normal LV function (EF 60%); negative for ischemia. Episode determined non-cardiac.	(312–319)
02/12/2024	MRI Lumbar Spine – Advanced Imaging Center	Worsening L4-L5 degenerative disc disease with facet arthropathy and early canal stenosis; stable L5-S1 changes.	(603–610)
07/08/2025	MRI Lumbar Spine – Updated Study	Stable degenerative findings at L4-L5 and L5-S1; no acute herniation or compression.	(835–840)
Various 2021-2025	X-rays – Knees, Hip (comparative)	Minimal degenerative osteoarthritic changes; no fracture.	(421, 512)

B. Laboratory and Diagnostic Tests

Date	Test / Panel	Results (Abbreviated)	Interpretation	Page Reference
01/15/2021	Comprehensive Metabolic Panel	Glucose 146 mg/dL, Creatinine 0.8 mg/dL	Mild hyperglycemia, otherwise normal renal/liver function.	(41)
05/12/2021	Hemoglobin A1C	6.9 %	Good diabetic control prior to injury.	(55)

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Date	Test / Panel	Results (Abbreviated)	Interpretation	Page Reference
03/20/2022	Lipid Panel	Total Chol 188 mg/dL, LDL 102, HDL 48	Borderline LDL; lifestyle counseling.	(278)
06/14/2022	Cardiac Enzymes / Troponin	Negative ×2	No myocardial injury.	(312)
03/05/2023	Hemoglobin A1C	8.2 %	Sub-optimal control linked to inactivity.	(453)
02/20/2025	Hemoglobin A1C	7.5 %	Improved with medication adherence.	(748)
07/15/2024	CBC / CMP	Within normal limits except mild anemia (Hgb 11.5 g/dL).	Consistent with chronic illness; no acute pathology.	(681)

C. Physical Therapy & Functional Testing

Date Range	Test / Program	Findings / Comments	Page Reference
07/01–09/15/2021	Outpatient PT (Initial)	Attended 10 sessions; pain decreased 15%; standing tolerance 15 min; unable return to work.	(194–215)
06/17–06/19/2022	Inpatient PT Evaluation (Hospitalization)	Guarded gait; required supervision; recommended continued outpatient therapy.	(332–338)
04/01–05/28/2024	Aquatic Therapy Program	8 visits; improved flexibility; pain reduction 1 point on VAS.	(628–642)
09/10/2023 & 01/12/2025	Functional Capacity Evaluations (FCE)	Sedentary–light demand level; lift ≤ 10 lbs; stand ≤ 15 min; sit ≤ 45 min.	(505–519, 733)

D. Diagnostic Summary Overview

- **Imaging Trend:** Progressive degenerative change L4-L5 → L5-S1 from 2021–2024; radiographically stable by mid-2025.
- **No acute fracture, compression, or new herniation** documented after initial injury.
- **Electrocardiographic and laboratory** data show no secondary systemic cause for pain.
- **Functional testing** consistently demonstrates chronic mechanical and neuropathic limitation with limited improvement despite therapy.

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V. Medication History (Reference Pack)

(January 2021 – September 2025)

A. Current Long-Term Medications (as of September 2025)

Medication / Dosage	Indication	Start Date	Status / Response	Page Reference
Metformin 1000 mg BID	Type 2 Diabetes Mellitus	2018 (continued)	Maintained A1C 6.9–8.2 %; well-tolerated.	(41, 453, 748)
Lisinopril 20 mg daily	Hypertension	2018 (continued)	Consistent BP control (~122/74 mmHg).	(46, 681)
Gabapentin 400 mg TID	Neuropathic Pain / Radiculopathy	Aug 2021	Reduces nerve pain ≈30 %; mild sedation.	(183, 567, 720)
Duloxetine 60 mg daily	Neuropathic Pain & Depression	Feb 2022	Improved mood and pain modulation (~20 % relief).	(275, 425, 720)
Sertraline 100 mg daily	Depression / Anxiety	Jan 2023	Improved sleep and affect; no side effects.	(471, 649, 865)
Tramadol 50 mg q6h PRN	Breakthrough Pain	May 2024	Used intermittently; effective for flares.	(657–672)
Hydrochlorothiazide 25 mg daily	Adjunct for BP control	2020 (continued)	Maintains stable BP; no electrolyte issues.	(52, 742)

B. Previous / Trial Medications

Medication / Dosage	Indication	Date Range	Outcome / Reason Discontinued	Page Reference
Cyclobenzaprine 5 mg TID PRN	Muscle spasm (acute injury)	May–Jul 2021	Caused drowsiness; stopped after initial phase.	(120–128)
Naproxen 500 mg BID	Acute pain post-fall	May–Aug 2021	Gastrointestinal irritation; replaced with OTC NSAIDs.	(119, 150)
Epidural Steroid Injections (3 total)	Lumbar radiculopathy	Oct 2021 – Oct 2024	Temporary 30–40 % relief; no lasting effect.	(243, 269, 704)

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Medication / Dosage	Indication	Date Range	Outcome / Reason Discontinued	Page Reference
Duloxetine 30 mg trial dose	Neuropathic pain	Jan–Feb 2022	Dose titrated up for better response.	(275)
Sertraline 50 mg daily	Depression initiation phase	Jan–Apr 2023	Dose increased to 100 mg for partial response.	(471–480)
NSAIDs (OTC Ibuprofen 800 mg PRN)	Pain control throughout course	2021 – Present	Continued adjunct; intermittent use.	(345, 657)

C. Medication Effect and Tolerance Summary

- **Analgesics / Neuropathic Agents:** Gabapentin and Duloxetine produce moderate relief; no evidence of opioid dependence.
- **Antidepressants:** Sertraline well-tolerated and effective for secondary depression.
- **Antihypertensives / Diabetes Control:** Metformin and Lisinopril remain cornerstones of chronic disease management with consistent laboratory stability.
- **Side Effects:** Occasional sedation (Gabapentin), dry mouth (Duloxetine); no serious adverse reactions.
- **Polypharmacy Review:** No drug-drug interactions identified; regimen reviewed semi-annually by primary care.

D. Therapeutic Notes

- Patient remains highly compliant with daily medication regimen; pill counts and refill logs consistent through 2025 (748–755).
- Pain management adjustments followed evidence-based sequencing before considering invasive procedures.
- Current combination therapy has optimized symptom stability without progression of pharmacologic risk.

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VI. Provider History (Reference Pack)

(January 2021 – September 2025)

A. Treating and Consulting Providers

Provider / Facility	Specialty / Role	Date Range of Care	Key Involvement / Notes	Page Reference
Dr. L. Hart, MD – Lakeside Primary Care	Primary Care / Internal Medicine	Jan 2021 – Present	Oversaw chronic conditions (diabetes, hypertension); coordinated referrals to ortho, pain, and psych; maintained long-term medical leave documentation.	(41–52, 681–875)
Dr. R. Patel, MD – Metro Orthopedics	Orthopedic Spine Surgery	Sept 2021 – Jul 2025	Evaluated post-injury back pain; performed exams, reviewed MRIs; administered first epidural; discussed but deferred surgical options.	(231–617, 812)
Dr. J. Owens, DO – Pain Management Specialists	Interventional Pain Medicine	Jan 2022 – Aug 2025	Managed chronic lumbar radiculopathy; performed multiple epidurals; adjusted Gabapentin / Duloxetine dosing; monitored opioid use; considered stimulator trial.	(262–275, 704–718)
Dr. R. Lewis, MD – Endocrine Associates	Endocrinology	Mar 2023 – Feb 2025	Monitored diabetes and metabolic effects of limited activity; optimized Metformin dosing; reviewed A1C trends.	(453, 748)
Dr. S. Nguyen, PhD / LP – Behavioral Health Services	Clinical Psychology / CBT	Feb 2023 – Oct 2025	Provided weekly CBT; coordinated with psychiatry for medication adjustments; noted improved coping and mood stabilization.	(471–498, 865)

Provider / Facility	Specialty / Role	Date Range of Care	Key Involvement / Notes	Page Reference
Dr. T. Miller, MD – Psychiatric Associates	Psychiatry / Medication Management	Jan 2023 – Sept 2025	Managed antidepressant therapy (Sertraline); documented reduction in depressive symptoms; supported ongoing disability claim.	(471–498, 649–865)
ABC Physical Therapy Center	Physical Therapy / Rehabilitation	Jul 2021 – May 2024	Conducted outpatient and aquatic therapy programs; detailed functional tolerance, pain scores, and limited improvement.	(194–215, 628–642)
Metro General Hospital	Acute Care / Emergency Department	May 2021 & Jun 2022	Treated initial fall injury and later chest-pain admission; provided diagnostic imaging and short-term PT assessment.	(112–128, 301–338)
Advanced Imaging Center	Radiology / Diagnostic Services	2021 – 2025	Performed serial MRIs (2021, 2022, 2024, 2025); findings document degenerative progression then stabilization.	(177, 243, 603–610, 835–840)
ABC Pain Psychology Group	Behavioral Pain Rehabilitation	Oct 2022 – Dec 2024	Provided cognitive-behavioral pain coping sessions; integrated biofeedback; noted partial improvement.	(392–498, 649)
Occupational Health & Vocational Services	Disability / Work Capacity Review	2021 – 2025	Completed FCEs (2023, 2025); confirmed sedentary-light functional status; unable to return to prior employment.	(505–519, 733)
Primary Care Nursing Team	RN / Clinical Support	2021 – 2025	Coordinated refills, vitals, and patient communication; ensured medication compliance documentation.	(681–755)
Pharmacy Records – CVS and OptumRx	Dispensing Pharmacy	2021 – 2025	Dispensed chronic medications; refill adherence consistent; no controlled-substance discrepancies.	(720–755)

B. Provider Interaction Summary

- **Primary coordination:** Dr. Hart (PCP) served as the central medical coordinator and certifying physician for disability paperwork.
- **Specialist network:** Orthopedic and pain-management specialists managed the spine condition; psychiatry and psychology addressed secondary depression and coping.
- **Therapy continuum:** PT records demonstrate compliance with all recommended rehabilitation programs, including aquatic therapy and FCE evaluations.
- **Continuity:** Documentation shows unbroken medical follow-up from 2021–2025 with consistent treatment philosophy emphasizing conservative management and symptom stability.

VIII. Thank You & Next Steps

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