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Chronological Medical-Records Narrative

Claimant: Mr. Jordan A. Sample (fictional) · DOB: 05/02/1982 · DOI: 03/14/2024 · Prepared: illustrative sample

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About this sample.

This is a representative, multi-page RecordsLens output illustrating the deliverable you receive as a Microsoft Word document: a unified, attribution-embedded chronology in dense clinical prose, imaging and electrodiagnostic findings in nested bullets, a differentiated premorbid section, and a closing reservation. Every name, date, facility, and finding below is fictional and contains no protected health information. Your actual output is generated solely from the records you upload, calibrated to a board-certified physician and Certified Life Care Planner house style — defensible at deposition, and yours to review, edit, and own.

Records reviewed

This narrative is based on the following illustrative source records:

- Mercy Regional Medical Center — Emergency Department and Radiology records (03/14/2024)
- Northside Orthopaedic Associates — office, operative, and follow-up records (03/2024–03/2025)
- Lakeview Imaging Center — MRI, radiograph, and addendum reports (04/2024–01/2025)
- Cascade Neurology & EMG — consultation and electrodiagnostic studies (06/2024)
- Summit Interventional Pain Management — procedure and office records (07/2024–12/2024)
- Apex Physical Therapy — evaluation, treatment, and discharge notes (05/2024–11/2024)
- Riverside Behavioral Health — psychological evaluation and treatment notes (08/2024–02/2025)
- Workability Functional Capacity Services — functional capacity evaluation (03/2025)

Chronological Narrative

Index event and emergency presentation

Records from Mercy Regional Medical Center are reviewed. On 03/14/24, Mr. Jordan A. Sample, a 41-year-old right-hand-dominant warehouse supervisor, presented to the Emergency Department by private vehicle approximately three hours after a rear-end motor-vehicle collision in which his stopped vehicle was struck from behind by a sport-utility vehicle at moderate speed. Mr. Sample was restrained, the airbags did not deploy, and he was ambulatory at the scene. He reported the immediate onset of posterior neck pain radiating into the right upper extremity, interscapular pain, lower-back pain, and right-shoulder pain, and denied loss of consciousness, headache, chest pain, or paresthesia of the lower extremities.

On triage, Mr. Sample was hemodynamically stable with a blood pressure of 138/86, heart rate 88, and oxygen saturation of 99% on room air, and rated his pain at 8/10. Examination documented cervical and lumbar paraspinal tenderness with palpable spasm, restricted and painful cervical rotation, a positive right-sided Spurling maneuver, tenderness over the right anterolateral shoulder, and a non-tender, atraumatic abdomen. The distal neurovascular examination of all four extremities was intact, with 5/5 strength, symmetric reflexes, and no sensory deficit. A trauma survey was otherwise unremarkable.

Diagnostic imaging obtained in the Emergency Department on 03/14/24 was reviewed and reported as follows:

- Cervical spine radiographs (AP, lateral, odontoid): no acute fracture or subluxation; loss of normal cervical lordosis consistent with muscle spasm; mild C5–C6 uncovertebral degenerative change.
- Lumbar spine radiographs (AP, lateral): no acute fracture or spondylolisthesis; mild multilevel disc-space narrowing and facet arthrosis.
- Right shoulder radiographs (AP, axillary, scapular-Y): no acute osseous injury or dislocation; type II acromion; preserved glenohumeral joint space.

Mr. Sample was diagnosed with cervical and lumbar strain and a right-shoulder contusion. He was treated with intravenous ketorolac and oral cyclobenzaprine with partial relief, provided home-care and return-precaution instructions, prescribed a short course of naproxen and cyclobenzaprine, and discharged in stable condition with a recommendation to follow up with orthopaedics within one week and to remain off work pending re-evaluation.

Initial orthopaedic evaluation and conservative care

Records from Northside Orthopaedic Associates are reviewed. On 03/22/24, Mr. Sample established orthopaedic care reporting persistent axial neck pain rated 6/10 with intermittent paresthesia of the right middle and index fingers, mechanical low-back pain with occasional radiation into the posterior right thigh, and anterolateral right-shoulder pain aggravated by reaching and overhead activity. He reported disrupted sleep and difficulty performing his supervisory duties, which required repetitive lifting and overhead reaching.

Examination on 03/22/24 documented cervical range of motion limited to approximately 40 degrees of rotation bilaterally with reproducible facet-loading pain, a positive right Spurling maneuver, and intact upper-extremity strength graded 5/5 except for subtle 4+/5 right shoulder abduction limited by pain. Shoulder examination revealed positive Neer and Hawkins impingement signs, a positive Jobe (empty-can) test, tenderness over the greater tuberosity, and pain-limited active forward elevation to approximately 140 degrees with preserved passive motion. Lumbar examination showed paraspinal tenderness, pain at end-range extension, and a negative straight-leg-raise bilaterally with intact distal strength and sensation.

Mr. Sample was diagnosed with cervical strain with right-upper-extremity radicular symptoms, right shoulder impingement with suspected rotator-cuff pathology, and lumbar strain. The provider initiated a structured course of conservative management including a referral to physical therapy three times weekly for six weeks, a tapering anti-inflammatory regimen, activity modification, and continuation of modified-duty restrictions limiting lifting to ten pounds and prohibiting overhead work. He was instructed to return in four weeks or sooner if symptoms worsened.

On 04/19/24, Mr. Sample returned reporting only modest improvement with therapy, with continued right-hand paresthesia and persistent night pain in the right shoulder that interrupted sleep. Repeat examination was largely unchanged, with continued positive impingement signs and a positive right Spurling maneuver. Given the persistence of radicular and shoulder symptoms despite four weeks of conservative care, the provider ordered magnetic-resonance imaging of the cervical spine, the lumbar spine, and the right shoulder, and continued modified-duty restrictions.

Diagnostic imaging

Records from Lakeview Imaging Center are reviewed. MRI of the cervical spine without contrast, 04/26/24, demonstrated the following:

- C5–C6 posterior disc-osteophyte complex with mild central canal narrowing and mild bilateral foraminal narrowing.
- C6–C7 right paracentral disc protrusion contacting and mildly displacing the exiting right C7 nerve root, with associated moderate right foraminal narrowing.
- Straightening of the cervical lordosis consistent with muscle spasm; no cord signal abnormality or marrow edema.

MRI of the lumbar spine without contrast, 04/26/24, demonstrated the following:

- L4–L5 broad-based disc bulge with mild bilateral facet arthropathy and mild ligamentum flavum thickening.
- L5–S1 right paracentral disc protrusion abutting the traversing right S1 nerve root without high-grade displacement.
- Maintained vertebral body heights; no acute compression deformity, marrow edema, or spondylolysis.

MRI of the right shoulder without contrast, 04/26/24, demonstrated the following:

- Articular-surface partial-thickness tear of the distal supraspinatus tendon involving less than 50% of the tendon thickness.
- Subacromial-subdeltoid bursitis with a type II (curved) acromion and mild acromioclavicular joint arthrosis contributing to outlet narrowing.
- Intact subscapularis, infraspinatus, and biceps tendons; no full-thickness tear and no labral detachment identified.

Neurologic and electrodiagnostic evaluation

Records from Cascade Neurology & EMG are reviewed. On 06/07/24, Mr. Sample underwent neurologic consultation for persistent right-upper-extremity radicular symptoms. He reported intermittent numbness of the right index and middle fingers and aching pain extending from the neck to the lateral forearm. Examination noted subjectively diminished light-touch sensation in the right C7 distribution, preserved 5/5 strength in all myotomes, a slightly diminished right triceps reflex relative to the left, and a negative Hoffman sign and negative Spurling on that date.

Electrodiagnostic testing performed the same day was reviewed. Nerve-conduction studies of the right upper extremity demonstrated normal median and ulnar motor and sensory latencies, amplitudes, and conduction velocities, with no evidence of focal slowing at the wrist or elbow. Needle electromyography of selected right cervical paraspinal and upper-extremity muscles was reported as follows:

- Increased insertional activity and chronic neurogenic motor-unit changes in a right C7 myotomal distribution (triceps and pronator teres).
- No active denervation (no fibrillation potentials or positive sharp waves) at the time of study.
- No electrodiagnostic evidence of median neuropathy at the wrist, ulnar neuropathy, or generalized peripheral polyneuropathy.

The neurologist interpreted the findings as electrophysiologic evidence of a chronic right C7 radiculopathy correlating with the C6–C7 disc protrusion identified on MRI, recommended continued non-operative

management with consideration of interventional pain procedures, and advised return for re-evaluation should progressive weakness or new neurologic deficit develop.

Interventional pain management

Records from Summit Interventional Pain Management are reviewed. On 07/15/24, Mr. Sample underwent a right C6–C7 transforaminal epidural steroid injection under fluoroscopic guidance with contrast confirmation; the procedure note documented that he tolerated the procedure without complication and was discharged in stable condition. At the 08/05/24 follow-up, Mr. Sample reported approximately 50% reduction in right-arm pain and improved sleep lasting roughly three weeks before partial recurrence.

On 09/09/24, given continued lumbar radicular complaints, Mr. Sample underwent a right L5–S1 transforaminal epidural steroid injection under fluoroscopic guidance, again tolerated without complication. At the 10/07/24 follow-up he reported partial and temporary improvement in right-leg symptoms with continued mechanical low-back pain. The pain specialist recommended continuation of a home exercise program, reasonable activity modification, and return to the referring orthopaedic surgeon for evaluation of the persistent right-shoulder pathology, and noted that repeat cervical injection could be considered in the future if symptoms recurred.

Physical therapy

Records from Apex Physical Therapy are reviewed. Mr. Sample participated in two courses of supervised therapy between 05/02/24 and 11/01/24, completing 34 of 38 scheduled visits. The initial evaluation of 05/02/24 documented restricted cervical mobility, reduced right-shoulder elevation, diminished trunk and scapular stabilization, and an inability to perform overhead lifting. Treatment addressed cervical and lumbar stabilization, postural retraining, scapular mechanics, and, following surgery, a structured rotator-cuff rehabilitation protocol.

Interval progress notes documented gradual improvement in cervical rotation and lumbar range of motion and improved tolerance of seated and standing activity, with persistent difficulty in overhead reaching prior to surgical intervention. The discharge summary of 11/01/24 documented near-full cervical and lumbar range of motion, improved trunk strength, residual mild right-shoulder stiffness with overhead activity, and transition to an independent home-exercise program with as-needed follow-up.

Operative course and post-operative follow-up

Records from Northside Orthopaedic Associates are further reviewed. On 10/28/24, given the failure of an extended course of conservative care for the right shoulder, the surgeon and Mr. Sample discussed operative options, including the risks, benefits, and alternatives, and Mr. Sample elected to proceed with arthroscopic intervention. On 11/12/24, Mr. Sample underwent right-shoulder arthroscopy with arthroscopic subacromial decompression, bursectomy, and rotator-cuff debridement; the operative report documented an articular-surface partial-thickness supraspinatus tear involving less than 50% of the tendon thickness, subacromial bursitis, and outlet narrowing consistent with the preoperative MRI, with the labrum and biceps anchor noted to be intact. Estimated blood loss was minimal and there were no intraoperative complications.

Mr. Sample was discharged the same day in a sling with instructions for pendulum exercises and outpatient physical therapy. At the 11/26/24 post-operative visit, the incisions were noted to be well healed without signs of infection, and he was advanced from passive to active-assisted range of motion. At the 12/10/24 follow-up, Mr. Sample reported improved shoulder pain with residual stiffness, demonstrated active forward elevation to approximately 150 degrees, and was advanced in his

rehabilitation protocol. At the 02/04/25 follow-up, he reported substantial functional improvement of the shoulder with intermittent residual cervical and lumbar pain aggravated by prolonged activity. The surgeon assigned permanent modified-duty restrictions limiting repetitive overhead activity and lifting above twenty-five pounds, recommended continuation of a home-exercise program, and released him to follow up on an as-needed basis. A final orthopaedic note of 03/18/25 documented that Mr. Sample had reached maximum medical improvement with respect to the right shoulder.

Psychological treatment

Records from Riverside Behavioral Health are reviewed. On 08/20/24, Mr. Sample underwent a psychological evaluation reporting sleep disturbance, situational anxiety related to driving and to being a passenger, irritability, and frustration secondary to his functional limitations and uncertainty about return to full duty. The evaluating clinician documented a diagnosis consistent with an adjustment reaction with anxiety related to the collision and recommended a course of cognitive-behavioral therapy. Mr. Sample engaged in twelve sessions between 08/20/24 and 02/11/25 directed at driving-related anxiety, sleep hygiene, and pain-related coping, with the treating clinician documenting gradual improvement in reported mood, sleep, and driving tolerance by the final session.

Functional capacity evaluation

Records from Workability Functional Capacity Services are reviewed. On 03/26/25, Mr. Sample underwent a functional capacity evaluation. The evaluator documented consistent effort across standardized testing and concluded that Mr. Sample demonstrated the capacity for medium-duty work with restrictions, including limitation of repetitive overhead reaching and occasional lifting above twenty-five pounds, findings the evaluator noted were consistent with the treating surgeon's permanent restrictions.

Premorbid Records

The following records predate the index event of 03/14/24 and are summarized separately to differentiate pre-existing from acute findings.

- 01/2019 — Primary-care note documenting intermittent, activity-related neck and low-back stiffness attributed to occupational lifting, managed conservatively with over-the-counter analgesics, without radicular complaints, imaging, or specialist referral.
- 06/2021 — Right-shoulder radiograph obtained for unrelated overuse complaints following recreational activity, reported as mild acromioclavicular degenerative change and a type II acromion without acute abnormality.
- 09/2022 — Routine annual examination noting an unremarkable neurologic assessment, full extremity strength, and no chronic pain or psychiatric diagnoses.
- 11/2023 — Urgent-care visit for a self-limited mechanical low-back strain after moving furniture, resolved within two weeks with conservative care and without imaging or follow-up.

This sample chronology is provided solely for illustration of format and house style. The claimant, providers, dates, and findings are fictional and contain no protected health information. In an actual engagement, all findings are derived from and should be verified against the underlying records before use in litigation, and nothing herein constitutes medical or legal advice. © 2026 ForensAssess LLC.