Nhung Phan, Psy.D., QME
PSY28271
Mailing Address:
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

November 2, 2020

Subsequent Injures Benefit Trust Fund
Department of Industrial Relations
Division of Workers' Compensation
160 Promenade Circle, Suite 350
Sacramento, California 95834

Workers Defenders Law Group
8118 E. Santa Ana Canyon Road, Suite 100-215
Anaheim Hills, California 92808

In Reference:	**Clarke, Deborah**
Date of Birth:	May 29, 1949
Dates of Injuries:	CT: May 5, 2017- April 4, 2018
	CT: June 1, 2017- March 25, 2018
Employer:	CVS Pharmacy
Employment Position:	Cashier
SIF Case No:	SIF11264503
Date of Examination:	October 14, 2020
Place of Examination:	770 Magnolia Ave., Suite #2K
	Corona, CA 92879

Please do not release this report directly to the examinee. This psychological report is CONFIDENTIAL. Showing or allowing the claimant to read this report could be detrimental and psychologically harmful to this individual. Misunderstandings, misinterpretations, and severe emotional reactions are often encountered when this happens without the presence of a qualified and competent psychological expert. Therefore, in the best interest of the claimant, with rare exceptions, it is advisable to discuss only pertinent findings with the applicant. Any emotional distress or violent reaction and other risk will be the responsibility of the person who allows the applicant to read or copy this report.

SUBSEQUENT INJURY BENEFITS TRUST FUND
PSYCHOLOGICAL ELIGIBILITY EVALUATION REPORT

To Whom It May Concern:

I conducted a psychological evaluation of Ms. Clarke at the request of Workers Defenders Law Group to help determine whether or not Ms. Clarke qualifies for benefits from the Subsequent Injuries Benefits Trust Fund.

Before the examination, Ms. Clarke was admonished that confidentiality and privilege normally extended to the psychologist-examinee relationship were waived for the purposes of this evaluation. Ms. Clarke was also informed that a copy of my findings would be sent to the Subsequent Injuries Benefits Trust Fund, her legal counsel and to the referring physician. Ms. Clarke indicated understanding and agreed to proceed. It is my opinion that she appeared competent to consent to this evaluation.

As per the Opinion and Decisions of *Susan Meyers vs. Council on Aging* (Case No. ADJ3374876/SJO0268303) " ... the parties may either agree to use a specified examiner like an AME, or they may each obtain an evaluation and reporting from a qualified physician like a QME. ***Any qualified physician who reasonably reports on the SIBTF claim is entitled to receive a reasonable fee to be paid by the SIBTF pursuant to section 4753.5 and in accordance with the official medical-legal fee schedule***." (***emphasis added***). This examination is being billed as an ML-104, Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances based upon the below listed complexity factors:

- ✓ Two hours or more of face to face
- ✓ Two or more hours of record review
1. Four or more hours or a combination of face to face time and medical record review which shall count as 2 complexity factors
2. Six or more hours spent on any combination of three complexity factors (1) – (3), which shall count as three complexity factors.

- ✓ Addressing the issue of medical causation.
- ✓ Addressing the issue of apportionment.
    1. Claimant's employment by three or more employer.
    2. Three or more injuries to the same body system or body region (as delineated by AMA Guides TOC).
    3. Two or more injuries involving two or more body systems or body parts (as delineated by AMA Guides TOC).
- ✓ A psychiatric or psychological evaluation, which is the primary focus of the medical-legal evaluation.

The psychological evaluation involved lengthy and detailed history, clinical examination, mental status, review of psychometric findings, and report preparation. All aspects of the evaluation except clerical and transcription duties were performed by myself. Psychological testing was administered and scored in the office and interpreted by myself. All opinions expressed herein are those of the undersigned. Verification under penalty of perjury of the total time spent in each of these activities:

Face to face time	2 hours	15 minutes
Medical records review	3 hours	45 minutes
Psychometric testing*	1 hour	00 minutes
Addressing the issue of causation	3 hours	15 minutes
Addressing the issue of apportionment	3 hours	30 minutes
Report preparation and editing	11 hours	30 minutes
Total time spent	**25 hours**	**15 minutes**

*Total Time spent for psychological testing, billed as CPT code 96101, includes face-to-face administration time, scoring, and interpretation.

TABLE OF CONTENTS

QUESTIONS PERTAINING TO COVID-19

Ms. Clarke states she has not traveled outside of the USA in the last 14 days. Her temperature today is 97.4ºF. She notes she has not been in close contact with anyone known to have COVID-

19. She has not been asked to self-quarantine. She denies symptoms of fever, lower respiratory symptoms, and shortness of breath. She denies cold symptoms such as cough and runny nose in the past two weeks, nor has there been a change in his ability to smell or taste during that time. She states she has had no fatigue, weakness, diarrhea, or general achiness in the last two weeks.

The claimant attests that her answers are true and accurate and accepts that there is always a risk of exposure to COVID-19 when she leaves his house to attend any outside event and/or meeting.

She agrees that her attendance at this evaluation is voluntary and that she attended under her own free will. She freely agreed to and attended this medical-legal evaluation recognizing that:

1. There is inherent risk in any person-to-person meeting.
2. That I have taken all reasonable precautions to prevent the spread of the virus.

She signed the questionnaire after filling it out.

PRE-EXISTING DISABILITY HISTORY

In order to adhere to the required format of an SIBTF medical-legal report I have demarcated the specific issues unique to this case. I have separated from the subsequent injury all the prior industrial injuries and pre-existing conditions and disorders that were present before the subsequent injury of CT: May 5, 2017- April 4, 2018 and CT: June 1, 2017- March 25, 2018 as established by the orthopedic QME doctor, Dr. Kesho Hurria, M.D. dated 09/24/18.

The following sections of this report will address the pre-existing disabilities, pre-existing labor disablement and pre-existing work restrictions. Below is a narrative of Ms. Clarke's disability history prior to the date of her subsequent work injury.

Identifying Information:

Ms. Clarke is a 71-year-old single Caucasian female. She is currently unemployed. She receives $1,329 per month in Social Security and two small pensions. Interpreting service was not provided, as Ms. Clarke was English speaking.

History of Childhood Events:

Ms. Clarke was born and raised in Jamesville, Wisconsin. She moved to Los Angeles in 1959. Her health was good. She was raised by both parents. Her father worked as an electrician. Her mother was a full-time housewife and mother was raising four children, but she also held several different odd jobs over the years. She had two brothers and one sister. She was the second oldest child. Her father always yelled at her and her siblings. She was afraid of her father and would wet the bed often. She describes being sad as a child because her father was overbearing. She was verbally abused by her father during her childhood and adolescent years. During her teen years, her father

"beat" her with a belt a couple of times. Her father's verbal and physical abuse made her "cry a lot" and she still thinks about the incidents. She denied ever being sexually abused. She generally had a close relationship with her siblings and they were supportive of each other. They lived in the "country," therefore, they had to entertain each other and they "had some good times." During her adolescent years, she sought affection from "teen boys," because her father did not show her affection. Her sister has rheumatoid arthritis and her mother and father had cancer. Her mother died from bladder cancer in 2005. There is no family history of mental illness.

Academic History:

Ms. Clarke completed 12 years of school. She did not like school and received adequate grades. During primary school, she attended the Lutheran School in town. She graduated from Bolsa Grande High School in Garden Grove, California in 1967. She was never suspended or expelled from school. She attended Santa Ana College for one semester and did not obtain a degree.

Military Service:

No military service.

Relationship History (before and after subsequent injury):

Ms. Clarke had two marriages. She was married to her first husband for 13 years. He was not romantic. He was "an adulterer who had many affairs." They divorced in 1982. She was married to her second husband for eight years and they divorced in 1994. Her husband requested the divorce and she was hurt, yet relieved. She has not been involved in a relationship since 2004. Since the subsequent injury, she has felt lonely.

She had one son from her first marriage and one daughter from her second marriage. Her son died on July 13, 2018 at age 42 from suicide. Her surviving daughter is 34 years old.

Work History:

She was employed as a cashier at Savon from 1972-1973. She quitted because she was pregnant. She did not work for three years. She was employed as a cashier at Thrifty from 1978-1980. She quitted to return to work at Savon. She was employed as a stocker at Savon from 1980-1986. She quitted because she was pregnant. She was employed as a cashier at Savon from 1989-2004. She quitted to take care of her parents. She was employed as a cashier at CVS from 2006-2018 and was terminated by her manager, Erin. She denied ever being fired for cause. She received EDD (Employment Development Department) benefits for six months in 1975. She received SSDI (Social Security Disability Insurance) benefits prior to this current workers' compensation claim.

During her employment at CVS between May 2, 2017 and March 8, 2018, her job duties as a cashier included using a cash register to check-out customers, stocking candy, straightening the

front aisles and cleaning counters. Physically she was required to stand, walk, bend, and lift bags of merchandise to hand to customers. Prior to her injury, she worked four hours a day, three days a week, and earned $15.00 per hour.

Medical History (before and after subsequent injury):

Ms. Clarke had five pregnancies; three miscarriages and two live births. Her first pregnancy was at age 26. She went through menopause at age 50. Menopause symptoms included hot flashes and being irritable when she was in pain. She had GERD (gastroesophageal reflux disease) for three years and had symptoms of stomach pain and nausea all day and night. She was diagnosed with a fatty liver one year ago. She was diagnosed with high cholesterol around six months ago. She began to have neuropathy two years ago. She was hospitalized for the births of her children in 1975 and 1986 and for gallbladder removal in 2006. She had hip surgery for a broken hip on March 8, 2016. She had no head injuries prior to the subsequent injury. In 2004, she was disabled due to a pinched nerve in her neck causing numbness in the left side of her left neck radiating down her left arm to her hand. She had no non-work-related injuries prior to the subsequent injury. Since the subsequent injury she often has pain in her neck, back, arms, hands, legs, and feet. She had chiropractic treatment, epidural injection, cortisone injection and TENS unit therapy, and the treatment helped ease her pain during treatment. She is not currently receiving treatment for any of her pain.

According to an undated medical record, Ms. Clarke had a previous work injury and was on modified duty when she reinjured her back and neck. She had low back and neck pain and could only stand for 50% of the time and bend for 25%.

According to a medical record by Dr. Kesho Hurria, M.D. dated 09/13/18, Ms. Clarke was unable to work on a non-industrial basis. She was advised to limit her walking for less than 30 mins and sitting for less than 15 mins to no more than 1-2 hrs/day.

According to a medical record by Dr. Kesho Hurria, M.D. dated 09/24/18, the examinee was involved in an automobile accident in 1997/1998 with injuries to her neck and back. She sustained a previous injury in March 2016. Her left hip was broken while working for CVS Pharmacy, and she was placed off work for 14 months until she went back to work in March 2017. She had cholecystectomy in 2009 and left total hip replacement in 2016.

She is currently taking the following medications.

Current Medications:	Dosage	Since	Frequency	Rx Doctor
Norco	325/5 mg	2017	1 per day	Dr. Harris
Ativan	.05 mg	2017	2 per day	Dr. Ghazi
Pantoprazole	40 mg	2019	1-2 per day	Dr. Ghazi
Rosuvastatin	5 mg	2020	1 per day	Dr. Ghazi

Ms. Clarke relayed her medications make her feel groggy, but do not affect her concentration or make her feel forgetful.

Medical/Psychological Conditions and Incidences (before subsequent injury)

Childhood:	Felt sad due to father's verbal abuse
Adolescent years:	Father beat her a couple times with a belt
Unknown:	Married to first husband for 13 years
1972-1973:	Cashier at Savon and quitted due to pregnancy, did not work for three years after
1975 (Age 26):	Birth of son (five pregnancies, three miscarriages)
1975:	Received EDD benefits for six months
1978-1980:	Cashier at Thrifty and quitted to return to Savon
1981:	In an abusive relationship for two years
1980-1986:	Stocker at Savon, quitted due to pregnancy
1982:	Divorced first husband due to his infidelity
1986:	Birth of daughter
1989-2004:	Cashier at Savon and quitted to take care of her parents
1994:	Second husband divorced her after eight years of marriage
1997/1998:	Injury to the neck and back
1999:	Menopause at age 50
2000:	Nervous breakdown due to mother's diagnosis of bladder cancer, collapsed at work
2000:	Off work for three months and received psychological counseling
2004:	Pinched nerve in her neck and was disabled
2004:	No intimate relationship since then, feeling lonely
2005:	Mother died from bladder cancer
March 2016:	Injury, left hip broken at CVS
2016:	Off work for 14 months due to work injury
2017:	Returned to CVS after time off work
2006-2018:	Cashier at Savon and managed by manager, Erin
2016:	Personal injury claim against an apartment complex where she fell
Unknown:	Received SSDI benefits
Unknown:	Prior work injury, injury to the back and neck

Medical/Psychological Conditions and Incidences (after subsequent injury)

2017:	GERD for three years
07/13/2018:	Son committed suicide at age 42
2018:	Neuropathy
2018:	Began having suicidal thoughts

May 2018:	Counseling by Dr. Sylvia and received Ativan
2019:	Fatty liver
2020:	High cholesterol
2020:	Recent thoughts of suicide wishing she was dead

Surgery (before subsequent injury)

2006:	Gallbladder removal
2009:	Cholecystectomy
03/8/2016:	Hip surgery for broken hip
2016:	Spinal stenosis

Surgery (after subsequent injury)
None

Mental Health History (before and after subsequent injury):

In 2000, she had a nervous breakdown when her mother was diagnosed with bladder cancer. She collapsed at work, received psychological counseling (duration unrecalled) and was off work for three months. She has never taken medication for psychological problems. She never had thoughts of suicide, attempted suicide, or tried to hurt herself before the subsequent injury.

According to a Deposition by the examinee dated 06/04/18, Ms. Clarke was seeking psychological counseling the previous month from Dr. Sylvia through SCAN recommended by Dr. Bilan. Ativan was prescribed by a nurse practitioner, Cathy. Ativan made her drowsy, but calmed her down to sleep.

She began to feel depressed and had thoughts of suicide in April 2018. She developed psychological symptoms after the subsequent injury because the way she was terminated from her job bothered her and still bothers her. She was devastated. She still sometimes has thoughts of suicide and a month ago she told her daughter she wished she was dead. Her daughter got mad at her. She would not kill herself, because she has a lot to live for. She denied having current suicidal thoughts. She has not received psychological treatment for the subsequent injury. She never had any psychiatric hospitalizations.

She is currently depressed, but has not had a depressed mood most days over the past two weeks. Since the start of her depression, she has not felt depressed for a period of two or more months straight. Her depression was due to the loss of her son, her chronic pain, and losing her job. Her pain was "bad" and she was unable walk by herself. Losing her job still bothers her, because she loved to work. She reported, "I keep everything in. I can't let it go." Not having a job made her feel bored. She reads the Bible. She used to do crossword puzzles when bored. She lives at a senior community and nobody goes outside due to COVID-19. It is "hard for her to get out of bed" due to pain and depression. She loved "fixing herself up," doing her hair and makeup for work, but does not want to anymore. She sometimes does not feel like taking a walk. She stated she should

"see nature" and talk to people. She denied ever having any auditory or visual hallucinations. She currently has anxiety and intrusive thoughts about her son's suicide and her fall injury. She has disturbing memories of her son's death every day. She had dreams of her fall, but not recurrent distressing dreams or nightmares of her son's death. Her son's urn was in her bedroom and when she lied down at night, she thought of her son because he used to come over to spend the night and slept on the couch.

According to a medical record by Psychological PQME Dr. Jeffery Coker, PsyD. dated 09/14/18, Ms. Clarke reported experiencing ongoing, depressed moods since her reported injuries at CVS Pharmacy. She endorsed diminished interest or pleasure in most activities, reduced appetite most of the time, psychomotor slowing or retardation, fatigue or loss of energy occurring nearly every day, feeling worthlessness, insomnia, difficulty falling and staying asleep (averaging 4-5 hrs per night, prior injury she slept for 7-8 hrs/night), diminished ability to think or concentrate, indecisiveness, ongoing crying or tearfulness episodes, and concerning suicidal ideations or suicide attempts. She had suicidal thoughts following her manager telling her she was being let go and after her sister drove her home, she attempted to walk into traffic with the intention of getting hit by a car. She denied having any other suicidal episodes.

She also reported developing significant anxiety following the subsequent injury, degree of worrying had been difficult to control, feelings of jitteriness, frequent panic attacks, panic episodes a couple of times a day, included feeling of intense fear as well as palpitations, sweating, trembling or shaking, chest pain, nausea or abdominal distress, dizziness or light headedness, derealization, fear of losing control, fear of going crazy, fear of dying, numbness and tenderness in her hands, and chills or hot flashes. She endorsed recurrent, bad memories of the injury. She had intense bodily tension and psychological stress when exposed to cues related to her work difficulties; noted it occurred when she would see a television commercial for CVS or see the CVS Pharmacy when inside a Target store. Additionally, she endorsed ongoing feelings of detachment or estrangement from others following her injuries. She reported becoming irritable much more easily, endorsed developing an exaggerated startle response, and had chronic stomach distress. When questioned about significant depressive episodes prior to her reported injuries at CVS, she noted she was depressed around the time her parents died. Both of her parents reportedly died in 2005 from cancer. She stated she is no longer depressed due to their deaths.

Regarding any significant periods of anxiety prior to her reported injuries, she noted she experienced anxiety "when my mom was diagnosed with cancer in 2000." Concerning previous psychiatric treatment, she indicated she was prescribed Valium and Prozac around the time her mother was diagnosed with cancer. She noted, regarding Prozac, "l took the pill and felt terrible, so I didn't accept any others." Regarding individual or group psychotherapy or counseling prior to her reported injuries, she reportedly took a class on codependency weekly for a year. She noted the classes were helpful. The following are her diagnoses: Axis I: 1) major depressive disorder, recurrent, moderate. 2) generalized anxiety disorder. 3) panic disorder. Axis II: Deferred. Axis III: Physical ailments. Axis IV: Occupational problems. Axis V: GAF - 48. Recommendations: Advised to enter into weekly psychotherapy for 4-6 months. She should receive psychoeducation

concerning depression, anxiety, panic, and stress management. Continued psycho-pharmacotherapy from a psychiatrist for her symptoms of depression and anxiety. Disability: Temporary Disability. Ms. Clarke had partial temporary disability on a psychiatric basis. She was unable to perform usual and customary work duties.

Substance Abuse History (before and after subsequent injury):

Before the subsequent injury, Ms. Clarke did not smoke cigarettes, drink alcohol, use marijuana or use other drugs. After the subsequent injury, she has not smoked cigarettes, drink alcohol, use marijuana or other drugs. She has never been treated for substance abuse.

Legal History:

She has never been arrested or incarcerated. She filed a personal injury claim/civil lawsuit in 2016 against the apartment complex where she fell. Prior to this current workers' compensation claim, she had no workers' compensation claims.

History of Crisis or Abuse:

Ms. Clarke notes beginning at age 32 she was in an abusive relationship for two years, but it did not interfere with her work and she never saw a psychiatrist/psychologist. She "just put up with it." She has never been the victim of sexual assault as an adult. She has never experienced a traumatic natural disaster.

When she was 69 years old, her 42-year old son committed suicide by jumping off the I-15 freeway. The police were after him and he did not want to go to jail. His death still affects her. She misses her son. They were close and "had fun together." She has not worked since her son's death, because her manager Erin "let her go and had no right to terminate her."

BEFORE the LAST Work Injury (also known as Subsequent Injury), Ms. Clarke did not have difficulty in any areas of functioning; such as self-care, communication, physical activity, sensory function, household activity, travel, sexual function, and sleep function.

Self-care and Personal Hygiene BEFORE the Subsequent Injury		✓	**No Difficulties**
	Urinating		Trimming toe nails
	Defecating		Dressing
	Wiping after defecating		Putting on socks, shoes, and pants
	Brushing teeth with spine bent forward		Putting on shirt/blouse
	Bathing		Combing hair
	Washing hair		Eating
	Washing back		Drinking
	Washing feet/toes		Shopping

Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Communication BEFORE the Subsequent Injury		✓	**No Difficulties**
	Speaking/talking		Writing
	Hearing		Texting
	Seeing		Keyboarding
	Reading (including learning problems, vision, or attention deficits)		Using a mouse
	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Physical Activity BEFORE the Subsequent Injury		✓	**No Difficulties**
	Walking		Sitting
	Standing		Kneeling
	Pulling		Climbing stairs or ladders
	Squatting		Shoulder level or overhead work
	Bending or twisting at the waist		Lifting and carrying
	Bending or twisting at the neck		Using the right or left hand
	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Sensory Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Smelling		Feeling
	Hearing		Tasting
	Seeing		Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Household Activity BEFORE the Subsequent Injury		✓	**No Difficulties**
	Chopping or cutting food		Mopping or sweeping
	Opening jars		Vacuuming
	Cooking		Yard work
	Washing and putting dishes away		Dusting
	Opening doors		Making beds
	Scrubbing		Doing the laundry

	Repetitive use of the right hand		Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Travel BEFORE the Subsequent Injury		✓	**No Difficulties**
	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?	
	Driving	If you have trouble driving, approximately how long can you drive before needing to rest?	
	Handling/lifting luggage	Approximately how many times per year do you travel BEFORE the Subsequent Injury?	
	Keeping arms elevated (right)		Holding or squeezing the steering wheel
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Sexual Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Erection		Painful sex (in the genital area)
	Orgasm		Back pain with intimate relations
	Lubrication		Neck pain with intimate relations
	Lack of desire		Joint pain with intimate relations
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Sleep Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Falling asleep		Sleeping on the right side
	Staying asleep		Sleeping on the left side
	Interrupted/restless sleep		Sleeping on the back
	Sleeping too much		Sleeping on the stomach
	Daytime fatigue or sleepiness	Did you ever taken any medications to help you sleep BEFORE the Subsequent Injury?	
How many hours could you typically sleep at a time without waking up during the night?		How many hours total were you able to sleep at night?	

If you indicated difficulties in this area, please describe how these difficulties make you feel:

Description of Pre-Existing Injury(ies):

Childhood:	Felt sad due to father's verbal abuse
Adolescent years:	Father beat her a couple times with a belt
Unknown:	Married to first husband for 13 years
1972-1973:	Cashier at Savon and quitted due to pregnancy, did not work for three years after
1975 (Age 26):	Birth of son (five pregnancies, three miscarriages)
1975:	Received EDD benefits for six months
1978-1980:	Cashier at Thrifty and quitted to return to Savon
1981:	In an abusive relationship for two years
1980-1986:	Stocker at Savon, quitted due to pregnancy
1982:	Divorced first husband due to his infidelity
1986:	Birth of daughter
1989-2004:	Cashier at Savon and quitted to take care of her parents
1994:	Second husband divorced her after eight years of marriage
1997/1998:	Injury to the neck and back
1999:	Menopause at age 50
2000:	Nervous breakdown due to mother's diagnosis of bladder cancer, collapsed at work
2000:	Off work for three months and received psychological counseling
2004:	Pinched nerve in her neck and was disabled
2004:	No intimate relationship since then, feeling lonely
2005:	Mother died from bladder cancer
March 2016:	Injury, left hip broken at CVS
2016:	Off work for 14 months due to work injury
2017:	Returned to CVS after time off work
2006-2018:	Cashier at Savon and managed by manager, Erin
2016:	Personal injury claim against an apartment complex where she fell
Unknown:	Received SSDI benefits
Unknown:	Prior work injury, injury to the back and neck

Periods of TTD from Pre-Existing:
Unknown

Pre-existing Psych Symptoms:
Major depressive disorder

PRE-EXISTING PSYCHIATRIC DIAGNOSES

AXIS I: **EPISODE OF MENTAL/CLINICAL DISORDER**
Major Depressive Disorder, Recurrent, Mild (296.3)

AXIS II: **PERSONALITY DISORDER**
No Diagnosis (V71.09)

AXIS III: **PHYSICAL DISORDERS AND CONDITIONS**
Status per the review of the medical records above.

AXIS IV: **SEVERITY OF PSYCHOSOCIAL STRESSORS**
Mild

(1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(2) Non-Industrial and concurrent stressful issues were identified and these include: abused as a child by father, two divorces, personal injury, death of parents

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - _66__

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF PRE-EXISTING DISABILITY RATING

Although Ms. Clarke experienced symptoms of depression prior to the subsequent injuries, she did not have impairment of her functional abilities. I conclude Ms. Clarke did not experience moderate work limiting impairments on a psychological basis prior to the subsequent industrial injuries.

Based on this clinical picture and the impact on her functioning, it is my opinion Ms. Clarke met criteria for Major Depressive Disorder. Additionally, her GAF score was 66 - which is equivalent to a WPI of 6%. This GAF falls into the 61-70 decile, which is described by the 2004 Permanent Disability Rating Schedule as follows:

Some mild symptoms (e.g., depressed mood and mild insomnia) *or* some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

It is my opinion Ms. Clarke had no disorder that impacted her occupational functioning causing pre-existing labor disablement.

There were no pre-existing restrictions prior to her subsequent industrial injuries.

SUBSEQUENT INDUSTRIAL INJURY

History of Subsequent Injury:

What follows is a narrative of Ms. Clarke's subsequent injuries, the resulting psychiatric disability, and existing work restrictions. Ms. Clarke worked at CVS Pharmacy beginning 2006-2018 and last worked in 2018. Ms. Clarke injured herself on CT: May 5, 2017- April 4, 2018 and CT: June 1, 2017- March 25, 2018 while employed as a Cashier at CVS Pharmacy. She sustained stress/psychological related type injuries; stress and depression due to repetitive movement for the CT: May 5, 2017- April 4, 2018 injury and stress, depression, and anxiety due to discrimination based on age and disability for the CT: June 1, 2017- March 25, 2018 injury.

After Ms. Clarke was injured from previous work injuries, she used a walker to ambulate and was given restrictions by her doctor and HR (human resource) agreed to the restrictions. Her manager Erin Black was very pushy, demanding, and not friendly. Erin told her to work faster so they would not have to call a second cashier. Erin would say to her coworker that Ms. Clarke could not clean the bathroom or do anything. Her coworker would ask Erin if she saw her with a walker. Erin never greeted her. Erin did not like her since day one. When she would clean the counters, Erin would say "she was worthless." She was not allowed to sit. Erin said she was really not working. Erin was mean to her, the other workers, and to customers. Erin reduced her hours significantly down to 8-12 hours and even to two hours per week. She had to beg Erin for more hours. She thought maybe Erin was embarrassed to have an employee who used a walker, but her customers loved Ms. Clarke. She would shake due to pain and customers would ask her if she was okay. She did not make mistakes at work. She focused on her duties and the customers. Erin made her feel very nervous at work. After work, she went home and cried. Ms. Clarke did not want to be around Erin, but she wanted to work until she was 80 years old. Erin verbally terminated her in front of everyone and deliberately embarrassed her. Her coworkers looked down toward the ground when Erin fired her. She wanted to commit suicide after Erin terminated her and in 2018. She almost stepped in front of a car "so it would run over her."

Ms. Clarke's treatment consisted of physical therapy for her low back, hip, and legs. She also received chiropractic treatment. She has not received surgery for her subsequent injuries.

According to a medical record by Dr. Clay Thomas dated 11/20/18, Ms. Clarke sustained work-related injuries on a CT basis during the course of her employment for CVS Caremark Corporation as a Cashier. She continued with pain in her neck, mid thoracic, LBP and L hip. She also had stomach pain. Her condition was worse after performing work duties. Her condition became worse

after a new manager would not adhere to her work modifications that included standing no longer than 50% of the time and bending at the waist no longer than 25% of her shift.

According to a medical record by QME Supplemental Report by Dr. Kesho Hurria, M.D. dated 01/31/19, under apportionment, Ms. Clarke's treating chiropractor Dr. Thomas, on 11/20/18, apportioned 10% of her L/S disability to an altercation with her son, resulted in broken L3 vertebrae. On 04/04/18, she described having "stress, depression, and anxiety due to discrimination based on age and disability" from 06/01/17 to 03/25/18. Her symptoms at the time included experiencing ongoing depressed moods since her reported injuries. Her emotional state was considered to be moderate-to-severe clinical range at the time.

MENTAL STATUS EVALUATION

General Appearance
Ms. Clarke is a 71-year-old single Caucasian female who is 5'1.5" tall and weighs 112 pounds. She appeared to look her stated age and presented with acceptable personal hygiene. She has gray hair and wore a face mask. She was dressed casual in a sweater type garment, wearing a gray sweater wrapped around a gray shirt and blue pants.

Manner of Relating
Ms. Clarke related in reasonably open, self-disclosing fashion and generally waited for me to ask questions rather than talk about her issues freely. She demonstrated no difficulty maintaining eye contact. I did not sense any sign of defensiveness or evasiveness. She was amiable and amenable to answering all of my questions. Ms. Clarke related in an irritable manner regarding her manager and former husbands. She became teary eyed when disclosing information about her termination and son's death. She was cooperative with the evaluation process and completed the psychosocial questionnaires with relevant detail.

Psychomotor Activities
Ms. Clarke walked slowly from the waiting room to my office. She used a walker for ambulation. When she sat down, she did so gingerly and in a rigid manner. She stood up one time midway through the interview to relieve the pain in her buttocks and hips and grimaced in pain.

Speech and Language
Ms. Clarke spoke at a high range volume; her speech rate was normal, with normal articulation. The examinee was lucid and linguistically coherent. Her ability to communicate was normal and her use of vocabulary and pronunciation was adequate given her level of experience and education. Slang or profanity was not used in conversation.

Orientation and Thought Content
Ms. Clarke appeared to be functioning at an average intellectual level, with a fund of knowledge appropriate for her age, educational level, and life experiences. She showed appropriate judgment and average abstract reasoning. Orientation in all spheres was intact. Ability to concentrate was

impaired. Long-term memory was intact. Her short-term memory was impaired. Ms. Clarke denied ever having auditory or visual hallucinations, bizarre sensory experiences, heightened tactile sensitivities, or other gross perceptual disturbances. Her thought processes did not show any signs of psychotic functioning. She did not express any paranoia, ideas of references, or admits to any delusionary beliefs. In general, she seemed rational and coherent, with no perceptual oddities observed.

Emotional Process
Her emotional expression was most noteworthy for her tearful affect indicative of her underlying significant depressed state.

Impulse Control
Ms. Clarke reported the presence of passive suicidal ideations one month ago where she sometimes wishes she was dead. However, she denied having any current suicidal ideations and any active plan or intent to harm herself at this time. She also showed no propensity towards aggressive behavior.

PSYCHOLOGICAL TESTS ADMINISTERED AND RESULTS

- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Epworth Sleepiness Scale (ESS)
- Hamilton Rating Scale for Depression (HAM-D)
- Hamilton Anxiety Rating Scale (HAM-A)
- Montreal Cognitive Assessment (MOCA)
- Pain Catastrophizing Scale (PCS)
- Pain Drawing (PD)
- A.M.A. Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 18

BECK DEPRESSION INVENTORY-II (BDI-II)

The BDI-II is one of the most widely used screening tests for depression. It is an easily scored test consisting of 21 items that are rated on a 4-point Likert scale ranging from 0 to 3. The maximum total score is 63. The test requires the examinee to rate himself across a wide range of common depressive symptoms including sadness, loss of pleasure, guilt, indecisiveness, changes in sleep patterns, fatigue, etc. The BDI-II items are consonant with the DSM-IV criteria for depressive based diagnoses. The cut off scoring criteria for the BDI-II is as follows:

TOTAL SCORE	RANGE
0-13	No or minimal depression
14-19	Mild depression

20-28	Moderate depression
29-63	Severe depression
Below 4	Possible denial of depression, faking good; lower than usual scores even for normal

On the Beck Depression Inventory, Ms. Clarke obtained a score of 16, thereby placing her in the mild range of clinical depression. In examining her overall pattern of symptoms, the examinee's responses appear to emphasize both affective and cognitive symptoms of depression. In terms of suicide potential, there is likely to be low concern with suicidal potential as she admitted having passive thoughts of suicide a month ago.

It is also important to note that the BDI results are not consistent with her interview demeanor.

BECK ANXIETY INVENTORY (BAI)

The Beck Anxiety Inventory (BAI) is a 21-item test that measures the severity of self-reported anxiety. The BAI requires the examinee to rate a set of symptoms across a 4-point Likert scale from 0-3. The maximum BAI score is 63. The cutoff scoring criteria for the BAI is as follows:

TOTAL SCORE	RANGE
0-7	Minimal anxiety
8-15	Mild anxiety
16-25	Moderate anxiety
26-63	Severe anxiety

The examinee obtained a total score of 16, which is suggestive of a moderate anxious state. It is also important to note that the BAI results are consistent with her interview demeanor.

EPWORTH SLEEPINESS SCALE (ESS)

The Epworth Sleepiness Scale (ESS) is a short test, recently developed at the Epworth Hospital in Australia that measures excessive daytime sleepiness. The ESS is an acceptable and well-regarded alternative for a time-consuming and expensive laboratory testing procedure. The ESS is a subjective, self-report instrument that describes eight different situations and four possible answers for each situation. Various authors have assigned differing cutoff scores to determine excessive daytime sleepiness. At the present time, there are no national norms available for the ESS. However, this instrument is likely the most widely used test for sleepiness.

The AME Guides define four sages of sleep-related impairment (pages 31 7-318). The ESS is an instrument that the clinician can utilize to assess sleep impairment vis-à-vis the effect of sleepiness upon alertness. However; it should be realized that the score obtained on the ESS is not norm-based and must be only used as general guide to assessing sleepiness or decreased alertness. An average score is probably 7-8. A score of more than 10 indicates the probable need for professional

assistance. Sleep Apnea examinees score from 11.7 (CPAP) to 16 (no CPAP), Narcolepsy examinees score about 7.5. The maximum possible score on the ESS is 24.

John, MW. (1991) A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. 1991

Scale
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situations	**Score**
Sitting & Reading	
Looking at TV	1
Sitting inactive in a public place	2
When a passenger in a car for 1 hour with no breaks	1
Lying down to rest in the afternoon	1
Sitting & talking to someone	0
Sitting quietly after lunch with no alcohol	1
In a car while stopped for a few minutes in traffic	0

Total Score = _6_

The examinee received a score of _6, reflecting that she is not excessively sleepy in the daytime.

Prior to the subsequent injury, it took her 30 minutes to fall asleep and she slept for 7-8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries, it takes her 1-2 hours to fall asleep and she sleeps for 4-6 hours each night. She does not wake up at night. She reported her sleep is "lousy."

HAMILTON DEPRESSION RATING SCALE (HAM-D)

The test was developed by Dr. Hamilton and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms – such as sleep, appetite, and sexual disturbance – in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms.

The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

TOTAL SCORE	RANGE
0 – 7	None/Minimal Depression
8 – 13	Mild
14 – 18	Moderate
19 - 22	Severe
23+	Very Severe

On the HAM-D, Ms. Clarke obtained a score of 32, thereby placing her in the very severe range of clinical depression.

It is important to note that the HAM-D results are consistent with her interview demeanor. She reported having depression in which she has suicidal thoughts.

HAMILTON ANXIETY RATING SCALE (HAM-A)

The **Hamilton Anxiety Rating Scale** (**HAM-A**) is a psychological questionnaire used by clinicians to rate the severity of a patient's anxiety. The scale consists of 14 items designed to assess the severity of a patient's anxiety. Each of the 14 items contains a number of symptoms, and each group of symptoms is rated on a scale of zero to four, with four being the most severe. All of these scores are used to compute an overarching score that indicates a person's anxiety severity. The scale is intended for adults, adolescents, and children.

Each item is scored independently based on a five-point, ratio scale. A rating of 0 indicates that the feeling is not present in the patient. A rating of 1 indicates mild prevalence of the feeling in the patient. A rating of 2 indicates moderate prevalence of the feeling in the patient. A rating of 3 indicates severe prevalence of the feeling in the patient. A rating of 4 indicates a very severe prevalence of the feeling in the patient. To implement the Hamilton Anxiety Rating Scale, the clinician proceeds through the fourteen items, evaluating each criterion independently in form of the five-point scale described above.

Upon the completion of the evaluation, the clinician compiles a total, composite score based upon the summation of each of the 14 individually rated items. This calculation will yield a comprehensive score in the range of 0 to 56.

TOTAL SCORE	RANGE
0 – 7	None/Minimal Anxiety
8 – 17	Mild

18 – 24	Moderate
25+	Severe

The examinee obtained a total score of 27, which is suggestive of a severe anxious state.

MONTREAL COGNITIVE ASSESSMENT (MoCA)

The Montreal Cognitive Assessment, MoCA, was created in 1996 (Copyright Z. Nasreddine MD). It was validated by: Ziad S. Nasreddine, Natalie A. Phillips, Valerie Bedirian, Simon Charbonneau, Victor Whitehead, Isabelle Collin, Jeffrey L. Cummings and Howard Chertkow, The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool for Mild Cognitive Impairment. J Am Geriatr Soc, 2005, 53:695-9. The MoCA test is a one-page 30-point test administered in 10 minutes. The test and administration instructions are freely accessible for clinicians at **www.mocatest.org**. The test is available in 34 languages or dialects. There are 3 alternate forms in English, designed for use in longitudinal settings.

The MoCA assesses several cognitive domains. The short-term memory recall task (5 points) involves two learning trials of five nouns and delayed recall after approximately 5 minutes. Visuospatial abilities are assessed using a clock-drawing task (3 points) and a three-dimensional cube copy (1 point). Multiple aspects of executive functions are assessed using an alternation task adapted from the trail-making B task (1 point), a phonemic fluency task (1 point), and a two-item verbal abstraction task (2 points). Attention, concentration and working memory are evaluated using a sustained attention task (target detection using tapping; 1 point), a serial subtraction task. (3 points), and digits forward and backward (1 point each). Language is assessed using a three-item confrontation naming task with low-familiarity animals (lion, camel, rhinoceros; 3 points), repetition of two syntactically complex sentences (2 points), and the aforementioned fluency task.

MOCA SCORES			
	Normal Controls (NC)	**Mild Cognitive Impairment (MCI)**	**Alzheimer's Disease (AD)**
Number of Subjects	90	94	93
MoCA Average Score	27.4	22.1	16.2
MoCA Standard Deviation	2.2	3.1	4.8
MoCA score range	25.2 - 29.6	19.0 – 25.2	21.0 – 11.4
Suggested cut-off score	≥26	<26	<26ψ
Although the average MoCA score for the AD group is much lower that the MCI group, there is overlap between them. The suggested MoCA cut-off score is thus the same for			

both. The distinction between AD and MCI is mostly dependent on the presence of associated functional impairment and not on a specific score on the MoCA test.

(MOCA Score is below 27;
Slight Behavioral Processing Difficulties Observed)

The MOCA has a maximum score of 30. A score of 26 or greater is considered normal. The examinee's cognitive performance on the MOCA was below the cut off score of 27. She received a total score of **25**. This finding suggests that there may very well be slight cognitive deficits that are interfering with her is ability to sustain concentration, attend to task, and retain information. In examining her MOCA performance, the following cognitive processing areas showed the greatest deficits.

1. **Visuospatial/executive** skills are assessed using a clock-drawing task, trail-making B task, and copying the three-dimensional cube task. Visuospatial/executive skills revealed deficits in executive functions in trail-making B and copying the three-dimensional cube tasks. She received a score of **3** out of 5 for the Visuospatial/executive domain.

2. **Attention** was noted to be strained as she was unable to repeat 3 digits backwards. She received a score of **1** out of 2.

3. **Abstraction** abilities were assessed to be poor as he had difficulty in comprehending how discrete items could be alike. This finding could infer a difficulty in complex problem solving abilities. She received a score of **1** out of 2.

4. **Delayed Recall (Short-term memory recall)** was weak as evidenced by the fact that she could only recall **4** items out of 5 items (e.g. face, velvet, etc.) after a five-minute time delay.

PAIN CATASTROPHIZING SCALE (PCS)

Pain catastrophizing is characterized by the tendency to magnify the threat value of a pain stimulus and to feel helpless in the presence of pain, as well as by a relative inability to prevent or inhibit pain-related thoughts in anticipation of, during, or following a painful event (Quartana, Campbell, & Edwards, 2009). Pain catastrophizing affects how individuals experience pain. Sullivan et al. (1995) state that people who catastrophize tend to do three things, all of which are measured by the PCS questionnaire; They ruminate about their pain (e.g. "I can't stop thinking about how much it hurts"), they magnify their pain (e.g. "I'm afraid that something serious might happen"), and they feel helpless to manage their pain (e.g. "There is nothing I can do to reduce the intensity of my pain").

Further, it is becoming increasingly clear that catastrophic thinking in relation to pain is a risk factor for chronicity and disability. In other words, catastrophizing not only contributes to

heightened levels of pain and emotional distress, but also increases the probability that the pain condition will persist over an extended period of time. As such, this measure is helpful for examining the current thinking and coping process as it relates to the current physical state, and quantifying an individual's pain experience, as well as providing information related to future adjustment and recovery. The available research shows that a PCS raw score of 30 (which falls at the 75th percentile in clinical samples at chronic pain treatment centers) when coupled with a Beck Depression score greater than 16, predicts that more than 70% of these patients will be totally disabled from working a year following the date of injury. Thus, a raw score of 30 will be considered clinically significant in this analysis.

Ms. Clarke received a raw score of <u>41</u> that reflects a nearly constant state of catastrophizing related to her pain condition.

<u>PAIN DRAWING (PD)</u>

The Pain Drawing (PD) is a pictorial representation of the human body on which examinees can indicate graphically where and how pain is affecting them. The PD is comprised of two images representing the front and back of the body respectively. A total pain score is calculated based on the extent of pain indicated on the diagrams. This score is useful both as a positive measure and as a guide for future treatment.

Scoring System for Pain Drawings

Unreal drawings. If one or more of the following pain localizations are drawn in, two points are assigned.

A. Total leg pain
B. Frontal aspect of one or both legs
C. Unilateral or bilateral anterior tibial pain
D. Back of leg (isolated, knee included)
E. Circumferential thigh pain

Drawings showing "expansion" or "magnification' of pain (one or two points per area, depending upon extent)

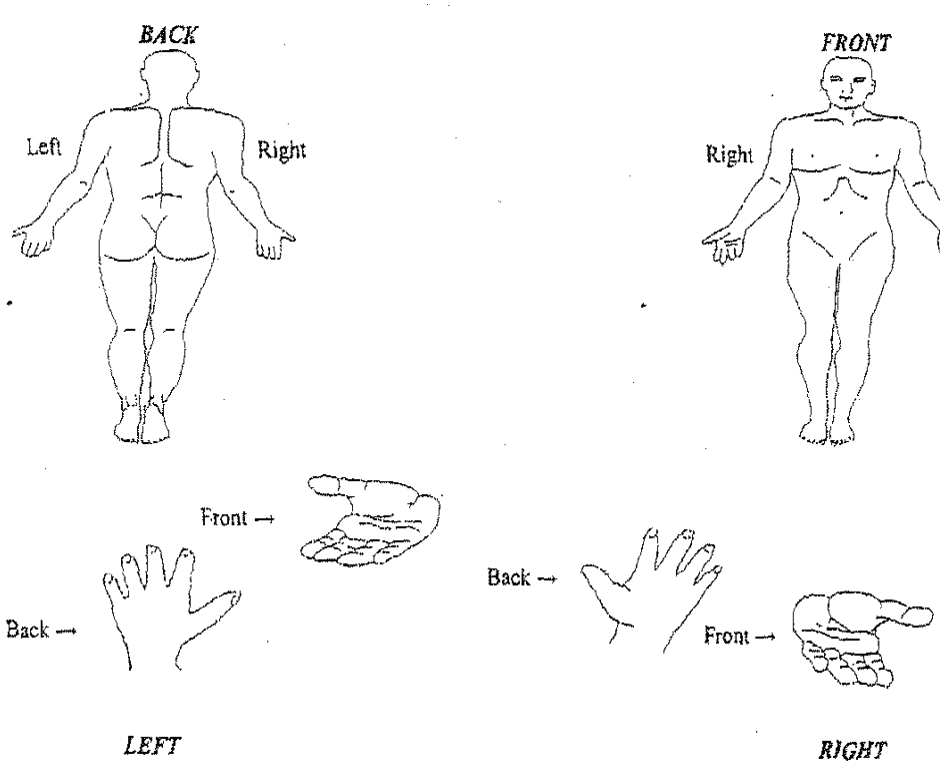
A. Pain drawn outside the outline as an indication of magnification.
"I particularly hurt here" indicators (each category scores one point).

1. *Additional explanatory notes*
2. *Circle painful areas*
3. *Draw lines to demarcate painful areas.*

D. Use arrows to describe anatomically not explainable pain. Use additional symbols.

With this rating system, a score of three or more is generally thought to represent a pain perception that may be influenced by psychological factors. Some of the readily apparent expressions of psychological distress include pain distributions that are non-anatomic or bizarre, drawings showing "magnification" or 'expansion" of symptoms, and drawings that demonstrate "look how bad I am indicators."

In reviewing the examinee's pain drawing, she has pain and numbness on the left side of the neck radiating down the left arm to the hand, pain in the center of the low back that radiates down the buttocks and to the back of both thighs, and burning pain in both knees.



On the front portion of this form, Ms. Clarke marked numbness in the left side of her neck, left arm, and left hand, and marked burning pain in both knees. On the back portion of this form, she marked radiating pain from her lower back to her bilateral thighs. In the last two months, the pain has fluctuated but overall has stayed the same.

It should be noted that the examinee's pain drawing was consistent with his report of somatic health concerns. This consistency provides additional validation for my assessment that I find her to be a credible historian.

A.M.A. GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 5TH EDITION, CHAPTER 18

TABLE 18-4, PAGE 576

I. Pain (Self-Report of Severity) Grey areas are what applicant circled

A. Rate how severe your pain is **right now, at this moment**

0	1	2	3	4	5	6	7	8	9	10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst**

0	1	2	3	4	5	6	7	8	9	10

None — Excruciating

C. Rate how severe your pain is **on the average**

0	1	2	3	4	5	6	7	8	9	10

None — Excruciating

D. Rate how much your pain is **aggravated by activity**

0	1	2	3	4	5	6	7	8	9	10

Activity does not aggravate pain — Excruciating following any activity

E. Rate how **frequently** you experience pain

0	1	2	3	4	5	6	7	8	9	10

Rarely — All of the time

II. Activity Limitation of Interference

A. How much does your pain interfere with your ability to **walk 1 block**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of grocery)?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to sit for ½ hour — Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to **stand for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with my daily activities — Completely interferes with with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse**?

0	1	2	3	4	5	6	7	8	9	10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely unable to do

any jobs around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Pain makes it impossible to at all shower or bathe without help

M. How much does your pain interfere with your ability to **write or type**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? **Not applicable**

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to engage in sex

P. How much does your pain interfere with your ability to **concentrate**?

0	1	2	3	4	5	6	7	8	9	10

Never — All the time

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week

0	1	2	3	4	5	6	7	8	9	10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

C. During the past week, how **depressed** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

D. During the past week, how **irritable** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all Extremely

E. In general, how anxious/worried are you about performing activities because they **might make your pain symptoms worse**?

0	1	2	3	4	5	6	7	8	9	10

Not at all Extremely

RELIABILITY AND CREDIBILITY

After a careful review of the above information, it is the undersigned's professional opinion that Ms. Clarke is a candid and generally credible historian who is not exaggerating her symptoms for secondary gain. I have factored in her self-reporting style of both over and under reporting of symptoms into my conceptualization of her diagnoses and level of impairment.

Ms. Clarke's account of her injury corroborated with the narrative of the injury outlined in the medical records.

Ms. Clarke's account of how her is psyche and functions of daily living were impacted by her orthopedic injuries were reasonable. She was able to coherently address how the combination of depression and anxiety negatively affected her mood, cognition, and behavior.

During today's evaluation, I paid close attention to Ms. Clarke's self-report of emotional pain and her non-verbal behavior. Generally speaking, if an individual complains of significant depression and anxiety, one would expect to see this manifested, to some degree in her body language during the examination. This observation practice represents one way of assessing an examinee's reliability, as emotional pain cannot be objectively measured. During today's interview, I observed the following relevant information pertaining to Ms. Clarke's pain behavior:

- ✓ She stood up at one point to relieve the pain in her hips and buttocks
- ✓ She cried when speaking of her injury and death of son

And finally, I turn to an analysis of the psychometric findings to gauge Ms. Clarke's reliability and validity.

The psychological test results showed an inconsistent elevation across multiple tests measuring depression and anxiety. She scored mild depression on the BDI and very severe depression on the HAM-D. She scored moderate anxiety on the BAI and severe anxiety on the HAM-A.

After a careful review of the above information, it is the undersigned's professional opinion that Ms. Clarke is a candid historian who is not exaggerating her symptoms for secondary gain. There is no psychological test data to support the phenomenon of pain amplification. There is no scientific basis to suggest that the examinee is consciously feigning malingering symptoms. She

self-disclosed appropriately during the evaluation process and I did not sense that she was minimizing personal problems existing before or after the discussed industrial injury.

SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

AXIS I: EPISODE OF MENTAL/CLINICAL DISORDER
Major Depressive Disorder, Recurrent, Severe (296.3)
Generalized Anxiety Disorder, Moderate (300.02)
Panic Disorder Without Agoraphobia (300.01)
Unspecified Trauma-and Stressor-Related Disorder (309.9)
Bereavement (V62.82)
Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89)
Sleep Disorder Due to a General Medical Condition, Insomnia Type (327.01)

AXIS II: PERSONALITY DISORDER
No Diagnosis (V71.09)

AXIS III: PHYSICAL DISORDERS AND CONDITIONS
Status per the review of the medical records above.

AXIS IV: SEVERITY OF PSYCHOSOCIAL STRESSORS
Severe

(3) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(4) Non-Industrial and concurrent stressful issues were identified and these include: Grieving over son's death and passive suicidal thoughts.

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF)
Current - 50

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

Major Depressive Disorder

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as a mood disorder. According to the DSM 5, the essential features of Major Depressive Disorder (MDD) include a total of nine (9) symptoms, of which a examinee must endorse at least five (5). Additionally, these symptoms must persist for a two-week period and represent a change from their previous level of functioning. Following her injury, Ms. Clarke reported the following symptoms:

- "I have ongoing, depressed mood, diminished interest or pleasure in most activities, a reduced appetite most of the time, psychomotor slowing or retardation, and suicidal thoughts a month ago."

Generalized Anxiety Disorder

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Generalized Anxiety Disorder include a total of six (6) symptoms, of which a examinee must endorse at least three (3). Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning. Following her injury, Ms. Clarke reported the following symptoms:

- "My worrying has been difficult to control and I have feelings of jitteriness. I worry too much."

Panic Disorder without Agoraphobia

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Panic Disorder without Agoraphobia include recurrent unexpected panic attacks and an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes. A total of four (4) or more symptoms of the 13, must be met. Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning. Following her injury, Ms. Clarke reported the following symptoms:

- "I have frequent panic attacks, panic episodes a couple of times a day, including feelings of intense fear as well as palpitations, sweating, trembling or shaking, chest pain, nausea or abdominal distress, dizziness or light headedness, derealization, fear of losing control, fear of going crazy, fear of dying, numbness and tenderness in my hands and chills or hot flashes. I have persistent worry or concern about having additional panic attacks."

Unspecified Trauma-and Stressor-Related Disorder

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as a trauma- and stressor-related disorder. According to the DSM 5, the diagnostic

criteria for Unspecified Trauma- and Stressor-Related Disorder include symptoms characteristic of a trauma- and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the trauma- and stressor-related disorders diagnostic class. Following his injury, Ms. Clarke reported the following symptoms:

- "I have recurrent, bad memories of the injury. I get intense bodily tension and psychological stress when exposed to cues related to my work difficulties. It happens when I would see a television commercial for CVS or see the CVS Pharmacy when inside a Target store. Additionally, I have ongoing feelings of detachment or estrangement from others following my injuries. I am becoming irritable much more easily and have an exaggerated startle response."

Bereavement

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as an uncomplicated bereavement disorder. According to the DSM 5, this category can be used when the focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode- for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. Following her injury, Ms. Clarke reported the following symptoms:

- "I am still affected by my son's death. I think about my son a lot. I have frequent dreams of him. I miss him."

Sleep Disorder Due to a General Medical Condition, Insomnia Type

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as a sleep-wake disorder. The diagnosis of insomnia disorder is given whether it occurs as an independent condition or is comorbid with another mental disorder (e.g., major depressive disorder), medical condition (e.g., pain), or another sleep disorder (e.g., a breathing-related sleep disorder). According to the DSM 5, the essential features of Insomnia Disorder is dissatisfaction with sleep quantity or quality with complaints of difficulty initiating or maintaining sleep (individual receiving less than 5 ½ hours of sleep per night on average without medications), fatigue, difficulty falling asleep, and frequently interrupted sleep. These sleep disturbances have been persisting for more than one month. Following her injury, Ms. Clarke reported the following symptoms:

- "Prior to the subsequent injury, it took me 30 minutes to fall asleep and I slept for 7-8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries, it takes me 1-2 hours to fall asleep and I sleep for 4-6 hours each night. I do not wake up at night. My sleep is "lousy."

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

Taking into consideration the available information, Ms. Clarke's cluster of symptoms would best be categorized as a somatic symptom and related disorder. According to the DSM 5, the diagnostic criteria for Pain Disorder Associated with Both Psychological Factors and a General Medical Condition include pain symptoms that cause clinically significant distress or impairment. The psychological or behavioral factors are judged to have an important role in onset, severity, exacerbation, or maintenance of pain symptoms. Following her injury, Ms. Clarke reported the following symptoms:

- "I have pain in my body from repetitive work. I have not had surgery for the subsequent injuries."

SUBSEQUENT INJURY IMPAIRMENT RATING

ANALYSIS AND EXPLANATION OF MS. CLARKE'S PSYCHOLOGICAL IMPAIRMENT RATING

On page 365 of the AMA guides, Table 14-1 provides a guide for rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment. The following are recommended as anchors for the categories of the scale.

Area of Aspect of Functioning	Class 1 No Impairment	Class 2 Mild Impairment	Class 3 Moderate Impairment	Class 4 Marked Impairment	Class 5 Extreme Impairment
Activities of Daily Living			✓		
Social Functioning		✓			
Concentration		✓			
Adaptation		✓			

ACTIVITIES OF DAILY LIVING

SELF CARE/PERSONAL HYGIENE ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I neglect to bathe or shower.	Often	Sometimes	Never	Not Applicable
2. I neglect to brush my teeth.	Often	Sometimes	Never	Not Applicable
3. I have no interest in my appearance.	Often	Sometimes	Never	Not Applicable
4. I have no interest in shaving or putting on make-up.	Often	Sometimes	Never	Not Applicable
5. I have no interest in getting dressed on	Often	Sometimes	Never	Not Applicable

most days.				
6. I have problems sleeping at night because I can't stop thinking or worrying.	Often	Sometimes	Never	Not Applicable
7. I do not feel rested in the morning when it is time to get up.	Often	Sometimes	Never	Not Applicable
8. I feel sleepy during the daytime.	Often	Sometimes	Never	Not Applicable
9. I lack the desire to have sexual relations.	Often	Sometimes	Never	Not Applicable
10. I am physically unable to have sexual relations.	Often	Sometimes	Never	Not Applicable
11. I no longer have a desire to travel (e.g., road trips or by airplane).	Often	Sometimes	Never	Not Applicable

HOUSEHOLD ACTIVITIES	**LEVEL OF IMPAIRMENT**			
1. I can't prepare a meal by myself.	Often	Sometimes	Never	Not Applicable
2. I forget to turn off the stove or close the refrigerator.	Often	Sometimes	Never	Not Applicable
3. I can't seem to organize the house. Everything is messed up.	Often	Sometimes	Never	Not Applicable
4. I have no energy to clean my house.	Often	Sometimes	Never	Not Applicable
5. I can't focus and repair things that are broken in the home.	Often	Sometimes	Never	Not Applicable

SOCIAL FUNCTIONING

FAMILY AND SOCIAL ACTIVITIES	**LEVEL OF IMPAIRMENT**			
1. I lack the energy to take care of children or pets.	Often	Sometimes	Never	Not Applicable
2. I can't take care of the people at home that I used to do before my injury.	Often	Sometimes	Never	Not Applicable
3. I spend many days in my room and have no interest in talking to others.	Often	Sometimes	Never	Not Applicable
4. I can't seem to listen to others and understand what they are saying to me.	Often	Sometimes	Never	Not Applicable
5. I lack the cognitive stamina to be involved with friends or family.	Often	Sometimes	Never	Not Applicable
6. I don't get along well with others.	Often	Sometimes	Never	Not Applicable
7. I don't want to initiate contact with friends and family.	Often	Sometimes	Never	Not Applicable
8. I don't think I can accept criticism appropriately from others.	Often	Sometimes	Never	Not Applicable

RECREATIONAL ACTIVITIES	**LEVEL OF IMPAIRMENT**			
1. I have no ability to concentrate and do my normal hobbies (e.g., gardening, fishing, etc.).	Often	Sometimes	Never	Not Applicable
2. I have no interest in attending social gatherings, meetings, or church events.	Often	Sometimes	Never	Not Applicable
3. I do not trust my driving abilities.	Often	Sometimes	Never	Not Applicable
4. I cannot concentrate on completing art projects, doing music activities, or building projects.	Often	Sometimes	Never	Not Applicable
5. I could not muster the energy and concentration to play board games, cards, or video games.	Often	Sometimes	Never	Not Applicable

CONCENTRATION

MEDICAL ACTIVITIES	**LEVEL OF IMPAIRMENT**			
1. I forget to take my medications.	Often	Sometimes	Never	Not Applicable
2. I forget my doctor's appointments.	Often	Sometimes	Never	Not Applicable
3. I can't seem to remember what my doctors instruct me to do.	Often	Sometimes	Never	Not Applicable
4. I have no energy to do home-based physical therapy exercises.	Often	Sometimes	Never	Not Applicable
5. I lost important papers that doctor gives me or the insurance company sends me.	Often	Sometimes	Never	Not Applicable
6. I am unable to complete a project near others without being distracted.	Often	Sometimes	Never	Not Applicable
7. My day is interrupted by my psychological symptoms.	Often	Sometimes	Never	Not Applicable

MANAGING FINANCES AND PERSONAL ITEMS	**LEVEL OF IMPAIRMENT**			
1.I cannot manage a checkbook.	Often	Sometimes	Never	Not Applicable
2. I get confused when paying for items at a store.	Often	Sometimes	Never	Not Applicable
3. I lose my wallet or purse or cell phone.	Often	Sometimes	Never	Not Applicable
4. I lose my keys or forget where I parked my car.	Often	Sometimes	Never	Not Applicable
5. I misplace important financial papers or documents.	Often	Sometimes	Never	Not Applicable

ADAPTATION

COMMUNICATION ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I start to fall asleep if I read something for more than a few minutes.	Often	Sometimes	Never	Not Applicable
2. I lose interest when watching television and stop watching the show.	Often	Sometimes	Never	Not Applicable
3. I have lost interest in communicating with others by email or by phone.	Often	Sometimes	Never	Not Applicable
4. I have lost interest in reading the newspaper or watching the news on T.V.	Often	Sometimes	Never	Not Applicable
5. I have stopped attending normal events and communicating activities (e.g., church, social clubs, volunteer events, visiting relatives, etc.).	Often	Sometimes	Never	Not Applicable

EMOTIONAL AND OCCUPATIONAL FUNCTIONS	LEVEL OF IMPAIRMENT			
1. I feel that I would be able to perform any job I am qualified for without problems at this time.	Strongly Agree	Agree	Disagree	Strongly Disagree
2. I feel I would be able to interact with coworkers respectfully and without any problems on my part.	Strongly Agree	Agree	Disagree	Strongly Disagree
3. I don't have the psychological energy to multi-task.	Strongly Agree	Agree	Disagree	Strongly Disagree
4. I become emotionally overwhelmed when demands are placed upon me.	Strongly Agree	Agree	Disagree	Strongly Disagree
5. I am hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and respond in anger when these occur.	Strongly Agree	Agree	Disagree	Strongly Disagree
6. I have difficulty controlling my emotions and this causes problems when I interact with people.	Strongly Agree	Agree	Disagree	Strongly Disagree
7. I am not able to maintain a productive schedule where I complete the goals I set for my household, family, and work (if employed).	Strongly Agree	Agree	Disagree	Strongly Disagree

Comparison of Daily Life BEFORE and AFTER SUBSEQUENT INJURY

Normal life shortly BEFORE the final (SUBSEQUENT) industrial injury

Please describe what a typical **weekday** was like for you shortly **before** the injury.

1. What time did you wake up? **Between 6 am and 8 am**
2. How often would you take a shower or bath? **3 times a week**
3. How many hours a day did you work on average? **4 hours**
4. Did you participate in any exercise or sports team? **Yes, walking and stretching**
5. What types of activities did you do after you finished work? **Eat and watch movies**
6. What would you normally do for fun during the week? **Read and go for nature walks around apartment complex.**
7. What time did you typically go to bed during the week? **10 pm**

Please describe what a typical **weekend** was like for you shortly **before** the injury:

1. What time would you typically wake up on the weekend? **10 am**
2. What was a typical weekend day for you like? **Wake up and have breakfast**
3. What type of social activities was normal for you to do on the weekends? **Spend time with son going to Walmart, playing cards, and watching movies.**
4. If you were sexually active shortly before the injury, how often was it normal for you to engage in sexual activity? **Not applicable.**

Normal Life at this time (Currently)

Please describe what a typical **weekday** is like for you **at this time after** your injury:

1. What time do you typically wake up? **11 am**
2. How often do you take a shower or bath? **3 times a week**
3. How do you spend most of your weekdays? **Watching television, go walking, and visiting friend in apartment complex.**
4. Do you participate in any exercise or sports at this time? **Yes, walking.**
5. What time do you typically go to bed? **11 pm to 12 am**
6. What do you normally do for fun/socializing during the week? **Talk to my friends and text my sister and daughter.**

Please describe what a typical **weekend** is like for you **at this time after** your injury:

1. What time do you typically wake up? **11 am**
2. How do you spend a typical weekend day? **Study for zoom church meeting, go for walks, visit people outside, and read Bible.**
3. What type of social activities are you doing on the weekend at this time? **Sometimes go to my sister's house for a visit and see her dogs.**
4. Are you sexually active at this time? **No**
5. If you are not active, or less active, when did you notice this change? **2004**
6. What do you think caused this change? **Gave up men.**

AFTER or BECAUSE of the SUBSEQUENT INJURY, Ms. Clarke has difficulty in the following areas of functioning; such as self-care, communication, physical activity, sensory function, household activity, travel, sexual function, and sleep function.

Self-care and Personal Hygiene CURRENTLY		✓	**No Difficulties**
	Urinating		Trimming toe nails
	Defecating		Dressing
	Wiping after defecating		Putting on socks, shoes, and pants
	Brushing teeth with spine bent forward		Putting on shirt/blouse
	Bathing		Combing hair
	Washing hair		Eating
	Washing back		Drinking
	Washing feet/toes		Shopping
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Communication CURRENTLY		✓	**No Difficulties**
	Speaking/talking		Writing
	Hearing		Texting
	Seeing		Keyboarding
	Reading (including learning problems, vision, or attention deficits)		Using a mouse
	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Physical Activity CURRENTLY			**No Difficulties**
✓	Walking	✓	Sitting
✓	Standing	✓	Kneeling
✓	Pulling	✓	Climbing stairs or ladders
✓	Squatting	✓	Shoulder level or overhead work
✓	Bending or twisting at the waist	✓	Lifting and carrying
✓	Bending or twisting at the neck		Using the right or left hand
✓	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Sore, hurt, pain, can't do some at all."**			

Sensory Function CURRENTLY		✓	**No Difficulties**
	Smelling		Feeling
	Hearing		Tasting
	Seeing		Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Household Activity CURRENTLY			**No Difficulties**
	Chopping or cutting food	✓	Mopping or sweeping
	Opening jars	✓	Vacuuming
	Cooking	✓	Yard work
	Washing and putting dishes away	✓	Dusting
	Opening doors	✓	Making beds
✓	Scrubbing		Doing the laundry
✓	Repetitive use of the right hand	✓	Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Incapable of most physical work. Hands hurt, mostly at night."**			

Travel CURRENTLY			**No Difficulties**	
	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?		**15-30 min**
	Driving	If you have trouble driving, approximately how long can you drive before needing to rest?		**30 min**
Can't	Handling/lifting luggage	Approximately how many times per year do you travel AFTER the Subsequent Injury?		**None**
Don't	Keeping arms elevated		Holding or squeezing the steering wheel. **No difference**	
Other difficulties:				
If you indicated difficulties in this area, please describe how these difficulties make you feel:				

Sexual Function CURRENTLY		✓	**No Difficulties**
	Erection		Painful sex (in the genital area)
	Orgasm		Back pain with intimate relations
	Lubrication		Neck pain with intimate relations
	Lack of desire		Joint pain with intimate relations

Other difficulties:				
If you indicated difficulties in this area, please describe how these difficulties make you feel:				
Sleep Function CURRENTLY			**No Difficulties**	
✓	Falling asleep	✓	Sleeping on the right side	
✓	Staying asleep	✓	Sleeping on the left side	
✓	Interrupted/restless sleep		Sleeping on the back	
	Sleeping too much		Sleeping on the stomach	
	Daytime fatigue or sleepiness	Have you ever taken any medications to help you sleep AFTER the Subsequent Injury? **Ativan**		**Yes**
How many hours can you typically sleep at a time without waking up during the night?	**3-4 hours**	How many hours total are you able to sleep at night?		**5-6 hours**
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Insomnia"**				

Collectively, the above outlined impairments suggest that Ms. Clarke is moderately impaired. The Schedule of Rating Disabilities (January 2005) provided the following guidelines for rating patients' GAF.

Starting at the top level of the GAF scale, evaluate each range by asking, "Is either the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

[**Author's Comment:** *Ms. Clarke is not gravely disabled, does not have auditory/visual hallucinations, but she has passive suicidal ideations. These descriptions are for individuals who fall in the serious symptom category. Despite her reported moderate impairment as mentioned above, she falls in the serious symptoms GAF range due to her suicidal ideations. Therefore, I have placed her in the severe range of the symptoms scale*].

Using these guidelines, Ms. Clarke's psychiatric disability falls into the 41-50 decile. This is the range of functioning described as:

<u>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</u>

All of her psychological testing combined indicates she is in the severe range of both symptoms severity and functional impairment (i.e., BDI, BAI, and etc.). Ms. Clarke describes limited social interactions as a consequence of both her physical limitations and psychological status following

the industrial injuries. Whereas Ms. Clarke previously enjoyed a rather active social life, following the industrial injuries this has been reduced and more limited to immediate family members.

Thus, after careful consideration of all of the information contained in this report, Ms. Clarke's score is placed at the level of 50, which translates to a Whole Person Impairment (WPI) of 30%.

Arousal and Sleep Disorder Impairment:

The AMA Guides on Page 317, Table 13-4, provides a guide for rating arousal and sleep disorder impairment on a four-category scale that ranges from no impairment to extreme impairment. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant Epworth Sleepiness Scale, Ms. Clarke appears to have developed a Class 2 Impairment related to her chronic sleep disorder.

Table 13-4	Class 1	Class 2	Class 3	Class 4
	Impairment	Impairment	Impairment	Impairment
	1-9%	10-29%	30-49%	70-90%
Sleep & Arousal Disorders	Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living	Reduced daytime alertness, interferes with ability to perform some activities of daily living	Reduced daytime alertness, ability to perform activities of daily living significantly limited	Severe reduction of daytime alertness, individual unable to care for self in any situation or manner
WPI %				

Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 2 Sleep and Arousal Disorder is one in which an individual experiences "Reduced daytime alertness, interferes with ability to perform some activities of daily living." A score of 6/24 is not equal to excessive sleepiness, or class 2 impairment. **Based upon his chronic sleep dysfunction, and her Epworth Sleepiness Scale score of 14, the level of his current sleep impairment is equal to a 10% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of her subsequent injury.**

She reported, "Prior to the subsequent injury, it took me 30 minutes to fall asleep and I slept for 7-8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries, it takes me 1-2 hours to fall asleep and I sleep for 4-6 hours each night. I do not wake up at night. My sleep is "lousy."

CAUSATION OF SUBSEQUENT DISABILITIES AND LABOR IMPAIRMENT

Ms. Clarke injured herself at CVS Pharmacy on CT: May 5, 2017- April 4, 2018 and CT: June 1, 2017- March 25, 2018 while employed as a Cashier. Specifically, she sustained stress/psychological injuries due to her manager's discrimination and hostile treatment. As a result of this subsequent injury, Ms. Clarke developed psychiatric symptoms. My evaluation on October 14, 2020 consisted of a clinical interview, mental status exam, review of medical records, and psychological testing. The results of my evaluation found that Ms. Clarke currently suffers from Major Depressive Disorder; Generalized Anxiety Disorder; Panic Disorder Without Agoraphobia; Unspecified Trauma and Stressor-Related Disorder; Bereavement; Pain Disorder Associated with Both Psychological Factors and a General Medical Condition; and Sleep Disorder Due to a General Medical Condition, Insomnia Type.

These disorders and her functional limitations qualified her for a GAF of 50 - which is equivalent to a WPI of 30%.
Ms. Clarke has been diagnosed with Sleep Disorder Due to a General Medical Condition, Insomnia Type caused by the subsequent injuries. Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 2 Sleep and Arousal Disorder is one in which an individual experiences "Reduced daytime alertness, interferes with ability to perform some activities of daily living." A score of 6/24 is equal to excessive sleepiness, or class 2 impairment. **Based upon his chronic sleep dysfunction that arose out of his subsequent injury, the level of his sleep impairment is equal to a 10% disability rating.**

It is my opinion that Ms. Clarke's subsequent psychiatric injury was predominantly caused by the actual events of employment. I reason that, given the longitudinal nature of Ms. Clarke's emotional difficulties, they are more than a mere "lighting-up" of her previous depressive and chronic pain symptoms typically seen during an exacerbation. Rather, they have been permanent and are more accurately described as an "aggravation."

This issue is clearly seen via an examination of her GAF and WPI scores prior to and subsequent to her injuries. Ms. Clarke's prior GAF score of 66 equates to a WPI of 6%. Following her subsequent injury, her psychiatric condition deteriorated significantly. The increase in depressive and anxiety symptoms resulted in a decrease of her GAF to 50 - which means her disability increased by 24% to 30%. The subsequent injury disability represents the predominant cause of her overall disability rating.

GIVEN THE LENGTH OF TIME THAT HAS EXPIRED AND THE CONSISTENCY OF PSYCHIATRIC SYMPTOMS SINCE THEIR INCEPTION, IT IS MY OPINION THAT MS. CLARKE'S PSYCHIATRIC DISABILITY IS NOW PERMANENT AND STATIONARY.

Ms. Clarke's psychiatric injury is labor disabling and requires the following work restrictions:

- **Part-time schedule with frequent breaks due to her fragile and emotional states (from her depression, anxiety, and bereavement).**

- **Flexible schedule to accommodate Ms. Clarke's need for weekly psychotherapy.**

- **Flexible schedule to accommodate Ms. Clarke's sleep disorder.**

- **No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people such as her former manager.**

Due to his cognitive difficulties from his depression and anxiety, Ms. Clarke requires the following:

- **Accommodation of increased time due to slower pace and persistence.**
- **Understanding supervisor to break larger tasks into a series of smaller ones.**

- **Frequent feedback on performance with sensitivity to Ms. Clarke's struggles.**

- **Time to reconnect with co-workers given Ms. Clarke's deteriorated social skills (resulting from her depressive symptoms of social withdrawal and lack of interest in men).**

- **Frequent feedback on performance by an understanding supervisor to accommodate Ms. Clarke's low self-esteem (due to her depression, past intimate abuse and betrayal, incontinence, and inability to function sexually).**

APPORTIONMENT BETWEEN DISABILITY STEMMING FROM SUBSEQUENT INJURY AND PRE - EXISTING DISABILITIES

As stated above, Ms. Clarke had a pre-existing psychiatric disability that was permanent and stationary, ratable, and work limiting. Her rating was as follows:

Preexisting Psychiatric Impairment: 6% WPI from GAF of 66

I believe that Ms. Clarke's psychiatric condition was aggravated by the subsequent injury and she subsequently experienced a significant psychiatric deterioration. I believe the increase of her psychiatric impairment is due solely to the subsequent injury. Ms. Clarke's current psychiatric disability rating is as follows:

Current Psychiatric Impairment: 30% WPI from GAF of 50

The subtraction method is applied 30% WPI minus 6 % WPI = 24%

24% WPI apportioned to the Subsequent Injury

PRE-EXISTING DISABILITY	SUBSEQUENT DISABILITY
Psychiatric disability - 6%	Psychiatric disability increased by 24% to 30%

Please note: The preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability.

The aforementioned ratings are unmodified and uncombined. Ms. Clarke's disability from the subsequent and pre-existing is greater than that which resulted from the subsequent alone.

DISCLOSURE NOTICE

The history contained within this report was provided by Ms. Clarke, and I personally took the necessary notes. I reviewed the complete history, testing, and notes, remarked on any additional information and made the necessary evaluations and interpretation.

The final draft was submitted to me for my review and signature. I reserve the right to change my opinion based on additional medical evidence.

The medical records were typed by a transcription service. However, I reviewed the medical records directly and this time is reflected in the Complexity Factors section.

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true." records

Disclosures, Disclaimers and Affidavit of Compliance: I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except to information I have indicated I received from others. As to that information, I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and I have not offered, delivered, received or accepted any rate, fund, commission, preference, patronage, dividend, discount, or any consideration, whether in the form of money of otherwise, as compensation, or inducement for any referred examination or evaluation, Moreover, Labor Code Section 4628J, requires the undersigned to indicated the county in which the document was signed. This document was signed in Corona, San Bernardino County.

Signed this November day of 2, 2020.

Respectfully,

Nhung Phan, Psy.D., QME
Clinical Psychologist
Ca. License No. PSY28271

Attached: Review of medical records

REVIEW OF MEDICAL RECORDS:
CLARKE, Deborah
DOB: 05/29/49

Pages Reviewed: 344

WC Claim Form dated 04/04/18, w/DOI: CT: 06/01/17-03/25/18. Stress, depression and anxiety due to discrimination based on age and disability.

WC Claim Form dated 04/04/18, w/DOI: CT: 05/05/17-04/04/18. Stress and depression due to repetitive movement.

Application for Adjudication, dated 04/05/18 w/DOI: CT: 06/01/17-03/25/18. Nervous system. Stress, depression and anxiety due to discrimination based on age and disability. Employed by CVS Pharmacy Inc. as a Cashier.

Application for Adjudication. DOI: CT: 05/05/17-04/04/18. Stress and strain due to repetitive movement. Neck, back, UE, LE and Leg – multiple parts any combination of above parts. Employed by CVS Pharmacy Inc. as a Cashier.

Compromise and Release dated 03/08/19, w/DOI: CT: 06/01/17-03/25/18; CT: 05/05/17-04/04/18. Nervous system and psyche; Neck, back, UE, LE and Leg, hips. Employed by Garfield Beach CVS LLC as a Cashier. Settlement Amount $24,950.00.

Undated - Dr's 1st Rpt by Illegible Signature. Pt had previous work injury as was on modified duty when she reinjured her back and neck. Pt has LBP and neck pain, can only stand for 50% of the time and bend for 25%. Pain rated at 9/10. Plan: Requested chiropractic therapy eval and tx 2-3x/wk x 3-4/wks. Modified duty with restrictions of no lifting, standing and bending.

06/06/17-09/29/17 (9 visits). Acupuncture Therapy Notes from Foothill Ranch. Completed 9 sessions of Acupuncture Therapy for low back, hip and legs. Reports balance problems, LBP improved, but pain increased with prolonged standing.

10/10/17-12/12/17 (6 visits). Acupuncture Therapy Notes from Foothill Ranch. Completed 6 sessions of Acupuncture Therapy for low back, hip and legs. Reports constant hip pain/leg cramps and aching. Pain level is 7/10. States therapy is helpful.

01/31/18-07/24/18 (10 visits). Acupuncture Therapy Notes from Foothill Ranch. Completed 10 sessions of Acupuncture Therapy for hands, low back, hip and legs. Reports bruising in both hands radiating to chest and neck. Also c/o dull and deep aching LBP L > R. Still using walker.

03/20/18-06/27/18 (3 visits). Chiropractic Therapy Notes from Unknown Facility. Completed 3 sessions of Chiropractic Therapy for C/S, T/S and L/S. C/o moderate-to-severe neck pain and LBP. Chronic pain, worsened in past 6 months. H/o hip surgery in 2016 and spinal stenosis. Ambulates with a walker. Decreased ROM in C/S and L/S, painful.

09/13/18 - Work Status Rpt by Kesho Hurria, MD. DOI: CT: 06/01/17-03/25/18. Work Restrictions: Pt is unable to work on non-industrial basis. She should limit walking for >30 mins, sitting for > 15 mins to no more than 1-2 hrs/day. She should also limit twisting, grasping, pushing and pulling to no more than 1-2 hrs/day. No bending, squatting, climbing, reaching, crawling and driving.

09/14/18 - Psychological PQME by Jeffery Coker, PsyD. DOI: CT: 05/05/17-04/04/18; CT: 06/01/17-03/25/18. Pt reported experiencing ongoing, depressed moods since her reported injuries at CVS. She endorsed diminished interest or pleasure in most activities since her reported injuries. Pt has a reduced appetite most of the time. Also indicated she has experiencing significant psychomotor slowing or retardation following her injuries. Reported fatigue or loss of energy occurring nearly every day. Also reported feeling or worthlessness subsequent to her reported injuries. Experiencing insomnia since injury. Has had difficulty falling and staying asleep, averages 4-5 hrs per night, prior injury slept 7-8 hrs/night. Experienced diminished ability to think or concentrate as well as ongoing, significant indecisiveness occurring since her injury. Endorsed ongoing crying or tearfulness episodes, concerning suicidal ideation or suicide attempts, experienced suicidal thoughts following her manager telling her she was being let go and after her sister drove her home, she attempted to walk into traffic with the intention of getting hit by a car. No other suicidal episodes. Reported developing significant anxiety following injury, degree of worrying has been difficult to control, feelings of jitteriness, frequent panic attacks, panic episodes a couple of times a day, included feeling of intense fear as well as palpitations, sweating, trembling or shaking, chest pain, nausea or abdominal distress, dizziness or light headedness, derealization, fear of losing control, fear of going crazy, fear of dying, N/T in hands and chills or hot flashes. She harbors a persistent worry or concern about having additional panic attacks. Also endorsed recurrent, bad memories of the injury. Also reported intense bodily tension and psychological stress when exposed to cues related to her work difficulties; noted it occurs when sees a TV commercial for CVS or see the CVS pharmacy when inside Target. Additionally, she endorsed ongoing feelings of detachment or estrangement from others following her injuries. Reported becoming irritable much more easily, endorsed developing an exaggerated startle response, and had chronic stomach distress. Indicate c/o HAs as part of her psychiatric sxs. Psychiatric History: When questioned about significant depressive episodes prior to her reported injuries at CVS, she noted she was depressed around the time her parents died. Both of her parents reportedly died in 2005 from cancer. She stated she is no longer depressed due to their deaths. Regarding any significant periods of anxiety prior her reported injuries, she noted she experienced anxiety "when my mom was diagnosed with cancer in 2000." She added, "l broke down and couldn't work." she noted she also experienced panic episodes around that time. She commented, "l had to take care of them for years." There is no Known history of suicidality or homicidal ideation prior to her reported injuries at CVS. Upon questioning in regard to previous physical and verbal abuse, she indicated her father abused her as such during her development. Moreover, she reported having a boyfriend in the 1990s for two years during which time her boyfriend was physically abusive; she noted he gave her two black eyes. Records reveal she got a restraining order against the ex-boyfriend. she added, "l used to dream about it but not anymore." ln addition, she denied any past history of mania, paranoia or other delusional beliefs. She has no known history of obsessive thoughts and/or ritualistic behaviors. Furthermore, she denied any history of traumatic brain injury or concussions with or without loss of consciousness. There is also known history of auditory,

visual, olfactory or tactile hallucinations. She also denied any past history of sexual prior to her reported injuries. Additionally, she denied any history of being victim of a traumatic natural disaster. she indicated her son who was married with an eight-year-old son and living in Sacramento committed suicide two months prior to this examination. She indicates she believed her son had bipolar disorder but did not receive treatment. She reported her son had lost his job and his car and became "caught up in depression" before taking his life. Concerning previous psychiatric treatment, she indicated she was prescribed Valium and Prozac around the time her mother was diagnosed with cancer. She noted, regarding Prozac, "l took pill and felt terrible so I didn't accept any others." Regarding individual or group psychotherapy or counseling prior to her reported injuries, She reportedly took a class on codependency weekly for a year. She noted the classes were helpful. She also indicated she has never been psychiatrically hospitalized. Following her reported injuries, She has been taking Ativan only. Records reveal she has been taking Ativan for two or three years. Records also indicate she sought psychological counseling through SCAN and saw a psychologist named Sylvia on one occasion. A nurse practitioner named Cathy reportedly prescribed the Ativan for her. Childhood & Family Hx: Pt was born in Janesville, Wisconsin. In 1959, when she approximately 10 years old, the whole family reportedly moved to California. In regard to developmental milestones, reportedly did not walk until she was 18 months old "because I was too chubby." As noted pt denied any childhood medical conditions. Furthermore, she did not report any serious injuries during her childhood or adolescence. When asked about her relationship with her mother when she was growing up, pt noted it was "good." Her relationship with her father was reportedly "okay." She noted he was "a little bit of a tyrant." As noted, her father verbally and physically abused her during her development. She remarked, "He was German and military so he had that attitude." Reportedly, pt's father worked as an electrician and her mother held different positions including working at a dime store and at an aerospace company making parts for spaceships. As noted, both of pt's parents died in 2005 from cancer. Her mother had bladder cancer and her father had pancreatic cancer. Moreover, she reported depression, anxiety and panic attacks after her mother was diagnosed with cancer in 2000. She was, reportedly treated with Valium as well as Prozac, she only took one dose of the Prozac before discontinuing it as it made her feel "terrible." Pt reportedly has one younger sister and two brothers. She noted, while growing up, her sister was a "brat." She noted she and one of her brothers teased each other while growing up - and, "as adults too." Currently, her sister lives locally, one brother lives in Morena Valley, California and the other brother lives in Oregon. She noted both of her brothers are doing okay. In addition, pt indicated her sister has arthritis and is "okay I guess." She added, "I worry about her more than she does about me." Pt had two children, one son and one daughter. Her daughter lives in Nevada and is reportedly doing okay. As delineated, pt's son committed suicide two months prior to this evaluation. She noted he had recently "lost his job and his car." She also stated, "l think he had bipolar, he seemed pretty happy usually but had his moments." As described above, she has a grandson who is eight years old who lives with his mother who is now a widow. They reportedly live in Sacramento. When asked how her daughter-in-law and grandson were doing, she noted she texts her daughter-in-law "but she doesn't text back sometimes maybe because of the grieving." Relationship Hx: She reported having four long-term, romantic relationships. She noted she was married once in the 1970s for 13 years. Pt and her first ex-husband reportedly divorced "around 1982." Additionally, as noted, she had a boyfriend who was physically abusive towards her in the 1980s. She noted she was with this ex-boyfriend for approximately two years. Pt's second marriage reportedly lasted eight years and

ended in 1994. Records indicate the two divorces occurred "because of ladies, and because the applicant told them to leave." She is reportedly not in a serious, romantic relationship currently. Education: She reportedly graduated from Bolsa Grande High School in Garden Grove in 1967. She was reportedly never diagnosed with a learning disability of any kind nor did she receive Special Education. She commented, "I didn't lite science or history but I graduated." When questioned about her performance during her school years, she noted she received C's and D's. Furthermore, she denied ever being suspended or expelled during her school years. Regarding college, she stated she took classes at Sacramento Community College, Santi Ana College as well as Orange Coast College. She noted she took courses at the colleges "for personal" interest "a long time ago" "before [she had] kids." She noted one of the classes was in child literature and another was related to environmental studies. There is no h/o education at a vocational training program. Employment Hx: While in high school, pt reportedly worked for cleaners in Westminster for "a few months." She also indicated she baby-sit for three months during High school for a family with five kids. Before graduating from high school, pt worked at K-Mart in Westminster for "months" - she could not recall exactly how many months. After she got married to her first husband, pt worked at a shoe store in Huntington Beach for "a few months." Following this position, she reportedly worked for Hallmark for "a few months" as well as bakery in Westminster for less than three months. Her next position was at Sav-On as a cashier and stocker at various locations. She noted she worked at Sav-On for "20-some years" and she "retired from there to take care of her parents with cancer in northern California for about a year." She added, "I sat in my room for a year grieving and my kids told me to get a job." Her next position was with Longs Drugs in northern California. She noted she believes it was less than a year "before CVS bought them out" and "it was then CVS for 12 years or since 2006." She noted she was never fired or laid off from any positions prior to her reported injuries at CVS. Moreover, there was no h/o WC case prior to her current one. Records indicate she filed for bankruptcy twice in the past. The first time was more than 20 years ago and the last time was approximately four or four and-a-half years ago. Social/Leisure History: In regard to leisure activities, she enjoyed prior to her reported injuries, pt indicated she was involved in several. She noted she used to be involved in going door-to-door as part of the efforts of the ministry in which she has been affiliated. In addition, she used to enjoy more often going to have lunch or dinner with friends. She also used to go the theatres prior to her reported injuries. Moreover, she would visit her family more often. She also noted she would cook and bake but now she has "no energy or the stamina" to do so; she added, "I can’t stand a long time." Substance Abuse: Pt denied past use of illicit drugs including cocaine, heroin, methamphetamine, hallucinogens and Ecstasy. Furthermore, she denied ever abusing cannabis or using it for medicinal purposes. She also denied past abuse of alcohol. Additionally, pt reported she has never abused prescription medications such as opiates or benzodiazepines. There is no record of treatment for alcohol or other substances. She also noted she has never smoke cigarettes. Regarding caffeine, pt reported she "can't" have it and she prefers ginger ale instead. Legal Hx: As noted, pt reported not having a previous WC case prior her to one with CVS. Additionally, she has never been arrested or incarcerated. She has also reportedly never been on probation or parole. There is no known h/o DUI. Moreover, pt reported she is not currently a plaintiff or defendant in a civil law suit. Records from 06/04/18 indicate, at that time, she has an attorney for a case against her former apartment complex in litigation regarding her fall and hip injury on 03/07/16. Mental Status: Dressed in comfortable and appropriate attire, grooming and hygiene are good. Her attitude in QME was co-operative and no signs of hostility and subtle signs of guardedness. Her mood was

dysphoric, irritable and anxious, affect was congruent. Denied any current suicidal or homicidal ideation. Speech was within normal limits. Eye contact was good. Her thought process was linear and coherent. There were no signs of any irrational thoughts or delusions. No evidence of paranoia, perceptual distortions or hallucinations. With respect to cognition, she was alert and oriented to person, place, time and situation. She was able to complete serial seven subtractions correctly. Her long-term memory appeared intact as she had no significant difficulty recalling information from his past. There was no noted serious impairment of attention and concentration. Insight was fair to good. No evidence of cognitive impairment. Millon Clinical Multiaxial Inventory-III: 85, BDI-II: 25, Beck Anxiety Inventory: 40. Dx: Axis I: 1) MDD, recurrent, moderate. 2) GAD. 3) Panic disorder. Axis II: Deferred. Axis III: Physical ailments. Axis IV: Occupational problems. Axis V: GAF - 48. Recommendations: Advised to enter into weekly psychotherapy for 4-6 months. She should receive psychoeducation concerning depression, anxiety, panic and stress management. Continued psycho-pharmacotherapy from a psychiatrist for her sxs of depression and anxiety. Disability: Temporary Disability. Pt has had partial temporary disability on a psychiatric basis. Currently, she is unable to perform usual and customary work duties. Pt is experiencing a moderate level of depression and severe levels of anxiety and panic that inhibit her from being as competitive as she once was before she developed a psychiatric disorder. She is and will be more tired at work because of her depression and anxiety. Furthermore, her ability to concentrate and maintain focus at work is diminished d/t continual sxs of depression and anxiety. Permanent Disability: Pt has not had permanent disability to her psychiatric functioning. She has not reached MMI. Has not had a significant amount of psychiatric tx except for meds. Industrial incidents were the predominant cause of pt's sxs of MDD, GAD and panic disorder. The temporary disability after the incident is at least 51% more d/t industrial exposure. Rationale: Pt sustained psychiatric disability directly related to the industrial exposure. Her supervisor's behavior is believed to represent harmful action versus a good faith personnel action of actions. Pt exhibits moderate sxs of MDD and severe levels of GAD and panic disorder that cause impairment in her functioning. Her son's suicide 2 months prior to her evaluation considered disability d/t non-industrial factors. There is insufficient evidence these are any other non-industrial factors taken individually in an aggregate account of 51% or more pt's psychiatric disability. Apportionment: Not indicated as there is no permanent disability. Pre-existing Disability and Non-industrial Factors: There is no indication to address pre-existing disability and non-industrial factors as pt does not have permanent disability. Treatment/Future Medical Care: Recommended psychotherapy 4-6 months, at least 1x/wk. Continued tx with psychiatric meds. Advised combined tx consisting psychotherapy and meds. Should not attempt to work extended, long periods w/o breaks d/t tiredness, anxiety, hypervigilance, low energy and difficulty concentrating and making decisions. Prognosis: Pt's emotional state is considered to be in moderate-to-severe clinical range at this time. Without appropriate intervention, her psychiatric sxs may worsen. She is also at risk for suicide w/o tx. The prognosis is good with ongoing appropriate tx. Impairment Rating: Not applicable as pt is not permanently disabled.

09/24/18 – QME by Kesho Hurria, MD. DOI: CT: 06/01/2017-03/25/2018. Employed by CVS Caremark Corporation as a Cashier/Stocker. Pt presents with c/o pain in neck, legs, back, and hips, sustained during the course of employment secondary to performing usual and customary duties, being on feet for prolonged periods, bending, stooping and lifting. Gradually developed neck, back, hips and legs pain, beginning in 07/2017. Not reported. Had a previous injury in 03/2016, L

hip broken while working for CVS, she was placed off work for 14 months until she went back to work in 03/2017, with restrictions of no lifting > 5 lbs, walking up to 50% of the shift, no climbing ladders, no torso or spine twisting and no driving. Pt started receiving tx on her own for back in 06/2017. Received acupuncture tx with Suzane for back intermittently from 2017 until now. Also received chiropractic tx with Dr. Johnson 2x, for lower back. Has not received any tx for this injury under WC. She is not currently seeing any doctor for her hip injury. She is only treating with PMD, Dr. Balin at Monarch Med Grp, user her private medical insurance. Dr. Balin referred her to a neurologist for pain in legs, back and neck. Pt has seen neurologist Dr. Falehi at Monarch Med Grp, he ordered NCS for legs. Pt relates she was told of nerve damage on BLE. States she did not receive any other tx or meds and surgery was not recommended. Currently, not receiving tx nor under supervised medical care by any physician or clinic. Pt is currently TTD. Last worked on 04/12/18. Worked for Savon Drugs as a Cashier/stocker from 1972-2004, retired in 2004 and went back to work in 2006. Employed with CVS Caremark Corporation as a Cashier/stocker since 08/2006. Worked 4 hrs/day, 2-3 days/wk. Physical demands included standing, walking, lifting, carrying, bending and light pushing. Heaviest item pt had to carry was 12 pack of beer, weighting 15 lbs, carry to a distance of 2-4 ft. States previous industrial injury in 03/17/16, L hip broken, underwent arthroplasty. Settled claim via Compromise and Release. Pt was involved in an automobile accident in 1997/1998 with injuries to neck and back. She saw a chiropractor for tx of injuries, related h/o anxiety and urinary incontinence. Family Hx: Has 2 brothers and 1 sister, all are alive and in good health. Mother and father are deceased from cancer. Social Hx: Pt is single. Has 2 children, one is deceased due to mental illness and committed suicide. One daughter lives alone. Does not smoke or consume alcohol. Has completed high school. Pt reports anxiety and urinary incontinence. Taking Gabapentin 300 mg, Oxybutynin 5 mg, Tramadol 50 mg, Pantoprazole 40 mg, Norco and Lorazepam. Had cholecystectomy in 2009 and L total hip replacement in 2016. Difficulty performing ADLs. She is not sexually active. States moderate-to-severe interference with sleep due to frequent waking cycles, inability to fall asleep due to pain, lack of sleep causing reduced daytime alertness. C/o intermittent moderate pain of back and neck radiating down the L arm all the way down the hand with N/T of fingers. C/o intermittent to constant, moderate-to-severe LBP radiating to BLE way down feet with N/T of legs and feet. C/o frequent, moderate shoulder pain radiating to the body. C/o constant and moderate-to-severe L hip pain and intermittent to moderate R hip pain. Also c/o sleep issues, HAs, stress, anxiety, emotional difficulties and GI disturbances such as abdominal pain, weight loss of 5 lbs, weakness of legs and balance problems. Uses walker. ROS: Sleep: Difficulty going back to sleep, changing position and walking up at night due to pain. GI: Intermittent bouts of GI problems, in the form of stomach irritation, also states she has diverticulitis. Psych: Since the injury, notes intermittent bouts of anxiety and frustration secondary to not being able to do anything physically. Urology: Frequent urination. Sexual Dysfunction: Not sexually active. PE: Thin and cooperative, in no apparent distress. Pt's previous medical records were reviewed. Dx: 1) C/S sprain with radiculopathy, non-industrial. 2) L/S sprain with radiculopathy, non-industrial. 3) Spinal stenosis, non-industrial. 4) S/p fracture L hip, non-industrial. Discussion: Pt has reached MMI and is deemed P&S on 06/01/18. Subjective Factors of Disability: Intermittent moderate pain of back of neck radiating down L arm down the hand with N/T of fingers. Intermittent to constant moderate-to-severe LBP with radiation of pain in both legs down feet with N/T of legs and feet. Constant moderate-to-severe pain of L hip and intermittent moderate pain of R hip. Objective Factors of Disability: Decreased C/S ROM on all planes. Antalgic gait. Decreased L/S ROM on all planes. Positive

Fabere's test B/L and seated and supine SLR B/L. Decreased B/L hip ROM except adduction. Weakness in UE and LE B/L on manual muscle testing. Difficulty to stand on heels, toes, foot and to squat, kneel and stoop. Causation: Non-industrial injury. Apportionment: Not applicable in this case. Periods of Disability: 04/12/18 to present (non-industrial). Work Restrictions: Pt is unable to work on non-industrial basis. She should limit walking for >30 mins, sitting for > 15 mins to no more than 1-2 hrs/day. She should also limit twisting, grasping, pushing and pulling to no more than 1-2 hrs/day. Future Medical Treatment: Past medical care was appropriate through Medicare and SCAN. Vocational Rehabilitation: Not applicable in this case. Impairment Rating: 3% WPI, non-industrial base. Pt has reached MMI and is deemed P&S for rating purposes. Other specialists may be necessary to address any additional impairments and subsequent treatments.

11/20/18 - PTP's P&S Rpt by Clay Thomas, DC. DOI: CT: 06/01/17-03/25/18; CT: 05/05/17-04/04/18. Date of Initial Exam: 11/13/18. Pt sustained work-related injuries on a CT basis during the course of her employment for CVS Caremark Corporation as a Cashier. C/o pain in neck, mid thoracic, LBP and L hip. Also had stomach pain. Reports condition is worse after performing work duties. States that her condition became worse after a new manager would not adhere to her work modifications that include standing no longer than 50% of the time and bending at the waist no longer than 25% of her shift. She received the modification from Dr. Joseph Tabet on 10/25/17. On 06/12/18, this examiner opined pt's condition have reached MMI and is P&S. C/o dull aching pain in neck, midback and L/S associated with cramps, stiffness and weakness, rated at 9/10. Has limited capacity with ADLs, rated pain at 5/10. 8/10 with movement. Epworth Sleepiness Scale: 8. PHQ-9: 8. PE: C/S: Palpable tenderness noted, neck pain/stiffness during all the end ROM. Positive Spinal Percussion, Cervical/Foraminal Compression test and Jackson Compression test, B/L. T/S: Palpable tenderness noted, midback pain/stiffness during all the end ROM. L/S: Palpable tenderness noted, atrophy of L gluteus and quadriceps muscles LBP/stiffness during all the end ROM. Positive seated SLR. Hips: Palpable tenderness noted, pelvic hypomobility, L hip pain/stiffness during all end ROM. Functional Capacity Assessment: Limited from standing and/or walking and sitting a total of < 2 hours/8 hr shift. She is frequently allowed to feel, see, hear and speak. She is allowed to do occasional reaching, handling and fingering. Not allowed to do climbing, balancing, stooping, kneeling, crouching, crawling and twisting. Due to her lower back disc problem and pain, performing any of the aforementioned activities would cause severe exacerbation. Appropriateness of Treatment: MRI studies were requested further identifying pathology. This examiner opined that these treatments are all medically reasonable and appropriate. Dx: 1) C/S disc syndrome. 2) L/S disc syndrome. 3) C/S segmental dysfunction. 4) T/S segmental dysfunction. 5) L/S segmental dysfunction. 6) C/S sprain. 7) L/S sprain. 8) L hip sprain. 9) Depression. Disability Status: Pt has reached a plateau. She has reached MMI. She is considered P&S for rating purposes. Subjective Findings: C/o pain in neck, mid back and LBP. Objective Findings: C/S: Palpable tenderness, limited ROM, positive orthopedic tests, and positive MRI findings. T/S/L/S: Palpable tenderness and limited ROM. L Hip: Palpable tenderness, limited ROM and positive orthopedic tests. Impairment Rating: 38%. C/S: 8% WPI. T/S: 5% WPI. L/S: 8% WPI. Combined: 20% WPI. L Hip: 20% WPI. Pain: 2% WPI. Causation: Industrial injury. Apportionment: 100% industrially related and 0% of impairment from other factors both prior to and/or subsequent to the industrial injury, CT: 05/05/17 to 04/04/18 and 06/01/17-03/25/18 with 0% of impairment from other factors both prior to and/or subsequent to the industrial injury. Apportioned 90% of industrial injury from CT: 05/05/17-04/04/18 and 10% to non-industrial

factor from altercation with her son resulting to broken L3. Apportioned 100% industrial CT: 06/01/17-03/25/18; CT: 05/05/17-04/04/18 and 0% to other factors both prior to and/or subsequent to the industrial injury. Work Restrictions: Opined that pt will not be able to return to her usual occupation. She is restricted from twisting the torso/spine, climbing ladders, driving and working on heights/scaffoldings. Supplemental Job Displacement benefits. Future Medical Care: Should be provided future medical care for flare-ups. Should include prescriptions of pain and anti-inflammatory meds, short courses of PT/chiropractic therapy, referral to specialist, f/u, injections, diagnostic studies including but not limited to radiographs and MRI scan. Surgery to L/S should be considered.

01/31/19 - QME Supplemental Rpt by Kesho Hurria, MD. DOI: CT: 06/01/17-03/25/18. Under apportionment, pt's treating chiropractor Dr. Thomas, on 11/20/18, apportions 10% of pt's L/S disability to an altercation with her son, resulted in broken L3 vertebrae. On 04/04/18 and "stress, depression and anxiety d/t discrimination based on age and disability" from 06/01/17 to 03/25/18. Currently her sxs included experiencing ongoing depressed moods since her reported injuries. She has diminished interest or pleasure in most activities. She has reduced appetite most of the time. She was experiencing significant psychomotor slowing or retardation. She endorsed fatigue, loss of energy, insomnia, difficulty falling and staying asleep, diminished ability to think or concentrate, and indecisiveness. She had feelings of hopelessness. She developed anxiety, frequent panic attacks, feeling of jitteriness, and feeling of intense fear. She had chronic stomach distress since her reported injuries, as well as headaches. MSE: on BDI-11, she scored 25, moderate clinical depression. On BAI, she scored 40 consistent with severe anxiety. Dx: Axis I: 1) MDD, recurrent, moderate. 2) GAD. 3) Panic disorder. Axis II: Deferred. Axis III: Physical ailments. Axis IV: Occupational problems. Axis V: GAF - 48. Recommendations: Weekly psychotherapy for 4-6 months. Psycho education concerning depression, anxiety, panic and stress management. Continued psycho pharmacotherapy. Disability: Pt has had partial temporary disability on psychiatric basis. Unable to perform usual and customary work. She has not reached MMI. Temporary disability after the incident was at least 51% or more d/t industrial exposure. Apportionment: Not indicated. Prognosis: Current emotional state was considered to be moderate-to-severe clinical range at this time. Prognosis was good with ongoing appropriate tx.

Deposition Deborah L. Clarke taken on 06/04/18 (97 Pages):

Page 7 - Pt took ½ pain pill in the last 24 hours. Pages 13, 14 - Involved in a car accident as a passenger 10 years ago, sustained an injury, a little jolt but she did not get any treatment. Broke her hip in 2016 when pt was walking on a uneven sidewalk where she fell. Worked at Sav-On in 2004, then started working at Longs in August 2006 and then turned into CVS. Pages 18-20 - PT's PCP is Dr. Natalia Bilan at group SCAN, been treating with the doctor for 5 months. Before that, it was Dr. Martinez at Kaiser and before that, pt had another PCP at Kaiser. Went to ER at Mission Hospital a couple of months ago for loss of appetite and being sick for 2 days. Also went to another ER at Kaiser for headaches. Was taken off work from 03/08/16 until 05/05/17. Underwent hip surgery at the hospital. also received rehabilitation. Returned to work on 05/05/17 with restrictions of not to stand 50% or 75% of the shift, not to bend over, not to climb ladders and walking and sitting with limit. Employer provided pt a chair and worked in that capacity until 04/12/18. Pt filed a CT injury claim from 06/01/17 through 3/25/18 alleging stress and age discrimination due to the events related to Erin and the district manager. Before Erin had that conversation and before

leaving work, pt was able to do her job with the accommodations. Beside the stress, pt also complained of headaches. Felt terrible because she wanted her job and wanted to keep working, but Erin just harassed her all the time and the supervisor wanted her to vacuum, clean, do bathroom, empty the trash, and gave her less hours which was just constant badgering. The supervisor kept reducing her hours constantly. Doctor advised pt only to work 4-5 hours/day and 2-3 days/week only. Was seeking psychological counseling starting last month from Dr. Sylvia through SCAN recommended by Dr. Bilan. Ativan was prescribed by a nurse practitioner, Cathy. Ativan made her drowsy, but calmed her down to sleep. Also filed another CT claim for an orthopedic injuryto her neck, upper extremity, back, lower extremity and leg while working at CVS. Without Ativan pt experienced sleep problems or problems falling asleep. Was experiencing problem falling asleep before, depending on stress. Currently unable to get a full night sleep, had trouble sleeping almost every night. Started noticing problems sleeping about 2 months ago due to anxiety and stress, and pain all over her claimed body parts. When pt took Ativan at 10:30 or 11:00 pm she was able to get 6 hours of sleep, did not feel sleepy in the daytime as long as she kept walking around. Usually went to bed around 11:00 pm and woke up around 5:00 am or 6:00 am, would try to go back to sleep but sometimes she did not. Had been taking Ativan for about 2-3 years. Been coming home from work and crying, cry at work, and on her break which she discussed with her psychiatrist. Pt also discussed her issues at church with some elders who knew that she had lost her job, church provided some counseling and spiritual support, and the elders had been coming over twice to talk to her. When pt was hired, her supervisor was Theresa, but as soon as Erin got on board, who was just the most arrogant person. Erin just wanted to get rid of her from the get-go. Pt was experiencing the vibration from Erin, and the supervisor would always be watching and talking bad about her. Pages 92-95 - Due to Erin, pt lost interest in the job. Now that Erin is not wotking, pt world retirn to work if the employer offers regular job with the restrictions and not as many hours. The doctors limited her to 2-3 times/week and 4-5 times at a time. The chair did help, but sometimes when it was very busy pt had to stand up for a prolonged time before her break and had to clear out the customers before she could sit down, and as she was about to sit down, someone would come up again. The employer also wanted to send her to a busier store because the last one was not so busy.

NOTE: Remainder of the record includes demographic Sheet, Cover letter, Declaration pursuant to labor Code section, Proof of service, Request for AME appointment and comprehensive report in psychology specialty, Comprehensive review of the case, Fax pages, Petition for discrimination benefits pursuant to labor code, Verification, Priority mail, Blank pages, Legal letter, AME/QME declaration of service of medical-legal report, Separator sheets, Law Office correspondence, Correspondence Cover Sheet, Fee Statement, Fee Disclosure Statement, Declaration, Declaration of Custodian of records, Subpoena Duces Tecum, Declaration for subpoena duces tecum, Declaration of service, Addendum, Notice to consumer or employee and objection, Proof of service of notice to consumer or employee and objection, Proof of service of objection to production of records, Proof of service by mail, Notice of party being subpoenaed, E-Cover sheet, Application Verification, Venue authorization, Notice of denial of claim for WC benefits, Request for QME Panel, For use with the QME panel request form 105, Attachment to Form.

NP/rpc