Paul M. Goodman, M.D., F.A.C.S.

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1680 Plum Lane
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November 10, 2020

Subsequent Injuries Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, California 95834

Workers' Defenders Law Group
8018 E. Santa Ana Cyn., Suite 100-215
Anaheim Hills, California 92808

Re:	**EVAN DISNEY**
Gender:	Male
Date of Birth:	April 17, 1978
Date of Injury:	CT Jene 5, 2015 to March 12, 2018; CT March 12, 2017 to March 2018
Employer:	Advances Management Company, SIBTF
SIBTF Claim number:	SIFI2037148
Evaluation Location:	**770 Magnolia #2K** **Corona, CA 92879**
Referring Attorney:	Natalia Foley, Esquire
Evaluation Date:	November 10, 2020

COMPREHENSIVE OTOLARYNGOLOGY SUBSEQUENT INJURY BENEFITS TRUST FUND EVALUATION

To Whom It May Concern:

I am evaluating Mr. Evan Disney on this date for potential SIBTF Benefits in order to determine if there are otologic symptoms which would contribute to eligibility for SIBTF benefits, for which the Subsequent Injuries Benefits Trust Fund may liable.

I have personally taken this gentleman's history and performed his physical examination.

Mr. Disney understands that I am not a treating physician and that no traditional doctor-patient relationship exists.

According to Labor Code 4751, "if an employee was permanently or partially disabled and receives a subsequent compensable injury resulting in additional permanent or partial disability so that the degree of disability caused by the combination of both disabilities is

greater than which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70% or more of the total, he or she shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury, compensation for the remainder of the combined permanent disability existing after the last injury...".

This shall be billed at the ML-103 level, noting the following:

A) Face to face time with the applicant: 1.00 hours
B) Record review time: 3.00 hours (4+ hours [A+B combined] = 2 factors)
C) Issue of causation addressed per request of referring party = 1 factor

SUBSEQUENT INJURY

Mr. Evan Disney is a 42-year-old man, who, in 2018, fell down 13 stairs, injuring his back, leg, and hip. He fell flat on his back with no loss of consciousness. He has chronic lower back pain with bulging discs, a hip disorder, and leg discomfort. His case was settled in March 2019 with an unknown rating.

PRE-EXISTING DISABILITY:

Mr. Disney has a history of hearing loss and tinnitus. He has had difficulty with tinnitus and hearing loss since 1997.

CURRENT COMPLAINTS

Mr. Disney has difficulty with hearing and tinnitus. With respect to his hearing, it seems to be more decreased on the right side. On one-to-one conversation, he hears fairly well. With any sort of background noise, he claims to have disability of not understanding words. He had an injury in the United States Navy in basic training in 1997, when here was a shot to the right ear with subsequent buzzing in the ear. He has had tinnitus since 1997.

The hearing itself has been stable. He apparently had a hearing test in the Navy, but none recently. The hearing does affect him. This gentleman does have attention deficit disorder and the hearing deficit does, indeed, make him worse. He plays the TV louder than for other family members.

Mr. Disney has had tinnitus, as noted above, since 1997. It is constant and "very bad." It interferes with his hearing and sleeping. The left ear has had a low-frequency hearing loss since December 2018 with a faint buzz. The majority of the tinnitus is in the right ear.

Mr. Disney has no history of ear pain or drainage. He denies a history of otitis medial or ear surgery. Mr. Disney has occasional dizziness. There is no true vertigo.

In summary, Mr. Disney complains of both hearing loss and tinnitus, occurring well before the subsequent injury.

PAST MEDICAL HISTORY

Mr. Disney has difficulty with attention deficit disorder and hip, leg, and back issues. He also has reflux esophagitis and asthma. In addition, he has depressive mood disorder and hypertension.

CURRENT MEDICATIONS:

Adderall, gabapentin, Flexeril, atorvastatin, and omeprazole.

PAST SURGICAL HISTORY:

None noted.

ALLERGIES:

Mr. Disney is allergic to penicillin.

REVIEW OF SYSTEMS

Review of systems regarding the cardiac, pulmonary, GI, GU, orthopedic, neurologic, and psychiatric issues is negative, except for the above.

OCCUPATIONAL HISTORY

Presently, Mr. Disney is not working. He works as a magician and has had difficulty getting work since COVID. While injured, this gentleman was working for Advanced Management Company from 2015 through December 12, 2018. This was in property management. He has had "36 jobs in 42 years" prior. These include Direct TV, a plumbing company, manufacturing, and others. He was in the United States Navy from 1996 through 1997.

SOCIAL HISTORY:

No smoking or drinking.

FAMILY HISTORY:

No history of hearing loss or tinnitus.

Date of Exam: November 10, 2020

PHYSICAL EXAMINATION

General:
The examinee is a well-developed man, appearing his stated age.

Vital Signs:
Height 6'1", weight 211 pounds, blood pressure 154/93 on the right and 145/86 on the left, pulse 97, respiratory rate 14, temperature 97.7.

Neck:
The neck was supple without adenopathy, masses, or thyromegaly. There are no bruits and the thyroid is normal.

Eyes:
The pupils were equally reactive to light and accommodation with full range of motion of the extraocular muscles and no nystagmus

Ears:
Tympanic membranes and ear canals are normal without evidence of middle ear effusion or disease.

Nose:
Nasal examination reveals a midline septum with the nasal mucosa normal in appearance. There is no drainage, polyps, or purulence noted.

Mouth:
The moth and tongue were normal without lesions or impaired mobility. The pharyngeal mucosa was normal. The tonsils were not seen.

AUDIOMETRIC EVALUATION:

A complete audiometric evaluation was performed on November 13, 2020 at Sonus Hearing Care Professionals in Corona, California and taken by Nancy Nicholson, MED-CCCA. This reveals a sensorineural hearing loss in the high frequency in the right ear. The left ear is normal. Speech reception threshold is 20 dB bilaterally with 100% word discrimination. Middle ear and Eustachian tube functions are normal.

DIAGNOSIS:

Left sensorineural hearing loss with tinnitus.

PERMANENT IMPAIRMENT RATING PER AMA GUIDES, FIFTH EDITION:

According to the American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition, page 248, table 11-2, there is 0% binaural hearing impairment. According to the AMA Guides, 4% is added for tinnitus due to the fact that there is documented sensorineural hearing loss. This is also due to the fact that this does interfere with sleep and hearing. Therefore, there is 4% binaural hearing impairment, which is a 1% relationship of binaural hearing impairment to impairment of the whole person.

I would therefore state that there is a 1% whole person impairment rating on Mr. Disney's hearing and tinnitus. It is my opinion that 100% of this is due to pre-existing hearing loss and tinnitus, which caused some limitations in his ability to compete in the open labor market with some difficulty maintaining concentration of clearly hearing over a telephone or soft-spoken individuals.

COMPLIANCE STATEMENT

"I personally evaluated this applicant and prepared this report. If others have performed any services in connection to this report, outside of clerical preparation, their name and qualifications are noted herein. 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 to be true."

I came to the above opinions based on the current examination findings, available medical records/diagnostic reports for review, credibility of the patient, historical information as provided by the patient and clinical experience both evaluating and treating individuals with the same or similar conditions. This report is signed in San Bernardino County. Assistance with preparation of this report was provided by Rapid Care, Record Summarizers, who were trained by Arrowhead Evaluation Services, Inc.

This examination and report is billed at a usual and customary fee, per hour of physician time spent on examination of the patient, review of the medical file and case conceptualization/formulation to answer the questions posed.

Date of Report: November 10, 2020. Signed this 14th day of December 2020, in San Bernardino County, California.

Sincerely,

Paul M Goodman MD

PAUL M GOODMAN, M.D., F.A.C.S.
Otolaryngology

PMG/lh

Attached: Review of Medical Records

REVIEW OF MEDICAL RECORDS
Disney, Evan
DOB: 04/17/1978

Pages Reviewed: 624

WC Claim Form, dated 03/12/18, with Date of Injury: Cumulative trauma 06/05/15 to 03/12/18. Stress and strain due to repetitive movements.

Application for Adjudication dated 03/12/18, with Date of Injury: Cumulative trauma 06/05/15 to 03/12/18. Stress and strain due to repetitive movements. Injured head, back, lower extremities, and upper extremities. Employed by Advances Management Company.

WC Claim Form, dated 03/12/18, with Date of Injury: Cumulative trauma 03/12/17 to 03/12/18. Stress and anxiety due to false defamatory statements, discrimination, harassment, hostile work environment.

WC Claim Form, dated 03/12/18, with Date of Injury: 02/14/18. Hit and run car accident on the property.

Application for Adjudication, dated 03/12/18, with Date of Injury: 02/14/18. Back. Hit and run car accident on the property. Employed by Advances Management Company as an Assistant Community Director.

WC Claim Form, dated 12/12/18, with Date of Injury: 12/12/18. Fell on stairs at work.

Compromise and Release dated 03/12/19, with Date of Injury: CT 06/05/15 to 03/12/18. Head, upper extremity, back, lower extremity. 02/14/18: Back. 12/12/18: Back, and body systems. 03/12/17 to 03/12/18: Stress and psych. Employed by Advanced Real Estate Services as an Assistant Manager. Settlement Amount: $50,000.00.

Undated - Authorization for Absence at Butler Family Chiropractic by Don R Butler, DC. Off work until 03/03/14.

10/13/03 - Progress Note by Illegible Signature. The patient has fractured finger.

10/13/03 - X-ray of Right Fifth Finger at Community Medical Center Interpreted by Mark W Elliott, MD.
Positive Findings: The volar aspect of the base of the right fifth middle phalanx shows abnormal lucency on the lateral projection only. This may represent fracture although the lucency is rather diffuse and not well delineated. The possibility of prior fracture is a consideration. A bony lesion cannot be entirely excluded. Clinical correlation regarding point tenderness at this site and the history of trauma would add specificity. Soft tissue swelling surrounding the PIP joint is noted.
Impression: Soft tissue swelling surrounding the right fifth PIP joint with abnormal lucency in the volar aspect of the base of the fifth middle phalanx which likely represents a fracture. Correlation regarding history of trauma and joint tenderness would be benefit. No significant malalignment

10/16/03 - First Report. Date of Injury: 10/13/03. The patient was removing bags of product from underneath a pallet being held by a customer. The customer dropped the pallet into patient's right hand breaking his little finger. Employed by Mountain Supply Co.

10/21/03 - Progress Notes by Calder Wood, MD. The patient fractured his finger eight days ago. A pallet fell on his finger hyperextending it and he got an avulsion prescription at the proximal interphalangeal joint at the volar aspect of his right fifth finger. Prescribed Lortab 7.5 mg. Recommended to re-x-ray his finger in about five weeks to make sure this is healed well. Keep the splint on all day long but take it off to wash and when he does take it off to wash, and just gently move it so he can get his range of motion back.

11/05/03 - Progress Note by Illegible Signature. The patient presents with fractured finger. (There is illegible information on this page.)

12/23/03 - Emergency Room Report at Community Medical Center by Scott Q Greer, MD. The patient was at work today trying to kick a frozen pipe loose off the ground when his other foot slipped out and he fell on his back. He first had his right arm stretched out behind him to break the fall and he landed on the arm and then he states it gave way. Since then, he had a pain in his anterior shoulder and a burning discomfort. He also feels some tingling in his fifth finger and ring finger. He broke his right fifth finger approximately two months ago and had some soreness and swelling since then. Diagnosis: Right shoulder and right hand sprain. Prescribed Lortab. Dispensed shoulder sling to wear for the next two to five days. Gentle range of motion exercises after two days. Recommended anti-inflammatory medications on a regular basis. Referred to Dr. Christopher Price. He was discharged in stable condition. Modified duty through 12/30/03 with keep right arm in a sling for the next week. After this date full duty. Follow up with Private Physician/Orthopedist if unable to return to full work duties in one week.

12/23/03 - X ray of Right Hand at Community Medical Center Interpreted by Michael R Tryhus, MD. Positive Findings: On the oblique view only, there is a questionable bony density separated from the volar plate of the fifth middle phalanx. There is some soft-tissue swelling in this region. Subacute volar plate injury would be difficult to exclude. A dedicated lateral view of the right fifth digit would be helpful for further evaluation.

12/23/03 - X ray of Right Shoulder at Community Medical Center Interpreted by Michael R Tryhus, MD. Positive Findings: Normal. No evidence of acute fracture or dislocation.

01/05/04 - Progress Note by T. Calder Wood, MD. The patient had a fall 10 days ago on the ice at work. He landed on a partially outstretched right hand. He came in complaining of major shoulder pain to the emergency room. He was x-rayed; there was no fracture, no dislocation. He is still quite sore. He has been working at Sails at the office. Normally his work is fairly physical. Again, his pain is still fairly substantial and it is mostly in the medial shoulder near the area of the coracoid. Diagnosis: Rotator cuff strain. Prescribed Vioxx 50 mg. He has some written exercises at Community Hospital. He should do those gently a couple times per day. Modified duty with limited pushing, pulling, and lifting to 25 pounds over the next three weeks.

01/05/04 - Attending Physician's First Treatment by Illegible Signature. Date of Injury: 02/23/03. The patient fell on ice. Diagnoses: 1. Rotator cuff strain. 2. Contusion, right shoulder. The patient treated with rest, exercise, anti-inflammatories. Present condition is work related.

01/26/04 - Progress Notes by T. Calder Wood, MD. Follow up of his shoulder pain. It is improving, but not quite better. When he elevates his arms above his head he feels a sharp pain in the coracoid region. Prescribed Bextra 20 mg.

01/03/05 - First Report. Date of Injury: 01/03/05. The patient carried box down stairs and lost foot and fell down stairs. Injured ribs, hand and ankle. Employed by Mountain Supply Co.

02/26/14 - Initial Evaluation at Butler Chiropractic Health Clinic by. Date of Injury: The patient was lifting a person with coworker from floor 220 lbs. The patient has burning, constant low back pain at right side only rated at 5/10. Pain radiating to right hip and to knee associated with intermittent numbness/tingling in the upper leg. Mid back sharp, stabbing, constant and pulling pain on left side with breathing and decreased range of motion. Pain rated at 7/10. Neck with sharp and catching pain for 3 days at 4-5/10 and 6-7/10 with turning head. Pain in right side radiating into right jaw associated with numbness/tingling in left arm, hand, and finger.

03/03/14 - Letter Correspondence by Don R Butler, DC. The patient presented with severe neck, mid back pain, low back pain with pain radiating into both legs and headaches. Diagnoses: 1. Cervical and lumbar disc irritation/herniation. 2. Cervical, thoracic and lumbar subluxations at C5-C6, T6-T7 and L4-L5. The patient to be given chiropractic treatment. Modified duty until 03/10/14. He is unstable to do any heavy lifting.

03/04/14 - First Report. Date of Injury: 01/23/14. The patient assisted another staff with lifting a client from the floor to the bed. He lifted him up in bed. He had flu that night and was suffering from really bad body aches. On Tuesday body aches

had stopped, but back was still hurting. Lower and mid back had two very painful areas and pain in neck. Employed by Opportunity Resources.

03/07/14 - Re-evaluation by Don R Butler, DC. Lower back pain radiating to left foot with numbness and tingling in foot and lack of strength, decreased to 6-7 but still constant. Pain worse on right than left. Pain is radiating down into left hip to left foot and numbness and tingling in left front thigh. Constant 8-9/10 with getting out of bed and bending and abdominal pain with movement. Mid back pain decreased 30% to 4-5/10, does better but comes back within a day. Assessment: He is better, but still severe and MRIs are needed to oval disc and any fragments that could be free floating. The 220# lift really hurt him. No work through next week. Plan: Chiropractic adjustments were performed.

05/06/14 - Neurosurgical Consultation by Chriss Mack, MD. The patient is referred by Dr. Butler who has been attempting to treat him with chiropractic manipulation. When he was not making satisfactory progress, Dr. Butler ordered a lumbar MRI scan, which was done at Advanced Imaging. The lumbar MRI scan is very compatible with his complaints, which have been primarily L3 dermatomal dysesthetic pain. It is about 50% better. It happened at the end of February, so two months into this mid about 50% better. The Lumbar MRI scan reveals an annular T2 weighed bright signal directly in front of the left L3 nerve root for laterally in the foramen that probably displaces enough perineural fat to apply some irritation to the L3 nerve root, which is completely consistent with his clinical symptoms. In addition, he does have a midline annular tear which is pretty modest as well, but centrally at L4-L5, subtly more deflection of the left L5 nerve root than the right. He is complaining of normal L5 radicular symptoms. His back pain is present, but not a primary contribution. He takes anti-inflammatories. He has not been working. It definitely still bothers him with any amount of playing with the kids. Impression: This is a nonsurgical annular tear laterally at L3-L4, which is producing a symptomatic L3 relative radiculopathy that is relatively improving and an annular tear at L4-L5 that is not of obvious clinical significance, but is probably contributing to some extent to his back symptoms. Consider undergoing surgical intervention in the form of a lateral left-sided L3-L4 microsurgical discectomy. Referred the patient to Spine Center to Chris Caldwell and the Spine Center for ultra endpoint conservative management.

05/12/14 - Letter Correspondence by Don Butler, DC. The patient has 2 bulging discs that are causing pain radiating into his left leg with numbness and tingling. Also had neck and mid back pain that is progressing well without any major concerns. Range of motion of low back and leg raises have improved steadily. His leg numbness and tingling is over 50% better. His severe low back pain has decreased to grade 3-6s from grade 10 range. Continue chiropractic therapy. Will drop a note in 6 weeks after the low back examination.

06/03/14 - Initial Evaluation. Date of Injury: 01/23/14. The patient was performing his normal job duties on 01/23/14. He was helping another staff member lift a client from the floor to the bed. He reported low back pain with a burning sensation down the left leg. He has a long history of chiropractic treatment with Dr. Don Butler, who has been treating him pretty aggressively without any long lasting results. Dr. Butler recommended an MRI, which was reviewed by Dr. Chriss Mack. Dr. Mack felt that there was not a surgical problem and referred him to Dr. Chris for consideration of injection therapy, but that was denied by the insurer. The patient not had any physical therapy. He reports that Dr. Mack prescribed him Neurontin and Robaxin and that helped his pain, but made him very sleepy and forgetful. He reports that with the medications and his level of pain, he was unable to return to his time of injury job. On 05/23/14, he decided to stop the medication and his head cleared, but then he had more pain. His diagrams pain in the left side low back into the left buttock wrapping around the top of the left thigh into the medial aspect of the left knee and down the medial aspect of the lower leg into the top of the foot. He admits to some anxiety regarding his pain situation. He reports that this has had an effect on his mood and he feels crabby all the time. He has difficulty sleeping. He reports increased sensation of the need to move his bowels, but denies any bowel or bladder incontinence. Past Medical History: Upper neck disc bulge in 2002 when he was hurt at work. Infantile asthma, but no problems since then. Impression: 1. Lumbar strain with MRI evidence of degenerative changes L3-4, L4-5 status post work-related injury 01/23/14. 2. Long history of chiropractic treatment for multiple spine problems and injuries. 3. Diminished function secondary to the above. Prescribed Neurontin and Robaxin. Recommended physical therapy. Stop chiropractic therapy.

06/24/14 - Follow up by Valerie Chyle, APRN. Since last seen on 06/03/14, the patient had 4 physical therapy visits. Physical therapy progress notes are reviewed. The last 2 notes are identical with the exception of a change in date so not very helpful,

but he reports overall feeling much better. He is reporting some burning, but feels that is related to increased activity. He is doing his home exercise program and lots of walking. He is back to work modified duty. He continues with difficulty sleeping. Psychosocial stressors continue in that he needs to be out of his apartment by 07/11/14. At work he was asked to put together a pressed wood dresser, but stopped before completing it secondary to increased pain. He is using ice, heat, and aloe vera juice. He did try the Neurontin, but reported restless legs with that medication. He is using Melatonin to help initiate sleep, but he is not able to remain sleeping. Pain diagram in the very low back and left buttock with some wrap around to the top of the left thigh. He rates his pain right now as a 5/10, at its worst an 8 to 9/10, and best at 3 to 4/10. Prescribed low dose Amitriptyline. Requested massage therapy. Continue physical therapy.

05/12/18 - MRI of Cervical Spine at Expert MRI interpreted by Adil Mazhar, MD.
Positive Findings: Bone Alignment: Curvature: Reversal of the cervical lordosis. Bone and marrow degenerative changes: Schmorl's node at inferior endplate of C3 down through C6. Discs: Disc desiccation at C2-C3 down through C6-C7. Mild-to-moderate associated loss of disc height seen at C3-4 down through C5-C6. C2-C3: A broad-based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.0 mm. C3-C4: A broad based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.3 mm. C4-C5: A broad-based disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord. Disc measures 2.3 mm. C5-C6: A broad based disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord. Disc measures 3.1 mm. C6-C7: A broad based disc protrusion is identified. Disc material abuts the thecal sac. Posterior annular fissure is identified. Disc measures 2.3 mm.
Impression: 1. Reversal of the cervical lordosis. 2. Disc desiccation at C2-C3 down through C6-C7. Mild-to-moderate associated loss of disc height seen at C3-C4 down through C5-C6. 3. C2-C3: A broad based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.0 mm. 4. C3-C4: A broad based disc protrusion is identified. Disc material abuts the thecal sac. Disc measures 2.3 mm. 5. C4-C5: A broad based disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord. Disc measures 2.3 mm. 6. C5-C6: A broad based disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord. Disc measures 3.1 mm. 7. C6-C7: A broad based disc protrusion is identified. Disc material abuts the thecal sac. Posterior annular fissure is identified. Disc measures 2.3 mm. 8. Schmorl's node at inferior endplate of C3 down through C6.

09/06/18 - Initial Orthopedic Panel Qualified Medical Examination. Date of Injury: 02/14/18. During the course of his employment as an assistant manager, around lunch time he was driving a 1996 Lincoln Town Car when a red car rear ended his vehicle. This impact was not that hard but it was enough to cause Whiplash, he panicked and went to see a doctor afterwards. On 02/14/18, he was referred to Kaiser by his employer. MRI of neck was obtained and a bulging disc was found. He was given Flexeril and was advised to rest. He was unable to finish his shift and was not able to return to work the next day. He was taken off work for 2 days. He is currently on modified duty that was declared on 08/20/18. He was advised that he can only work for 4-5 hours a day and to undergo therapy. He did not feel any benefit from therapies, has been doing for five months. His physician advised him to rest for 2 weeks, gave him stretches on paper and watch YouTube videos of stretching exercise that could be done at home. The patient is currently complaining of aching, stabbing sensation and weakness to the neck, left shoulder, left hand and fingers and left leg that is always present. The neck, left shoulder pain, left hand and fingers and left leg pain is rated as 7/10 radiating down to the left shoulder, left arm, left hand, left fingers and left leg. Symptoms aggravated by rotating the neck and left shoulder and staying in one position for a long period of time. Hot baths, heat and ice application, stretching exercises and medication helps a little in relieving the pain. Has some difficulty in doing stretching exercises but this helps a little in alleviating the pain. Has difficulty with the activities of daily living. Diagnoses: 1. Cervical sprain/strain and complaints of radiculopathy. 2. Lumbar sprain/strain and complaints of radiculopathy. Recommended orthopedic surgery/spine specialist evaluation. Ordered MRI of the lumbar spine. Requested report of cervical spine MRI done in April 2018 for review. At this point, the patient is not permanent and stationary nor has reached maximum medical improvement. Continue regular duty while proceeding with additional treatment. Will withhold his impairment rating until he has been declared permanent and stationary. Causation: A portion of causation for the cervical spine and lumbar spine is industrial, based on the submitted medical records and his history as provided. His lumbar spine is casually related to a specific fall in April 2017, while working for Advanced Management Company. On this date, he was walking backwards, fell sideways, twisted and experienced severe low back pain. This mechanism of injury is reasonable to caused injury and the need for treatment on an industrial basis. He was then rear-ended on 02/14/18. The hit was not very hard, but it was enough to cause a whiplash injury to his neck. This mechanism of injury is reasonable to caused injury and the need for treatment on an industrial basis. Apportionment: The medical records forwarded to this examiner discussed

previous low back issues, pre-existing his employment with Advanced Management Company, however, he do not have any records prior to July 2016. If the previous records can be provided they will assist him when it comes time to determine apportionment. According to the patient's history obtained during the evaluation, he did not describe a CT injury while at Advanced Management Company, only the low back injury in April 2017 and a MVA on 02/14/18 involving his neck; however this contradicts his testimony given at deposition.

10/15/18 - Primary Treating Physician's Permanent and Stationary Report at The Wellness Studio by Harold Iseke, DC. Date of Injury: 02/14/18; CT 06/05/15-03/12/18. The patient while employed with Advances Management Company as an assistant community director, he sustained injuries on a cumulative trauma basis from 06/05/15 to 03/12/18 and on a specific date 02/14/18. The patient has been employed for this company for a period of two and a half years. The patient's date of hire was in June 2015. From 06/05/15 to 03/12/18, the patient started to experience headaches, pain in his back, bilateral upper extremities and bilateral lower extremities, which he attributed to constant sitting, twisting and bending. The patient also states that the back pain worsened when he twisted his back as he was walking off a side walk. The incident was known but his employer did not make any recommendations. He managed the pain by seeking medical attention on his own around the end of April 2017 with a private physician in Garden Grove where he was evaluated, diagnostic studies were taken, was prescribed medication, started on a course of physical therapy and returned to work with restrictions. He continued to work with persistent symptoms. He continued to attend follow-up visits and treatment until approximately September 2017, at which time despite the pain he decided to stop seeking medical attention until 02/14/18. On 02/14/18, while the patient was driving during work. He sustained aggravating injuries and later developed worsening headaches and sleeping problems when he was involved in a motor vehicle accident. He was exiting an off ramp and was rear-ended in a hit and run accident. The patient experienced worsening pain to his back and sought medical care at Urgent Care in Garden Grove. He was evaluated was prescribed medication, placed off work and discharged. No further care was rendered. The patient has since continued to work with restrictions on his own to present. Dr. Iseke initially seen this patient on 03/29/18 for evaluation of his cumulative trauma injuries from 06/05/15 to 03/12/18 and on a specific date 02/14/18, while working as an assistant community director for Advances Management Company. At the time of the evaluation, he complained of headaches, back pain, pain on upper and lower extremities, and sleeping problems. He was recommended with physical therapy, chiropractic treatment, acupuncture, ECSWT and medications. During this evaluation, he is still symptomatic despite reporting some improvement in pain after treatment. He is currently working. Currently complains of frequent occipital, frontal sharp, throbbing headache radiating to down left arm with nausea exacerbated with stress, activity and prolonged work; constant mild achy neck pain and stiffness becoming sharp, throbbing, burning severe pain radiating to left hand with numbness, tingling, weakness, cramping and muscle spasms with sudden or repetitive movement, lifting 10 pounds, looking up, looking down, bending and twisting; constant mild mid back pain and stiffness becoming sharp, throbbing, burning severe pain radiating to left hand with numbness, tingling, weakness, cramping and muscle spasms with sudden or repetitive movement, lifting 10 pounds, looking up, looking down, bending and twisting; constant moderate achy low back pain and stiffness becoming sharp severe pain radiating to bilateral legs with numbness, tingling, weakness, cramping and muscle spasms with sudden or repetitive movement, lifting 10 pounds, standing, walking, bending, kneeling, twisting and squatting. There is complaint of loss of sleep due to pain. Due to pain, he feels like his condition will never improve and is causing anxiety, stress, depression and irritability. Prior Industrial Injuries: Neck injury in 2006. Fully recovered. Case closed. Low back injury in 2011 while working for a different employer in a different state. Fully recovered. Case closed. Prior Motor Vehicle Accidents: Previous automobile accident in 1997. Diagnoses: 1. Headache. 2. Spinal enthesopathy, cervical region. 3. Radiculopathy, cervical region. 4. Cervicalgia. 5. Spinal enthesopathy, thoracic region. 6. Pain in thoracic spine. 7. Low back pain. 8. Radiculopathy, lumbar region. 9. Spinal enthesopathy, lumbar region. 10. Sleep disorder, unspecified. 11. Acute stress reaction. 12. Major depressive disorder, single episode, unspecified. 13. Anxiety disorder, unspecified. 14. Irritability and anger. 15. Chronic pain due to trauma. 16. Myalgia. 17. Myositis, unspecified. Disability Status: At this point, the patient has reached maximum medical improvement with regard to orthopedic conditions and is therefore, classified to be permanent and stationary for rating purposes. Subjective Factors of Disability: 1. Headache. 2. Neck pain and stiffness. 3. Mid back pain and stiffness. 4. Low back pain and stiffness. 5. Loss of sleep. 6. Anxiety, stress, depression. Objective Factors of Disability: Cervical Spine: 1. There is tenderness to palpation of the bilateral sternocleidomastoids, bilateral trapezii, cervical paravertebral muscles, cervicothoracic junction, spinous processes and suboccipitals. 2. There is muscle spasm of the bilateral sternocleidomastoids, bilateral trapezii, cervical paravertebral muscles, cervicothoracic junction and suboccipitals. 3. There is limited range of motion. 4. Positive orthopedic tests. 5. MRI findings revealed abnormal findings. Thoracic Spine: 1. There is tenderness to palpation of the bilateral levator scapulae, bilateral rhomboids, bilateral scapular area, bilateral trapezii, spinous processes,

thoracic paravertebral muscles and thoracolumbar junction. 2. There is muscle spasm of the bilateral levator scapulae, bilateral rhomboids, bilateral scapular area, bilateral trapezii and thoracic paravertebral muscles. 3. There is limited range of motion. 4. Positive orthopedic tests. Lumbar Spine: 1. There is tenderness to palpation of the bilateral gluteus, bilateral SI joints, lumbar paravertebral muscles, sacrum, spinous processes and thoracolumbar junction. 2. There is muscle spasm of the bilateral gluteus, lumbar paravertebral muscles and thoracolumbar junction. 3. There is limited range of motion. 4. Positive orthopedic tests. Impairment Rating: Cervical Spine: 8% WPI. Thoracic Spine: 5% WPI. Lumbar Spine: 5% WPI. The patient has been assigned an additional 2% WPI for his pain-related impairment yielding a total of 19% whole person impairment. Causation: It is within reasonable medical probability that the patient's permanent disability to the cervical, thoracic and lumbar spine are directly related to the injuries sustained while working for the Advances management Company as an assistant community director. Apportionment: Based from the information provided, there are no substantial medical evidences of symptoms, disability or impairment prior to the patient's employment at Advances Management Company as an assistant community director. Thus, it is opined that his injuries arose out of, and in the course of his employment with the aforementioned employer. As such, 100% is apportioned to the cumulative trauma from 06/05/15 to 03/12/18 and 02/14/18 accidents. Apportionment in regards to the patient's psychological disabilities is deferred to appropriate specialist. Work Restrictions: The patient's condition has reached maximum medical improvement (MMI) on 10/15/18. He can return to his previous occupation as assistant community director on modified duty with the following permanent work restrictions: In regard to the neck, he is precluded to no overhead activities, and no activities involving repetitive motion of the neck or involving comparable physical effort. In regard to his mid and lower back, he is restricted from heavy lifting, squatting, stooping prolonged standing, sitting, climbing, twisting, walking on uneven grounds, or other activities involving comparable physical effort. Future Medical Care: It is Dr. Iseke's opinion that this patient be provided future medical care for flare-ups that would be reasonably expected for his condition. Additional treatment which may involve up to 24 sessions of physical therapy per year for any acute flare-up. In addition, due to chronic pain, the ACOEM practice guidelines also recommends acupuncture treatments. In addition, the patient may necessitate pharmaceutical agents to include, but not limited to analgesics and NSAID'S. These medications would be prescribed by his medical physician. Moreover, due to the patient's residual neck, mid back, and low back, it is also medically probably that he will require periodic orthopedic specialty evaluation, as well as medications, bracing, injections and even additional diagnostic studies (including x-rays, diagnostic ultrasound, MRI scans, EMG/NCV studies, etc.), in order to monitor for potential progression of the patient's industrially-related injury/pathology. Orthopedic specialty consultations should be provided. The issue of future medical care should be evaluated on an annual basis. Vocational Rehabilitation: If the work restrictions noted above are not honored by his employer, then he should be regarded as a Qualified Injured Worker (QIW), and therefore would be eligible for Supplemental Job Displacement Benefits.

11/28/18 - Supplemental Orthopedic Panel Qualified Medical Evaluation Report by Todd Peters, MD. Discussion: Patient had some hypesthesia in the left lateral calf and posterior calf. At present, his radicular complaints are not verified, but he would recommend that he receive treatment to include possible lumbar epidural steroid injections. He has not received any additional diagnostic studies as it pertains to his cervical spine. This examiner previously requested the April 2018 MRI study of the cervical spine be forwarded for review. Otherwise cervical epidural steroid injections are recommended to help cure/relieve the effects of the 02/14/18, industrial motor vehicle accident.

02/24/2020 - Vocational Rehabilitation Evaluation. Opinion and Conclusion: Based on research with the sources noted, considering the synergistic effect of the patient functional limitations, while also considering his pre-existing non-industrial and industrial injuries, combined with his industrial injury, the counselor believes he has incurred a one hundred percent (100%) loss of labor market access. This determination is an accurate representation of the patient level of disability. In this case, the vocational evidence comes in contrast to the usual application of the schedule for rating permanent disabilities. The schedule should not apply in this case as the actual effect of the industrial injury and the pre-existing problems leads to a total loss of earnings and total permanent disability. To the extent a mechanical application of the schedule might lead to a different result, the actual facts of this case contradicts the application. In the counselor's opinion, the patient qualifies as one hundred percent (100%) totally vocationally permanently disabled. The counselor has determined that the patient Mr. Disney is not amenable to any form of vocational rehabilitation. His functional limitations combined with the intensity, duration, and nature of his chronic and disabling pain will preclude his pre-injury skills and academic accomplishments. He did not believe that he is amenable to any form of vocational rehabilitation and thus has sustained a total loss in his capacity to meet any

occupational demands (AMA Guides). This result in the patient's experiencing a total loss of labor market access, and a total loss of future earning capacity (2005 PDRS) irrespective of any impermissible factors.

08/03/20 - Subsequent Injury Benefits Trust Fund Psychological Eligibility Eval Report by Nhung Phan, Psy.D. The patient had infantile asthma. The patient was hospitalized at 2 years old after falling off a table, breaking a plastic wall socket with his head. The patient had gastroesophageal reflux disease (GERD) and irritable bowel syndrome in 1996, and back pain and migraines in 1997. The patient believes his medical problems were a result of psychotropic medications of Depakote and Zoloft while he was in the Navy. The patient took these medications for four weeks and never took them again. The patient was not sure of the condition he took the Zoloft for, but the Depakote was for seizures. The patient notes he has been hit in the head at least four times in high school from playing football and basketball, and that he these sports "played hard." The patient lost consciousness briefly approximately three times. The patient was hospitalized once at 19 years old after encountering a motor vehicle accident. The patient went to an emergency room, because he was emotionally overwhelmed and was hospitalized for three or four days. In 1997, he got into a verbal argument with the commander in the Navy and was admitted into a psychiatric hospital once for being a danger to him as a result. The patient states he had not been medically disabled before his injury. After the subsequent injuries, he developed medical problems of 10% hearing loss in his right ear. The patient has been already been partially permanently disabled with 60% of rated disability with residuals fractured left pinky finger, tinnitus bilateral hearing loss, adjustment disorder with depressed mood, irritable bowel syndrome and GERD, tension headaches, erectile dysfunction, left lower radiculopathy of the sciatic nerve, degenerative arthritis thoracolumbar spine, cervical strain and loss of vision. Taking Adderall, Gabapentin, Vitamin D, Lipitor, Ibuprofen and Flexeril. The patient began developing depression at 19 years old while serving in the Navy, but more so after his motor vehicle accident, in which he was hospitalized for three or four days. The patient endorsed suicidal thoughts of killing self during this time. The patient began taking Depakote and Zoloft while he was in the Navy in 1997. The patient also got into a verbal argument with the commander and was admitted into a psychiatric hospital once while in the Navy for being a danger to him in 1997. In 1997, he received counseling from a psychologist for 4-5 weeks while in the Navy. In 1998 or 1999, he was discharged from the Navy for being diagnosed with a mood disorder and personality disorder. Since his subsequent injuries, he feels even worse than he did prior, noting his mobility is impaired and he is more depressed than ever. The patient reported he has ADHD, for which he sees a therapist and takes Adderall medication. Subsequent Injury Psychiatric Diagnoses: Axis I: Major depression, single episode severe. Generalized anxiety disorder, moderate. Pain disorder associated with both psychological factors and a general medical condition. Male erectile disorder. Male hypoactive sexual desire disorder. Sleep disorder due to a general medical condition, insomnia type. Axis II: No diagnosis. Axis III: Physical disorders and conditions: Status per the review of the medical records above. Axis IV: Severe: 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: suicidal ideations, financial problems etc.. Axis V: GAF - 48. Impairment Rating: The whole person impairment was 34%. Arousal and Sleep disorder impairment: The whole person impairment rating was 11%. Sexual dysfunction disorder impairment: 13%. Causation: Based upon his chronic sleep dysfunction that arose out of his subsequent injury, the level of his sleep impairment is equal to an 11% disability rating considering a pre-existing sleep disorder. Based upon his chronic sexual dysfunction that arose out of his subsequent injury, the level of his sexual impairment is equal to a 13% disability rating. Based on his history, his condition is attributable to compensable consequences of orthopedic issues. Work restrictions: Part-time schedule with frequent breaks due to his fragile and emotional states. Flexible schedule to accommodate pt's need for weekly psychotherapy. Flexible schedule to accommodate pt's sleep disorder. No assignment of excessive job pressure such as multiple, frequent deadlines or frequently working with difficult people. Apportionment: Pre-existing psychiatric impairment: 29% WPI from GAF of 51. Current psychiatric impairment: 34% WPI from GAF of 48. Pre-existing disability: Psychiatric disability: 29%.
Subsequent disability: Psychiatric disability increased by 5% to 34%.

08/06/20 - Comprehensive Independent Medical Evaluation in Neurology SIBTF Evaluation Report by Lawrence M. Richman, MD. The patient does report multiple other medical problems that preceded his date of hire, which was in June 2015. The patient reports that in 1997 while serving with the U.S. Navy in Illinois as an electronic technician he was involved in a motor vehicle accident. The patient was a passenger in the front seat of a car that was driven on a local street. The car was impacted on the front passenger side where he was sitting. The patient reports that his face struck the dashboard. The air-bag deployed resulting in injuries to the stomach and pelvis. The patient reports that the air-bag also caused a whiplash injury. Emergency medical technicians were called and he was taken to U.S. Navy Hospital in Illinois where he was evaluated in the

emergency department. The patient was subsequently released. As a result of the motor vehicular accident in 1997, he reports having experienced neuralgic-type headache pain over the right-side of the scalp occurring up to 50 or 60 times per month. The patient describes an ice pick-type of sensation of pain. The pain is located of times over the right temple and last ten to fifteen seconds; typical of neuralgic pain. The pain has persisted to the present. Another complaint that arose from the 1997 motor vehicle accident was impaired sleep, which he attributes to pain from the scalp that occurs at night, as well, awakening him three to four times per night. The patient does provide of Epworth score of 0 regarding his impaired sleep. The patient states that he simply does not dose off during the day because the pain keeps him in an awakened state. The patient reports that as a result of the motor vehicle accident in 1997, he has experienced difficulty with memory and concentration, word-finding difficulties and irritability. The patient does respond affirmatively to the Clinical Dementia Rating from Table 13-5 of the AMA Guides Fifth Edition. The patient reports that he forgets what to purchase at a store, he forgets where he places personal belongings and loses direction easily. The patient forgets things that he should know. The patient has keeping track of time and time-relationships. The patient has had diminished interest in his avocation as a magician. Another complaint that has arose from the motor vehicle accident of 1997 is that of low back pain with radiation into the left lower limb and into the outer foot consistent with SI radiculopathy, as well as fascicular pain consistent with lumbar instability and probable listhesis of the lumbar spine. The patient reports another incident that occurred during his course of service in the U.S. Navy at which time another seaman in Illinois fired a weapon in proximity of the examinee's right ear in 1996 causing the applicant chronic tinnitus on the right side. The patient reports the tinnitus, however, does not keep him up at night, but rather the pain over the scalp keeps him up. Other injuries that the patient reports that he has sustained are related to his first course of employment at Mountain Supply Plumbing located in Missoula, Montana (the patient's home slate). The patient reports that while employed by Mountain Supply Plumbing he fell down seven or eight steps causing increasing low back pain, greater than that experienced from the motor vehicular accident in 1997. The patient reports that the above noted back pain was a lesser level of discomfort and then increased to a higher level following that fall. The pain still radiated into the left lower limb to the outer foot. The patient notes that his next injury occurred in 2005 while employed by Schwan's Frozen Foods in Missoula, Montana. The patient was employed as a delivery driver. The patient reports that he when he was working for Schwan's Frozen Foods; he was struck by a 2'x4' piece of wood at the base of the head and neck sustaining altered mental status and was dazed. The patient experienced blurring of vision. The patient's memory complaints from the earlier 1997 motor vehicle accident increased by approximately 20% worsening. The patient reports that his memory problems have since leveled off/plateaued. Following this injury, he experienced blurring of vision from the blow to the head by the 2'x4' while employed by Schwan's Frozen Foods. The patient was evaluated at the community hospital. The patient drove himself to the hospital the following day. The patient was evaluated and then released. The patient reports that his headaches over the scalp also increased in frequency and severity. The cervical spine pain, however, did not increase. The patient reports that in 2013 he injured his low bock while lifting a client while employed as a home health specialist; further increasing his low back pain and the left lower limb in the SI distribution while employed in Missoula, Montana. The patient reports that in high school, as a sophomore, he was riding a bicycle and he was wearing a helmet. The patient fell from the bicycle and sustained a concussion. The patient was taken by EMT to a local hospital where he was released. The patient had headaches from that incident, which subsequently resolved. The patient does not report having experienced trouble with memory from that accident, although he does report difficulty with concentration. The patient's medical history also includes an Attention Deficit/Hyperactivity Disorder for which he has been treated with Adderall. The patient's history also includes a history of depression, diagnosed in childhood. The patient reports that he was discharged from the navy for depression with an Honorable Discharge, but earlier than his expected duration of service. The patient reports that he was asked to leave the service. The patient was diagnosed with depression in 1999. The patient reports ongoing problems with memory and concentration, wide spreading neuralgic pain over the right-side of the scalp, difficulty with memory and concentration and Attention Deficit/Hyperactivity Disorder. In addition, he reports frequent headaches, rated as 10 out of 10. The patient has occasional cervical Spine pain that radiates into the left upper limb, described as a 10. The patient has constant low back pain that radiates into the left lower limb and outer foot, described as a 7. Other complaints include impaired memory, concentration, irritability and word-finding difficulties. The patient reports diminished sensation on the left upper limb in the C6 7 distribution, as well as in the SI distribution. The patient is currently taking Adderall, Gabapentin, Ibuprofen, Flexeril and Lipitor. Diagnoses: 1. Pre-existing post-traumatic/post concussive syndrome. 2. Pre-existing Attention Deficit/Hyperactivity Disorder. 3. Pre-existing post-traumatic headaches. 4. Pre-existing traumatic induced neuralgia of the right scalp. 5. Pre-existing cervical radiculopathy on the left. 6. Pre-existing lumbar radiculopathy on the left. 7. Pre-existing convergence insufficiency resulting from the head injury he sustained during his course of employment with Schwan's Frozen Foods, 2005. Impairment Rating: The final whole person impairment rating was 48%.

08/08/20 - Subsequent Injury Benefits Trust Comp Medical-Legal Report by Sameer Gupta, MD. In April 2016, the patient involved in a cumulative trauma injury developing increased pain in his neck, lower back, as well as increased headaches, after he had stepped off a sidewalk and stumbled backwards and "jarred" his entire body. Continued to perform his customary work duties in pain. Sought medical treatment. In about late 2017 or 2018 he began being harassed by the HR department and he felt he was the "black sheep" of the company. The patient requested an interview to be promoted to assistant community director and after sending several letters, he obtained an interview and given the job. Shortly thereafter, he was attending the assistant community director class and felt he was being looked at. The patient felt his director was not following the policy following the death of a resident. On 02/14/18, he was driving home after attending the assistant community director's class while stopped on an off ramp, when he was rear-ended. The patient developed increased pain in his neck and lower back, reported the accident to his supervisor and sought medical treatment. The patient began developing increased headaches, depression, and irritability, secondary to stress. The patient sought medical treatment at Kaiser Permanente Emergency Room in Costa Mesa. The patient was examined and diagnosed with a whiplash. The patient was taken off work for three days. Secondary to the harassment and being mistreated by his supervisor he began documenting issues occurring at work. In late February 2018, a "surprise" meeting with the COO and regional manager secondary to an incident that occurred the day prior with a security guard. The patient's girlfriend was dropping him off at work and parked in a parking spot to pick up his vehicle. A security guard approached him and said they were not allowed to park at that particular space and he explained he was only picking up his vehicle and the security guard kept telling them about the issue. There were vehicles were parked behind him that prevented him from backing up. He then maneuvered his car back and forth between two empty spots and was able to leave the parking lot. The patient was told he had backed into a gate, which he did not. A resident issue came up and he emailed his supervisor regarding the issue and was told a meeting was going to be hostile. The patient took a day off and had stomach issues. The patient received word that he was being transferred to another location and being demoted. He was given a box of business card with no job title listed on it. In March/April 2018 he began developed blurred vision, which he attributes to looking at a computer monitor for prolonged periods of time. The patient retained legal counsel and referred him to Dr. Iseke, a chiropractor. The patient was examined, x-rays were taken, a course of chiropractic and physical therapy was initiated, and released to work with a restriction of no stair climbing, no lifting greater than 10 pounds, no stooping, squatting, and be able to move about as needed. The patient's work duties entailed answering and making telephone calls and inputting information into a computer. In late September 2018, a job became available as a community director; however, he was told he could not apply secondary to his restrictions. The patient wrote letters to the City of Santa Ana and HR. This made him angry. Later, the position became available; he obtained an interview and was hired. Cameras were installed in his office directed toward his desk and was always being watched. On 12/12/18, he was descending stairs when his left leg became weak and he fell and fell onto his back and slid down about eight steps. The patient's cell phone that was in his back pocket broke in half. The patient was having difficulty breathing and noted increased pain in his neck and lower back. The patient "hobbled" to the office and sent his supervisor a text and calling his supervisor with no response. The patient denies any current asthma symptoms. The last time he had an asthma episode was at age 17. Recollect parents telling him he has a childhood history of significant asthma with recurrent ER visits and hospitalizations when he was an infant all the way up to age 5. Since that time has not had any significant asthma flare-ups. Currently is not on any inhaler treatment. However on additional questioning docs note and occasional wheeze from time to time. The wheezing episodes have been happening every 3-4 times a year, has not had this address by treating providers. Docs not even have an inhaler but thinks that that would be a good idea to have whenever the patient does develop these wheezing episodes. Does note that cold air seems to bring it on. Complains of recurrent headaches at the left temple that lasts for a seconds and felt like he was having a stroke. This affects his vision problems. Complains of bilateral blurred vision and recurrent watery eyes. Complains of depression, anxiety, nervousness, and irritability. Complains of recurrent pain in his neck with a stabbing sensation in his neck, with pain radiating to his left shoulder blade. The patient has headaches as mentioned above. The patient has recurrent numbness and tingling in the fingers of his left hand. The patient has recurrent popping and continuous stiffness in his neck. The patient notes no weakness in his upper extremities. The pain is aggravated with turning his head from side to side, looking up and down, tilting his head to the sides, and reaching. The patient's symptoms are alleviated with hot baths and showers. The patient complains of continuous aching and recurrent sharp, pressure, and burning pain in the mid back. The patient's symptoms are aggravated with bending, twisting, turning, reaching, and prolonged sitting, standing and walking. The patient's symptoms are alleviated with hot baths and showers. The patient believes the numbness and tingling in the left hand is radiating from his neck. Complains of continuous aching and recurrent sharp, pressure, and burning pain in the lower back, with pain radiating down the left leg to his third and fourth toes. The patient also has pain radiating to left testicle. The

patient has recurrent tingling in the left leg. Weakness is noted in the left lower extremity. The symptoms are aggravated with bending, twisting, turning, reaching, ascending and descending stairs, and prolonged sitting, standing, and walking. The patient's symptoms are alleviated with medication, hot baths, and showers. Complains of depression, anxiety, and nervousness. Complains of difficulty sleeping. The patient sleeps an average of four hours of interrupted sleep per night. The patient has some difficulty urinating, defecating, getting dressing, and eating. The patient has much difficulty sitting, standing, walking, and reclining. The patient recurrently has some too much difficulty climbing stairs. The patient has some difficulty gripping, grasping, or tactile discrimination. The patient has much difficulty riding and driving, as well as some difficulty flying. The patient has much sexual dysfunction. The patient has much difficulty with restful and nocturnal sleep pattern. Diagnoses: 1. Upper GI issues of medication associated gastritis and GERD. 2. Lower GI issues of irritable bowel syndrome and diverticulitis. 3. Neurological issues of traumatic brain injury and headaches, cognitive issues, etc. 4. Vision issues. Causation: 60% partial permanent disability with a diagnosis of IBS and GERD. Impairment Rating: The whole person impairment rating to the upper GI issues was 25% and lower GI issues were 2%. Apportionment: 100% of the upper GI and lower GI issues are related to pre-existing condition and that 0% are related to the recent industrial injury.

08/08/20 - Comprehensive Independent Medical Evaluation by Paul J. Marsh, DC. The patient has a chief complaint of low back pain is with radiating pains down his left leg to his toes. The pains are best described as burning in nature with numbness and tingling as well. When asked to rate the pain(s) today on a 1-10 scale, the patient states that the pain(s) are at a #8/10 and Constant. The patient's secondary complaint is that of sleep disturbances and states that he only gets approximately 2-4 hours a night of restful sleep and that his sleep patterns are broken up due to pain stress, anxiety, and GI issues. The patient has a tertiary complaint of psychological condition best described as a sense of hopelessness, depression fatigue. To complicate matters he states that his father had 3 jobs which can best be described as Superman (firefighter, police officer and EMI), and because of his conditions as listed prior he has been unable to find gainful employment and has had over the course of his life 32 different jobs. The patient states that he always has tension headaches, still gets migraine headaches to this day and a lot of this comes from his neck and shoulder region. When asked to rate the pain(s) today on a 1-10 scale, the patient states that the pain(s) are at a #6-9/10. The pains in his neck and head are best described as gripping, with episodes of sharp pain. Associated with the migraine headaches is nausea, with visual disturbances. The patient states that he suffers from restless leg syndrome which can be associated with a slight tremor as well and if he does not take his medications (Gabapentin and Flexeril). There is no chance of him sleeping at night. On occasion the patient states that he gets arthritis type aches and pains in his 2 pinkies', and finds himself catching his left pinky on things at times causing a sprain strain type injury. Memory loss with inability to form accurate and or complete sentences. Difficulty to concentrate for any length of time. Diagnoses: Musculoskeletal: 1. Lumbar spine HNP with radiculopathy. 2. Sciatica. 3. Cervical spine HNP with radiculopathy. 4. Thoracolumbar facet irritation. 5. Tension headaches. 6. Migraine headaches. 7. Positive orthopedic screening consistent with mild thoracic outlet syndrome. 8. Swan-neck deformity of #5 digit on the left. 9. TMD dysfunction. 10. Multiple ankle sprains as a teen playing sports. Non-musculoskeletal: 1. Asthma. 2. Poor vision double vision "watering of his eyes". 3. Chest pain anxiety. 4. High cholesterol. 5. GERD/IBS. 6. Frequent urination at night. 7. Kidney stones. 8. Erectile dysfunction (presumably from the low back injuries, airbag and psych). 9. High cholesterol. 10. Anxiety, depression. 11. Memory Loss. 12. Sleep disorders. Impairment Rating: Lumbar spine and sciatica 8% WPI. Cervical spine 8% WPI. Cervicogenic and migraine HA 3% WPI. Thoracic spine 0% WPI. Thoracic outlet syndrome/disorder 1% WPI. Causation: Based upon the medical records presented to me and the history taken at the tune of the evaluation, it appears that this patient has musculoskeletal, impairment and or disability which can be directly correlated to both industrial and non-industrial causes to which apportionment was clinically indicated. Based upon the medical records presented to Dr. and the history taken at the time of evaluation, it appears that this patient has non musculoskeletal impairment and or disability that of which will need to be evaluated by the appropriate specialists including but not limited to: Psychology, internal medicine, rheumatology, dental HEENT. PPD with no lifting, pushing, or pulling of greater than 10-20 pounds from floor to waist. No overhead work. No repetitive gripping/grasping and or fingering. No prolonged postures including but not limited to sitting and/or standing. This contemplates that the injured worker/patient is best suited for a sedentary type job with the ability to change task and or position at will to prevent a flare-up or exacerbation.

04/19/18 - Deposition of Evan Alan Disney, Volume I. (138 pages).

Page 8: The patient took Ibuprofen 600 mg on the day of deposition. He has been taking it once in a while. A couple weeks ago, he had taken it besides that morning.

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Page 9: He was given prescriptions in February. He took it that day because he knew the car ride from Fullerton might make him sore.
Page 10: He has had his deposition taken once in 2003 due to work-related injury.
Page 11: The deposition happened when he was injured at work but deposition was wrongful termination. It was 15 years ago and felt things were foggy. He was scheduled to work from 9 to 12 on the day of deposition.
Page 12: He had taken off of work to attend that day's deposition. His hourly rate of pay was $17.50 an hour. He drove himself from his home for deposition.
Page 17: He is making payment on his arrears. His wages are being garnished. He paid $423 plus the fees.
Page 18: He is responsible for child support of 3 children.
Page 19: He had served in the navy for a year. He was discharged honourable for personality disorder. He had severe attention deficit hyperactive disorder. His parents told him he had it as a kid. He had knowledge of that issue when he was in navy. He is currently employed with Advancement Management Company. He started working in June 2015.
Page 20: He was a residential management and doing the position of a leasing agent but they have currently stripped him of his title.
Page 21: He was promoted to assistant manager of a property and was demoted for reporting a Fair Housing violation 10 shifts later. When he pressed them for title, a business card was given to him with no title so he is currently performing the job of a leasing agent, but he business cards they had sent him was different from others'. He reported the violation to HR for Advanced Management Company. He is currently investigating the process to take it further. He had filed with the State of California retaliation complaint for the demotion for no cause.
Page 21: As a leasing agent, he managed office, went on tours, cleaned and moved when need to. When did tours, he walked people to prospective apartments and he was doing stairs which was a challenge. He occasionally swept, vacuumed, desk polished. Moved packages mostly although that was diminishing. Packages were UPS, FedEx. They took large packages in the office because they don't fit in the parcel boxes. Usually the packages he was dealing with were on the larger side. He was the bigger body in the office to move things. He was not allowed to lift more than 40 pounds.
Page22 In office, he took residents, answered phone calls, typed up work orders, visited residents at their households and did inspections. It had a lot of up and down. Currently his property has 3 employees in the office and they managed 200 units. He also did a lot of handwritten paperwork, and leases.
Page 23: He did daily notes, did 3 pages per day on the flow of the office and signed about 30 in a row. Notes were typed in computer. His supervisor told him to do that and he was a faster hand writer than a typist. He worked approximately as assistant manager for 10 shifts. He had more responsibilities with notices, customer relations, training people how to use the lifts in the carport, walk the property to make sure everything was to standards, fill in and take everything that was in the job.
Page 24: Assistant community director was his title. Prior to AMC, he was self-employed and was a sub-contractor for Missouola Copy Center. Owner was Doug Hannan and the patient did odd jobs for him and managed the customers for 7 years before coming out. He is a magician and a member of the Magic Castle in Hollywood. He raises money for nonprofits and prevents bullying in schools. He has been a working as a magician for about 20 plus years.
Page 25: He was averaging 30 minute/month. He did a performance on 03/24/18 in a 10-minute set. He was master of ceremonies at the Renaissance School International Talent Show on 03/21/18. He did filming on 02/12/18.
Page 26: His magician side of job was inconsistent because he did not have a daily regimen. Sometimes it was a donation and he was just showing up as a friend for a friend. He was never paid for the above other than Renaissance. He was also not paid for America's Got Talent audition.
Page 27: He had an audition for 90 seconds. He won't be on America's Got talent that upcoming season. In the last 6 months, he had done magic performances for pay 2-3 with Renaissance for Christmas season. He felt he might have done an in home birthday party on 01/06/18. He had a director of business. His girlfriend took care of those and he paid nothing to her.
Page 28: He was a close-up artist and used hands. Nothing heavy and nothing was repetitive. He had done every possible position in his 20 year career probably with magic and card tricks. Most of the magic was delivered from a standing upright position and he does not stand unless he was getting paid for longer than 40 minutes.
Page 29 At the Magic Castle on 02/12/18, he recorded a 20-minute set for the entertainment director so that he could get hired by Magic Castle at some point in his career. He was in a game show 2 years ago. He was a contestant in Let's make a Deal.
Page 30: Most of his work for Missoula Copy Center was paid cash which he had had to claim on his own. He was an independent contractor and sub-contractor for it. He did job from running deliveries to make phone calls, collect delinquents. The job he was working while he was doing that before he came out there was a casino job for Lucky Lil's. He has been doing work for Missoula Copy Center for 10 years and still does when visits him.

Page 31: He went twice a year for four days a pop. He went back in November for a family vacation and he had some things he had to take care of with his parents. He ran errands in trade for business cards when he went back in November. He did not get paid but he traded for services which he did often for him. He worked for Montana Little Lil's from December 2014 to February 2015. He was a runner. He just basically paid people their tickets and brought them their drinks. It was all walking and no bending, pushing, cleaning and it was a really easy job. It was all exchange and barter there.
Page 32 At Missoula Copy Center, he didn't earn any income. He would purchase things for the patient for the work but never gave him the actual money for it. The patient was taken out for dinner or his tank would be filled with gas, or there was a couple of occasions his rent was paid and he had to spend 2-3 months paying that off but he never received cash money.
Page 33: He got $9 an hour plus tips. He stopped working there as he moved to California to pursue his magic. Prior to Lucky, he worked for Opportunity Resources from 2012 to 2014.
Page 34: He was like a CNA without certification, a nursing assistant. He took care of the residents, bathe them, cleaned them, got them from their bed to the wheelchairs, wiped their tuchus after they went potty, took them to church, cooked them breakfast. He did the daily ins and outs of everyday life. He provided them the best quality of life. He earned $11 per hour.
Page 35: In 2013 at the end of his employment at Opportunity Resources, he had injured his lower back. He was lifting a resident off the floor under the direction of his supervisor and he didn't want to use the lift and he went ahead with his command and did it anyway. When they lifted him off the floor and turned, something popped in his back and caused him some severe pain and issues in his lower back. He received medical treatment from Butler Chiropractic in Montana.
Page 36: His attorney sent him to other doctors but he didn't have the specifics. He then got a $1000 to help wrap up the rest of his medical. He did physical therapy and took care of himself. Prior to working for Opportunity Resources, he was employed with Direct TV around 2008 to 2011.
Page 37: He was the team support specialist at Direct TV. He handled all the supervisor calls and train agent, held them accountable, kept them up and active all their stations while they were on. He worked in a call center and rarely worked on a computer. Their team support specialist job was to be up and visual so their agents would have energy. He was always positive and hyper and hence ADHD made him perfect within 6 months. He received $14 an hour.
Page 38: He sustained injury to left ankle and low back at Direct TV. He was with couple of supervisors and he tripped over something and twisted his ankle. He could not recall specifics of the incident. He remembered being off of work for ankle twist.
Page 39: He would also have injured his low back but he was unable to recall. He filed claim in 2012 for neck with Liberty Life Insurance Company of Boston. He was working for Schwan's helping a customer with her groceries. Her car alarm went off. It started him and he got smacked in the back of the head when he stood up by 2 by 4 beam on a shed or a garage car port. He didn't know when he worked for Schwan's. In 2012, his neck would have been injured at Opportunity Resources.
Page 40: He recalled working for Schwan's in early 2000s and he was fired when he was out on that issue. He ended up losing home at that point.
Page 41: He has Kaiser health insurance. He had been to Kaiser Garden Grove. He visited an ER last year for chest pain. Until 3 weeks ago, he had seen a chiropractor in Long Beach.
Page 42: He had a physical the previous year and he didn't know if the doctor was family doctor and it was assigned by Kaiser.
Page 43: He had been diagnosed with diverticulitis or bout in California the previous year. His current source of income is from AMC. He charged usually $500 for his magic shows or performances at a birthday party or corporate event. He had not made more than $1500 but he quote higher than that depending on the job where it came through. He just never got any of those jobs.
Page 44: He worked for trade so he did get for the Eric Zuley birthday party and he usually bartered. If he could work out for food or for tickets, he did that. For school performances he got paid about $500.
Page45: He was paid $350, for basically an hour and a half performance but he had breaks in there where he could sit down and rest. School performance was 2 Mondays ago. When he was paid money, he was paid by cash and by check. It was 50/50. He wished to become a full-time magician sometime.
Page 46: He is always animated even when he is not feeling well during the performances. It was his ADHD. He had done Vivo Video. He had to post 15 minute videos of him doing magic. He does nature magic a lot. He got reached out from someone from the Magic Castle asking him to do and also that he will be paid $500. He had a reduction that month and was sure he could use the extra cash.
Page 47: He last posted a video the previous day.

Page 48: He and his girlfriend received $612 as foot stamps. They both shared the household. She worked at Renaissance school and the MC was unique. He was offered MC for $500.
Page 49: He had received Worker's Compensation benefits around 2012.
Page 51: He fell down a flight of stairs at Mountain Supply. He didn't know if he had filed claim but he had injured at work. He was hired there 3 times and he worked for about 4 years in 3 different employment.
Page 52: He remembered receiving 2 times in his life a continuous workmen's compensation check for a period of time because he needed the money to survive because he wasn't working.
Page 53: He received disability benefits for 6 weeks and the benefits ran out and he requested doctor make it so he could go back to work because he needed the money. During those 6 weeks from May to June 2017, Dr. Robert Bautista certified him.
Page 54: He was out of vacation time, sick time. He got injured in April with AMC but if they reported to their property, it affects everybody's bonus.
Page 55: He didn't work for any entity during that time. He was involved in 2 automobile accidents in 1997 and other in 1996.
Page 56: He injured his mid to upper back in 1996 accident. He injured a little lower than his shoulder blades up into about where his neck started. It was more in his shoulder.
Page 57: He received treatment at United States Navy Corps Hospital, Great Lakes. He was a passenger and he signed off something and he could not recall as he was a kid. He had myofascial pain disorder which was diagnosed in 2004. When he was going through worker's compensation case, he was malingering and he was put through 72 hour psyche evaluation and was found to have the disorder.
Page 59: He didn't have back pain until April of last year. He felt stiff and had worked for job for a year.
Page 60: Since his start with AMC he worked for a brief job with Costco selling Direct TV. He worked from April 2015 until he started to work with AMC.
Page 62: He availed FMLA from May 2017 to June 2017 as he was injured. As a result of AMC work, he had numbness and tingling to left leg.
Page 63: He had pain to lower back, left leg, left arm, at the base of his left neck and it wrapped around into his sinus almost. He had symptoms in his right leg.
Page 64: He felt pain in body parts could be due to over time. First time, he noticed pain in his low back in November or December 2016.
Page 65: He first noticed pain in his left leg in January 2017. Left arm issues and neck were there since February 2018.
Page 66: Right leg issues started in April 2017. He felt low back pain started when they were doing Thanksgiving turkey boxes for the residence. They had an assembly line from reaching boxes up in the truck and brought them down. Next day he felt sore.
Page 68: Complaints in body parts got worse over time. When he sat at his desk, he noticed that he started to get fidgety and left leg felt tingling and numb.
Page 69: He couldn't stay in one position for a long time. He had to go from sitting to standing.
The promotion and demotion occurred in February 2018.
Page 70: He went for community director training every Wednesday. He spoke to HR and to the COO of the company because HR told to ask COO about the Fair Housing issue. After the meeting, when he was driving back to property, he was rear-ended around 12:15. He contacted the supervisor, went back to the property and the supervisor told him to go to NowCare.
Page 71: Accident occurred on a freeway off ramp. It jarred him forward and back. There wasn't any damage.
Page 72: Date of injury was 02/14/18.
Page 74: He never stated it was signed on the property but it happened while at work.
Page 75: He told to his co-workers that he had to deliver flowers to his girlfriend and he specifically asked if he needed to go to the property first to clock out. After the accident, he got the flowers.
Page 76: He stopped for gas before accident. He went to the property, checked in with boss and then stopped.
Page 77: In April 2017, he tweaked his back while doing a tour of a unit and he mentioned it to his assistant manager.
Page 78: His assistant manager, was his mentor and he let him go do some of the onsite jobs to get relief when he had pain in various body parts.
Page 79 There was no formal report made as he needed the job and money.
Page 80: He called his dad who was a police officer and texted his manager after the accident. He didn't call police as he felt there was no damage to car and he was only shaken up.
Page 82: He went to Montana in February 2017 to get his daughter. He drove there and back for 14 hours. He told his co-worker about prior work back injury.

Page 83: He told doctors at Kaiser that he felt sore and he was treated like a number.
Page 84: In April, he couldn't function well due to back pain and he told his boss about the issue.
He went to Kaiser doctor. He was given restricted note and if it couldn't be accommodated, he should be off of work. For 14 days, he was off work in 2016 due to low back pain. A week of sick time and 2 days of vacation time.
Page 86: Doctor's restrictions were to not sit or stand for extended periods of time, no lifting, minimum bending, squatting, twisting and turning.
Page 87: AMC accommodated him and after he had exhausted every time off resource that he had. AMC allowed him to come back with a minimum schedule. He was put back to modified duties by the chiropractor. It was 5 hours a day of work.
Page 88: Currently it was all accommodated. He last received medical treatment for work-related
injuries at AMC in end of April 2017.
Page 89: He had been seeing Dr. Iseke for 3 weeks.
Page 90: He went to Kaiser on February l4th between 3 and 4. He went to see his boss and then boss suggested Kaiser.
Page 91: He was diagnosed with whiplash in neck and was taken off of work for 2 days. In April 2017, he was diagnosed with a bulging disc with a narrowing nerve canal.
Page 92: Doctors attributed pain to right leg, left leg to chronic lumbar back.
Page 93: Kaiser referred him to pain management.
Page 94: He was also referred to physical therapy but he told them he didn't have money to pay the co-pay and he would do at home. His friend did massage therapy and it helped for an hour.
Page 95: Dr. Iseke did acupuncture and muscle stimulation. He didn't feel difference in 2 weeks and doctor said it would take some time to feel the difference. Page 98: Finances was a stress and work was the cause. He wanted them to take accountability and he is still trying to do job to the best of his ability. Page 99: He got demoted on February 21st and his stress and depression started since then. He was okay with the new position. Page 100: He had heartburns sometimes, couldn't sleep. Page 101: He felt his breathing going up and light-headed. Felt like throwing up and very emotional.
Page 105: The company figured his hours wrong. He was told he had less hours and problems started when he went on his FMLA. He was applied for the assistant manager, he was interviewed and he was ready for the position.
Page 108: He is seeking legal for slander, defamation of character. He sent them an email, but received no response.
Page 109: He recalled sending mail indicating he would seek counsel to defend himself against retaliation and attempts to constructive discharge. Page 110: He wanted to keep his job and not have a bad reputation with the company. He felt he was being fair than being underhanded. Page 111: He had filed bankruptcy about 17 or 18 years ago.
Page 112: He borrowed his car from his father and not owning it. He had low back pain during deposition.
Page 113: He rated pain to low back as 7.5/l0. Randomly it went about that pain level. Hot water, ice, weightlessness, float in water helped with the pain. Ibuprofen didn't help much. Right and left legs were off shoot pain. Currently, his left leg is numb and has tingling in hand. He couldn't feel his left hand and it is ice cold now. Page I14: His right leg is okay now. When he had issues with right leg, he had burning, tingling down the front side once every couple of weeks or couple of months. Left side of neck has tightness. He had pressure in his sinus because of his neck and had a hard time turning it. It was a challenge to drive, he wasn't told he should not drive but it was hard for him to look in the blind
spot and turn neck. He still had no function. Page 115: Because of pain he couldn't play basket ball and with kids. He last played the previous year. He is able to bathe and dress himself but at times he had difficulty in tying his shoes as he could not reach with his back. He did not do household chores but felt like having good sleep. He never got a good sleep.
Page 116: His injuries had worsened and everything had just aggravated over the last month. Dr. Iseke wanted to get an MRI of neck, and nothing was told to him as to why the doctor was still doing the thing. He had gone out with his family for dinner a couple times. He did like the AMC as it had reclining chairs and he could get comfortable at the movies. He had been doing it once/twice a month and he gets a free birthday movie. Tuesdays it was $5 and he could swing that.
Page 117: He went to the Magic Castle that Sunday for his birthday. Free meal was given to him as he was the member there. For being a member of the castle, he passed his audition among 14 members that were in-charge there. He paid membership dues. He raised 5 grand for pediatric cancer because he is a member of the Magic Castle previous year. In his free time, he watched a lot of TV. At that moment, he owned a bull python for therapy which he felt was a human stress ball.
Page 118: His girlfriend had an 8 year old daughter.
Page 119: Girlfriend's daughter's father was mentally challenged and on SSI. Child support is paid to her by SSI. They both were on food stamps because they live on a household, hence they received one sum for all of them to manage.

PG/rpc

State of California

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: **EVAN DISNEY** *(employee name)* v **Advances Management Company, SIBTF** *(claims administrator name, or if none employer)*

Claim No.: **SIFI2037148**

EAMS or WCAB Case No. *(if any)*: _____

I, **MARIA MORENO** *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: **1680 PLUM LANE, REDLANDS, CA 92374**
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	12/15/20	ubsequent Injuries Benefits Trust Fund - SENT ELECTRONICALLY
A	12/15/20	Workers' Defenders Law Group 8018 E. Santa Ana Cyn., Suite 100-215 Anaheim Hills, California 92808
A	12/15/20	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 12/15/20

Maria Moreno
(signature of declarant)

Maria Moreno
(print name)