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July 28, 2021

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
8018 E. Santa Ana Canyon, Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

In Reference:	**Rooks, Floreen**
Social Security #:	XXX-XX-8510
Date of Birth:	June 20, 1949
Date of Injury:	CT: December 30, 2004- April 16, 2016
Employer:	D'Veal Family and Youth Services
Occupation:	Licensed Marriage Family Therapist/Intake Coordinator
WCAB	ADJ10825285; ADJ7024643; ADJ7024645
SIF Case No:	SIF10825285
Date of Examination:	May 17, 2021

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.

COMPREHENSIVE INDEPENDENT MEDICAL-LEGAL EVALUATION SUBSEQUENT INJURY BENEFITS TRUST FUND

Dear Workers Defenders Law Group,

Per your request I performed an Independent Medical-Legal Evaluation of the above-noted applicant to determine eligibility for the Subsequent Injury Benefits Trust Fund pursuant to Labor Code 4751. This evaluation is not for the applicant's current function and is not related to their above-noted industrial injury. This evaluation is being performed to address the applicant's pre-existing disability to differing body parts, other than the industrial injury. I have been requested to evaluate the industrial injury and any pre-existing problems. I have also been advised to order further evaluations if needed from other specialists.

The Applicant was informed that a doctor-patient relationship was not established today and that a copy of my medical-legal report would be sent to the requesting parties. This history and physical are not intended to be construed as a general or complete medical evaluation; it is intended solely for medical-legal purposes and focuses on those issues in question by the parties. By performing this medical-legal examination, no treatment relationship is established or implied.

This evaluation was performed in my office in Huntington Park, California on May 17, 2021. I have personally evaluated this patient and the following represents my findings, opinions, and conclusions in this matter.

Per code of regulation 9795, this report is billed as ML 201-96 (Comprehensive Initial Medical Legal Evaluation by PsyD) noting 90 minutes face to face time and an ML-PPR, which is used to identify charges for review of records in excess of 200 pages included in medical-legal numerical billing codes.

MLPRR - In addition, I have received and reviewed medical records which included a declaration and attestation (copy enclosed). The total attested pages reviewed was *1,958.*

REVIEW OF RECORDS

In compliance with Labor Codes 4062.3 (d), 4628 (a) (2), and Title 8 CCR 10606 and Title 8 CCR 41 (b)(2), attached at the end of this report is a listing and summary of the records that I received, reviewed, and relied upon in the preparation of this report.

Per regulations 9793 (n), any documents sent to the physician for review must be accompanied by a declaration under penalty of perjury that the provider of the documents has complied with the provisions of Labor Code section 4062.5 before providing the documents to the physician. The declaration must also contain an attestation as to the total page count of the documents provided.

Per the attached declaration and attestation, 1,958 pages of medical records were sent for review (see attached listing).

INTRODUCTION

Per labor code 4751: If an employee who is permanently partially disabled receives a subsequent compensable injury resulting in **additional** permanent partial disability so that the degree of disability caused by the **combination of both disabilities** is greater than that 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 total, he 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 as provided in this article; provided, that either (a) the previous disability or impairment **affected** a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury **affects the opposite and corresponding member**, and such latter permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to **5%** or more of total, **or** (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to **35%** or more of total.

The Subsequent Injury Benefits Trust Fund (SIBTF) liability deals with pre-existing impairment and/or pre-existing disability. In other words, disability which was present prior to the industrial injury noted above. In essence, we are looking into the past to determine to what extent the injured worker was disabled, at some time prior to the settled industrial injury noted above.

A contemporaneous and retrospective review of the medical history and medical records is performed to determine if it is medically probable that there was labor disabling impairment, which pre-existed the date of the last injury in question and whether or not the sum of the combined industrial and nonindustrial impairment rates to 70% disability or more. Prior impairment ratings for industrial injuries are reviewed for accuracy and if necessary, re-rated.

INITIAL SIBTF SUMMARY:

1. **Did the worker have industrial injury?**

   Yes. The applicant suffered cumulative trauma on CT: December 30, 2004 - April 16, 2016 to her shoulder, wrists, mid back, left knee, and left ankle due to repetitive movements, and managerial harassment and discrimination.

2. **Did the industrial injury rate to 35% disability without modification for age and occupation?**

   Defer to orthopedic specialist.

3. **Did the worker have a preexisting labor disabling permanent disability?**

   Yes— She had pre-existing labor disablement, evidenced by her work duty limitations beginning at age 14 as a result of her right eye problem, her suicidal thoughts in 1975 as a result of impoverishment and being a single mom, inability to tolerate anyone yelling or raising their voices at work causing her anxiety, having to take time off work on a stress leave at Cal Tech from 06/1993-11/2000, 1994 DUI arrest that required class attendance, 1998 counseling for depression and grief over family deaths, and time off work twice due to work related stress and medical condition consequent to extreme stress.

4. **Did the preexisting disability affect an upper or lower extremity, or eye?**

   Defer to Orthopedic specialist.

5. **Did the industrial permanent disability affect the opposite and corresponding body part?**

   Defer to Orthopedic specialist.

6. **Is the total disability equal to or greater than 70% after modification?**

   Unknown at this time.

7. **Is the employee 100% disabled or unemployable from other preexisting disability and work duties together?**

   The patient is currently not working. Once the total disability is determined, it would be prudent for the patient to undergo an evaluation with a licensed vocational rehabilitation specialist to determine employability.

8. **Is the patient 100% disabled from the industrial injury?**

   No.

9. **Additional records reviewed?**

   Yes, defer to review of records for summary of pertinent records reviewed.

10. **Evaluation or diagnostics needed?**

    No.

COMPLAINTS SECONDARY TO THE INDUSTRIAL INJURY OF CT: December 30, 2004 - April 16, 2016:

08/09/2007:	Slipped on a piece of cucumber and fell onto concrete pavement at work
11/10/2007:	Fell onto ground/gravel and fractured her right foot
2007:	Off work for 9 months after left knee surgery
04/28/2008:	Underwent arthroscopic surgery of her knee
04/28/2008:	Off work for approximately 4-5 weeks
09/04/2009:	The week before she twisted her left knee from getting out of a car
After 04/16/16:	Problems concentrating, slurred speech, difficulty balancing, chronic pain,

irritability, and insomnia.

11/01/2017: Atherosclerosis of aorta, intermittent vertigo, and Vitamin D deficiency

COMPLAINTS SECONDARY TO PRE-EXISTING INJURIES OR CONDITIONS:

5 years old: Right eye problem

6-7 years old: First experienced emotional difficulties in her life, because her parents separated and her father left the family home. She was close with her father and missed him.

8 years old: Began having depression and anxiety related to family problems
1962, 7th grade: Diagnosed with a heart murmur
1964: Left index finger, received 20 stitches
10-16 years old: Verbally abused by her mother
12-16 years old: Physically abused by her mother
14 years old: Began working and had limitations due to eye problem
Childhood: Allergies
Unknown: Two MVAs with injuries resulting in chronic pain

Teenage years: Became responsible for her siblings
17 years old: Experienced black out in NY for a couple of days, poor condition
18-48 years old: Experienced several deaths of family members

18 years old: Her father died in a window washing accident and she became responsible for burying family members

18 years old: Left the family home and moved to California
20 years old: Eye surgery

1971: Cesarean section delivery surgery

21-25 years old: She gave birth to daughter and eventually had to turn her over to the father and his parents because she could not afford to care for her.

26 years old: Separated from her daughter's father

1975: Thoughts of suicide emerged due to poverty and taking care of daughter alone

1977: Workers' comp claim for a torn meniscus in her left knee and a broken toe
1977: Work related injury to the left knee and broke her toe
1985: High blood pressure
1980s: Headaches during menopause
1980s: Married to first husband for five years

1984:	At age 35, first husband held her at gunpoint due to jealousy
1985:	Diagnosed with high blood pressure
1988:	Divorced first husband who threatened to kill her
1989-1990s:	Menopause in her 40s and had mood swings and depression
1993:	Broke left ankle in three places
06/1993-11/2000:	Took time off work on a stress leave at Cal Tech
1994:	Arrested for a DUI
1996-1997:	Married to second husband for one year
1998:	At age 50, divorced second husband who was unfaithful
1998:	First time receiving psychotherapy due to family relationships and multiple family deaths
12/2004- 04/2016:	Took time off work on a stress leave at D'Veal Family
04/27/2007:	Underwent a partial medial meniscectomy and an abrasive chondroplasty of medial femoral condyle of the left knee

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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: December 30, 2004- April 16, 2016.

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. Rooks's disability history prior to the date of her subsequent work injury.

Identifying Information:

Ms. Rooks is a 71-year-old single African-American female who has been receiving Social Security Income benefits since 2015, which is her only current source of income. Interpreting service was not provided, as Ms. Rooks was English speaking. Ms. Rooks's employment duties as a Licensed Marriage Family Therapist (LMFT)/Intake Coordinator were as follows: Conducted Department of Mental Health (DMH) psychosocial assessments; formulated treatment plans and goals; provided counseling to individuals, groups, and families; conducted home and community visits; referred clients to community resources while assessing client needs, and documented progress reports.

History of Childhood Events:

Ms. Rooks was born and raised in New York City. She was raised by both parents until she was 7 years old. Her parents separated when she was 7 years old, father left the family home, and she and her siblings were raised by her mother. Her father worked as a postman and high-rise window washer. Her mother worked as a secretary. She had four brothers and one sister and Ms. Rooks was the eldest child (some of her siblings have passed away).

She reported her family life was generally okay. They got along at times and at other times they disagreed with others like all families do. During her childhood, she was generally a "loner." She was anxious during her childhood, because the neighborhood changed from fairly "okay to chaotic with the influx of drugs and gangs." She was in poor health as a child. She had problems with her right eye since childhood, which began when she was 5 years old. She started work at age 14 and was limited to work duties because of her eye problem. She was teased frequently and was called "Hawkeye," which affected her self-esteem.

In 1962, when she was in the 7th grade, she was diagnosed with a heart murmur and she continues to have. She denied ever being sexually abused as a child or adolescent. She was physically abused by her mother when she was 12-16 years old. After her parents separated, her mother became "harsh with rules." Her mother gave her and her siblings "beatings when they didn't obey the rules." Ms. Rooks ran away from home to her father. She was verbally abused by her mother when she was 10-16 years old; her mother "cursed a lot." These experiences made her feel nervous and ashamed. She stated, "I became nervous, anxious, and frightened. I was unable to tolerate anyone

yelling or raising their voices. Eventually, I married an abusive husband." Ms. Rooks left the family home when she was 18 years old and moved to California.

Ms. Rooks first experienced emotional difficulties in her life when she was 6-7 years old when her father left home. She was very close to her father and she missed him. During her adolescent years, she became responsible for her siblings, serving as a pseudo parent. When she was 18 years old, her father died while working. His safety belt/harness broke and he fell out of a window. Every family member began dying when Ms. Rooks turned 18 years old, and she became responsible for burying all of her family members.

Somewhere between the ages of 21-25, she gave birth to a daughter who she had to eventually "turn over" to her daughter's father and his parents. She could not afford to care for her daughter. She had a terrible and demeaning relationship with her daughter's father.

Academic History:

Educationally, Ms. Rooks reported doing adequately in school completing the 12th grade. She graduated from high school in 1967 or 1968. She denied ever having any history of learning disabilities and was never involved in special educational classes. Behaviorally, the examinee denied any history of being suspended or expelled from school. She completed six years of college education. She attended Seton Hall University and in 1978 she received a Bachelor of Science degree in Communications. In 2004, she received a Master's degree in Marriage Family Therapy from Cal Tech. She became a Licensed Marriage and Family Therapist in 2014.

Military Service:

The examinee never served in the armed forces.

Relationship History (before and after subsequent injury):

Ms. Rooks had three serious relationships in her lifetime, two of which were marriages. Her first serious/long-term relationship lasted seven years and he was the father of her only child, her 49-year-old daughter. Her second serious/long-term relationship was with her first husband. The marriage lasted for five years. They divorced around 1988. Her third serious/long-term relationship was with her second husband. The marriage lasted for one year and they divorced around 1998. She requested both divorces. Her first husband was very abusive. He held her at gunpoint and threatened to kill her. At the time, she thought his jealousy was an expression of care for her. She felt less anxious when she divorced her first husband. She felt betrayed by her second husband, because he cheated on her. Before the subsequent injury, she was not in a serious relationship and has not had a serious relationship since her second divorce.

Ms. Rooks resides in Pasadena, California. During today's evaluation, I inquired the examinee if there were any coexisting family stressors that could be contributing to her presenting psychological complaints, and she denied this to be the case.

Work History:

Prior to the subsequent injury, Ms. Rooks reported she worked for the following employers:

Employer	Start Date	Date Left	Position Held	Reason for Leaving
California Institute of Technology	06/1993	11/2004	Senior Administrative Assistant and Events Coordinator	Sought psychotherapy position
D'Veal Family and Youth Services	12/2004	04/16/2016	Intake Coordinator	Discrimination

The examinee represented she had a stable work history. She became an LMFT in her 50s. She has worked for approximately two different companies in her career. She stated the professors at Cal Tech were "White" and there was underlying racism; she was ignored. They often called her a different name than her legal name. She denied ever being fired from a previous employer for cause. She collected unemployment benefits (E.D.D.). Prior to this workers' compensation claim, she received disability benefits.

According to the medical record of Forensic Vocational Analysis Report by Madonna Garcia, MRC, VRTWC dated 08/24/20 for the date of injury (DOI): 04/16/06, Ms. Rooks worked as a Licensed Marriage and Family Therapist and Intake Coordinator for D'Veal Family & Youth Services from 12/2004 through 04/2016. She worked for University of Phoenix as a Work Certified Facilitator from 04/2013-06/2013. She also worked for California Institute of Technology and was employed from 06/1993-11/2000 as a Senior Assistant & Events Coordinator. The reason for leaving was to be employed as a Marriage & Family Therapist Intern. Also worked for Pacific Oaks College. She was employed from 09/2004 – 12/2004 as an Adjunct Faculty.

Medical History (before and after subsequent injury):

Ms. Rooks had vision impairment in her right eye since age 5. She was diagnosed with a heart murmur in 1962 when she was in the 7th grade and had regular doctor visits and electrocardiogram (EKGs) as a child. She had allergies since her childhood. She was diagnosed with high blood pressure in 1985. She had no history of an involvement in a serious automobile accident requiring emergency treatment. To the best of her knowledge, she has never sustained a head injury. She became pregnant at age 21. She had one pregnancy and one live birth. She had headaches during her menopause in her late 40s. The symptoms included: irritableness, hot and cold flashes, mood swings, tense muscles, anxiety, poor concentration, tiredness, problems sleeping, and depression. There is a family history of lung cancer and high blood pressure in her mother and chronic viral infections in her brother and sister.

Before the subsequent injury, she has never been medically disabled, but she had a prior work-related injury in 1977 to her left knee and a broken toe. She also had a prior non-work related injury to her left ankle in 1993.

Prior to the current industrial injury, the examinee indicated she was in reasonably good health. She did not use sick leave excessively during her employment. After the subsequent injury, she developed medical problems of difficulty concentrating, slurred speech, difficulty balancing, chronic pain, irritability, and insomnia. She currently has high blood pressure, chronic pain in her legs, back, and shoulders, and insomnia.

According to the WC Claim Form dated 08/30/07 with DOI: 08/09/07, Ms. Rooks slipped on a piece of cucumber and fell onto concrete pavement.

According to the medical record of Comprehensive Orthopedic Evaluation by Dr. Ralph Gambardella, M.D. dated 09/10/07, the examinee presented for an injury to her left knee that she sustained on 08/09/07. She was employed by D'Veal Family and Youth Services and stated she slipped and fell on a piece of a cucumber.

According to the WC Claim Form dated 11/16/07 w/DOI 11/10/07, Ms. Rooks fell onto ground/gravel and fractured her right foot to prevent rolling car from entering into oncoming traffic.

According to the medical record of Ortho Permanent & Stationary (P&S) Report by Dr. Tomas Saucedo, M.D. dated 12/05/08 for DOI: 11/10/07, she underwent a partial medial meniscectomy and an abrasive chondroplasty of medial femoral condyle of her left knee on 04/24/07.

According to the medical record of Ortho Supplemental Report at Dr. Tomas Saucedo, M.D. dated 01/23/09, Ms. Rooks underwent arthroscopic surgery of her knee on 04/24/08 at Plaza Surgical Center. She was off of work for approximately 4-5 weeks.

According to the medical record of Ortho Re-exam by Dr. Tomas Saucedo, M.D. dated 09/04/09, the examinee reported past week while getting out of a friend's car, she twisted her left knee causing to develop pain and discomfort of the left knee.

According to the medical record of Ortho AME by Dr. Tomas Saucedo, M.D. dated 03/17/11 for DOI: 08/09/07; 11/10/07, Ms. Rooks sustained 1st injury around 08/2007, when she slipped fell and twisted her left ankle and left knee. While still healing from this injury, she had a second injury in November 2007. She was picking up clients at work when she noticed that the car was rolling. She jumped in to pull up tension on the brake. In doing so, she fell striking her left knee on the ground and her right foot turned in. She had ongoing pain in the left knee and right ankle. She was told at Kaiser ER that she had two fractures of the right foot. She was placed in a Cam walker, which she wore for a number of weeks. She was then treated with Dr. Saucedo. As her right foot got better, she had persistent pain in her left knee. She had an MRI and eventually surgery of the left knee, which helped her left knee. However, she has had residual ongoing symptoms of the left knee ever since the surgery. She was released in 2008 or so by Dr. Saucedo. Ms. Rooks injured her left ankle a number of years ago in the mid 90s. It was fractured medially and laterally. She had surgery. She injured her left knee in both the 08/09/07 and 11/10/07 work incidents.

According to the medical record of Progress Notes by Dr. Kelly Ching, M.D. dated 11/01/17, the examinee had intermittent vertigo for weeks. The following were her diagnoses (Dx): 1) L BPPV. 2) Smoking cessation counseling. 3) Smoker. 4) Obesity, BMI 30-34.9, adult. 5) Atherosclerosis of aorta. 6) Screening. 7) Vitamin D deficiency. 8) Vaccination for Influenza. 9) Left ankle joint pain.

According to the medical record of PQME Orthopedic Eval by Dr. Gregory Heinen, M.D. at California Sports Cartilage Institute dated 02/28/18 for DOI: 04/16/06, Ms. Rooks worked for D'Veal Corp as a Therapist. She sustained continuous (CT) injury from her 12 years of employment. She developed pain from repetitive use of her upper extremity (UE) and lower extremity (LE). She drove to clients' homes going in and out of cars over the last three years. She drove clients approximately 5 times per week with her intake job. She climbed up and down stairs of clients home (1-2 short flights of steps per day). She typed intake reports everyday (2-3 hours/day). She developed psyche issues. She worked for D'veal Corp as a marriage and family therapist for 12 years. She stopped employment in 04/2016. She had eye surgery at 20 years old. She hurt her left ankle and had left knee meniscectomy. Dx: 1) C/S degenerative arthritis. 2) C/S degenerative arthritis without radicular symptoms. 3) Reported C/S stain/pain. 4) B/L shoulder degenerative arthritis R greater than L. 5) Bilateral (B/L) hand CMC joint mild degenerative arthritis/numbness. 6) T/S degenerative arthritis. 7) L/S degenerative arthritis with radicular symptoms. 8) B/L knee degenerative arthritis L greater than R. 9) L ankle severe degenerative arthritis s/p fx, s/p surgical intervention and fixation. 10) R ankle mild degenerative changes. 11) S/p R foot metatarsal fractures. 12) Reported stress reaction-stress associated pain. 13) Reported visual changes.

According to the medical record of Independent Medical Eval in Neurology SIBTF Eval Report by Dr. Lawrence Richman, M.D. dated 12/14/20, the examinee had a history of depression following separation of her parents at the age of 8 that has persisted to the present time. She had a history of anxiety during that same time frame and that has persisted to the present. She had a history of two motor vehicular accidents with injuries to the C/S resulting in chronic C/S pain from both accidents, head injury from both accidents associated with diminished memory and concentration. There was also a prior slip and fall accident down a staircase in 1993 and another slip and fall incident while in 99 Store. Dx: 1) Blindness in the R eye. 2) H/o post-traumatic head syndrome, no industrial causation. 3) Post-traumatic headaches, no industrial causation. 4) B/L cervical radiculopathy, no industrial causation. 5) Gait instability, no industrial causation. 6) Lack of depth perception, no industrial causation. 7) Heart murmur and hypertension (HTN), no industrial causation. 8) Anxiety and depression, no industrial causation. 9) Multiple orthopedic complaints to be addressed by a board-certified orthopedist.

According to the medical record of AME Report by Dr. Eric E Gofnung, D.C. dated 12/21/20 for DOI: CT 12/30/04-04/16/16; 11/10/07; and 08/09/07, the following is information regarding the injuries. Ms. Rooks sustained a work-related specific injury on 08/09/07 when she slipped and fell and suffered injury to her left ankle/foot. On 11/10/07, she sustained a work-related injury to her left knee and right foot/toes. She underwent left knee surgery. She was off work for approximately 9 months. After the surgery, she used a cane for assistance with ambulation at all times. CT Injuries: 12/30/04 -04/16/16, she sustained a work-related injury to her eyes, neck, UE, back, LE and nervous system. She started having headaches and pain in her shoulders, arms, fingers of both

hands with stiffness and pain in her neck, upper, mid, and lower back. She developed psyche and eye issues. She suffered harassment from the CEO of her company. He would get into her face and pushed a phone to her face. She was unable to work for the next two days. She was paranoid at times if anyone got close to her.

Prior Work History (Hx): Worked at CalTech from 1993 to 2004 as a Senior Assistant and Events Coordinator. She had concurrent employment as a Teacher at University of Phoenix once a week, for less than six months in 2013. Severe depression and other psychopathologies caused by parents' divorce, difficult relationship with domestic violence, death of all members of the family due to violent crimes and serious diseases, necessity to give up her own daughter for several years and other tragic personal life circumstances, which caused her to experience memory issues, confusion, difficulty concentrating, light and/or sound sensitivity, difficulty communicating, headache, dizziness, nausea/vomiting, loss of coordination/balance, chronic pain, poor vision, irritability, sadness, anxiety, denial and lack of self-efficacy.
She takes medications for all of these conditions. Below are her medications.

Current Medications:	Dosage	Frequency	Prescribing Doctor
Lisinopril	20 mg	1x daily	Dr. R. Ching
Nabumetone	500 mg	2x daily	Dr. R. Ching
Trazodone	50 mg	As needed	

Trazodone was prescribed for sleep when she was working at D'Veal Family and Youth Services. Ms. Rooks relayed that trazodone makes her feel groggy. She is not sure if the medications affect her concentration or make her forgetful. She had tried to reduce or stop taking medications, but found she could not do so; she became more anxious and got chest pain when she did not take Lisinopril.

Mental Health History (before and after subsequent injury):

Before the subsequent injury, Ms. Rooks experienced depression due to multiple family deaths and family relationships and received psychological counseling, initially around 1998. She saw four therapists, but only one therapist was effective. She has never been treated with medication for psychological problems. There was no reported family history of mental illness.

She had thoughts of suicide in 1975 because she was "very poor," but her daughter who was 3 or 4 years old prevented her from making plans to attempt suicide. She has never attempted suicide or tried to hurt herself in any way before the subsequent injury. The last time she had suicidal thoughts was in 1975. She denies having any current suicidal ideations.

Before the subsequent injury, while employed at Cal Tech, she became constipated due to extreme stress. She "went off work" on stress leave and went to a chiropractor to relieve the stress and treat her constipation. She also took off work on stress leave while employed at D'Veal Family and Youth Services. She does not recognize her stress until she has a nervous breakdown and goes to the hospital. However, she denies ever been hospitalized for psychiatric reasons.

After the subsequent injury, Ms. Rooks developed psychological symptoms including fear, loss of

control, anxiety, depression, and easily being startled. She had not had any periods of improvement in the symptoms, but has felt a worsening in the symptoms. Ms. Rooks has not received psychological/psychiatric treatment for the subsequent injury.

Current Psychological Symptoms:

Ms. Rooks currently feels sad and depressed at this time due to limited physical activities. She reported, "I feel sad because I am unable to participate in family activities." She had a depressed mood most of each day for the past two weeks, stating, "Sometimes I have feelings of hopelessness and unable to fulfill my personal goals." She had a decreased interest in most activities most of each day for the past two weeks. She disconnects emotionally with each person's death, it is how she protects herself, reporting, "I have less interest in my hobbies such as playing chess with my grandson, writing poetry, knitting, and creating greeting cards." She had feelings of worthlessness or low self-esteem, stating, "I sometimes have feelings of low self-esteem, because I feel my confidence levels have decreased since 2016." She has felt fatigue or loss of energy, stating, "I experience loss of energy due to my physical handicaps, which cause me pain, as well as a lack of sleep." She has had problems with thinking, problems concentrating, or difficulty making decisions, reporting, "I have more difficulty making decisions due to my lack of confidence in decision-making and only able to concentrate for short periods of time."

Over the past three months her level of depression has become much worse. She had a weight change or change in appetite. She weighed 213 pounds before the subsequent injury and had gained 7 pounds since the subsequent injury, and now weighs 220 pounds, saying, "I eat way more than usual. As such, the weight gain has increased my depression and I have lower levels of self-esteem." She has had a change in her sleep since her subsequent injury.

She feels anxious and worried at this time. She first noticed feelings of worry in 1967. She has had excessive worry or anxiety more days than not for the last six months. She reported, "I worry about my health declining, finances, family, and dying." She has difficulty controlling worries, stating, "Most times I'm unable to control worrying, which causes lack of sleep." She has experienced feeling restless, reporting, "Mostly feel on edge which causes unwarranted outburst to family members." She has experienced anxiety causing irritability, saying, "Family members have expressed I need to calm down because I make them feel anxious." She has experienced anxiety causing problems concentrating, saying, "Only able to concentrate for short periods at a time, because I may experience headaches and/or my body becomes tense." She has experienced anxiety causing problems sleeping, stating, "I have extreme difficulty falling asleep." She has experienced anxiety causing muscle tension, saying, "I experience muscle tension when trying to sleep or when concentrating becomes too much."

Ms. Rooks sometimes experiences her heart pounding or racing. She said, "My heart pounds mostly when driving as a passenger in a car due to fear of crashing in a car." She has experienced trembling or shaking in her body, stating, "Legs and hands tremble." She sometimes experiences dizziness or lightheadedness, reporting, "Feel dizzy mostly when bending down." She has experienced chest pains or discomfort/ tightness in her chest, reporting, "Sometimes I experience a tightness in my chest." She has experiences shortness of breath/problems breathing, stating, "I mostly experience shortness of breath when walking." She has experienced nausea or abdominal

distress not related to medication, stating, "Sometimes I experience sharp abdominal pain, but don't know why." She has experienced fear of losing control or going crazy, saying, "I fear losing control when driving." She has experienced fear of dying, reporting, "I fear dying in a car crash." She mentioned, "I don't necessarily have a blown-out panic attack." She has experienced chills or hot flushes, stating, "I am menopausal." She has experienced numbness or tingling in her body not related to physical injury, saying, "I experience both numbness and tingling in my hands."

She first experienced anxiety or panic-type symptoms in 1993 before her subsequent injury and had the symptoms weekly. She has felt unable to travel without a companion and this first happened in 1989 when a family member died, and she had to travel to New York.

Substance Abuse History (before and after subsequent injury):

Before the subsequent injury, Ms. Rooks drank alcohol 1x per week and never drank alcohol excessively. After the subsequent injury, she drinks 2x per week. Before the subsequent injury, she smoked one pack of cigarettes per week. After the subsequent injury, she has been smoking three times per week. Before the subsequent injury, she did not use marijuana. After the subsequent injury, she has not used marijuana. Before the subsequent injury she did not use any other drugs. After the subsequent injury she has not used other drugs. Before the subsequent injury, she never had a problem with drugs and had never received substance abuse treatment.

According to the medical record of Office Visit by Dr. Sabrina Renee Villalba, M.D. at Kaiser dated 08/30/10, Ms. Rooks presented for annual physical exam and blood pressure (BP) check. She had been smoking 4-5 cigarettes/day for 43 years.

Legal History:

The examinee was arrested in 1994 for driving under the influence. She paid a fine and attended driving school. She had never been incarcerated. From a civil perspective, the examinee denied ever being involved in a lawsuit—whether it be as a plaintiff or as a defendant. She had a prior workers' compensation claim in 1977 resulting in a torn meniscus in her left knee and a broken toe. She underwent surgery on her left knee and recovered. She received a settlement. There was no psychiatric component to the claim.

History of Crisis or Abuse:

The examinee denied ever being subjected to any type of sexual abuse as a child or an adult. During her childhood she was subjected to physical and verbal abuse by her mother. She was subjective to domestic violence and emotional abuse by her first husband in her adulthood.

As an adult, she had experienced shocking and traumatic events. At age 26 she separated from her daughter's father due to his preference for drugs over their relationship. At age 35 her first husband held her at gunpoint due to his jealousy. He also hid her object of worship to prevent her from praying. At age 50 she separated from her second husband due to his infidelity. At age 67 she was threatened by the chief executive officer (CEO) of D'Veal Family and Youth Services where she

worked when she made a comment about her dislike of the reorganization process. He "ran into her face" with a telephone.

She experienced a traumatic natural disaster at the of age 17. There was a black out in New York City that lasted for a couple of days and she was stuck inside the school during the black out. Between ages 18-48, Ms. Rooks experienced the deaths of close family members. She grew up with five siblings and her parents. However, her father and mother separated when she was 7 years old. Her father died when she was 18 years old. He was only 42 years old. She was living in California at the time. At his funeral in New York, while he laid dead in his coffin, she unbuttoned his shirt and put her head to his heart in hopes of hearing a heartbeat. She stated, "I didn't." When she was 23 years old, her next to youngest brother died due to unknown causes. She was told her oldest brother tried to revive him and the ambulance was too late.

When she was 29 years old, her oldest brother was stabbed and died while trying to protect their sister. When she was 30 years old her youngest brother died of a chronic viral infection. When she was 39 years old, her 58-year-old mother was dying. Ms. Rooks flew back home from California and cared for her mother until her death. When she was 45 years old, her sister died from a chronic viral infection. He sister was the middle sibling. Ms. Rooks went back to New York to care for her sister. She got her sister out of the hospital and took her home to care for her. When she was 48 years old, her second oldest brother died. These experiences still affect her. She said, "I continue to recall how and why my family of origin died. Because of their untimely deaths, I get depressed and most times I fear my own death, which is probably why I isolate myself. Isolating myself makes me feel safer."

BEFORE the LAST Work Injury (also known as Subsequent Injury), Ms. Rooks had difficulty in the following areas of functioning; 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: **"I felt handicapped and depressed because I couldn't bend or reach certain areas of my body without difficulty. Never took baths, because I was afraid of having an accident getting in and out of a tub. Therefore, I am very careful and slow. Sleep was interrupted due to constant urination."**			

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: **"Mostly had vision problems, which limited my driving and impacted my social activities. Sometimes my speech is slurred when talking. Also have difficulty concentrating for long periods of at a time."**			

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: **"These areas limited my ability to perform everyday normal tasks, as well impacted how my living situation should be structured."**			

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: **"Due to lack of normal vision in my right eye, always felt handicapped because I want to know what it feels like looking out of two normal eyes."**			

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:

"Don't feel like I have the strength I used to have in my right hand to perform these household tasks. I feel I have to break these tasks into increments in order to accomplish them."

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?	**30 mins**
✓	Driving	If you have trouble driving, approximately how long can you drive before needing to rest?	**Local only**
✓	Handling/lifting luggage	Approximately how many times per year do you travel BEFORE the Subsequent Injury?	**1x**
	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:

"I feel very anxious driving as a passenger because I have no control. I only drove locally. Have to depend on others to help with handling and lifting luggage, which makes me feel helpless. However, I have no need for luggage, but ask groceries to pack my bags lightly so I can carry them."

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:

"Several positions were limited due to joint pain, which made me feel mad at times."

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?		**Yes**
How many hours could you typically sleep at a time without waking up during the night?		**6 hours**	How many hours total were you able to sleep at night?		**6 hours**
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"I feel I am becoming less healthier due to lack of sleep and my concentration has suffered. Sleeping on the right side causes severe pain in my right shoulder, arm, and back."**					

Description of Pre-Existing Injury(ies):

5 years old:	Right eye problem
6-7 years old:	First experienced emotional difficulties in her life, because her parents separated and her father left the family home. She was close with her father and missed him.
8 years old:	Began having depression and anxiety related to family problems
1962, 7th grade:	Diagnosed with a heart murmur
1964:	Left index finger, received 20 stitches
10-16 years old:	Verbally abused by her mother
12-16 years old:	Physically abused by her mother
14 years old:	Began working and had limitations due to eye problem
Childhood:	Allergies
Unknown:	Two MVAs with injuries resulting in chronic pain
Teenage years:	Became responsible for her siblings
17 years old:	Experienced black out in NY for a couple of days, poor condition
18-48 years old:	Experienced several deaths of family members
18 years old:	Her father died in a window washing accident and she became responsible for burying family members
18 years old:	Left the family home and moved to California
20 years old:	Eye surgery
1971:	Cesarean section delivery surgery
21-25 years old:	She gave birth to daughter and eventually had to turn her over to the father and his parents because she could not afford to care for her.

26 years old:	Separated from her daughter's father
1975:	Thoughts of suicide emerged due to poverty and taking care of daughter alone
1977:	Workers' comp claim for a torn meniscus in her left knee and a broken toe
1977:	Work related injury to the left knee and broke her toe
1985:	High blood pressure
1980s:	Headaches during menopause
1980s:	Married to first husband for five years
1984:	At age 35, first husband held her at gunpoint due to jealousy
1985:	Diagnosed with high blood pressure
1988:	Divorced first husband who threatened to kill her
1989-1990s:	Menopause in her 40s and had mood swings and depression
1993:	Broke left ankle in three places
06/1993-11/2000:	Took time off work on a stress leave at Cal Tech
1994:	Arrested for a DUI
1996-1997:	Married to second husband for one year
1998:	At age 50, divorced second husband who was unfaithful
1998:	First time receiving psychotherapy due to family relationships and multiple family deaths
12/2004- 04/2016:	Took time off work on a stress leave at D'Veal Family

Periods of TTD from Pre-Existing:

06/1993-11/2000:	Took time off work on a stress leave at Cal Tech
12/2004- 04/2016:	Took time off work on a stress leave at D'Veal Family
2007:	Off work for 9 months after left knee surgery
04/28/2008:	Off work for approximately 4-5 weeks

Pre-existing Psych Symptoms:

Verbally and physically abused by mother
Depression since childhood
Pain from previous injuries
Several deaths of family

PRE-EXISTING PSYCHIATRIC DIAGNOSES

AXIS I: EPISODE OF MENTAL/CLINICAL DISORDER

Physical Abuse of Child (V61.21)
Major Depression, Single Episode, Moderate (296.00)
Pain Disorder Associated with a General Medical Condition (307.89)
Bereavement (V62.82)

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**
Moderate

(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: right eye problem since childhood, verbal and physical abuse by mother, parents divorced, DUI, marital and relational discord, abusive husband, and deaths of family members.

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - 54

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

Ms. Rooks experienced symptoms of depression and impairment of her functional abilities. I conclude Ms. Rooks experienced moderate work limiting impairments on a psychological basis prior to the subsequent industrial injury. The following issues contributed to her pre-existing psychological disability:

Ms. Rooks first experienced emotional difficulties in her life when she was 6-7 years old when her father left home. She was physically abused by her mother when she was 12-16 years old and verbally abused by her mother when she was 10-16 years old. Due to the abuse, she was unable to tolerate anyone yelling or raising their voices. At age 14, she had work duty limitations beginning at age 14 as a result of her right eye problem. She married an abusive husband. She had thoughts of suicide in 1975 because she was "very poor," but her daughter who was 3 or 4 years old prevented her from making plans to attempt suicide. The last time she had suicidal thoughts was in 1975. She had to take time off work on a stress leave at Cal Tech from 06/1993-11/2000. In 1994, she was arrested for a DUI. She saw a few therapists in 1998 for depression and bereavement of family deaths.

Before the subsequent injury, while employed at Cal Tech, Ms. Rooks became constipated due to extreme stress. She "went off work" on stress leave and went to a chiropractor to relieve the stress and treat her constipation. She also took off work on stress leave while employed at D'Veal Family

and Youth Services. She does not recognize her stress until she has a nervous breakdown and goes to the hospital.

Based on this clinical picture and the impact on her functioning, it is my opinion that Ms. Rooks met criteria for Physical Abuse of Child; Major Depression, Single Episode, Moderate; Pain Disorder Associated with a General Medical Condition; and Bereavement. Additionally, her GAF score was 54 - which is equivalent to a WPI of 24%. This GAF falls into the 51-60 decile, which is described by the 2004 Permanent Disability Rating Schedule as follows:
Moderate symptoms (e.g., flat affect and circumlocutory speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

It is also my opinion that these disorders significantly impacted Ms. Rooks's occupational functioning causing pre-existing labor disablement, evidenced by her work duty limitations beginning at age 14 as a result of her right eye problem, her suicidal thoughts in 1975 as a result of impoverishment and being a single mom, inability to tolerate anyone yelling or raising their voices at work causing her anxiety, having to take time off work on a stress leave at Cal Tech from 06/1993-11/2000, 1994 DUI arrest that required class attendance, 1998 counseling for depression and grief over family deaths, and time off work twice due to work related stress and medical condition consequent to extreme stress.

Ms. Rooks's symptoms had reached a plateau and she was able to work for other companies before she became industrially injured in spite of her psychological impairment. Thus, these psychological diagnoses were permanent and stationary prior to her subsequent industrial injury of CT: December 30, 2004- April 16, 2016. Consequently, the following actual psychological work restrictions existed prior to the subsequent injury:

- **Due to her symptoms of depression and chronic pain, Ms. Rooks required a flexible work schedule to accommodate her need for weekly psychotherapy sessions and monthly psychiatric consultations.**

- **An understanding supervisory to provide feedback to Ms. Rooks in a sensitive manner due to her fragile self-esteem.**

- **Slow increase in complexity of job duties and tasks given Ms. Rooks's deficits with concentration, focus, and memory.**

- **Promoting as much predictability as possible in the employee's daily tasks.**

- **Providing clear guidelines and instructions, possibly in writing due to her poor eyesight.**

- **Allowing for flexibility with regard to pace of work and timing of breaks.**

- **Working as part of a team to decrease the employee's sense of loneliness or isolation.**

- **Avoiding excessive work hours, overtime, and insisting on Ms. Rooks taking normal breaks and a lunch.**

- **No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people because she could not tolerate yelling or aggression.**

These actual pre-existing restrictions provide evidence of Ms. Rooks's actual labor disablement that was present prior to her subsequent industrial injury.

SUBSEQUENT INDUSTRIAL INJURY

History of Subsequent Injury:

What follows is a narrative of Ms. Rooks's subsequent injury, the resulting psychiatric disability, and existing work restrictions. Ms. Rooks worked at D'Veal Family and Youth Services beginning December 2004 and last worked in April 2016. Ms. Rooks sustained a repetitive type of injury on CT: December 30, 2004- April 16, 2016 to her shoulder, wrists, mid back, left knee, and left ankle due to repetitive trauma and managerial harassment and discrimination. She reported the following:

Specific Injury 2007:
"I incurred a work injury which caused a torn meniscus in my left knee. I had surgery. However, this incident has since caused loss of coordination and chronic pain in both legs. Additionally, I incurred a broken toe during the same injury."

CT: 12/30/04-04/16/16:
"I did not have a private room or office. I did therapy at a cubicle with other therapists and clients around me. Then the clinic put therapists in a room too close to each other. I complained about not having enough office space and was threatened and told never to ask for an office. The owner put the phone to my face and threatened to call human resources. My colleagues witnessed the event. I did a lot of assessments. My colleague Mayra was Spanish and the director was Spanish too. Mayra got two weeks to complete her intakes but I only got the weekend. The human resources person knew nothing about therapy. My supervisor could not take it that I answered too many clinical questions and fired me. The clinic fired a lot of Black people. Since 2016 and overtime I have incurred more eye problems and due to repetitive movements, over time I had experienced upper and lower pain."

According to the medica record of AME Report by Dr. Eric E Gofnung, D.C. dated 12/21/20 for the DOI: CT: 12/30/04-04/16/16, 11/10/07, and 08/09/07, Ms. Rooks sustained a work-related injury to her eyes, neck, UE, back, LE and nervous system. She started having headaches and pain in her shoulders, arms, fingers of both hands with stiffness and pain in her neck, upper, mid, and lower back. Pain in her neck and shoulders started gradually over the last two years approximately of her employment due to prolonged daily computer work. She began to notice pain in her back in the last couple of years and noticed difficulty bending down.

Ms. Rooks did not receive positive feedback at D'Veal Family and Youth Services before the subsequent injury occurred. She worked 8 hours per day, 5 days per week and made $5,000 per month. She no longer works for the company and is no longer employed with them. She is not currently working for any employer. She received disability benefits from Workers' Compensation Insurance and from Statue Unemployment Insurance.

Ms. Rooks often has pain in her neck, right shoulder, arm, hand and wrist, mid back, lower back, left knee, both legs and feet, and right ankle. She has numbness in her right arm. The pain in her neck travels to her shoulders, arms, upper back, and lower back. The pain in her right ankle travels to both knees.

The pain in her right ankle, left knee, neck, and right shoulder is at a pain level of 10, the pain in her mid-back is at a pain level of 8, the pain in her lower back is at a pain level of 8-9, the pain in her legs and feet are at a pain level of 7, and the pain in her right hand and wrist with numbness and tingling are at a pain level of 6 (on a scale of 0-10, 10 being the most severe pain).

Ms. Rooks's treatment consisted of physical therapy, brace, and surgery. She received surgery for her right ankle and left knee torn meniscus. Her right ankle was placed in a cast following surgery. She had physical therapy following surgery. The surgeries and treatment were helpful. However, she continues to have pain and swelling in her right ankle and left knee almost every day and her physical activities are extremely limited. She has to take pain medication due to the pain in her ankle.

Ms. Rooks reported she had feelings of depression since the deaths of her family members. Since the start of feeling depressed, there had not been a period of two or more months where she did not feel depressed. She denied ever having any instances of auditory or visual hallucinations. She reported:

"I feel both sad and depressed due to limited physical/social/recreational/family activities. I feel sad because I'm unable to participate and enjoy in most family activities."

ACTIVITIES OF DAILY LIVING CHECKLIST

SELF-CARE/PERSONAL HYGIENE

Ms. Rooks often neglects to bathe or shower. She sometimes neglects to brush her teeth. She often has no interest in her appearance. She often has no interest in shaving or putting on makeup. She often no interest in getting dressed. She often has problems sleeping at night because she cannot stop thinking or worrying. She sometimes does not feel rested in the morning when it is time to get up. Feeling sleepy during the daytime is not applicable. She often lacks the desire to have sexual relations. Being physically unable to have sexual relations is not applicable. She often has no desire to travel.

HOUSEHOLD ACTIVITIES

She sometimes has a problem organizing or cleaning the house. She sometimes has no energy to clean her house. She sometimes has problems focusing and repairing things that are broken in the house.

FAMILY AND SOCIAL ACTIVITIES

She often spends many days in her room and has no interest in talking to others. She sometimes lacks the cognitive stamina to be involved with friends and family. She sometimes does not want to initiate social contact with friends and family. She sometimes does not accept criticism appropriate from others.

RECREATIONAL ACTIVITIES

She often has problems concentrating long enough to do her normal hobbies. She often has no interest in attending social gatherings, meetings, or church events. She often has a lack of trust in her driving abilities. She sometimes has problems concentrating on art projects, music activities or building projects. She sometimes cannot muster the energy or concentration to play board games, cards, or video games.

MEDICAL ACTIVITIES

She sometimes forgets to take her medications. She often has no energy to do home-based physical therapy exercises. Her day is often interrupted by her psychological symptoms.

MANAGING FINANCES AND PERSONAL ITEMS

She sometimes loses her wallet, keys or cell phone, or forgets where she parked her car. She sometimes misplaces important financial papers or documents.

COMMUNICATION ACTIVITIES

She sometimes loses interest when watching television and stops watching the show. She often loses interest in communicating with others by email, text, or phone. She often does not attend normal events and communicating activities (e.g. church, social clubs, volunteer events, visiting relatives, etc.).

EMOTIONAL AND OCCUPATIONAL FUNCTIONS

She agrees she does not have the psychological energy to multi-task. She agrees that she becomes emotionally overwhelmed when demands are placed upon her. She strongly agrees her hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and responds in anger when these occur. She agrees she has difficulty controlling her emotions and this causes problems when she interacted with people. She agrees that she is not able to maintain a productive schedule where she completes the goals she sets for her household or family.

STRESS TOLERANCE

She finds herself on the verge of losing control over things as simple as television commercials. She finds herself highly irritated with changes in routine. She feels she might make hasty decisions and does wish to make independent decisions. Her feeling of being overwhelmed has adversely affected her sleep.

MENTAL STATUS EVALUATION

General Appearance
Ms. Rooks is a 71-year-old single African-American female who is 5'5" tall and weighs 213 pounds. She appeared to look younger than her stated age and presented with acceptable personal hygiene. She was dressed casual in a faded grey hat, blue frame glasses, blue mask, blue denim jacket, and blue and white turtleneck.

Manner of Relating
Ms. Rooks 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. Rooks related in a rather distressed manner indicative of someone who is emotionally overwhelmed at this time. She became teary eyed when disclosing information about her injury. She was cooperative with the evaluation process and completed the psychosocial questionnaires with relevant detail.

Psychomotor Activities
Ms. Rooks walked slowly from the waiting room to my office. When she sat down, she did so gingerly and in a rigid manner. She stood up one time to relieve the pain in her back and grimaced in pain throughout the interview. She also adjusted herself in her seat to accommodate the pain in her back. While reaching for paperwork, she grimaced in pain.

Speech and Language
Ms. Rooks spoke at a middle 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 Cognition
Ms. Rooks appeared to be functioning at an above 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.

Thought Content and Processes
Ms. Rooks 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. Rooks **denied** the presence of any **suicidal ideations**-whether they are passive or active in nature. She also showed no propensity towards aggressive behavior. She comes to have **adequate self-control.**

PSYCHOLOGICAL TESTS ADMINISTERED AND RESULTS

- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Epworth Sleepiness Scale (ESS)
- Montreal Cognitive Assessment (MOCA)
- Modified Somatic Perceptions Questionnaire (MSPQ)
- Pain Catastrophizing Scale (PCS)
- Pain Drawing (PD)
- AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 18 (18-4, Page 576)

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 herself 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. Rooks obtained a score of 48, thereby placing her in the severe 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, the BDI-II manual recommends that the examinee pay careful attention to the examinee's responses to item #2 (pessimism) and item #9 (suicidal ideas). The combination of hopelessness with recurrent suicidal thoughts with intent are considered better indicators of self-destructive behavior than the emotional intensity of depression. On items #2 and #9, the examinee obtained a combined score of **2** indicating that there is likely to be no concern with suicidal potential.

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 43, which is suggestive of a severely anxious state.

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

Total Score = 8

The examinee received a score of 8, reflecting that she has average daytime sleepiness.

Prior to the subsequent injury, it took her 1 hour to fall asleep and she slept for 6 hours each night and woke up 2 times per night due to pain, anxiety, or depression. She started to have problems with sleep in 2007. It takes her 3 hours to fall asleep and she sleeps for 4 hours each night. She wakes up 4 times per night to urinate. She reported, "Sleep is horrible." She thinks "a lot" during sleep. She believes she cannot sleep due to fear of dying so she has to keep herself awake.

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 be very mild cognitive deficits that are interfering with her 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 copying the three-dimensional cube. She received a score of **4** out of 5 for the Visuospatial/executive domain.

2. **Delayed Recall (Short-term memory recall)** was weak as evidenced by the fact that she could only recall **1** item out of 5 items (e.g. face, velvet, etc.) after a five-minute time delay.

MODIFIED SOMATIC PERCEPTIONS QUESTIONNAIRE

The MSPQ is a 13 item self-report scale for patients with chronic pain or disabilities. It can help identify somatic complaints that may be associated with psychological responses such as anxiety or depression. The higher the score, the more marked the general somatic symptoms. The number of perceptions at each intensity level can help gauge the number of limiting symptoms. A person with significant somatic complaints would be a candidate for psychological interventions to aid coping.

Each item is scored on a scale from zero (0) to three (3). Patients who produce a score of 12 or greater (maximum score is 39) are at risk for a prolonged recovery. The questionnaire contains a

total of 22 items, but only 13 are used to calculate the score. The remaining items are included to reduce the possibility of a response bias. The higher the score, the more hypersensitive the examinee is to bodily sensations, processes, and discomfort.
Ms. Rooks received a raw score of 17, which reflects risk for a prolonged recovery and a likely pattern of somatic hypersensitivity.

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. Rooks received a raw score of 41 that reflects a nearly constant state of catastrophizing related to her pain condition.

PAIN DRAWING (PD)

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.

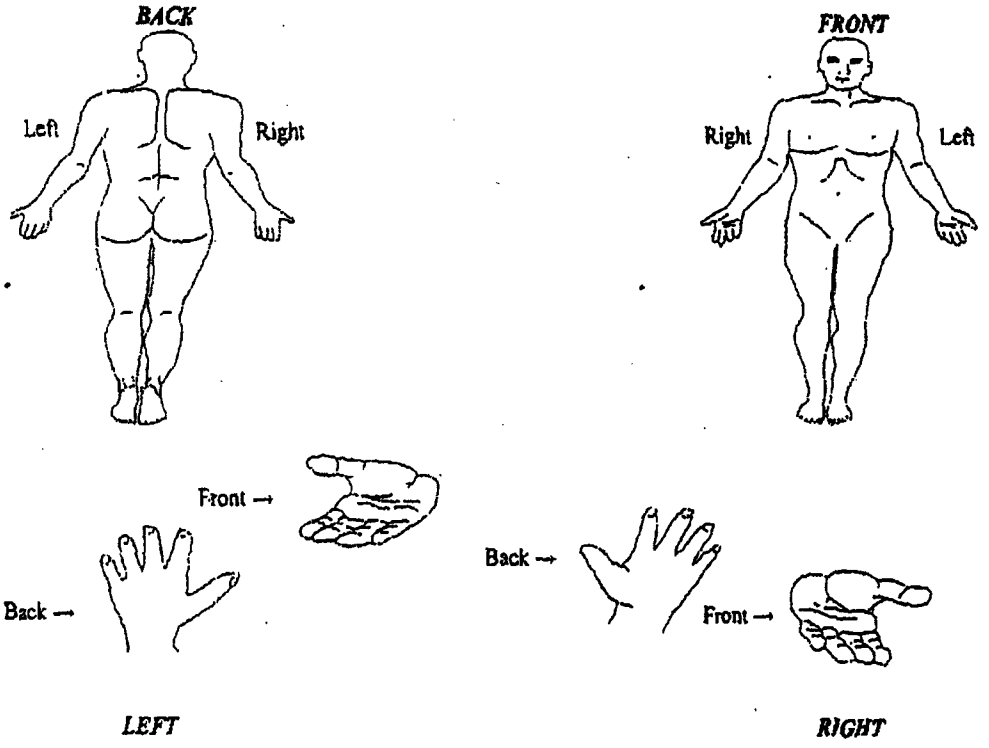
"I particularly hurt here" indicators (each category scores one point).

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, none of these domains were found.



On the front portion of this form, Ms. Rooks complains of numbness in the right shoulder, hand, and index finger. On the back portion of this form, she did not mark any complaints. In the last two months, her condition has fluctuated.

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

AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 5TH EDITION, CHAPTER 18

TABLE 18-4, PAGE 576

I. Pain (Self-Report of Severity)

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 — My 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**?

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

Ms. Rooks's account of how her 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. Rooks' 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. Rooks's pain behavior:

- ✓ She grimaced in obvious pain several times during the interview.
- ✓ She began to cry spontaneously when talking about her chronic pain state.

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

The psychological test results showed a consistent elevation across multiple tests measuring depression and anxiety.

After a careful review of the above information, it is the undersigned's professional opinion that Ms. Rooks 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 Depression, Single Episode, Moderate (296.00)
Generalized Anxiety Disorder, Moderate (300.02)
Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89)
Insomnia Related to Anxious Disorder (327.02)
Female Hypoactive Sexual Desire Disorder (625.8)

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**
Moderate

(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: Lack of male companionship and limitations in physical activities.

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - 52

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. Rooks'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 an 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. Rooks reported the following symptoms:

- "I feel sad because I am unable to participate in family activities. Sometimes I have feelings of hopelessness and unable to fulfill my personal goals. I have less interest in my hobbies such as playing chess with my grandson, writing poetry, knitting, and creating greeting cards. I sometimes have feelings of low self-esteem because I feel my confidence levels have decreased since 2016. I have more difficulty making decisions due to my lack of confidence in decision-making and only able to concentrate for short periods of time."

- "I eat way more than usual. As such, the weight gain has increased my depression and I have lower levels of self-esteem. I have gained 7 pounds since the subsequent injury. I weighed 213 pounds before and now I weigh 220 pounds."

Generalized Anxiety Disorder

Taking into consideration the available information, Ms. Rooks'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 an 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. Rooks reported the following symptoms:

- "I feel anxious and worried at this time. I have excessive worry or anxiety. I worry about my health declining, finances, family, and dying. I have difficulty controlling worries. Most times I'm unable to control worrying, which causes lack of sleep. I experience feeling restless, mostly feel on edge which causes unwarranted outburst to family members. I have anxiety causing irritability. Family members have expressed I need to calm down because I make them feel anxious. I experience anxiety causing problems concentrating. Only able to concentrate for short periods at a time, because I may experience headaches and/or my body becomes tense. I have anxiety causing problems sleeping. I have extreme difficulty falling asleep. I have anxiety causing muscle tension. I experience muscle tension when trying to sleep or when concentrating becomes too much."

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

Taking into consideration the available information, Ms. Rooks'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. Rooks reported the following symptoms:

- "I had surgery for my injury and I still feel a lot of pain. Although I received medical treatment and it was helpful, my body still hurts a lot."

Insomnia Related to Anxious Disorder

Taking into consideration the available information, Ms. Rooks's cluster of symptoms would best be categorized as a sleep-wake disorder. According to the DSM 5, the essential features of Insomnia Related to Anxious Disorder include sleeplessness (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. Rooks reported the following symptoms:

- "I have a change in my sleep since my injury. I am not able to sleep well. Prior to the subsequent injury, it took me 1 hour to fall asleep and I slept for 6 hours at night and woke up 2 times at night due to pain, anxiety, or depression. After the injury in 2007, it takes me 3 hours to fall asleep and I sleep for 4 hours each night. I wake up 4 times at night due to urination. My sleep is horrible. I think a lot when I sleep. I believe I have difficulty sleeping due to fear of dying in my sleep."

Sexual Dysfunction Due to a General Medical Condition

Taking into consideration the available information, Ms. Rooks's cluster of symptoms would best be categorized as a sexual dysfunction disorder. According to the DSM 5, the diagnostic criteria for Sexual Dysfunction Due to a General Medical Condition include pain associated with intercourse, hypoactive sexual desire, male erectile dysfunction, or other forms of sexual dysfunction (e.g., Orgasmic Disorders) and must cause marked distress or interpersonal difficulty. Following her injury, Ms. Rooks reported the following symptoms:

- "I lost interest in sex seven years ago. I feel lonely not having a male companion."

SUBSEQUENT INJURY IMPAIRMENT RATING

ANALYSIS AND EXPLANATION OF MS. ROOKS'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 most days.	Often	Sometimes	Never	Not Applicable
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

If yes, please describe/provide examples:

"Overall, I feel I have neglected my appearance and routine hygiene habits due to depression which has caused me to have insomnia, gain weight, and lack of interest in sex. I have also lost my desire to travel long distances by car/airplane for fun or to visit family and friends."

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

If yes, please describe/provide examples:
"I used to have the energy to maintain my household in an orderly and organized fashion, as well as pay attention to the upkeep of my home. However, I force myself to do the best I can, like preparing meals and maintaining my safety."

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

If yes, please describe/provide examples:
"Although I have long-time friendships, most times I don't feel like talking with them on the phone or visiting, which has caused some strains in some of my friendships. My family no longer invites me to social gatherings, because they know I will decline. Mostly every day I spend time alone in my bedroom."

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

If yes, please describe/provide examples:
"My recreational activities have decreased greatly due to my lack of concentration. I don't write poetry as much as I used to or play chess or game boards with my family as I've done in the past. Furthermore, I no longer trust my driving abilities due to my anxiety and visual acuity impairments. I only drive close to home and don't take freeways like I used to."

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

If yes, please describe/provide examples:
"I often forget to take my blood pressure medication; lack energy to exercise because I know I will experience even more pain (i.e., swelling, pain in my ankles, knees, and legs) when I try. Can't seem to focus or concentrate on one project at a time due to restlessness and also have difficulty putting my thoughts into words, because sometimes they get jumbled when I try to speak."

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

If yes, please describe/provide examples:
"I have sometimes misplaced my house keys and cell phone even if they are in my home. I have lost my wallet several times containing important bank and ID cards of which I had to replace or were mailed back to me. Without a doubt I have often forgotten where I have parked."

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

If yes, please describe/provide examples:
"I enjoy watching movies on television. However, I often find myself constantly changing channels when bored or don't have the patience to see a program through. I communicate less by telephone and email on computer with friends and family. I communicate more via text because it's quicker and involves less person-to-person communication with others."

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

If yes, please describe/provide examples:
"I would think my emotional work performance would be dependent on the environmental components and work tasks. For example, I'm extremely easily startled and don't respond well to noise or people who don't announce themselves first; easily overwhelmed and less focused if I have to multi-task; and difficulty controlling my emotions when treated unfairly. Additionally, my physical limitations would limit my ability to maintain a productive work schedule."

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? **"6:30am"**
2. How often would you take a shower or bath? **"6x week"**
3. How many hours a day did you work on average? **"10 hours"**
4. Did you participate in any exercise or sports team? **"Yes"** If yes, please describe
5. What types of activities did you do after you finished work? **"Sometimes I would swim"**
6. What would you normally do for fun during the week? **"Talk with friends or occasionally participate in social activities, i.e., food/bar restaurants"**
7. What time did you typically go to bed during the week? **"11pm"**

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? **"10am"**
2. What was a typical weekend day for you like? **"Visit with family and friends"**
3. What type of social activities was normal for you to do on the weekends? **"Entertain with family, i.e., dinners"**
4. If you were sexually active shortly before the injury, how often was it normal for you to engage in sexual activity? **"N/A"**

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? **"11:30am"**
2. How often do you take a shower or bath? **"1x week"**
3. How do you spend most of your weekdays? **"In bed; watching tv, listening to videos"**
4. Do you participate in any exercise or sports at this time? **"No"** If yes, please describe
5. What time do you typically go to bed? **"2-3am"**
6. What do you normally do for fun/socializing during the week? **"Nothing - hardly talk to friends"**

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

1. What time do you typically wake up? **"11:30am"**
2. How do you spend a typical weekend day? **"Spend most of my time alone"**
3. What type of social activities are you doing on the weekend at this time? **"None"**
4. Are you sexually active at this time? **"No"** If so, how many times on average is it normal for you to engage in sexual activity?
5. If you are not active, or less active, when did you notice this change? **"7 years ago"**
6. What do you think caused this change? **"Lost interest in sex"**

AFTER or BECAUSE of the SUBSEQUENT INJURY, Ms. Rooks indicated difficulties or limitations in areas below.

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: **"I feel handicapped due to having to now use a bath chair to wash, help reach my back and toes. I feel my personal grooming, i.e., trimming toes has suffered. I feel a lot of pain putting on my socks, shoes, and pants due to arthritis. Also, I hardly shop because my ankles, knees, and legs swell up."**			

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: **"Sometimes my speech is slurred. My vision is blurry. My attention span is erratic."**			

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:

"Given all the areas I indicated, makes me feel my body is no longer functioning as a healthy and physically whole individual. I feel sad and decrepit."

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:

"My depth perception is off due to a condition of having a "lazy eye" since childhood."

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:

"Due to loss of strength in my right hand and my physical well-being, it generally takes me longer to complete the areas indicated above."

Travel CURRENTLY			**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 AFTER the Subsequent Injury?		**None**
	Keeping arms elevated		Holding or squeezing the steering wheel	

Other difficulties:

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

"I feel very anxious riding as a passenger and only drive locally, because I am no longer confident in my driving abilities."			
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: **"I feel lonely due to lack of male companionship."**			
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?	**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 hours**
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"My sleep is constantly interrupted due to trouble falling and staying asleep. I feel restless and fear my health is failing."**			

Collectively, the above outlined impairments suggest that Ms. Rooks 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. Rooks is not gravely disabled, does not have auditory/visual hallucinations, and does not have suicidal ideations. These descriptions are for individuals who fall in the serious symptom category. She does not fall in the serious symptoms GAF range. Therefore, I have placed her in the moderate range of the symptoms scale*].

Using these guidelines, Ms. Rooks's psychiatric disability falls into the 51-60 decile. This is the range of functioning described as:

Moderate symptoms (e.g., flat affect and circumlocutory speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

All of her psychological testing combined indicates she is in the moderate to severe range of both symptom severity and functional impairment (i.e., BDI, BAI, and etc.). Ms. Rooks describes limited social interactions as a consequence of both her physical limitations and psychological status following the industrial injuries. Whereas Ms. Rooks previously enjoyed a rather active social life, following the industrial injury this has been reduced and more limited to immediate family members isolation in her bedroom.

Thus, after careful consideration of all of the information contained in this report, Ms. Rooks's score is placed at the level of 52, which translates to a Whole Person Impairment (WPI) of 27%.

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. Rooks 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 8/24 is equal to average sleepiness, or class 2 impairment. **Based upon her chronic sleep dysfunction, and her Epworth Sleepiness Scale score of 8, the level of her current sleep impairment is equal to a 14% disability rating**

attributed to the chronic pain and psychological symptoms that arose as a result of her subsequent injury.

She reported, "I have a change in my sleep since my injury. I am not able to sleep well. Prior to the subsequent injury, it took me 1 hour to fall asleep and I slept for 6 hours at night and woke up 2 times at night due to pain, anxiety, or depression. After the injury in 2007, it takes me 3 hours to fall asleep and I sleep for 4 hours each night. I wake up 4 times at night due to urination. My sleep is horrible. I think a lot when I sleep. I believe I have difficulty sleeping due to fear of dying in my sleep."

Sexual Dysfunction Disorder Impairment:
The AMA Guides on Page 163, Table 7-9, provides a guide for rating permanent impairment due to vulval and vaginal disease on a three-category scale that ranges from no impairment to extreme impairment. This particular table covers abnormalities involving female reproductive organs. Per AMA Fifth Edition Guides, Table 7-9, page 163, and other tables under Section 7.8 and other do not cover the issues adequately. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant difficulties or limitations chart, Ms. Rooks appears to have developed a Class 1 Impairment related to her sexual dysfunction disorder.

Table 7-5 Criteria for Rating Permanent Impairment Due to Vulval and Vaginal Disease

Class 1 0%- 15% Impairment of the Whole Person	Class 2 16%- 25% Impairment of the Whole Person	Class 3 26-35% Impairment of the Whole Person
Vulval or vaginal disease or deformity symptoms and signs do not require continuous treatment ***and*** sexual intercourse possible ***and*** vagina adequate for childbirth if premenopausal	Vulval or vaginal disease or deformity symptoms and signs require continuous treatment ***and*** sexual intercourse possible only with some degree of difficulty ***and*** limited potential for vaginal delivery if pre-menopausal	Vulval or vaginal disease or deformity symptoms uncontrolled by treatment ***and*** sexual intercourse not possible ***and*** vaginal delivery not possible if pre-menopausal

Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under female Reproductive Organs Table 7-9 of the AMA Guidelines states that a Class 1 female Reproductive Organs Impairment is one in which an individual experiences "Vulval or vaginal disease or deformity symptoms and signs do not require continuous treatment ***and*** sexual intercourse possible ***and*** vagina adequate for childbirth if premenopausal." According to Ms. Rooks, she has no sexual

desire and feels lonely due to lack of male companionship.

Based upon her mild sexual dysfunction of Class 1 impairment, the level of her current sexual impairment is equal to a 6% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of her subsequent injury.

CAUSATION OF SUBSEQUENT DISABILITIES AND LABOR IMPAIRMENT

Ms. Rooks was injured at D'Veal Family and Youth Services on CT: December 30, 2004- April 16, 2016 due to cumulative trauma while employed as an LMFT/Intake Coordinator. She also sustained psych injury as a result of managerial harassment and discrimination. Specifically, she injured her eyes, neck, UE, back, LE and nervous system. She started having headaches and pain in her shoulders, arms, fingers of both hands with stiffness and pain in her neck, upper, mid, and lower back. Pain in her neck and shoulders started gradually over the last two years approximately of her employment due to prolonged daily computer work. She began to notice pain in her back in the last couple of years and noticed difficulty bending down.

Ms. Rooks was not provided a private room or office to do therapy with her clients. She complained about not having enough office space and was threatened and told never to ask for an office. The owner put the phone to her face and threatened to call human resources. As a result of her injury, Ms. Rooks developed psychiatric symptoms. My evaluation on May 17, 2021 consisted of a clinical interview, mental status exam, review of medical records, and psychological testing. The results of my evaluation found that Ms. Rooks currently suffers from Major Depressive Disorder, Generalized Anxiety Disorder, Insomnia Related to Anxious Disorder, Sexual Dysfunction Disorder (specifically Female Hypoactive Sexual Disorder), and Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.
These disorders and her functional limitations qualified her for a GAF of 52 - which is equivalent to a WPI of 27%.

Ms. Rooks has been diagnosed with Insomnia Related to Anxious Disorder caused by the subsequent injury. 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 8/24 is equal to average sleepiness, or class 2 impairment. **Based upon her chronic sleep dysfunction that arose out of her subsequent injury, the level of her sleep impairment is equal to a 14% disability rating.**

Ms. Rooks has been diagnosed with Sexual Dysfunction Disorder, specifically female Hypoactive Sexual Desire Disorder caused by the subsequent injury. Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under Female Reproductive Organs Table 7-9 of the AMA Guidelines states that a Class 1 Female Reproductive Organs Impairment is one in which an individual experiences "Vulval or vaginal disease or deformity symptoms and signs do not require continuous treatment ***and*** sexual intercourse possible ***and*** vagina adequate for childbirth if premenopausal." Her problem with no sexual desire and feelings of loneliness due to lack of male companionship is equal to mild impairment, or class 1 impairment. **Based upon her moderate sexual dysfunction that arose out of her subsequent injury, the level of her sexual impairment**

is equal to a 6% disability rating. Based on her history, her condition is attributable to compensable consequences of orthopedic issues.

CONCLUSIONS

It is my opinion that Ms. Rooks's subsequent psychiatric injury was predominantly caused by the actual events of employment. I reason that, given the longitudinal nature of Ms. Rooks'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. Rooks's prior GAF score of 54 equates to a WPI of 24%. Following her subsequent injury, her psychiatric condition deteriorated significantly. The increase in depressive and anxiety symptoms resulted in a decrease of her GAF to 52 - which means her disability increased by 3% to 27%. The subsequent injury disability represents the predominant cause of her overall disability rating. ***The subsequent injury was the prominent cause of the 3% increase.***

MS. ROOKS'S PRE-EXISTING PSYCHOLOGICAL ISSUES WERE PERMANENT & STATIONARY (P&S) PRIOR TO THE SUBSEQUENT INDUSTRIAL INJURY OF CT: DECEMBER 30, 2004 - APRIL 16, 2016. *GIVEN THE LENGTH OF TIME THAT HAS EXPIRED AND THE CONSISTENCY OF PSYCHIATRIC SYMPTOMS SINCE THEIR INCEPTION, IT IS MY OPINION THAT MS. ROOKS'S PSYCHIATRIC DISABILITY IS NOW PERMANENT AND STATIONARY.*

Ms. Rooks'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 and anxiety).**
- **Flexible schedule to accommodate Ms. Rooks's need for weekly psychotherapy.**
- **Flexible schedule to accommodate Ms. Rooks's sleep disorder.**
- **No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people such as her CEO.**

Due to her cognitive difficulties from her depression and anxiety, Ms. Rooks 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 due to her inability to concentrate for an extended amount of time.**

- **Frequent feedback on performance with sensitivity to Ms. Rooks's struggles with her self-esteem.**

- **Time to reconnect with co-workers given Ms. Rooks's deteriorated social skills (resulting from her depressive symptoms of social withdrawal from families and friends).**

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

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

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

Preexisting Psychiatric Impairment: 24% WPI from GAF of 54

I believe that Ms. Rooks'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. Rooks's current psychiatric disability rating is as follows:

Current Psychiatric Impairment: 27% WPI from GAF of 52

The subtraction method is applied 27% WPI minus 24 % WPI = 3%
3% WPI apportioned to the Subsequent Injury

PRE-EXISTING DISABILITY	SUBSEQUENT DISABILITY
Psychiatric disability - 24%	Psychiatric disability increased by 3% to 27%

Please note: The preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability. Based on the examinee's history and reasonable medical probability, I would apportion Ms. Rooks' psychological injury as follows. She has pre-existing psychological or mental health conditions that played a continuing role in the present psychological picture This includes her work duty limitations beginning at age 14 as a result of her right eye problem, her suicidal thoughts in 1975 as a result of impoverishment and being a single mom, inability to tolerate anyone yelling or raising their voices at work causing her anxiety, having to take time off work on a stress leave at Cal Tech from 06/1993-11/2000, 1994 DUI arrest that required class attendance, 1998 counseling for depression and grief over family deaths, and

time off work twice due to work related stress and medical condition consequent to extreme stress, hence, there is non-industrial per-existing apportionment of 60%. Ms. Rooks' industrial depression and anxiety resulting from her stress injury are apportioned 40% regarding injuries to her shoulder, wrists, mid back, left knee, and left ankle due to repetitive trauma and managerial harassment and discrimination.

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

I reserve the right to alter any opinions noted above if provided further medical records which may warrant a change of my opinions.

REASONS FOR OPINION

1. History as related by the patient.
2. Findings on examination.
3. Review of the medical file.
4. Consistency of the objective findings with subjective complaints.
5. Genuineness of the patient.

DISCLOSURE/AFFIRMATIONS AND SIGNATURE

"I personally evaluated this patient 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."

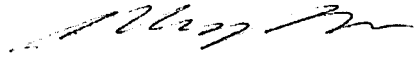
Any reference to the Guides in this report refers to the 'Guides to the Evaluation of Permanent Impairment, Fifth Edition.'

I came to the above opinions based on the current physical 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.

Thank you for asking me to see and evaluate Ms. Floreen Rooks. I will be available for review of medical records or to produce supplemental reports at the request of parties concerned.

Signed this 3rd day of August, 2021.

Respectfully,



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

Attached: Review of medical records

REVIEW OF MEDICAL RECORDS:
ROOKS, Floreen
DOB: 06/20/49

Attestation: Declared total page count of the documents provided to the physician: 1958.

WC Claim Form dated 08/30/07 w/DOI: 08/09/07. Pt slipped on a piece of cucumber and fell onto concrete pavement.

WC Claim Form dated 11/16/07 w/DOI 11/10/07. Fell onto ground/gravel and fractured R foot to prevent rolling car from entering into oncoming traffic.

Compromise and Release dated 03/05/12 w/DOI: 11/10/07. Injured R foot, L knee and R ankle. DOI: 08/09/07. Injured L knee, L ankle and L hip. Settlement Amount: $62,000.00.

Stipulations with Request for Award dated 10/22/09 w/DOI: 11/10/07. Injured L knee. The injury caused permanent disability of 1% for which indemnity is payable at $230.00 per week beginning 09/15/08 in the sum of $690.00 less credit for such payments previously made.

Stipulations with Request for Award dated 10/22/09 w/DOI: 08/09/07. Injured L knee and L ankle. The injury caused permanent disability of 6% for which indemnity is payable at $230.00 per week beginning 09/17/07 in the sum of $4,140.00, less credit for such payments previously made.

Compromise and Release w/DOI: 11/10/07. Injured foot and knee. DOI: 08/09/07. Injured knee and ankle. Settlement Amount: $80,000.00.

Compromise and Release dated 11/06/18 w/DOI: CT 12/30/14-04/16/16. Settlement Amount: $24,000.00.

Wage Calculation Rpt.

12/13/06 – Progress Note by Kelly Ching, MD at Kaiser. Pt c/o N/V x 2 day. Positive malaise. Slept 12 hours last night. She is achy, has chills and neck pains. Positive diarrhea and cramping. Stopped the BP after 1 dose. Talked to people and got her scared. PE: NAD. Dx: 1) Essential HTN. 2) Obesity (BMI 30-39.9). 3) Smoker. 4) Gastroenteritis. Rx: Promethazine. Plan: Ordered x-ray of bilateral screening mammography. Recommended fluids, diet and rest. Avoid dairy. D/c tobacco. Cont diet/ex.

06/26/07 – Laboratory Rpt at Kaiser. Tuberculin skin test: Normal.

06/26/07 - Nurse note by Felisa V Mamiit, LVN at Kaiser. Pt is here today for placement of PPD test. Tuberculin skin test applied to L ventral forearm.

06/28/07 - Nurse note by Felisa V Mamiit, LVN. Pt is here for PPD skin test reading.

08/09/07 - Dr's 1st Rpt by Dan Le, DO at Dreamweaver Med Grp. This afternoon she slipped & fell onto L hip from ground level. No pop or crack was noted. States she now has pain in L hip, L knee and L ankle. Ankle being the most painful area. She also has pain in R shoulder. She cannot describe how pain in R shoulder originated. Dx: L knee, hip and ankle pain. Rx: Naprosyn. Plan: Wear splint and use cane. Off work until 08/15/07.

08/10/07 - X-ray of L knee Interpreted by Richard Chao, MD at Pacific Medical Imaging & Oncology Ctr.
Impression: 1) Generalized demineralization. 2) Suspect small louse body within the central joint. 3) No acute fracture nor subluxation is demonstrated.

08/10/07 - X-ray of L ankle Interpreted by Richard Chao, MD at Pacific Medical Imaging & Oncology Ctr.
Impression: 1) Old post-traumatic changes of the malleoli, status post prior ORIF. 2) There is secondary deformity and secondary osteoarthritic changes at the distal tibia and talus.

08/10/07 - X-ray of Pelvis and Lateral L hip Interpreted by Richard Chao, MD at Pacific Medical Imaging & Oncology Ctr.
Impression: Negative study.

08/14/07 - Progress Note by Dan Le, DO. Pt is feeling moderately better. She still has swollen L ankle. She has been just lying in bed x 4 days. Shoulder is better. Dx: 1) L ankle sprain. 2) L knee pain. 3) L hip pain. Rx: Ultram. Plan: Modified duty w/no continuous walking or prolonged standing. Must be sitting the majority of work shift. Sitting work only. Must keep L foot elevated major of work shift. Limited driving (to & from work).

08/27/07 - Progress Note by Dan Le, DO. L knee/ankle/hip injury on 08/09/07. She has taken 2 Naproxen since the injury. She has relief w/Naproxen. Without Naproxen, she becomes bedridden secondary to pain. X-rays shows small loose body in the central L knee joint. She still has pain and swelling in L knee. R heel also has weird feeling x 1 ½ weeks. PE: Overweight, NAD and A&O x3. Dx: L knee sprain w/swelling. Plan: Ordered MRI of L knee. Recommended PT. Off work until 09/04/07.

09/04/07 - Initial Orthopedic Consultation by Kenneth Jung, MD. Pt presents for evaluation of L ankle injury sustained on 08/09/07. Pt reports slipping on a piece of cucumber and falling. She injured her knee and ankle. She was initially seen and given a cane and a prescription for Naprosyn. She has been using an elastic ankle brace and taking anti-inflammatories as needed. She reports sharp, achy, cramping, incapacitating pain. It bothers her all day. There is swelling, tenderness and giving way. Her history is significant for L ankle fracture sustained about 14 years ago. She underwent an open reduction and internal fixation. This injury did not occur at work. It occurred after she fell down some stairs. PE: A pleasant female in no acute distress. Alert and oriented x 3. Dx: 1) L ankle posttraumatic arthritis, s/p open reduction and internal fixation ankle fracture. 2) Industrial injury secondary to fall. 3) Ankle pain after industrial fall. Plan: Recommended use of a lace-up ankle brace. Scheduled to see Dr. Ralph Gambardella w/regards to her L knee on 09/10/07. TTD until 09/10/07. Pt is cleared for sedentary work. If she is doing better, Dr. Jung would plan to clear her for a full duty w/regards to her L ankle.

09/10/07 - Comprehensive Orthopaedic Evaluation by Ralph Gambardella, MD. Pt here today for comprehensive orthopedic evaluation or treatment regarding an injury to her L knee that she sustained on 08/09/07. History is obtained today from direct interview of pt, as well as review of records that are available. These are records from Dr. Jung. Pt was employed by D'Veal Family and Youth Services and states that she slipped and fell on a piece of a cucumber. She felt falling on her entire L side, the ankle being the most painful. Pt, however, has persisted w/some discomfort in the L knee, some overall irritability and had onset of swelling. She c/o swelling w/activities and the pain pattern, which is diffuse as tenderness, more on the medial side than on the lateral side. There is previous injury to the L ankle. PE: Normal appearance and well nourished. Mood and Affect: Normal mood and affect, cooperative, no apparent distress and in good spirits. Dx: 1) Synovitis of the L knee w/underlying early degenerative osteoarthritis of L knee including patellofemoral early arthrosis with mild patellofemoral malalignment, L and R knees. 2) Pes bursitis, L knee. Plan: Recommended PT and ankle exercise program and also some intermittent elevation. Since there was no improvement with Naproxen, switched her to Voltaren. Modified duty w/sedentary type of work activities, no climbing, a lifting restriction of 10 lbs, no squatting or kneeling activities, and standing and walking limited to no more than 15 minutes per hour. If these restrictions are not available, pt will remain TTD pending follow up evaluation in 6 weeks.

09/18/07 - Notice Regarding Temporary Disability Benefits. Pt was paid $2398.16 as Temporary Disability benefits for a period from 08/22/07 through 09/16/07 at $645.66 per week.

09/18/07 - Notice Regarding Permanente Disability Benefits. Pt's medical condition will be monitored until it is P and S. At that time, a medical evaluation will be performed to determine the existence and extent of permanent disability and the need for continuing medical care.

11/12/07 - ED Provider Note by Kristen Cannizzo, MD at Kaiser. Pt c/o R foot pain and L ankle pain since Saturday. She tried preventing a car from rolling onto street and tried jumping into driver's seat and twisted her ankle and turned her foot under. PE: She is oriented. Appears nontoxic, not dehydrated, not diaphoretic and not distressed. Dx: Foot fracture. Plan: Elevate foot. Keep moonboot as recommended.

11/12/07 - Consultation by Jennifer Graham, MD at Kaiser. Pt was attempting to stop a car from rolling into the street and twisted her R foot. Pain rated 9/10. PE: Well developed, well nourished and in no acute distress. Dx: R Foot, 4th/5th fracture - metatarsal neck and B/L ankle sprain. Plan: LE post-op shoe applied and weight bearing as tolerated. Off work for 7 days. Pt cannot drive because of R foot fracture.

11/12/07 - X-ray of R foot Interpreted by Matthew Tan, MD at Kaiser.
Impression: Fracture at the R fourth and fifth metatarsal bone.

11/12/07 - X-ray of L ankle Interpreted by Matthew Tan, MD at Kaiser.
Impression: 1) No osseous fracture. 2) Status-post open reduction and internal fixation of the left distal fibula and the tibia. 3) Severe degenerative joint disease at the left ankle.

11/20/07 - Dr's 1st Rpt by Michael Hadley, MD at HealthCare Partners. DOI: 11/10/07. Pt fell on to ground gravel and fractured R foot to prevent car from rolling into oncoming traffic. She injured R foot. On 11/10/07 while trying to enter her vehicle that was moving even though it was parked, she tripped on the ground and fell. She hit her L knee and she twisted her L ankle and also her R foot. Because of these injuries, pt developed pain mostly in her R foot. She went to Kaiser ER for evaluation and treatment. While at Kaiser ER, she was told that she had a fracture to R foot, sprain to L ankle and a bruise to L knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. Pt did so and she was referred here by her Workers Compensation insurance carrier. Today is her initial visit at this facility. Pt does c/o mild discomfort in her L ankle and her L knee. However, she does c/o significant discomfort in her R foot. PE: No acute distress. Dx: 1) Fracture, R foot. 2) Sprain, L ankle. 3) Contusion, L knee. Rx: Motrin and Extra strength Tylenol. Plan: Pt does have hardware in her L ankle and this may impact her rate of recovery. Referred to ortho. Modified duty w/no driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

11/20/07 - X-ray of R foot Interpreted by Michael Vo, MD at Health Care Partners.
Impression: 1) Fractures of the fourth and fifth metatarsals. 2) Abnormal report. A preliminary report was sent to Dr. Halley's office on 11/21/07.

11/20/07 - X-ray of L ankle Interpreted by Michael Vo, MD at Health Care Partners.
Impression: Postoperative findings in the distal tibia and fibula. There is significant degenerative narrowing of the ankle mortise.

11/20/07 - X-ray of L knee Interpreted by Michael Vo, MD at Health Care Partners.
Impression: 1) Mild osteoarthrosis in the left knee. 2) Questionable 0.8 cm loose body.

11/26/07 - P and S Rpt by Ralph Gambardella, MD. Pt was initially seen by me on 09/10/07, relative to a work injury. At the time, pt sustained an injury to her L knee on 08/09/07. This had occurred when she had slipped on a piece of cucumber and fell. Pt had injured her L knee as well as her ankle for which she had been under the care of Dr. Jung, who referred pt here for an evaluation regarding her L knee. At the time of her evaluation, she was found to have synovitis of L knee with mild pes bursitis w/underlying early degenerative osteoarthritis and patellofemoral arthrosis with mild patellofemoral malalignment. We recommended a comprehensive PT program. Pt is here today. She has returned and states that she did undergo her PT program and w/PT did see improvement of her knee condition. She is no longer having any type of significant discomfort w/the knee. She still gets some aches and minimal irritability. There has not been any recurrent swelling. Pt feels that her knee condition has improved to the point that she is capable of returning back to her regular employment. In the interim has also had a new work injury, which occurred to her RLE resulting in a fracture in her R foot and today she is ambulatory with the assistance of a cane and in a Moon boot. Pt is aware of the fact that she is being seen separately for her RLE injury. We have asked pt again and she has agreed and is comfortable with the fact that in the absence of her present R foot condition, she would be able to return back to regular work relative to her L knee and her L knee has overall been significantly improved w/only the occasional remaining symptomatology as outlined above. Dx: Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral mal-alignment, L knee s/p post-traumatic synovitis and pes bursitis, L knee. Pt is P and S. Impairment Rating: 17% LE impairment

rating which then using table 17-3 translates into a 7% WPI rating. Causation: Direct injury. Work Restrictions: Released to her regular work activities effective 11/26/07. Future medical care requirements: In the future, pt may have a flare-up of her condition that may require the use of oral anti-inflammatory medications, PT and/or Cortisone injection and/or arthroscopic surgical intervention.

11/29/07 - Orthopedic Consultation by Thomas Saucedo, MD at Specialists. DOI: 11/10/07. Pt sustained an injury to her R foot. At that time, she indicates while working, she apparently parked on a gravel road and when the car apparently started rolling without her in it, she ran towards the car, got into the car to put the emergency parking brake on and in that process twisted her R foot, fractured the fourth and fifth metatarsal, injured her L knee, as well as her L ankle. She was seen at Kaiser initially and subsequently by Dr. Hadley. She has been treated with a Cam walker for the R foot and indicates that the pain has improved significantly; however, she continues to have discomfort especially of the L ankle and to a lesser extent, the left knee. She has been on medication. She has been in a Cam walker and has been off of work. PE: Well developed and well nourished. Dx: 1) R foot fourth and fifth metatarsal fracture. 2) L ankle posttraumatic degenerative osteoarthritis. 3) L knee sprain. Plan: Continue Motrin, use of a Cam walker and off work.

12/20/07 - Orthopedic Supplemental Rpt by Thomas Saucedo, MD. Pt has been under care w/diagnosis of fracture of her R fourth and fifth metatarsal. She has been using a Cam walker and indicates that her pain has steadily improved. Also c/o pain and discomfort of her L knee and L ankle, which she indicates has been improving subjectively since her last visit. Dx: 1) Healing R fourth and fifth metatarsal fracture. 2) L knee sprain. 3) L ankle sprain. Plan: Provided knee immobilizer. Recommended to weightbear as tolerated w/the assistive devices. Continue off work.

12/20/07 - X-ray of R Foot Interpreted by Michael Vo, MD at Health Care Partners.
Impression: Healing fractures of the fourth and fifth metatarsals.

01/17/08 - Orthopedic Supplemental Rpt by Thomas Saucedo, MD. Pt sustained a fracture of her R fourth and fifth metacarpals. She also has an injury to her L knee as well as L ankle. She indicates that her R foot pain has steadily improved; however, she c/o pain especially of her L knee w/swelling and effusion of knee, difficulty w/squatting, kneeling and climbing activities. She also c/o soreness of her L ankle. Dx: 1) Healing R fourth and fifth metatarsal fracture. 2) L knee internal derangement. 3) L ankle sprain. Plan: Ordered MRI of L knee. Continue Tylenol and off work.

01/17/08 - X-ray of R Foot Interpreted by Michael Vo, MD at Health Care Partners.
Impression: 1) No significant interval change. 2) There is continued healing of fracture involving the fourth and fifth metatarsals.

02/21/08 - Orthopedic Supplemental Rpt by Thomas Saucedo, MD. Pt sustained a fracture of her R foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained L ankle sprain and L knee injury, and most recently her L knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her RLE and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury, as well as the underlying degenerative osteoarthritic changes from which pt already suffers.

Dx: 1) Healing R fourth and fifth metatarsal fracture. 2) L knee internal derangement. Plan: Recommended MRI of L knee. Continue off work.

02/21/08 - X-ray of R Foot Interpreted by Michael Vo, MD at Health Care Partners.
Impression: Continued healing of fractures involving tee fourth and fifth metatarsals.

03/19/08 - MRI of L knee Interpreted by Anthony Bledin, MD at HealthCare Partners.
Impression: 1) Tear, posterior horn, medial meniscus (Grade III). 2) Early osteoarthritic change of the medial compartment of the knee joint. 3) Knee joint effusion.

03/20/08 - Orthopedic Re-Exam by Thomas Saucedo, MD. Pt sustained a fracture to her R foot involving the fourth and fifth metatarsals and at this time indicates that she has no pain or discomfort. She also has no significant pain of her L ankle; however, she continues to c/o L knee pain. MRI of the L knee was performed. Dx: 1) L knee internal derangement with evidence of medial meniscus tear. 2) R fourth and fifth metatarsal fracture, healed. 3) L ankle sprain. Plan: Requested authorization and approval for surgery arthroscopically of her L knee, which will be done as an outpatient. Continue off work.

03/20/08 - X-ray of R foot Interpreted by Michael Vo, MD at Health Care Partners.
Impression: Continued healing of fourth and fifth metatarsal fractures.

04/15/08 - Review Determination by Pebbles Draper, RN. Requested Polar unit/cold therapy unit were non-certified and Crutches were certified.

04/17/08 - Orthopedic Supplemental Rpt by Thomas Saucedo, MD. Pt has been under our care. She has been treated for a fracture of her R foot. The fracture at this time has healed completely. She has no pain or discomfort. However, she does continue to c/o L knee pain primarily with squatting, kneeling and climbing. She has minimal soreness and discomfort of her L ankle; otherwise, she notes pain increasing of the L ankle when she is required to stand for prolonged periods of time. Dx: 1) Healed R foot fourth and fifth metatarsal fracture. 2) L knee internal derangement w/evidence of medial meniscus tear. 3) L ankle postop degenerative osteoarthritic changes w/limited ROM. Plan: Scheduled for surgery arthroscopically of her L knee on 04/24/08. Advised to undergo preop evaluation and treatment before surgery on 04/24/08. Continue off work.

04/23/08 - Orthopedic Supplemental Rpt. L knee pain. Dx: L knee internal derangement. Plan: TTD.

04/24/08 - Operative Rpt by Tomas Saucedo, MD at Plaza Surgical Ctr. Pre-Op Dx: L knee internal derangement. Post-Op Dx: 1) Evidence of L knee complete tear of the medial and lateral meniscus. 2) Evidence of cartilage tears of the patellofemoral groove, tears of the medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau. Operations Performed: 1) L knee diagnostic and surgical arthroscopy. 2) L knee partial medial and partial lateral meniscectomy. 3) L knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and tibial plateau cartilage.

05/09/08 - Orthopedic Supplemental Report at Associated Sports Therapy. L knee pain. Dx: L knee pain. Plan: Further treatment required. TTD.

05/11/08 - Orthopedic Supplemental Rpt. Sharp L knee pain. Dx: L knee pain. Plan: PT. TTD.

05/22/08-06/06/08 (6 visits) Physical Therapy Notes from Associated Sports Therapy. Completed 6 PT sessions for L knee. C/o poor endurance to BUE. Continue POC.

06/06/08 - PR-2 by Thomas Saucedo, MD at Eastside Orthopedic Med Associations. Pt is approx 6 weeks s/p arthroscopic surgery of L knee. Her pain has improved significantly with surgical procedure. She has been in PT for last 4 weeks and responded favorably. Dx: S/p L knee arthroscopy. Plan: Continue PT and HEP. Continue Vicodin. Off work.

06/09/08 - 07/07/08 (8 visits) Physical Therapy Notes at Associated Sports Therapy. Completed 8 sessions of PT for L knee. Pain is 3-4/10. Tolerated Tx well. Reinforced HEP. Continue POC.

07/11/08 - Progress Note by Thomas Saucedo, MD. Plan: Recommended additional PT sessions. She is unable to return to regular work.

07/11/08 - 07/16/08 (2 visits) Physical Therapy Notes at Associated Sports Therapy. Completed 2 sessions of PT for L knee. Tolerated Tx well. Continue skilled PT.

07/30/08 - Office Visit by Kelly S. Ching, MD at Kaiser. Pt is here for f/u on BP. She is not on meds. She has been only eating 1x/day. She c/o moderate hot flashes x 15 yrs and would like Tx. It is worse at night and has difficulty sleeping. PE: A&O. No acute distress. Dx: 1) Obesity (BMI 30-39.9). 2) Smoker. 3) Menopausal symptoms. Rx: Clonidine 0.1 mg. Plan: Ordered Pap and HPV co-test. Advised on diet and exercise.

07/30/08 - Laboratory Rpt at Kaiser. Pap Test. Specimen: Cervix. Dx: Negative for intraepithelial lesion or malignancy. HPV Co-test: Result: Negative.

08/08/08 - Ortho Supplemental Rpt. Pt is 14 weeks s/p arthroscopic surgery of L knee. Dx: S/p L knee arthroscopy. Plan: Recommended additional PT. Continue Vicodin and Motrin. TTD.

08/14/08 - 08/22/08 (4 visits) Physical Therapy Notes at Associated Sports Therapy. Completed 4 sessions of PT for L knee. She is not doing well. Continue therapy.

08/28/08 - Ortho Supplemental Rpt. Pt is 16 weeks s/p arthroscopic surgery of L knee. C/o 2 weeks of severe electrical type pain in lateral LLE. Dx: S/p L knee arthroscopy. Plan: Continue Motrin and PT.

09/05/08 - PR-2 by Tomas Saucedo, MD. Pt has undergone arthroscopic surgery of L knee on 04/24/08. Since then, she has been placed on an aggressive PT program, HEP and her pain has improved significantly. She does c/o some associated pain to lower back and some radiculopathy of LLE. Dx: 1) S/p L knee arthroscopy. 2) Lumbosacral spine strain. 3) LLE radiculopathy. Plan:

Continue Ibuprofen and strengthening program. Modified duty and to avoid prolonged standing, walking, squatting, climbing and pivoting type of activities.

09/05/08 (1 visit) - Physical Therapy Note at Associated Sports Therapy. Completed 1 session of PT for L knee. C/o pain with exercise. Continue POC.

09/18/08 - Notice Regarding Temporary Disability Benefits. Pt was paid $28,487.36 as Temporary Disability benefits for a period from 11/12/07 through 09/14/08 at $647.44 per week.

09/22/08 - Notice Regarding Permanent Disability Benefits. Pt was paid $4140 as permanent disability benefits for a period from 09/17/07 through 01/20/08.

10/10/08 - Ortho Supplemental Rpt. Pt reports pain worse. Dx: L knee pain with underlying DJD. Plan: Continue Motrin 500 mg, Vicodin, PT and HEP. Modified duty.

12/05/08 - Ortho P&S Rpt by Tomas Saucedo, MD. DOI: 11/10/07. Pt underwent a partial medial meniscectomy and an abrasive chondroplasty of medial femoral condyle of L knee on 04/24/07. Since then, her pain has improved, however, not completely resolved. She does have some mild discomfort of L knee. Dx: 1) S/p L knee arthroscopy with partial meniscectomy. 2) S/p L knee abrasive chondroplasty. Disability Status: Reached MMI. Pt is P&S. Subjective Factors of Disability: Her subjective complaints are rated in range of intermittent minimal not exceeding that level. Objective Factors of Disability: Objectively, she did undergo a partial meniscectomy as well as an abrasive chondroplasty and has responded favorably. Impairment Rating: 1% total WPI for partial menisectomy. Work Status: Full duty w/o restrictions. Future Medical Care: Pharmacotherapy, PT for aggravation or recurrence of symptoms as a result of initial injury.

01/08/09 - Notice Regarding Temporary Disability Benefits. Pt was paid $690 as final permanent disability payment for a period from 09/18/08 through 10/05/08.

01/23/09 - Ortho Supplemental Rpt at Tomas Saucedo, MD. Pt underwent arthroscopic surgery of her knee on 04/24/08 at Plaza Surgical Ctr. She underwent partial medial and partial lateral meniscectomy with an abrasive chondroplasty of patellofemoral groove, medial femoral condyle, medial tibial plateau, lateral femoral and lateral tibial plateau. Since then, she was considered P&S on her visit of 12/05/08. In reviewing her history, she denied any prior injuries noted in her L knee. However, she does give a h/o having injured L ankle in 08/2007. She was off of work for approximately 4-5 weeks, she informed us of this; however, in reviewing report by Dr. Ralph Gambardella, it appears that she did sustain an ankle sprain which was treated by Dr. Gambardella's associate Dr. Jung. As a result of having developed pain to L knee, she was referred to Dr. Gambardella who awarded her a 7% lower extremity impairment rating based on joint space narrowing of knee and a 10% lower extremity impairment rating as a result of the patellofemoral joint space narrowing, a total of 17% which corresponds to a 7% whole person impairment rating. On this basis, it appears that in fact this pt does in fact have a preexisting underlying degenerative OA of her knee with previous pain which apparently improved and/or resolved and at this time has had a recurrence of the same problem. Examiner would apportion this to at least 50% present industrial injury of 11/10/07 and would be apportioned to her prior injury of her L knee as noted by Dr. Gambardella.

03/06/09 - Office Visit by Kelly S. Ching, MD. Pt is here for PE. Wants to stop smoking; wants Zyban. She had been disabled and wants L knee surg. Residual LLE swelling. PE: A&O. No distress. Dx: 1) Obesity (BMI 30-39.9). 2) Smoker. 3) Menopausal symptoms. 4) OA. 5) Essential HTN. Rx: Bupropion 150 mg, Ibuprofen 800 mg, Lisinopril-Hydrochlorothiazide 20-25 mg. Plan: Ordered labs, B/L screening mammogram and ECG. BP checked. Counseled on diet and exercise.

09/04/09 - Ortho Re-exam by Tomas Saucedo, MD. Pt reports past week while getting out of a friend's car apparently twisted L knee causing to develop pain and discomfort of L knee. She was concerned that she may have re-injured her knee and therefore sought medical attention. She has not lost time from work. X-ray taken today revealed evidence of mild medial joint space narrowing. PE: Well developed and well nourished young lady. Dx: 1) L knee re-injury. 2) L knee evidence of mild degenerative OA. Rx: Motrin. Plan: Full duty.

10/22/09 - Office Visit by Terre Jay Watson, MD at Kaiser. Pt presents for eye exam with history or strabismus (exotropia); difficulty studying and taking exams on computer. Dx: 1) Myopia. 2) Astigmatism. 3) Strabismus. 4) Amblyopia. 5) Presbyopia. Plan: Spectacle Rx prescribed.

11/07/09 - Ortho Supplemental Rpt. Reports L knee pain is same. Dx: 1) L knee arthroscopy. 2) L knee OA. Rx: Motrin 800 mg, Vicodin and Prilosec. Plan: HEP. Modified duty.

11/09/09 - Office Visit by Khine Khine Win, MD at Kaiser. Pain in upper back and low back, 2/10. Pain worse when going to work. C/o ankle and knee pain. She has stress at work and reports worse neck muscle pain. This has been ongoing for a few months. Takes Ibuprofen 800 mg bid for ankle and it still does not help with neck pain. Also this am has chest pain, 4/10. She has pain with pressing. No activity. Dx: 1) Myofascial pain syndrome. 2) Chest wall pain. 3) Muscle spasm. Rx: Robaxin 750 mg. Plan: Ordered ECG.

02/23/10 - Notice Regarding Permanente Disability Benefits. Pt was paid $4140 as Permanent Disability benefits, an estimate of 6%. Payment of $4554 was sent separately. Additionally, check includes a 10% self-imposed increase to $414.

08/30/10 - Office Visit by Sabrina Renee Villalba, MD at Kaiser. Pt presents for annual physical exam and BP check. She is not taking meds since she does not like to. Social Hx: Smokes 4-5 cigarettes/day for 43 years. Alcohol use, 2 drinks containing 0.5 oz of alcohol per week. PE: Oriented. No distress. Psych: Affect normal. Dx: Essential HTN. Rx: Lisinopril-Hydrochlorothiazide 20-25 mg. Plan: Ordered labs, B/L screening mammogram and Adacel vaccine. BP re-check in 1 week.

10/11/10 - Laboratory Rpt at Kaiser. Serum BUN (H) 40. Cholesterol (H) 206. Triglycerides (H) 162. Sodium (H) 146. Chloride (H) 112.

10/11/10 - Ortho Re-Exam by Tomas Saucedo, MD. Pt presents with pain and discomfort to lower back with associated radiculopathy to LLE. This is a new problem and she is quite concerned. Dx: 1) S/p L knee surgical arthroscopy. 2) Lumbosacral spine strain with LLE radiculopathy. Plan: Examiner reports lower back is not a continued medical problem from a previous injury and this

should be seen and treated according to either a new industrial injury or non-industrial injury depending on pt's presentation of the problem to the newly treating doctor. For L knee there is no need for any acute ongoing medical care. She was provided with anti-inflammatory and analgesic meds.

10/15/10 - Call Documentation by Sabrina Renee Villalba, MD. Spoke with pt and given number to call for colonoscopy. Discussed benefits of colon cancer screening and early detection. Advised recent lab tests and to stay hydrated. Discussed risks of uncontrolled BP, including kidney failure and need to f/u to check BP and optimize control.

11/17/10 - Procedure Note by Donald Charles Gerety, MD at Kaiser. Procedure Performed: Colonoscopy.

01/26/11 - Ortho Supplemental Rpt by Tomas Saucedo, MD. Pt has been under our care having previously undergone arthroscopic surgery of her knee. Surgery was performed on 04/24/08. She did well; however, she did have some residual soreness, this soreness has steadily become more pronounced. Denies any new injuries to L knee, any other problem to L knee and indicates that she has continued to work with D'Veal Family Youth Services performing her work related activities. However, she does c/o increased pain of her L knee especially over the last few months. X-ray of L knee reveals evidence of grade III medial compartment narrowing of L knee with osteophyte formation noted primarily in medial compartment. Dx: L knee evidence of medial compartment degenerative OA. Tx: Administrated intra-articular cortisone. Plan: Provided anti-inflammatory meds. Consider knee arthroplasty if no improvement. Full duty.

01/26/11 - Orthopedic Supplemental Rpt by Tomas Saucedo, MD at Eastside Ortho Med Associates. DOI: 11/10/17. Pt is s/p arthroscopic surgery of her knee on 04/24/08. She did well, however, she did have some residual soreness. This soreness has steadily become more pronounced. She has continued to work performing her work-related activities. However, she does c/o increased pain of her L knee especially over the last few months. X-ray of L knee reveals evidence of grade III medial compartment narrowing of the L knee with osteophyte formation noted primarily in the medial compartment. Dx: L knee evidence of medical compartment degenerative OA. Tx: Administered intra-articular Cortisone injection to L knee. Noted immediate improvement of the pain and discomfort. Plan: Treat conservatively at this point with use of anti-inflammatory med. If no improvement, consider knee arthroplasty of L knee. She will continue to work with no restrictions.

03/17/11 - Ortho AME by Tomas Saucedo, MD. DOI: 08/09/07; 11/10/07. Pt's sustained 1st injury around 08/2007, when she slipped fell and twisted L ankle and L knee. She was seen in an industrial clinic and treated with bracing for both of these, as well as PT. While still healing from this injury, she had a second injury in November 2007. She was picking up clients at work when she noticed that the car was rolling. She jumped in to pull up tension on the brake. In doing so, she fell striking her left knee on the ground and her right foot turned in. She had ongoing pain in the L knee and R ankle. She elevated and iced it. Because of pain, she went to Kaiser ER where she was evaluated and had x-rays. She was told that she had two fractures of R foot. She was placed in a Cam walker, which she wore for a number of weeks. She was then treated with Dr. Saucedo. As R foot got better, she had persistent pain in L knee. She had an MRI and eventually surgery of L

knee, which helped her L knee. However, she has had residual ongoing symptoms of L knee ever since the surgery. She was released in 2008 or so by Dr. Saucedo. She returned to him a couple of months ago because of pain in L knee. At that time, she could not use the clutch of her car. Dr. Saucedo had told her that she would need to get a different kind of car because of the clutch, but she continued to use the clutch. He took x-rays of her knee and gave her a Cortisone injection. She was off work for about a week. The injection helped a lot. However, she developed a skin burn from the topical used to freeze her knee prior to the injection. Dr. Saucedo told her she was bone on bone laterally and may need total knee replacement surgery in future. Currently c/o L ankle/knee symptoms. Ankle pain is medial and lateral. L knee pain is a diffuse peripatellar pain. Knee does not have any locking or buckling, but it has stiffness. Prior injuries: Pt injured her L ankle a number of years ago in the mid 90s. It was fractured medially and laterally. She had surgery. Since then, she has had pain, which became worse after the incident of 08/2007. PMH: Arthritis of knee, heart murmur and HTN. PSH: Knee and L ankle surgery. Social Hx: Admits to smoking cigarettes and drinking alcoholic beverages. Family Hx: Mother deceased from cancer and father deceased from trauma. Current Meds: Lisinopril, Hydrochlorothiazide, Ibuprofen and Vicodin. Dx: 1) S/s of L knee aggravating degenerative arthritis of L knee. S/p arthroscopic partial lateral and medial meniscectomies. 2) Sprain of L ankle temporarily aggravating significant pre-existing arthritis of L ankle. 3) Fx of R foot, fourth and fifth metatarsals healed. Disability Status: Pt is MMI. Impairment Rating: 20% total WPI for lower extremity includes L knee/ankle. Work Status: Pt may do her present job without any formal restrictions. However, in the open labor market, she would be precluded from more than occasional squatting, kneeling and precluded from any type of climbing and more than occasional use of stairs. Causation & Apportionment: With regards to her R foot, this was injured in 11/2007 work incident and 100% of any residual disability is due to the incident of 11/2007. With regards to L knee, prior to work incidents, she was asymptomatic in L knee even though she had arthritis. She injured L knee in both the 08/09/07 and 11/10/07 work incidents. The arthritis appears to have gotten worse since the injuries. Based upon these records and examination today, examiner would apportion 20% to pre-existing pathology and the remaining 80% to aggravation of pre-existing pathology, further s/s and tears of the menisci as a result of the two work incidents of August and November 2007. Examiner cannot separate these two as to which one caused the tear of the meniscus and which one caused more injury to the knee and put them together as one injury. With regard to L ankle, while she temporarily aggravated L ankle in 08/09/07 fall and 11/10/07 incident, she also had pre-existing arthritis from a prior injury that required surgery. At this point, any residual is 100% apportioned to the pre-existing arthritis, examiner thinks she had a temporary aggravation of L ankle arthritis due to the sprains, but this settled back down. Sprain in ankle would cause laxity and looseness of the ankle, not tightness of the ankle. This does not appear to be residual of the ankle sprain. Future Medical Care: L knee: Allowance should be made for repeat orthopedic visits for her L knee including but not limited to evaluations, x-rays and Corticosteroid injections. For more lasting relief than the Corticosteroid injections, viscous supplementation such Synvisc would be beneficial. Should the left knee symptoms become such that they interfere significantly with her quality of life, then she would be a total knee replacement candidate. She is not a knee replacement candidate at this time; however, this could change in the next few years. X-rays findings are not indicative of the need for total knee replacement. Only the pain and its effect on the quality of living is an indication for a knee replacement. L ankle: With regards to L ankle, any further care of L ankle would be treatment of her pre-existing arthritis of L ankle, not injury of 08/2007 or 11/2007.

03/23/11 - X-ray of L Knee interpreted by John Crues, MD at Synergy Imaging Ctr. Impression: Findings compatible with DJD primarily involving the lateral compartment.

03/23/11 - X-ray of L Ankle interpreted by John Crues, MD at Synergy Imaging Ctr. Impression: 1) Old fx involving distal L fibula and medial malleolus with internal fixation. 2) Severe degenerative disease of mortise joint. 3) Soft tissue swelling.

04/29/11 - Notice Regarding Temporary Disability Benefits. Pt was paid $1347.14 as Permanent Disability benefits and sent separately for the period from 03/17/11 through 04/26/11.

05/14/11 - Office Visit by Kris Wai-Min Lum, OD at Kaiser. Pt presents for routine eye exam. Dx: 1) BAL OD, CMA OS presbyopia. 2) Strabismic amblyopia OD. 3) Anisometropia. 4) Cataracts OU. Plan: Spectacle Rx prescribed.

06/03/11 - Notice Regarding Temporary Disability Benefits. Pt was paid $460 as Permanent Disability benefits and will be sent on 06/07/11 for the period from 05/25/11 through 06/07/11.

06/06/11 - Supplemental Job Displacement Benefits. Pt is not prevented from returning or has returned to work for the employer; therefore, pt is not entitled to the supplemental job displacement benefit.

08/11/11 - Office Visit by Kelly S. Ching, MD. Pt is here for Pap/physical exam. S/p fall, tripped on pavement 2 days ago. She had no head trauma but few scrapes and B/L anterior knee pain. PE: A&O. No acute distress. Dx: 1) OA. 2) Essential HTN. 3) Obesity (BMI 30-39.9). 4) Smoker. 5) Menopausal symptoms. 6) Abrasion. Rx: Lisinopril-Hydrochlorothiazide 20-25 mg and Ibuprofen 800 mg. Plan: Ordered labs and B/L screening mammogram. Continue diet/exercise. Rest, ice, NSAIDs.

08/11/11 - Laboratory Rpt at Kaiser. Pap test. Specimen: Cervix. Result: Negative for intraepithelial lesion or malignancy. HPV Co-test. Result: Negative.

10/19/11 - Office Visit by Kelly S. Ching, MD. C/o L hand and forearm constant tingling x 2 weeks. All fingers were involved. She admits to leaning and sleeping on hands all the time. Took ASA. Dx: 1) Paresthesias. 2) OA. 3) Essential HTN. 4) Obesity (BMI 30-39.9). 5) Smoker. 6) Menopausal symptoms. Rx: Motrin 800 mg and Lisinopril-Hydrochlorothiazide 20-25 mg. Plan: Ordered vaccines for pneumococcal, zoster virus and influenza. Avoid compressing hand at work or during sleep. Diet/exercise. Try to wean tobacco.

10/24/11 - Diagnostic R Mammography interpreted by Caroline Lim Fong, MD at Kaiser. Impression: Probably benign. The stable cluster of calcifications in R breast appears probably benign.

11/08/12 - Call Documentation at Kaiser. Appt offered for BP check with Dr. Ching or HTN group visit on 11/29/12. Pt declined all. States she is busy now and will call later to get appt.

09/27/13 – Office Visit by Terre Watson, OD at Kaiser. Presents for general eye exam, feels like strabismus OD, may be increasing. PE: Alert and oriented x3, normal dress, behavior, mood affect, speech and thought content, normal range, appropriate, mood congruent and clear. Dx: 1) Myopia. 2) Astigmatism. 3) Presbyopia. 4) Hx of strabismus surgery. Plan: Primary reason for visit was to discuss her perception that her R eye may have drifted further. Agreed it is possible that it has, however, only viable solution would be to consider surgery again. Pt decline and is not interested in additional surgery.

12/16/13 –Nurse on Call Telephone Records at Kaiser. Reason for call L arm tingling and back pain. Tingling sensation in L arm (wrist and up) > 1 month. Pain to left side of back.

12/17/13 - Progress Notes by Kelly Ching, MD. Constant LUE fingers tingling x 1 month. Thought it may be related to how she slept. PE: No acute distress, well developed and well nourished. Dx: 1) L arm paresthesia. 2) Screening for breast cancer. 3) Smoking cessation counseling. 4) OA. 5) Smoker. 6) Essential HTN. 7) Obesity. 8) Menopausal symptoms. Plan: Ordered B/L mammogram and labs. Consider steroids for paresthesia if persists. Restart Lisinopril/Hydrochlorothiazide 20/25 mg and BP titration protocol. Diet/exercise for weight. DASH. Check BP in 1-2 weeks. Referral to neurology.

04/01/14 - Call Documentation by Rebecca Contado, LVN at Kaiser. Wanted to inform pt about a special group visit for those with high BP and also since her BP was slightly high and to go to NC for BP check, but pt was not reachable.

10/29/14- Call documentation at Kaiser. Requested appointment for having problems with his lenses, needs a new vision exam.

11/11/14 – Progress Notes by Terre Watson, OD. Here of eye exam, constantly has to remove glasses to see lately. PE: Pt is alert, oriented x 3, normal dress, behavior, mood, affect, speech and thought content, normal range, appropriate, mood congruent and clear. R exotropia and amblyopia longstanding. Plan: Discussed dilation.

12/31/14 - Call Documentation by Elaine Ravare, LVN at Kaiser. Spoke with pt regarding request for work note for days missed 12/29/14 and 12/30/14. Pt missed work due to cold symptoms. She has not been seen by PCP in > 1 year. Offered pt same day appointment with Dr. Ching for eval of symptoms.

12/31/14 - Office Visit by Jamie McKinney, MD at Kaiser. Pt with PMH of HTN, who presents with 4 days of URI symptoms and need note for work also. Symptoms include sneezing, runny nose and nasal congestion. She has been resting. Pt is not taking her BP meds in over 8 months. PE: She is oriented to person, place and time and well-developed, well-nourished and in no distress. Mood and affect normal. Dx: 1) URI. 2) HTN. 3) Screening. Rx: Fluticasone 50 mcg nasal suspension. Loratadine 10 mg. Plan: Avoid Sudafed given HTN. DMI given for work. Encouraged compliance, take first dose of BP starting today. F/u with BP check in 2 weeks and continue BP management. Ordered labs.

01/09/15 - Office Visit by Paul Reehal, MD at Kaiser. Presents with cough and URI symptoms x 1 week. Also BP noted to be low today after starting new BP med. Pt is asymptomatic. ROS: Positive for malaise and fatigue. PE: Well-developed, well-nourished, in no distress. Dx: Cough, URI symptoms. Rx: Cheratussin AC. Plan: Saline nasal spray. Supportive measures discussed.

01/09/15 - X-ray of Chest Interpreted by Fernando Torres, MD at Kaiser.
Findings/Impression: The lungs are clear. No pleural effusions are seen. The cardiomediastinal silhouette is normal. Aortic atherosclerosis.

01/09/15 - Laboratory Rpt at Kaiser. Sodium (L) 133. Chloride (L) 99. HgbA1c (H) 5.7. 25-Hydroxy Vitamin D (L) 14. RBC, automated (L) 3.97. creatinine (H) 1.82. monocytes % (H) 19.0. Cell Morphology Smear showed Polychromasia (A) few. Macrocytes (A) few. Platelets, large, blood microscopy (A) Few.

01/12/15 - Call Documentation by Kelly Ching, MD. Advised pt to repeat labs in 1-2 days and f/u at nurse clinic for BP check.

10/02/15 - Progress Notes by Terre Watson, OD. Here for vision exam due to concerns about best corrected visual acuity for each eye and limitations in peripheral vision. PE: Pt is alert, oriented x 3, normal dress, behavior, mood, affect, speech and thought content, normal range, appropriate, mood congruent and clear. Plan: Recommended she self restrict driving to daytime and street (rather than night or freeway).

11/24/15 - Call Documentation by Rebecca Contado, LVN. Wanted to inform pt that she is due for seasonal flu shot, but pt was not reachable.

03/01/16 - Office Visit by Daniel Lin, DO at Kaiser. Here for 4 days of worsening URI symptoms. PE: Well-developed, well-nourished in no distress. Dx: Acute URI. Rx: Codeine-Guaifenesin 10/100 mg. liquid. Plan: Supportive care. Rest, increase fluid intake and OTC meds for symptom relief.

03/08/16 – Office Visit by Sandra Montes, MD at Kaiser. Pt presents with cough x 2 weeks. Did not go to work yesterday and tried to go to work today and was sent home from work. PE: Well developed, well nourished and in no distress. Dx: 1) Cough. 2) Screening mammogram for breast cancer. 3) Vaccination for Influenza. 4) Vaccination for Strep pneumonia with Prevnar 13. Rx: Azithromycin 250 mg and Benzonatate 100 mg. Plan: Continue supportive care. Gave note for work as requested. Pt works as a therapist so has to talk, does not feel ready to go back yet. Ordered mammogram. Vaccine was declined.

03/09/16 - Mammogram Screening Bilateral Interpreted by Paul Didomenico, MD at Kaiser.
Impression: Incomplete. Needs additional imaging eval. The cluster of coarse heterogeneous calcifications in the R breast appears indeterminate. Magnification views are recommended.
BI-RADS: 0 indeterminate.

03/18/16 - TAV by Kelly Ching, MD. Pt worried about mammogram call back. She was reassured after review. Dx: 1) Abnormal mammography. 2) Smoker. Plan: Requested mammogram diagnostic, B/L.

10/14/16 - TAV by Kelly Ching, MD. She needs refill of Motrin for ankle pain/swelling about 2x/wk. She is aware of the risks of meds but not interested in change since it works. Dx: 1) Medication refill. 2) Smoker. 3) Counseling. Plan: Declined Meloxicam. She is to work on diet/exercise for weight and smoking. Offer Wellness Coach. Picked 12/31/16 as quit date.

11/07/16 - Office Visit by Kevin Bromage, MD at Kaiser. Pt sent from dentist for high BP. BP at dentist office was 198/122. States she smoked a cigarette just before going to the dentist. A wrist cuff was used to take her BP at the dentist, unsure if it was the appropriate cuff size. Pt is also very anxious regarding this dental appointment. Had high BP in the past, but no longer needed BP med after some significant lifestyle changes. BP came down to normal limits while in urgent care with no Tx. PE: Well-developed, well-nourished, in no distress. She is alert. Mood, memory, affect and judgment normal. Dx: 1) Elevated BP reading without HTN dx. 2) Vaccination for Influenza. 3) Vaccination for Strep pneumonia with Prevnar 13. 4) Smoker. Plan: Ordered Afluria MDV and Prevnar 13 vaccine. Reassurance provided, counseled smoking cessation, diet, weight loss and home BP monitoring.

12/09/16 - TAV by Kelly Ching, MD. Called to f/u on smoking cessation plan. Not smoking today since has cold symptoms. Dx: 1) Smoker. 2) Smoking cessation counseling. Plan: Declined assistance/meds right now. She is to stop on her own.

01/25/17 - TAV by Kelly Ching, MD. Pt adamant needing Motrin. Prescription refilled for her chronic ankle pain. Not been to see me for 3 years. Did not get labs done as recommended. Still smoking, only 3 per day per pt. Dx: 1) Other reason for consultation. 2) L ankle joint pain. 3) Smoker. 4) Atherosclerosis or aorta. Plan: Advised pt would like eval for labs for kidney function and to evaluate her pain and physical every 12 months, if med is prescribed. Can use Tylenol or OTC Advil as needed. Consider smoking cessation and Wellness Coach.

01/30/17 - Progress Notes by Kelly Ching, MD. Pt overdue and wanted her Motrin refilled. Using about 1 Motrin 2x/wk. She is not sure why BP is up. PE: No acute distress, well developed and well nourished. Dx: 1) OA. 2) Tobacco smoker. 3) Vitamin D deficiency. 4) Medication refill. 5) Elevated BP reading without HTN dx. 6) Smoking cessation counseling. 7) Vaccination for Strep pneumonia with Prevnar 13. 8) Vaccination for Influenza. 9) Screening mammogram for breast cancer. 10) Atherosclerosis of aorta. 11) Menopausal symptoms. 12) Obesity, BMI 30-34.9, adult. Rx: Bupropion 150 mg. Vitamin D3 1000 unit, Calcium Acetate 667 mg. Motrin 800 mg. Plan: Ordered B/L mammogram, Prevnar 13 and Fluvirin PF vaccine.

02/01/17 - Call Documentation by Kelly Ching, MD. Recommended Calcium supplement.

02/09/17 - Office Visit by Richard Gin, OD at Kaiser. Here for eye exam. C/o slight blur and eye strain. Wants annular exam. PE: Alert and oriented. Appearance, mood and speech are normal.

06/21/17 - F/u Ortho Eval by Jonathan Nissanoff, MD at Advanced Ortho Ctr. Reported pain from repetitive use of her arms, neck and low back, and numbness in her RUE. She has stiffness and swelling. Pain level 9/10 and numbness in her fingers. Does have bladder and bowel dysfunction sometimes. Surgery on her L ankle that she sustained from a non-industrial accident. Currently, she is wearing a brace on L ankle that she feels has been aggravated since the CT injury. Also claims she has been traumatized from work by her boss, who had threatened her and she would like to have a psychiatric eval. ROS: Anxiety and depression. Dx: 1) S/p non-industrial L ankle fx. 2) S/p ORIF, L ankle. 3) Aggravation work-related injury for L ankle. 4) L knee non-industrial meniscectomy. 5) R/o arthrosis. Aggravated by work. 6) LBP. 7) Cervical pain. 8) R shoulder pain. 9) Rotator cuff tendonitis. 10) R elbow and wrist pain. Rx: Naprosyn and Prevacid. Plan: Requested PT, Pain Management consult and x-rays of the ankle, knee, back and neck. Referral for psychiatric eval. TTD. Causation: Industrial.

10/05/17 – Progress Note by Kelly Ching, MD. Ordered labs and to start meds. Recommended DASH diet and BP check 1-2 weeks. Prescribed Lisinopril/Hydrochlorothiazide 20/25 mg. Hydrochlorothiazide 25-50 mg. Lisinopril 10-40 mg. Losartan 25-100 mg. Amlodipine 2.5-10 mg. Spironolactone 12.5-25 mg. Atenolol 25-50 mg. KCL 20-40 mEq.

10/11/17 - Urgent Care Visit by David Shaw, MD at Kaiser. Here with c/o room spinning dizziness intermittently for the past 2 weeks. Worried that she has L facial drop and may have a stroke. PE: Well developed and well nourished. No acute distress. Alert and oriented. Affect appropriate. Dx: Vertigo. Rx: Meclizine.

10/23/17 - Laboratory Rpt at Kaiser. Cholesterol/HDL ratio, creatinine, LDL cholesterol, direct, HgbA1c and electrolyte panel were performed and found to be within normal range.

10/23/17 - Nurse Visit by Mi Pham, LVN at Kaiser. Here for BP check. C/o dizziness and back pain.

10/23/17 - Call Documentation by Leilani Macasieb, RN at Kaiser at 5:21 pm. Spoke with pt, stating having upper L shoulder pain since last night, 3-4/10. She was able to speak clearly and is A&O x 4. Reports taking BP meds at night instead of morning.

10/23/17 - Progress Note by David Morris, MD at Kaiser at 5:32. Here for BP check. She is asymptomatic.

10/24/17 – Nurse Visit by Mi Pham, LVN. Here for BP check.

10/24/17 - Progress Note by Kelly Ching, MD at 2:26 pm. Hold BP meds. BP check in 1-2 weeks.

10/24/17 - Laboratory Rpt at Kaiser. Urine microalbumin performed and found to be within normal range.

10/25/17 – Pain Management f/u Eval by Jonathan Nissanoff, MD. Seen for chronic LBP that she has had for greater than one year. Pain level 8/10. (Partial Document.)

10/25/17 - TAV by Kelly Ching, MD. Vertigo and low BP. C/o pain all over. Dx: 1) F/u exam after non-cancer tx completion. 2) Vertigo. 3) Dizziness. Plan: Advised to visit nurse clinic if not feeling well.

11/01/17 - Progress Notes by Kelly Ching, MD. Pt is not feeling well. She has intermittent vertigo x 3 weeks. Dx: 1) L BPPV. 2) Smoking cessation counseling. 3) Smoker. 4) Obesity, BMI 30-34.9, adult. 5) Atherosclerosis of aorta. 6) Screening. 7) Vitamin D deficiency. 8) Vaccination for Influenza. 9) L ankle joint pain. Tx: Administered Influenza 0.5 mL IM. Rx: Voltaren 1% topical gel. Plan: Ordered labs and Dik Hallpike maneuver. F/u Mammo/US. Wellness Coach. Diet and exercise for weight.

11/05/17 - Call Documentation by Kelly Ching, MD. Discontinue Calcium Acetate 667 mg.

11/01/17 - Laboratory Rpt at Kaiser. Electrolyte panel, ALT and creatinine were performed and found to be within normal range.

12/07/17 - Office Visit by Paul Ho, OD at Kiaser. Pt is here for an eye exam. C/o blurred vision at distance and near. Feels vision is worse. Pt has PAL but would like singe vision prescription glasses. PE: Alert and oriented x 3, normal dress, behavior, mood, affect, speech and thought content.

02/28/18 - PQME Orthopedic Eval by Gregory Heinen, MD at California Sports Cartilage Institute. DOI: 04/16/06. Pt works for D'Veal Corp as a Therapist. Sustained CT injury from her 12 years of employment. She developed pain from repetitive use of her UE and LE. She drives significantly to clients homes going in and out of cars over the last 3 years. She estimates that she would have to drive to clients approximately 5 times per week with her current intake job. She would have to climb up and down stairs of clients home (1-2 short flights of steps per day) She would have to type intake reports everyday (2-3 hours/day). States that she also developed psyche issues (awaiting psyche eval and looking forward to this). States that she has also seen a doctor for her eyes. She doesn't remember when she started developing symptoms. Never sought care for any of these issues prior to Dr. Nissanoff. She notes that she would change her daily practice. She did not like driving freeways as eyesight changed. She was getting nervous about this and joined carpools. She suffered harassment from one of her co-workers (CEO of the company). States he got into her face and pushed a phone to her face. She was unable to go to work for the next two days. She is paranoid at this time if anyone gets close to her. She did not have any tx from the time she left to the time she saw Dr. Nissanoff. She has had ongoing care with this doctor once a month. She also has ongoing care with Dr. Javid Ghandehari for med refills. She sees him once a month for refill of Ibuprofen and Gabapentin. Requests x-rays, PT, TENS units and psychiatrist referral but have not been approved. She has not had any care up to this point. Currently, she c/o on and off neck pain that radiates down her back. She has to turn the neck slowly. Back pain is debilitating. She is unable to move when back gets stuck. She can have this shooting down her back. Sometimes can hardly walk. For B/L shoulders, she has constant aching to the top of her shoulders. This radiates down to her elbow for B/L shoulders. For B/L hands, she has stiffness and locking, this is painful. For B/L knees, she has swelling and constant ache. She is unable to walk at times. She feels instability in B/L knees. Balance is an issue. Occupational Hx: Pt works for D'veal Corp as a marriage and family therapist. Pt worked there for 12 years. She stopped employment in 04/2016.

Past Work-Related Injuries: Reports L knee injury getting out of the car. She does not recall the year of which this happened at same employer. She had surgery for torn meniscus. She has swelling all the time. Also had injury to her toe to the L foot. Had recovery with this for the toe. Knee still hurt. PMH: HTN. Family Hx: Cancer. PSH: Eye surgery at 20 years. L ankle. L knee menisectomy. Allergies: Penicillin versus Potassium. Current Meds: Ibuprofen 800 mg and Gabapentin 100 mg. Social Hx: Occasional alcohol. Smoking currently 3 cigarettes/day. PE: Alert and oriented, well-nourished, well-developed, and in no apparent distress. Mood and affect are appropriate. Dx: 1) C/S degenerative arthritis. 2) C/S degenerative arthritis without radicular symptoms. 3) Reported C/S stain/pain. 4) B/L shoulder degenerative arthritis R greater than L. 5) B/L hand CMC joint mild degenerative arthritis/numbness. 6) T/S degenerative arthritis. 7) L/S degenerative arthritis with radicular symptoms. 8) B/L knee degenerative arthritis L greater than R. 9) L ankle severe degenerative arthritis s/p fx, s/p surgical intervention and fixation. 10) R ankle mild degenerative changes. 11) S/p R foot metatarsal fractures. 12) Reported stress reaction-stress associated pain. 13) Reported visual changes. Causation: Her job activities could reasonably have contributed to the cause and/or aggravated her symptoms and diagnosis to her B/L hands on a work-related CT basis. Daily activities and using ambulatory aids may also contribute. Care for the pt's B/L ankles, R foot, and knees should be treated directly as a result of her 2007 injury that has been settled by compromise and release. Impairment: 38% WPI. Apportionment: Based on the information provided, pt's shoulders, spine, knees, ankles and feet are 100% apportioned to nonindustrial issues or are the result of her previous injuries and subsequent compromise and release. Do not recognize a separate specific injury or CT trauma injury. For the hands, it felt work related. Would apportion 70% to her work activities and 30% top her personal nonindustrial issues. Work Restrictions: Hands and wrists should be precluded from very forceful use of B/L hands. For shoulders, she should be precluded from repetitive over shoulder activities. She should be precluded from very heavy work. For LLE, should be precluded from prolonged standing and walking, no squatting and kneeling or climbing. Vocational Rehab: If the restrictions for the hands cannot be met, pt would be considered a qualified injured worker. Future Medical Care: Pt should have future medical care with an eval from an ortho surgeon, meds, injections, PT, diagnostic studies and possible surgical intervention.

03/19/18 - MRI of L Knee Interpreted by Anthony Bledin, MD at HealthCare Partners.
Impression: 1) Tear, posterior horn, medial meniscus (Grade III). 2) Early osteoarthritic changes of the medical compartment of the knee joint.
3) Knee joint effusion.

06/12/18 - Office Visit by Kim Lee, MD at Kaiser. Itchy patchy rash on the mid back x 1 week ago with darkening of skin on forehead and chin area. Requests meds. PE: Pt in no distress. Dx: 1) Dermatitis. 2) Smoking cessation counseling. 3) Declines vaccination. 4) Advance directive status counseling. 5) BP elevation. 6) Atherosclerosis of aorta. 7) Hyperpigmentation of skin. Rx: Kenalog 0.1% topical cream. Hydroquinone-sunscreen 3-5-4% topical cream. Plan: Skin care. Follow hypertension diet and increase exercise.

02/07/19 - Progress Notes by Kelly Ching, MD. Pt presents with skin problem, She is feeling lazy and is gaining weight. Denies depression. Lighter skin on face x months but growing. PE: No acute distress. Performed PHQ9 Questionnaire. Dx: 1) Rash. 2) Atherosclerosis of aorta. 3) Verruca vulgaris. 4) Smoker. 5) Obesity, BMI 30-34.9, adult. 6) Smoking cessation counseling. 7) Malaise

and fatigue. 8) Screening for osteoporosis. 9) Vaccination for influenza. 10) Vaccination for Strep pneumonia with Prevnar 13. Tx: Destroyed 14 benign lesions, Administered influenza and pneumococcal. Plan: Ordered DEXA bone density, hip and spine.

02/08/19 – Call Documentation by Kelly Ching, MD. Rash on forehead/face noted. Request to provide non-urgent advice based upon pt photo. Pt gave verbal consent to participate in Tele-dermatology.

02/10/19 - Virtual Dermatology Visit by Gary White, MD at Kaiser. Dx: Significant dispigmentation. Assume the lighter areas are the abnormal. Probable post-inflammatory hypopigmentation from seborrheic dermatitis, but seborrheic dermatitis not obvious here.

02/13/19 – Office Visit by Paula Tran Imoto, OD at Kaiser. Here for vision exam. PE: Appears oriented to time, place and person x 3. Mood is normal. Dx: 1) Anisometropia. 2) B/L astigmatism. 3) L myopia. 4) B/L incipient cataract. 5) R exotropia. Tx: Refraction assessment performed. Plan: Prescription as per refraction. Adaptation discussed.

02/21/19 - E-mail by Silvia Davalos, LVN at Kaiser. Emphasized the importance of keeping BP appointment to successfully manage BP.

03/15/19 - E-mail Kristopher Largo, LVN at Kaiser. Reminder to complete DEXA bone density exam.

04/08/19 - Call Documentation by Kelly Ching, MD. Hold Ibuprofen refill for now and Tylenol ES 500 mg. Pt due for BP check.

04/11/19 - Call Documentation by Mark Eslava, LVN at Kaiser. Pt declined appointment scheduling for BP check and states she will just walk in.

05/31/19 - Office Visit by Jarlath Ryan, MD at Kaiser. Pt presents with redness, swelling x 6 days over R 1st finger, started after accidentally cutting finger a few days ago, noted worsening redness and swelling and noted warmth over the area. PE: Well developed, well nourished and in no distress. Dx: 1) R finger paronychia. 2) HTN. 3) Insomnia. Tx: Performed I & D of lesion. Rx: Atenolol 25 mg, Keflex 500 mg, Trazodone 50 mg and Metoprolol 25 mg. Plan: Check BP.

06/11/19 - Progress Notes by Richard Gin, OD. Presents for eye exam. C/o slight blur and eye strain. Pt wants annual exam. PE: Alert and oriented. Appearance. Mood and speech are normal.

07/31/19 - E-mail by Sybil Bernard, MA at Kaiser. Reminded of special group visit for those with high BP.

09/06/19 – Call Documentation by Sybil Bernard, MA. Reminder to attend HTN BP Workshop, but pt not reachable.

09/20/19 - E-mail by Sybil Bernard, MD. Reminder to attend a special group for high BP.

10/19/19 - Call Documentation by Kelly Ching, MD. Pt requested Ibuprofen 800 mg.

10/26/19 - E-mail by Linda Ho, MA at Kaiser. Ordered non-fasting blood tests prior to office visit.

11/04/19 - TAV by Kelly Ching, MD. Wanted NSAID refill. H/o ankle fx in the past, now with ankle aching. Dx; 1) Medication refill. 2) Screening for osteoporosis. 3) Screening mammogram for breast cancer. 4) R finger paronychia. 5) Vaccination. Tx: Administered Shingles vaccine. Rx: Mobic 7.5 mg. Plan: Ordered DEXA bone density of hip and spine and B/L mammogram.

01/06/20 - E-mail by Jiao Feng, RN at Kaiser. Bone density test order expired. Requested to order the test again.

02/20/20 - Call Documentation at Kaiser. Pt wanted to speak to Dr. Roque for her personal problem. Requested to make appointments.

02/21/20 - Call Documentation by Ella Saavedra, RN at Kaiser. Contacted pt in regards to abnormal BP readings in the past and discussed appointment days.

04/30/20- E-mail by Kristopher Largo, LVN. Notified pt's BP was elevated, advised to check BP for 3 days and if elevated arrange an appointment.

05/04/20 – E-mail by Jiao Feng, RN. Notified Bone Density test ordered is now expired. Advised to make a new order.

08/24/20 – Forensic Vocational Analysis Rpt by Madonna Garcia, MRC, VRTWC. DOI: 04/16/06. Pt was injured in 08/2007 and she slipped and fell injuring her L ankle and L knee and received Tx. Reported a second injury in 11/2007 when she was picking up clients at work and noticed the car was rolling. She jumped into the car to pull the brake and fell striking her L knee on the ground and twisting her R foot. She had pain in the L knee and R ankle. She was seen at the Kaiser ER and was told she had two fractures in the R foot and was treated with a Cam walker. Under the tx of Dr. Saucedo, the R foot became better but she had continued pain in the L knee. She eventually underwent an MRI of the L knee and surgery, which was of benefit. She continued to have ongoing symptoms in the L knee since the surgery. She was released from care by Dr. Saucedo in approximately 2008. Returned to Dr. Saucedo a couple of months ago due to L knee pain and inability to use the clutch in her car. She was provided a Cortisone injection to the knee, which was of significant benefit. Subsequently developed a burn to the skin from the topical used to freeze the knee prior to receiving the injection. She was told by Dr. Saucedo that she had bone-on-bone laterally and would need a TKR in the future. Prior Injuries: L ankle injury, medial and lateral fractures, treated surgically. Pain continued and was worsened by the accident in 08/2007. She denied left knee symptoms prior to the injury in 08/2007. Present Complaints: R foot was asymptomatic. L knee and L ankle symptoms occurred at the same time due to prolonged walking, climbing stairs, squatting and kneeling with swelling to the knee and followed by the ankle: Ankle pain was medial and lateral. PMH: Two work injuries, arthritis of the knee and a heart murmur. H/o HTN. Meds included Lisinopril, Hydrochlorothiazide, Ibuprofen and Vicodin. Surgeries included L knee surgery for the current injury and prior L ankle surgery. Background/Social/Economic Considerations: She drove herself to this morning appointment and

was casually dressed and well-groomed. She was forthcoming and cooperative throughout the interview. She indicated that she did not have any criminal convictions and denies serving in the military. Indicated it is difficult to meet her fixed monthly expenditures and barely makes the mortgage payment. The only financial help she receives is from her husband. Stated she has a reliable vehicle, which she could utilize for employment purposes. She had no vehicle code violations or accidents currently on her driving record. Indicated she would be willing to travel approximately 15 minutes to work in one direction should she be able to work. She would not be willing to use public transportation because of the physical strain it would put on her body given her conditions of disablement. Should she be able to work, would be available to work Monday through Friday during the day. Pt's subjective physical tolerances include difficulty sitting and standing for long periods of time. During the assessment, pt had difficulty sitting in her chair for long periods of time and had to alternatively sit, stand and stretch. Reported difficulty walking on a flat surface, walking on incline and walking down on a decline. Reported difficulty crouching, bending, stooping, crawling, kneeling and maintaining her balance. She must always cautiously maintain her balance, especially in the shower or to avoid falling from stairs. At home she often drops cups. She can no longer open jars. For her shoulders, pt has chronic pain and loss of ROM. She can no longer do overhead work. Because of her arm pain, she is incapable of vacuuming. She has some difficulty driving and also experiences problems getting in and out of the car and opening and closing doors. She could not turn her head while driving and because of this she could not drive more than 15 minutes. She relied on her family members to drive. With regard to vision, reports difficulty watching TV or reading a book and writing as well as seeing up close and seeing things far. During the assessment, pt needed assistance reading the questions out loud. Reports difficulty sleeping at night. Tries to go to bed around 11:00 p.m. and will sometimes sleep at 2, 3, 4, or even 5 am. It takes her several hours to fall asleep, though she wakes up every 2-3 hours and experiences difficulty going back to sleep. Reported difficulty walking up and down a flight of stairs. Reported difficulty with forward flexion of the neck, as well as difficulty twisting and turning her neck from L to R. Reported much difficulty reaching above shoulder level with B/L arms. Reported difficulty pushing and pulling objects and gripping a glass of water or carrying a gallon of milk with one or both hands. Reported difficulty lifting more than 5 lbs and much more difficulty lifting more than 10 lbs and 20 lbs, and much more difficulty lifting more than 50 lbs. Reported difficulty with fine finger manipulation like turning screws and bolts, using a cell phone or texting and having trouble with repetitive movements and simple and firm grasping. Reported difficulty with her sensory functions, her ability to feel, smell and taste. The greater of these issues is mostly her touch sensations due to her neuropathy and nerve damage issues. Employment Hx: Worked as a Licensed Marriage and Family Therapist and Intake Coordinator for D'Veal Family & Youth Services. Employed from 12/2004 through 04/2016. Her job duties included providing individual, marital, and family counseling services to adults and children, to assist clients to identify personal and interactive problems, and to achieve effective personal, marital, and family development and adjustment: Collects information about clients (individuals, married couples, or families), using interview, case history, and observation techniques, funnel approach, and appraisal and assessment methods. Analyzes information collected to determine advisability of counseling or referral to other specialists or institutions. Reviews notes and information collected to identify problems and concerns. Consults reference material, such as textbooks, manuals and journals, to identify symptoms, make diagnoses and develop therapeutic or treatment plan. Counsels clients using counseling methods and procedures such as psychotherapy and hypnosis, to assist clients in gaining insight into personal and interactive problems, to define goals and to plan action reflecting

interests, abilities and needs. Stated that she left her job due to her age, health conditions and differences in opinions with her professional abilities. Also worked for University of Phoenix as a Work Certified Facilitator from 04/2013 – 06/2013. Her job duties include developing training modules and workshops that help employees learn essential skills in the workplace. The duties of a training facilitator include assessing the skill level of current employees, creating effective training materials and delivering training programs. A skills development facilitator has regular contact with senior leadership to ascertain the needs of the organization. Some training is delivered to individuals and other skills are taught in a group setting. Delivery of training in a virtual format is often included in a facilitator job description. Strong interpersonal skills, creativity, technological skills and attention to detail are important qualities of a skills development facilitator. Reported that the reason for leaving her job is because she did not realize she had to work at least one semester during a course year. Also worked for California Institute of Technology and was employed from 06/1993 – 11/2000 as a Senior Assistant & Events Coordinator. Her job duties included coordinating all the details required to ensure an event runs smoothly and successfully. Event coordinators can work independently as freelancers but are often hired by corporations, trade associations and nonprofit organizations to work as an employee. In-house event coordinators can expect to manage a variety of events for their organizations including trade shows, sales meetings, business meetings, employee appreciation events and virtual events. The reason for leaving was to be employed as a Marriage & Family Therapist Intern. Also worked for Pacific Oaks College. She was employed from 09/2004 – 12/2004 as an Adjunct Faculty. Her job duties include teaching courses in universities and community colleges in addition to evaluating students and conducting student conferences and develop lectures, conduct seminars and serve other administrative rules within the department. The reason she left the job is because it was only a part time position. Indicates she has not worked in any capacity since 2014 and is not currently working due to her limited capabilities. Current Meds: Meloxicam, Trazodone 50 mg and Atenolol 25 mg. Effects of Med on Full-Time Employment: The side effects of the med pt is required to take because of her disabilities severely limit her employability. The side effects experienced by pt and her physical limitations will make it very difficult to find employment. Even if she was able to find work, her physical limitations and the side effects of the medication will significantly interfere with her ability to work. General Observation During Vocational Interview: She drove 30 mins to the eval. Did not take any of her meds prior to the eval since her meds side effects will cause her to fall asleep. She was cooperative and interactive and had normal response timing. Pt was moving around a lot in her chair but did not get up. She said standing would not help her pain. She was able to answer all her interview questions with assistance by reading out loud the questionnaires and assisting her in writing her responses. Vocational Testing Administered: RAVEN Standard Progress Matrices: Pt's test results showed that she scored in category Grade II "Intellectually average" the score lies between the 25th and the 75th percentiles, showing that she has average intelligence which indicates that she seems to have greater reasoning ability and greater cognitive capacity to analyze information. Results reveal that she can excellently make insights and comprehend relationships among nonverbal figures or designs. Results also show that she has quickness of mind and has the ability to infer and apply patterns and obtain the ability to deal with mental complexity in which are all aspects of our general intelligence. Pt's test scores also show that she has the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas and learn quickly from experience. Pt's test scores show that she has the ability to adapt effectively to the environment either by making change in oneself or by changing the environment and finding a new one. Also states she has the capacity to reorganize her behavior

patterns and have the ability to act more effectively appropriately. She can excellently make insights and comprehend relationships among nonverbal figures or designs. She has quickness of mind and has the ability to infer and apply patterns and possesses the ability to deal with mental complexity, which is all of the aspects of one's general intelligence. Career Ability Placement Survey: Pt scored 50th percentile score in Mechanical Reasoning. This is considered average. Scored 50th percentile score in Spatial Relations. This is average. This test measures how well you can visualize or think in three dimensions and mentally picture the position of objects from a diagram or picture. Scored 20th percentile in Verbal Relations. This is low. Scored 20th percentile score in Numerical Ability, also considered low. Scored 70th percentile score in Language Usage. This is considered high. Scored 30th percentile score in Word Knowledge. This is considered low. Scored 30th percentile score in Perceptual Speed and Accuracy, this is considered low. Scored 20th percentile score in Manual Speed and Dexterity which is considered below average. The results of pt's test reports that her strongest areas were in the area of Language Usage. This ability is especially important in jobs requiring written or oral communication and in clerical jobs, as well as professional level occupations in Science and in all levels of Business and Service. In areas of Mechanical Reasoning, this ability is important especially in courses in Industrial Arts and occupations in Technology as well as jobs in Science. In addition in areas of Spatial Relations, this ability is important in courses in Art and Industrial Arts and jobs in Science, Technology and Arts. Transferrable Skills Analysis: Pt's work history shows that she had the capacity to work at an SVP level of 3 which is considered skill. The OASYS system determined that pt given her functional limitations has incurred a 92% loss of labor market access. The functional limitations assigned to pt further erode the labor market that would be available to her at a sedentary level of physical functioning. There are limited jobs or increasingly fewer jobs that she can do due to this "eroding occupational base" for sedentary work. With pt's multiple work-related limitations, the occupational base for sedentary work has been significantly eroded to the point that there are no sedentary jobs she is capable of doing due to her physical limitations. Pt is unable to return to work in any position or occupation. The OASYS system does produce occupations occurring at an SVP of one or two. Jobs in these categories are considered simple jobs that do not require multiple steps to complete job tasks. These jobs were taken in consideration during the completion of the transferable skills analysis. However, the loss of capacity of her BUE significantly reduces the labor market available for pt at a sedentary level of physical functioning. Dr. Gregory Heine stated that pt has mild impairments in ADL, social functioning, concentration and adaptation, as well as depression, anxiety, low self-esteem and other psychological factors, all of which would also contribute to pt's labor disablement. Also, pt's side effects from her meds, which includes dizziness, drowsiness, weakness and blurred vision will greatly affect and impair her concentration and remembering information essential for her job as a Marriage and Family Therapist. Furthermore, pt's job requires frequent sitting, walking, standing as a Marriage and Family Therapist. As mentioned, pt is restricted from prolonged sitting and standing and lifting more than 10 lbs. The synergistic effect of the previously mentioned functional limitations resulting from pt's pre-existing non-industrial and industrial injuries, combined with her CT industrial injury of pt in all vocational probability has incurred a total loss of labor market access. Pt cannot perform this job due to the fact that the physical requirements require constantly sitting, walking and or standing frequently, pushing and or pulling of arm and or leg controls, reaching frequently and extending hands and arms in any direction. Frequent handling, seizing, holding, grasping and turning, fingering and occasionally picking, pinching or otherwise working primarily with fingers rather than with the whole hand or arm. Amenableness to Rehab: When considering the synergistic effect

of pt's pre-existing non-industrial and industrial functional limitations, combined with the functional limitations resulting from her industrial injury. Pt's amenability to rehabilitation is significantly impaired meaning that vocational rehabilitation will not return her to the open labor market. Montana Factors: Pt's ability to work, health, willingness and opportunities to work, skill and education, general condition of the labor market, and employment opportunities for individuals that are similarly situated render pt is unable to return to suitable gainful employment in the open labor market. Willingness and Opportunities to Work: Pt has been unable to find any sustainable employment since her industrial injury. She attempted to find employment but could not. She believes this is a result of her constant pain from her injuries. Pt has attempted to apply for job but had limited work experiences and the physical requirements needed for the job. Based on this information, believe that pt has demonstrated the willingness to work but has not been provided the opportunity to return to work because of the synergistic effect of the functional limitations resulting from her pre-existing non-industrial and industrial injuries, combined with her industrial injury. Pt's opportunities to return to work are slim because of all the accommodations the employer will need for the job. Pt's job as Marriage and Family Therapist will require an adjustment to her job or work environment which makes it possible for an individual with a disability to perform the essential functions of her job. Pt will need accommodations and modifications to the work environment and even adjustments to her work schedules or responsibilities due to physical limitations of her job as a Marriage and Family Therapist/Attendant. As noted, the accommodations and modifications pt would require are simply too burdensome and unrealistic for an employer to make. Accommodations and Vocational Analysis: Employers are required to provide reasonable accommodations to allow an individual to complete the essential functions of their job. An employer however does not have to provide reasonable accommodations if those accommodations will result in undue hardship. Pt's work limitations includes unable to lift or carry objects required, unable to sustain continuous or prolonged paced movement of the arms, hands, or fingers, unable to sustain a continuous or prolonged standing or sitting position of the body, unable to sustain consistent physical work effort, significantly restricted in ability to tolerate typical psychological stresses in the work environment. Pt's work limitation prevents her from being able to tolerate the common environmental conditions found at work, unable to sustain a consistent mental work effort and unable to complete tasks at a pace comparable to that of the average person in the general population. Pt's employer will not be able to provide reasonable accommodations. Pt's employer will need to provide reasonable accommodations such as job restructuring, which alters the essential function of her job as a Marriage and Family Therapist. Pt's employer cannot modify her work schedules due to her medical appointments and hospital visit, since she will be in and out of the hospital. Pt has lists of meds to take into consideration. The meds side effects will affect her work performance that will prevent her from doing her job properly. Pt's need for accommodations will cause undue hardship to the employer if it requires significant difficulty or expense when considered in light of factors such as an employer's size and financial resources. If pt will return to her job as a Marriage and Family Therapist, it will not be cost effective to the employer because her employer will be required to hire another person to help with her job. Pt will not be capable of doing her work without the help of another person. Pt will nevertheless still be expected to perform the essential functions of the job with or without reasonable accommodations. In the case of pt, it would be unreasonable and unrealistic for an employer to fully accommodate pt such that she would be capable of adequately performing in any capacity. In reaching vocational opinion regarding pt, considered the synergistic effect of the functional limitations resulting from her pre-

existing non-industrial and industrial injuries combined with her industrial injury during the interpretation of the vocational testing results and the transferable skills analysis. In this case, considering all her functional physical limitations resulting from her pre and post injuries, pt's disabilities have rendered her unable to perform the substantial and material acts necessary to perform any job in the usual or customary way in which the job is meant to be performed. Conclusion: Pt is significantly restricted in ability to meet typical physical employment requirements to perform previous job or usual line of work, such as unable to lift or carry objects required, unable to sustain continuous or prolonged paced movement of the arms, hands or fingers, unable to sustain a continuous or prolonged standing or sitting position of the body, unable to sustain consistent physical work effort, significantly restricted in ability to tolerate typical psychological stresses in the work environment, unable to tolerate the common environmental conditions found at work, unable to sustain a consistent mental work effort and unable to complete tasks at a pace comparable to that of the average person in the general population. Pt's opportunities to return to work are slim because of all the accommodations the employer will need for the job. Pt's job as Marriage and Family Therapist will require an adjustment to her job or work environment, which makes it possible for an individual with a disability to perform the essential functions of her job. Pt will need accommodations and modifications to the work environment and even adjustments to her work schedules or responsibilities due to her physical limitations. Determined that pt is not amenable to any form of vocational rehabilitation. Her functional limitations combined with the intensity, duration and nature of her chronic and disabling pain will preclude her pre-injury skills and academic accomplishments. Do not believe that pt is amenable to any form of rehabilitation and thus has sustained a total loss in her capacity to meet any occupational demands.

09/10/20 - PD Rating Rpt. On 03/21/12, final PD 8% and on 02/04/08, final PD 8%

09/14/20 - PD Rating Rpt. On 04/24/12, final PD 24%. On 04/29/11, final PD 25%. On 04/24/08, final PD 5%.

10/22/20 - Subsequent Injury Benefit Trust Fund Rpt by Marvin Pietruszka, MD/Koruon Daldalyan, MD at Del Carmen Med Ctr. DOI: CT 12/30/04 to 04/16/16; 11/10/07; 08/09/07. Pt has filed claims dated 12/30/04 to 04/16/16, 11/10/07 and 08/09/07, for injuries that she sustained during the course of her employment. States that in 2007, she had to transport various individuals for her workplace. She had parked on a hill or an incline at that time. When she got out of the car, she noticed that her car began to roll. She tried to jump back into the car to stop the vehicle and she caused injuries to her L knee, ankle and foot. She suffered these injuries and reported them to her supervisor. She was then evaluated by a physician who had diagnosed her with a meniscus tear of the L knee and a fx of the great toe of the L foot. She also suffered L ankle injury including a s/s of the ankle. She was operated on with a meniscus repair of the L knee and she then underwent PT. She was later released back to work. She continued working; however, she continued to have LLE pain. She does mention that she had a significant amount of stress at work. She was able to complete all of her work in a timely fashion, but there was some favoritism to other various employees. One of the employees she worked with was always behind and she would always have favoritism. This caused her a significant amount of stress. She later found it difficult to perform her therapy sessions while working. She would constantly see people walk past her in the office and states that this would disrupt her therapy sessions. She tried to present her issues to her

supervisors; however, she had retaliation against her. Also felt there was a degree of discrimination while performing her job duties. This also caused a significant amount of stress. C/o difficulty sleeping, difficulty concentrating, difficulty making decisions, forgetfulness, headaches, vertigo symptomatology and urinary frequency. Prior to suffering the work injuries, she had related problems with her L ankle. Occupational Hx: Her job duties involved providing counseling to individuals and families, completed admission intakes, psychosocial histories and formulated treatment plans, conduct home and community visits and computer intake information. Physically, the job required for her to stand, squat, bend, climb, walk, stoop, kneel and twist. She was not required to lift heavy objects. Pt was exposed to excessive noise during the course of her work. PMH: She was diagnosed with HTN in 2000. She has undergone L knee surgery in 2007 and ocular surgery in 1973. Sustained L ankle injury in 1993, which required surgical intervention. She had related memory problems prior to her work injury in 2007. Social Hx: She smokes three cigarettes per week. She drinks one alcoholic beverage per week. Family Hx: Mother died as a result of a window accident. Her father died of lung cancer. She had four brothers and one sister. All of her brothers died of various causes, which are not stated. Her sister died of complications of AIDS. Dx: 1) Musculoskeletal injuries involving C/S, T/S, L/S, B/L shoulders, elbows, and hands, L hip, B/L knees, R ankle and B/L feet. 2) CTS, B/L wrists. 3) Cognitive dysfunction secondary to anxiety, depression and chronic pain. 4) Chronic pain syndrome. 5) Epicondylitis B/L elbows. 6) Internal derangement B/L shoulders. 7) C/s s/s. 8) L/S s/s. 9) Myospasms of cervical, thoracic and L/S. 10) Abnormality of gait due to L LE weakness. 11) Use of assistive device (cane). 12) L knee internal derangement, s/p surgical repair. 13) Fx of L hallux, s/p medical tx. 14) B/L plantar fasciitis. 15) Internal derangement, B/L ankles. 16) HTN (2000) exacerbated by workplace injury. 17) Myopia, R eye (pre-existing). 18) Blurry vision, R eye (pre-existing). 19) Ocular surgery (1973). 20) Cephalgia. 21) Vertigo. 22) Visual disorder. 23) Sinus problems. 24) Chest pain. 25) Palpitations. 26) Dyspnea. 27) Nausea/vomiting. 28) Weight gain. 29) Urinary frequency. 30) Peripheral edema/swelling of ankles. 31) Anxiety disorder. 32) Depressive disorder. 33) Sleep disorder. 34) Allergy to penicillin. Disability Subjective Complaint: 1) Headaches. 2) Dizziness. 3) Lightheadedness. 4) Visual difficulty. 5) Sinus problems. 6) Cough. 7) Postnasal drip. 8) Chest pain. 9) Palpitations. 10) SOB. 11) Nausea. 12) Vomiting. 13) Weight gain. 14) Urinary frequency. 15) C/S pain. 16) T/S pain. 17) L/S pain. 18) B/L shoulder pain. 19) B/L elbow pain. 20) B/L hand pain. 21) B/L knee pain. 22) R ankle pain. 23) B/L foot pain. 24) Peripheral edema and swelling of the ankles. 25) Anxiety. 26) Depression. 27) Difficulty concentrating. 28) Difficulty sleeping. 29) Difficulty making decisions. 30) Forgetfulness. 31) Dermatologic complaints. 32) Intolerance to excessive heat. Disability Objective Findings: 1) Chest increased bronchial markings B/L, per x-rays (10/22/20). 2) C/S moderate to severe degenerative changes noted, per x-rays (10/22/20). 3) L/S multilevel degenerative changes, more specifically at L3-4 and L4-5. There is straightening of the normal lordosis, per x-rays (10/22/20). 4) R shoulder decreased joint space of the AC and glenohumeral joint. There is severe arthritic changes noted, per x-rays (10/22/20). 5) L shoulder decreased joint space of the AC and glenohumeral joint. There is severe arthritic changes noted, per x-rays (10/22/20). 6) L knee mild to moderate degenerative changes and decrease joint space, per x-rays (10/22/20). 7) L ankle findings consistent with an operative repair of the tibia and fibula head, per x-rays (10/22/20). Permanent Impairment Rating (prior to CT 12/30/04-04/16/16; 08/09/07; 11/10/07): Pt L ankle impairment 4% WPI. Aggravated HTN 10% WPI. R eye impairment 10% WPI. Pt's whole-body impairment is 22%. Permanent Impairment Rating (After CT 12/30/04-04/16/16; 08/09/07; 11/10/07): C/S impairment warrants a low DRE Cervical Category II rating of 5% WPI. L/S impairment warrants a low DRE Class II rating of 5% WPI. R

shoulder rounds to a 3% UE impairment. L shoulder round to a 3% UE impairment. Both UE impairments convert to 4% WPI. L hip impairment corresponds to 3% WPI. R knee impairment equals 3% WPI. L knee impairment equals to 10% WPI. L ankle impairment equals to 6% WPI. R foot impairment warrants a 3% WPI. R eye impairment warrants a moderate Class II rating corresponding to 15% WPI. Aggravated HTN qualifies for a high Class II rating corresponding to a 29% WPI. Cognitive dysfunction qualifies for a moderate Class II rating, with a CDR of 10, equating to a 20% WPI. Urinary frequency warrants a high Class I impairment rating, equating to a 14% WPI. Cephalgia qualifies for a low Class I rating (mild facial neuralgic pain, intermittent frequency, mild interference with ADL) equating to a 5% WPI. Sleep impairment warrants a low Class I rating corresponding to a 5% WPI. Vertigo warrants a Class II rating corresponding to a 4% WPI. Pt's whole body impairment is 77%. Work Restrictions: For pt's c/o cervical and L/S pain, she should be precluded from work involving heavy lifting, repetitive pushing, pulling, stooping, or overhead work with the UE. For pt's c/o BUE pain, she should be precluded from repetitive overhead work, heavy lifting, rapid repetitive gross motor activity, pushing, pulling, and activities that require flexion, extension, and twisting of the upper extremities. For pt's BLE pain, she should be precluded from work on girders, climbing ladders, rooftops or unprotected heights, work on platforms greater than 5 feet and work near dangerous moving machinery. For pt's stress-aggravated HTN, she should be precluded from working in emotionally stressful environments, work that involves frequent to constant deadlines, work that involves reasonably probable exposure to significant psychological trauma (violence, crime, death, disease), and occasional to frequent undue stress from co-workers and management.

12/14/20 - Independent Medical Eval in Neurology SIBTF Eval Rpt by Lawrence Richman, MD. Pt reports having sustained a slip and fall injury on a banana peel during a company outing. She sustained a fx of the L toe and an injury to the L knee. The latter occurred on another occasion when she attempted to put on the brakes of a car before going into traffic. In an orthopedic report of Dr. Heinen dated 02/28/18 refers to an injury date of 04/16/06 and CT for 12 years due to repetitive use of the upper and lower limbs. Pt would frequently drive cars. Reports being subjected to harassment from one of her coworkers. Reported constant aching of B/L shoulders and elbows. She was unable to walk at times. Pt has been legally blind in her R eye since birth, which is lack of depth perception. She has h/o depression following separation of her parents at the age of 8 that has persisted to the present time. She has h/o anxiety during that same time frame and that has persisted to the present. She has a h/o two motor vehicular accidents with injuries to the C/S resulting in chronic C/S pain from both accidents, head injury from both accidents associated with diminished memory and concentration. Pt responds to the Clinical Dementia Rating Scale. Reports that she forgets what to purchase at a store, has to keep a list of objects to purchase, forgets where she places her personal belongings, loses direction easily and forgets things and people that she should know. She has difficulty figuring out solutions for day-to-day problems, difficulty keeping track of time and time relationships. She has loss of interest in hobbies, such as playing chess. She reports that these cognitive complaints have been present since both motor vehicular accidents. Pt reports anxiety, depression, impaired concentration and dizziness. She believes that this is secondary to anxiety. Reports a h/o headaches, rated between a 6-7/10 and is frequently present since both motor vehicle accidents. C/o lower limbs and knees. Feels imbalance. The L/S was found to be tender on examination. Pt was diagnosed with arthritis of the C/S, C/S pain, arthritis of the B/L shoulders, T/S, L/S, lumbar radicular symptoms, arthritis of the B/L knees, L>R, severe degenerative arthritic changes of the L knee, s/p surgery to the L knee, degenerative arthritis of the

R ankle and fx of the R foot. Her shoulder complaints could not be related to CT. She was provided with a 30% WPI for c/o B/L upper limbs, C/S, T/S and L/S, B/L knees and B/L lower limbs. It is reported that her hands were considered to be work related whereas the other orthopedic injuries were not work-related. The PQME did mention that there were multiple pre-existing non-orthopedic injuries that predated her employment. Pt's pre-existing longstanding orthopedic injuries should be addressed by a board certified orthopedic examiner to address her pre-existing orthopedic complaints and that this is beyond scope of expertise. Pt does have a pre-existing h/o several medical problems preceding her date of hire. She has been legally blind in the R eye since birth. She has lack of depth perception. The cause of her ocular disorder was not known. She has a prior history of a heart murmur since childhood, as well as a h/o HTN. Her heart condition and HTN should be addressed by a board certified internal medical specialist/cardiologist. She has a longstanding h/o anxiety and depression, which has persisted to the present that could be addressed by a board certified psychiatrist. She sustained injuries in two motor vehicular accidents, both of which were associated with cerebral concussions, as well as muscular injuries. The musculoskeletal injuries should be addressed by a board certified orthopedist. Pt does respond affirmatively to the Clinical Dementia Rating Scale consistent with a cognitive impairment. She has h/o headaches after both accidents. There is also a prior slip and fall accident down a staircase in 1993 and another slip and fall incident while in 99 Store, which should be addressed by an orthopedist. Reports ongoing headaches at the back of the scalp; muscle tension in type. As mentioned, she responds affirmatively to the Conventional Rating Scale, which qualifies her for a rating. C/o of dizziness associated with anxiety. Currently, from a neurological perspective, pt states that she has ongoing difficulty with memory and concentration. Reports dizziness and frequent occipital tension headaches rated as a 7/10. Reports musculoskeletal complaints which will be deferred to an orthopedic examiner. Reports frequent N/T in the R hand and a sensation of weakness in the lower limbs. ADLs: Reports urinary frequency. Difficulty bathing, grasping, lifting, writing, flying, driving and impaired sleep due to pain, anxiety and depression. She averages four to five hours of sleep per night. She has difficulty with vision, standing, sitting, walking, climbing stairs, writing and seeing. She scores 8 (out of 24) on the Epworth Sleepiness Scale. Dx: 1) Blindness in the R eye. 2) H/o post-traumatic head syndrome, no industrial causation. 3) Post-traumatic headaches, no industrial causation. 4) B/L cervical radiculopathy, no industrial causation. 5) Gait instability, no industrial causation. 6) Lack of depth perception, no industrial causation. 7) Heart murmur and HTN, no industrial causation. 8) Anxiety and depression, no industrial causation. 9) Multiple orthopedic complaints to be addressed by a board certified orthopedist. Impairment and Apportionment: With respect to the pt's non-work-related injuries, opinioned the pt qualifies for a 12% WPI due to a class 1 mental status impairment with 100% apportionment of permanent disability due to the pt's nonindustrial motor vehicular accidents. For the pt's post-traumatic headaches, opinioned she qualifies for a 3% WPI with 100% apportionment of permanent disability to the injury of her two nonindustrial motor vehicular accidents. For cervical radiculopathy, opinioned the pt qualifies for a Diagnosis-Related Estimate Category III rating from with a 17% WPI and 100% apportionment of permanent disability to long standing degenerative arthritis of the C/S. For the pt's visual loss of the R eye, as well as loss of visual fields, both impairments are addressed for visual acuity loss of the R eye. Practically speaking, the R eye is blind and qualifies for a Class III rating of 49% which also takes into consideration the pt's visual field loss. This can further be addressed by a board certified ophthalmologist. For the pt's gait disturbance, opinioned this is related to loss of depth perception. She qualifies for a 5% WPI. Pt's final WPI is 73%.

12/21/20 – AME Rpt by Eric E Gofnung, DC. DOI: CT 12/30/04-04/16/16; 11/10/07; 08/09/07. Specific Injury on 08/09/07, she sustained a work-related injury when she slipped and fell and suffered injury to her L ankle/foot. On 11/10/07, she sustained a work-related injury to her L knee and R foot/toes. She fractured two toes in her R foot and suffered a torn meniscus in the L knee. She was transporting clients to an event. Her car was rolling into the street and she jumped into the car to pull up on the brake and when she did this, she felt her R foot flipped twist and her L knee hit the ground. She underwent L knee surgery. She was off work for approximately 9 months. After the surgery, she used a cane for assistance with ambulation at all times. CT Injuries: 12/30/04 -04/16/16, she sustained a work-related injury to her eyes, neck, UE, back, LE and nervous system, She started having headaches and pain in her shoulders> arms, fingers of both hands with stiffness and pain in her neck, upper, mid and lower back. Pain in her neck and shoulders started gradually over the last two years approximately of her employment due to prolonged daily computer work. She states she began to notice pain in her back in the last couple of years and noticed difficulty bending down. She had a gradual onset of stiffness in the fingers of both hands with locking of the R index and middle fingers and R thumb which she had experienced over the last several years of her employment. Because of the prior injury to her L knee, ankle and foot, she began over-compensating by putting more weight on her RLE and began experiencing pain in her R knee and ankle/foot. Her vision was affected due to prolonged computer work required by her job duties. She attributes the injuries due to the repetitive use of her upper and lower extremities. She performed significant driving to clients' homes, going in and out of cars for the last three years, and prior to that she would drive to clients' homes more often up to 6-7 times per day. She would have to climb up and down stairs at client's home and several times a day at the office. She would type intake reports 2-3 hours per day. She developed psyche and eye issues. She suffered harassment from the CEO of her company. He would get into her face and pushed a phone to her face. She was unable to work for the next two days. She was paranoid at times if anyone got close to her. Prior Work Hx: Worked at CalTech from 1993 to 2004 as a Senior Assistant and Events Coordinator. She had concurrent employment as a Teacher at University of Phoenix once a week, for less than six months in 2013. PMH: Severe depression and other psychopathologies caused by parents' divorce, difficult relationship with domestic violence, death of all members of the family due to violent crimes and serious diseases, necessity to give up pt's own daughter for several years and other tragic personal life circumstances, which caused her to experience memory issues, confusion, difficulty concentrating, light and/or sound sensitivity, difficulty communicating, headache, dizziness, nausea/vomiting, loss of coordination/balance, chronic pain, poor vision, irritability, sadness, anxiety, denial and lack of self-efficacy. Pain and ADL Questionnaire: Beck Anxiety Inventory Score 45 – which equals potentially concerning levels of anxiety. PHQ9 Score 18 indicating moderately severe depression. Epworth Sleepiness Scale Score 8 deferred to neurologist. Headache disability index score 84 indicating significant adverse effect on quality of life and performance of work/ADL. Neck disability index score 66% indicating significant disability secondary to neck pain, consistent with pt's complaints. Modified Oswestry LBP Questionnaire Score 66% indicates significant disability secondary to back pain, consistent with pt's complaints. UE Functional Scale Score 30% indicating significant greater than moderate difficulties in performing ADL. LE Functional Scale Score 5% indicating significant (more than moderate) difficulties in performing ADL. Dx: 1) Cephalgia. 2) Vertigo. 3) Vision problems/cataracts. 4) C/S myofasciitis. 5) Cervical facet-induced versus discogenic pain. 6) T/S myofasciitis. 7) Thoracic facet induced versus discogenic pain. 8) Cyst over T/S. 9) L/S

myofasciitis. 10) SI joint dysfunction, s/s. 11) Lumbar facet induced versus discogenic pain. 12) B/L shoulder tenosynovitis/bursitis. 13) B/L shoulder rotator cuff tear, r/o. 14) B/L shoulder impingement syndrome, r/o. 15) De Quervain's stenosing tenosynovitis of the thumb, B/L. 16) B/L CTS. 17) L knee s/p surgery. 18) B/L knee internal derangement. 19) L ankle s/p surgery, arthritis. 20) R ankle sinus tarsi syndrome, arthritis. 21) HTN. 22) Urinary frequency. 23) Anxiety, depression, and insomnia. 24) Per Babak Kumar, O.D - Optometrist: 1) Glare sensitivity. 2) H/o amblyopia, associated with exotropia, R eye. 3) Exotropia, R eye. 4) Regular Astigmatism both eyes. 5) Myopia, B/L. 6) Presbyopia both eyes. 25) Per Lawrence Richman, M.D. - Neurologist: 1) Blindness in the R eye. 2) H/o post-traumatic head syndrome. nonindustrial causation, 3) Post traumatic headaches, nonindustrial causation. 4) B/L cervical radiculopathy, nonindustrial causation. 5) Gait instability. nonindustrial causation. 6) Lack of depth perception, nonindustrial causation, 7) Heart murmur and HTN, nonindustrial causation. 8) Anxiety and depression, nonindustrial causation. 9) Multiple orthopedic complaints. 26) Per Koruon Daldalyan, M.D - Internist: 1) Musculoskeletal injuries involving C/S, T/S, L/S, B/L shoulders, elbows, and hands, L hip, B/L knees, R ankle and B/L feet. 2) CTS, B/L wrists. 3) Cognitive dysfunction secondary to anxiety, depression and chronic pain. 4) Chronic pain syndrome. 5) Epicondylitis B/L elbows. 6) Internal derangement B/L shoulders. 7) C/S s/s. 8) L/S s/s. 9) Myospasms of cervical, thoracic and L/S. 10) Abnormality of gait due to LLE weakness. 11) Use of assistive device (cane). 12) L knee internal derangement, s/p surgical repair. 13) Fx of L hallux, s/p medical tx. 14) B/L plantar fasciitis. 15) Internal derangement, B/L ankles. 16) HTN (2000) exacerbated by workplace injury. 17) Myopia, R eye (pre·existing). 18) Blurry vision, R eye (pre-existing). 19) Ocular surgery (1973). 20) Cephalgia. 21) Vertigo. 22) Visual disorder. 23) Sinus problems. 24) Chest pain. 25) Palpitations. 26) Dyspnea. 27) Nausea/vomiting. 28) Weight gain. 29) Urinary frequency. 30) Peripheral edema/swelling of ankles, 31) Anxiety disorder. 32) Depressive disorder. 33) Sleep disorder. 34) Allergy to penicillin. Subjective Factors of Disability: 1) Vision, worsening vision of the L eye due to straining while using the computer and compensating for R eye loss of sight. 2) Neck pain, moderate and the symptoms occur frequently. There is stiffness and restricted range of motion in the head and neck. 3) B/L shoulder pain, the pain is moderate and the symptoms occur frequently, R>L. The pain radiates to her arms and hands. There is report of clicking and grinding sensations. 4) B/L Hands/Wrist pain, frequent moderate pain with stiffness, N/T in the R and L wrist and hand and fingers. 5) Mid/LBP, slight to moderate in the mid-back and moderate (at times increasing to moderate/severe) and the symptoms occur frequently in the mid and lower back, which increases becoming sharp and stabbing. The pain radiates down her buttocks and back of her thighs to her feet. 6) B/L knee pain is moderate to severe and frequent, The pain increases with flexing, extending, prolonged standing and walking. She is unable to go up and down stairs, stoop, squat or walk on uneven surfaces or slanted surfaces. 7) B/L ankles/feet pain, pain is slight to moderate. The symptoms occur frequently in the B/L ankles and feet. There is report of swelling of the ankles. The pain is aggravated with standing and walking. 8) Sleeping difficulty, anxiety and depression, p has continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. Objective Factors of Disability: With regards to C/S, the objective factors of disability consist of: 1) Palpatory tenderness. 2) Decreased and painful ROM. 3) Muscle guarding on the exam. 4) Tenderness and hypomobility. 5) X-ray (imaging studies). With regards to B/L shoulder, objective factors of disability consist of: 1) Palpatory tenderness. 2) Decreased and painful ROM. 3) Abnormal orthopedic testing. 4) Decreased muscle strength. With regards to B/L wrists, the objective factors of disability consist of: 1) Palpatory tenderness. 2) Decreased and painful ROM. 3) Abnormal neurological examination findings. 4) Decreased grip strength. With

regards to thoracolumbar spine, the objective factors of disability consist of: I) Palpatory tenderness. 2) Decreased and painful ROM. 3) Abnormal orthopedic testing. With regards to knees and lower legs, the objective factors of disability consist of: 1) Healed post-arthroscopic surgical scar at L knee. 2) Palpatory tenderness. 3) Painful ROM. 4) Abnormal orthopedic testing. With regards to ankles and feet, the objective factors of disability consist of: 1) Palpatory tenderness. 2) Painful ROM. 3) S/p surgery with retained hardware in L ankle. P & S: Pt's condition is P & S. Causation: With regard to C/S, T/S, L/S, R shoulder, R wrist, hand and thumb, L shoulder, L wrist, hand and thumb: Industrial due to CT 12/30/04 to 04/16/16. L knee – Secondary to subsequent injury of 11/10/07 and CT from 12/30/04-04/16/16 and due to aberrant gait secondary to L ankle fx/surgery. L ankle/foot – Secondary to 1992 fx and subsequent injury of 08/09/07 and CT from 12/30/14 to 04/16/16. R knee – Secondary to subsequent injuries CT from 12/30/14 to 04/16/16. R foot – Secondary to subsequent injury of 11/10/17. Apportionment: With regard to C/S, T/S, L/S, R shoulder, R wrist, hand and thumb, L Shoulder, L wrist, hand and thumb: 100% to CT 12/30/04 to 04/16/16. L Knee – 60% to 11/10/17 and 10% to CT and 30% to 1992 L ankle fx/surgery injury. L Ankle/Foot – 80% to 1992 fx and 20% to 08/09/07 subsequent injury and CT combined. R knee – 90% to CT and 10% to prior injury to the L ankle in 1992 and aberrant gait secondary to that. R Foot – 100% to subsequent injury of 11/10/17. MMI: With records to C/S, T/S, L/S, R shoulder, R wrist, hand and thumb, L shoulder, L wrist, hand and thumb, L knee, L ankle/foot, R knee, R foot: Reached MMI one year from the DOI. Work Restrictions: With regard to C/S: Pt's condition was not labor disabling. Following subsequent work injury, no lifting over 10 lbs. With regard to T/S, L/S: Pt's condition was not labor disabling. Following subsequent work injury, no lifting over 10 lbs. No repeated bending or twisting. With regard to B/L shoulders: Pt's condition was not labor disabling. Following subsequent work injury, no overhead work with R arm. No lifting, pushing or pulling over 10 lbs with R arm. With regard to B/L wrists, hands and thumbs: Pt's condition was not labor disabling. Following subsequent work injury, no repeated or forceful use of R hand for pulling, pushing, grasping, torqueing. No prolonged writing and typing. L Knee: Pt's conditions were labor disabling. No prolonged standing and walking. Following subsequent work injury, no prolonged standing or walking. No squatting, kneeling or climbing. L Ankle/Foot: Pt's conditions were labor disabling. No prolonged standing and walking, no repeated climbing. Following subsequent work injury, pt's condition were labor disabling. No prolonged standing or walking, no repeated climbing, must be able to work predominantly in a seated position. R Knee: Pt's conditions was not labor disabling. Following subsequent work injury, no prolonged standing or walking. No squatting, kneeling or climbing. R Foot: Pt's conditions were not labor disabling. Following subsequent work injury, no prolonged standing or walking. No walking over uneven ground. No climbing. Impairment Rating: C/S 6%, T/S 5% and L//S 7% (Spine total impairment 17% WPI). RUE total impairment, 34% by combining 30% wrist impairment with 6% shoulder impairment or 20% WPI. LUE total impairment 32% by combining 30% wrist impairment with 3% shoulder impairment or 19% WPI. BUE total impairment is 55% by combining 34% R with 32% L UE impairment or 33% WPI. LLE total impairment is 47% by combining L ankle 30% and L knee impairment 24% or 19% WPI. RLE total impairment is 14% by combining R knee 10% with R ankle/foot impairment 4% or 6% WPI. BLE Impairment is 54% by combining R 14% and L 47% LE impairment or 22% WPI. Total Orthopedic Impairment is 57% WPI by combining 17% spinal total impairment with 33% UE total impairment with 22% LE total WPI. Total calculated WPI is 91% by combining 17% spinal impairment with 33% UE WPI with 22% LE WPI with 49% R eye impairment with 22% cognitive/Mental Status impairment with 4% vertigo impairment with 5% cephalgia impairment with 5% sleep impairment with 29%

HTN impairment per internist with 14% urinary frequency impairment per internist with 5% gait impairment as per neurologist. Vocational Rehabilitation Benefits: Pt is a qualified injured worker; however, based on review of records including the vocational expert Madonna R. Garcia's report dated 08/24/20, it is determined this patient is not amenable to any form of rehabilitation and thus has sustained a total loss in her capacity to meet any occupational demands. Plan: Recommend psychiatric versus psychological eval for further assessment of additional psych impairment. Recommend MRI of C/S, L/S, B/L shoulder, L knee and NCV/EMG of UE. Pt meets initial SIBTF criteria. There does appear to be adequate evidence to conclude with reasonable medical certainty that pt had previous partial disability as per the work restrictions. The combined effect of the preexisting impairment and the impairment due to the subsequent injury is likely to result in a permanent disability equal to, or greater than, 70%. The permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or age of the employee, exceeds the 35% threshold.

12/26/20 - Subsequent Injuries Benefits Trust Fund Evaluation by Babak Kamkar, OD. DOI: 12/30/04-04/16/16. DOE: 12/22/20. Pt was working at D'Veal Family and Youth Services as a therapist from 2004 to 04/16/16. During this period, she had CT resulting in pain accumulated due to repetitive movements to her upper and lower extremities, upper and lower back and nervous system. On one occasion, her parked car started rolling backwards as she had parked on an incline on gravel. She had to jump back inside and pull up the emergency parking brake lever. She injured her legs in this attempt, causing a tear in the L knee meniscus, fracturing L toe and fracturing her R leg. She did not realize the extent of her injuries at first, especially the R leg, which she did not know about for several years and continued her driving that day. However, by the end of the day, she was in pain and asked other people to drive her clients back to their homes. X-rays taken a few days later at Kaiser showed her injuries. She suffers from HTN, arthritis and has a heart murmur. She also c/o headaches, dizziness and insomnia. She has memory problems, anxiety, depression and PTSD. Prior Injuries and Surgeries: Pt had an injury to her L ankle, when she tripped over a few steps in the backyard of a friend's house. She does not recall the date, but it was sometime between 2007 and 2009. She broke her L ankle in three places and was transported to the hospital via an ambulance. She underwent an ortho surgery at the hospital and it took about 9 months before she was able to walk normally again. This was not a work-related injury. She slipped and fell at a 99 Cent Store in 2010. She received PT and her case was resolved with about $1,000 settlement. She has had two auto accidents both more than 10 years ago, and both rear-ended while she was parked. The first time, she did not report the accident and did not recall any significant injuries. The second she had injuries and had to wear a neck brace. She could not recall the dates or the specifics of the accidents, but said they were not work-related. She had strabismus surgery on her R eye in her 20s to improve the cosmetic appearance of her R eye turn. She feels it was a waste of time and money as her eye turn has remained about the same. She had surgery on her middle finger in 1962. She had a C-section in 1971. Family Hx: There is history of high BP and arthritis in her mother. There is history of cancer in her mother, grandparents and aunts. Social Hx: She denies using tobacco products, does not drink alcohol, and does not use illegal drugs. She can drive but has difficulty driving at night because of glare. Since her subsequent injury, she no longer can engage in walking, lifting, climbing, or standing for a long period. She complains that many things have become difficult for her to do including cooking, cleaning and laundry. PE: Oriented to time, place and person. Dx: 1) Glare sensitivity. 2) H/o amblyopia, associated with exotropia, R eye. 3) Exotropia, R eye. 4) Regular astigmatism both eyes. 5) Myopia, B/L. 6) Presbyopia both eyes.

Subjective Factors: Subjective factors of pt's ocular conditions include poor vision in her R eye, poor sense of peripheral vision, poor depth perception, and glare sensitivity. Objective Factors: 1) Glare sensitivity. 2) Reduced visual acuity. 3) Reduced visual fields. MMI: Reached MMI. Causation: The subsequent industrial injury did not cause any ocular impairment in this case. The cause of visual impairment is likely 100% natural. Apportionment: 100% to natural causes. Total impairment becomes 39.34%. Work Restrictions: Pt suffers from glare sensitivity. Work preclusions include working under bright artificial lights, such as stadiums and concert halls. Due to her disabling glare at night, any occupation that involves driving at night can be hazardous to her and others. Her limited visual acuity and history of eye turn disqualifies her from numerous positions that require normal or near normal visual acuity in both eyes. Jobs where detailed depth perception is necessary are precluded, such as dental assistants, hairdressers, dressmakers, cutlery, glass blowing, carpentry, etc. Future Medical Care: Needs annual eye examination to manage her refractive and age-related ocular conditions.

Deposition of Floreen Rooks on 10/19/17. (77 Pages)

Pages 6-9–Pt was driven to depo by attorney from Pasadena. Currently unemployed and living by herself at North Allen Avenue, Pasadena. Had adult children. Pages 10-12–Possessed master's degree in Marriage and Family Child Therapy. She had a previous depo many years ago. About 30 years ago, had a slip and fall at 99 Cents Store on a wet floor and injured the L leg, fully recovered from that injury. Medicare was health insurance provider. Currently treating with PCP, Dr. Ching, at Kaiser in Pasadena. Page 13-15 - Had been following with Dr. Ching for the past 10 years. Started working for D'Veal Family Youth Services in December 2004, last worked on 04/16/16. Worked as Marriage and Family Child Therapist. First started working at Fair Oaks Avenue and then switched to 855 in Pasadena. Last drawn salary in 2016 was $70,000. Ms. Rafaela Velgado was the supervisor. Worked Monday through Friday from 9:30 a.m. to 6 p.m. Pages 16-17 –Last worked in Intake Department where lots of clients came in and also had community clients, estimated to work with 5-7 patients. Pt did intake for new patients coming to D'Veal Family and Youth Services. She had more than one job in intake. Particular job was to qualify a person during intake to receive mental health service based on psychological and medical history. Pages 19-22 –Community clients were foster care patients. Her job sometimes included traveling to conduct an intake. Pt travelled all over. She would give therapies at job location as well as at people home. Concurrently worked at University of Phoenix teaching a class for 3-4 months. Took classes about intakes and family therapy in Pasadena. No longer worked for D'Veal Family Youth Services. Enjoyed working there, and she was the only licensed therapist, and everything was fine for a while, was terminated, felt being discriminated. Pages 24-27 - Sustained work-related accident, injured L foot. Currently treating with Dr. Nissanoff, started seeing him from June 2017. Had complaints in neck, low back, R shoulder, R upper arm, R hand, R wrist, R thumb, L ankle and R foot. L foot pain was more severe than R foot. Alleged injuries that the pt listed as a result of daily duties at D'Veal Family and Youth Services were headaches, shoulder pain, arms and fingers getting stiff, lot of stress in low back, and difficulty bending down. Had compensatory pain on R leg due to the L leg injury. Entire back was stressed. Had nuts and bolts in L ankle, which caused more stress on the right side of body. Pages 28-29 - Involved in work-related accident in 2006 at D'Veal, broke toe in two places in L foot and ended up having a torn meniscus in L knee. Currently having issues with right side of body, headache, shoulders, both arms, fingers on hands, entire back, L ankle, feet, and neck getting stiff. Pages 30-31 - Alleged psychological injury due a

lot of stress, as she was harassed by the CEO. Suffered with PTSD symptoms and nightmares when she thinks about this man. Had to take leave for two days and then returned to work. Alleged vision to have changed since working at the job. Page 32 –Noticed worsening of sight, used glasses, was not sure if it was for near sight or far sight. Had to keep the computer close at work, which made her paranoid. Visited Optometry at Kaiser Permanente in Pasadena. Pages 33-34 - Claimed to have certain injuries accumulated over time. She never felt having these symptoms before being hired for that job. Pt injured L foot, broke 2 toes, L knee and torn meniscus in the process of transporting clients to an event. Page 35 - In an event, her car was getting ready to roll into the street, she had to jump into her car to pull up the brake more, and in that process her L foot flipped over and her knee hit the ground. Pages 36-37 - She believed that the issues with her shoulders, arms, spine, fingers and feet are the result of physical nature of the job duties and stress at work. Time spent outside the office depended on the work course. Pages 39-41 - Her job required climbing a two story building, which got difficult at a point. She would sometimes climb upstairs to the second floor practically to MIS department. Sometimes she would need help. Sometimes had to climb outside office. She had to type notes, reports and her intakes all the time. Page 42 –Pt was right hand dominant. After hired at D'Veal, first noticed symptoms in her back in the last couple of years. Pages 43-45 - Had problems bending down in the last couple of years. Her neck pain was like a gradual, insidious onset pain that started about 2 years ago. Complained about back and neck pain to her colleagues from 2014 to 2016, and developed shoulder pain around the same time. Pages 46-48 - Had stiffness in her fingers. R hand middle finger, index finger, and thumb locked up and felt stiff. Also had stiffness and locking up in her L hand middle, index, and thumb fingers, which started several years before she was terminated. Also had issues with her upper arms. Noticed tightness, ache and a sharp pain that happened gradually. Was not able to mark a particular day, was stressed out gradually over time. Felt achy in upper arm. Page 49 - Had symptoms in L foot since the event, where she had to jump inside the moving car. Pt had pain on the right side of her body. Pages 50-51 - Had difficulty walking, had to hold on things or grasp objects. Felt the entire right side of her leg was going off balance and it was hard to walk. Before injury, she used to dance. Felt the R leg to be weak. Felt difficult to walk even one block. Page 53 - She feels off balance even at home with activities like walking or standing. Felt stumbled using the pain killers. Pages 54-56 - Experienced pain in her R foot while working for D'Veal due to shifting weight. She had L knee surgery when she had torn meniscus in 2006. Had L ankle surgery in 2006 during the car incident. Her foot was casted and fractures have healed. She injured her two toes and knee at the accident at her job. Pages 57-58 - Had L ankle surgery before she worked at D'Veal, had screw and plate fixed. Ever since the surgery, had swelling in L ankle. Sometimes had difficulty walking without holding onto something. Sometimes used a cane. Using a cane to balance ever since she has been working with D'Veal. Cane helped her walking. Pages 59-60 - Hired at D'Veal in 2004, involved in an accident in 2006. Did not use the cane prior to the accident. Since 2006 accident, she had been having symptoms in her L ankle. Her accident was covered by WC. Before being fired, had treatment to L knee and toes of L foot as a result of 2006 accident. Pages 61-63 - Whenever pt visited a doctor at Kaiser for treatment of back, neck, and shoulder, she would complain about stress and take some days off work. Related the stress to be both emotional and physical. Felt the emotional stress to be part of the physical stress accumulated due to the symptoms of neck, back and shoulder. Pages 65-66 - Currently seeing Dr. Nissanoff due to of back pain. Complained back pain to Dr. Nissanoff. Reported feeling stressed due to back pain to regular physician. Received worker's comp settlement for the 2006 case. Pages 68-69 - Before she was fired, complained verbally to her supervisor, Rafaela in 2015 or early 2016 about her symptoms,

showed letter from eye doctor. Also complained about being discriminated by age factor, and harassment at the job. Stated that the way pt was mistreated at work caused a lot of mental and physical stress. Page 71 - Due to vision problem, doctor gave limitations to not drive at night, but her work required her to drive at night. Page 73 - Currently having back pain, not being able to walk up the steps, which she complained to co-workers.

NP/rpc/sm/ra

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: **Rooks, Floreen** *(employee name)* v **D'Veal Family and Youth Services** *(claims administrator name, or if none employer)*

Claim No.: **SIF10825285** EAMS or WCAB Case No. *(if any)*: **ADJ10825285**

I, **RAYLENE TENORIO** *(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	08/09/21	Subsequent Injures Benefit Trust Fund 160 Promenade Circle, Suite 350 Sacramento, California 95834
A	08/09/21	Workers Defenders Law Group 8018 E. Santa Ana Canyon, Ste. 100-215 Anaheim Hills, CA 92808

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 08/09/2021

Raylene Tenorio
(signature of declarant)

RAYLENE TENORIO
(print name)