ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604 • Los Angeles, CA 90048 • Tel: (323) 933-2444 • Fax: (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the County aforesaid: and I am over the age of eighteen years and not a party to the within action: my business address is 6221 Wilshire Boulevard, Suite 604 Los Angeles, CA 90048.

On 20 day of January 2021, I served the within concerning:

Patient's Name: Rooks, Floreen

SIF Case: SIF10825285

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in Los Angeles, California, to be hand delivered Via United States Mail.

[ ] MPN Request	[ ] QME Appointment Notification
[ ] Notice of Treating Physician	[ ] Designation Of Primary Treating Physician
[ ] Medical Report _____	[ ] Initial Comprehensive Report
[ ] Itemized – (Billing) / HFCA 12/21/2020	[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Doctor's First Report	[x] Agreed Medical Evaluator's ML 104 Report Subsequent Injury Benefits Trust Fund
[ ] RFA	[ ] Permanent & Stationary
[ ] Financial Disclosure	[ ] Authorization Request for Evaluation/Treatment 12/21/2020

List all parties to whom documents were mailed to:

cc: Workers Defenders Law Group
Natalia Foley, Esq.
8018 E. Santa Ana Cyn Suite 100-215
Anaheim Hills, CA 92808

Subsequent Injury Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, CA 95834
Att: Victor Lladoc, WC Consultant

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 20 day of January 2021.

Ilse Ponce

WORKERS DEFENDERS LAW GROUP

8018 E Santa Ana Cyn Ste 100-215
Anaheim Hills CA 92808
Tel: 714 948 5054
Fax: 310 626 9632
workerlegalinfo@gmail.com
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Natalia Foley, Esq
Managing Attorney
Tel: 310 707 8098
nfoleylaw@gmail.com
UAN: WORKERS DEFENDERS ANAHEIM
ERN: 13792552

TO: Victor Lladoc Workers Compensation Consultant
SUBSEQUENT INJURIES BENEFIT TRUST FUND
160 PROMENADE CIRCLE, STE. 350
SACRAMENTO, CA 95834

TEL 916 928 4601
FAX 916 928 4705

Via Fax and
First Class Mail

RE: FLOREEN ROOKS VS DVEAL FAMILY AND YOUTH SERVICES,
SUBSEQUENT INJURIES BENEFIT TRUST FUND
WCAB: ADJ10825285; ADJ7024643; ADJ7024645
SIBTF: SIF10825285

DATE:12/09/2020

AMENDE NOMINATION OF AMEs

DEAR GENTLEPERSON(s) :

Due to Coronavirus difficulties on obtaining medical appointments, we have to amend our list of nominated AMEs.

To resolve disputed issues of pre-existing impairment and pre-existing level of permanent disability as it relates to this claim, let me nominate the following to serve as Agreed Medical Examiners and evaluators:

SPECIALTY	AME
CHIROPRACTIC	Dr.Eric Gofnung DC
INTERNAL MEDICINE	Koruon Daldalyan M.D.
PSYCHOLOGY	Nhung Phan PsyD
OPHTHALMOLOGY	Dr. Babak Kamkar OD
NEUROLOGY	Dr Lawrence Richman, MD
VOCATIONAL EXPERT	Madonna Garcia, MRC

The appointments are being scheduled.
Thank you for your anticipated courtesy and cooperation herein.

Very truly yours,

WORKERS DEFENDERS LAW GROUP

By Natalia Foley, Esq

PROOF OF SERVICE

1. I am over the age of 18 and not a party of this cause. I am a resident of or employed in the county where the mailing occurred. My residence or business address is

8018 E Santa Ana Cyn Rd Ste 100-215 Anaheim Hills CA 92808.

2. I served the following documents:

AMENDE NOMINATION OF AMEs

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by enclosing a true copy in a sealed envelope addressed to each person whose name and address is shown below and depositing the envelope in the US mail with the postage fully prepaid.

- Date of Mailing: 12/09/2020
- Place of Mailing: Los Angeles, CA

3. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 12/09/2020

By Irina Palees, Legal Assistant
to Attorney Natalia Foley

Name and Address of each Person to whom Notice was Mailed

SUBSEQUENT INJURIES BENEFIT TRUST FUND
160 PROMENADE CIRCLE, STE. 350
SACRAMENTO, CA 95834

SUBSEQUENT INJURIES BENEFIT TRUST FUND
OFFICE OF O.D. LEGAL
1515 CLAY STREET, STE. 701
OAKLAND, GA 94612

WCAB (AHM)
1065 N PACIFIC CENTER DR STE 170
ANAHEIM CA 92806

FLOREEN ROOKS
125 NORTH ALLEN AVENUE
UNIT 321
PASADENA, CA 91106

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604 ● Los Angeles, California 90048 ● Tel. (323) 933-2444 ● Fax (323) 933-2909

December 21, 2020

Subsequent Injury Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, CA 95834
Attn: Jeff Souza, WC Consultant

Workers Defenders Law Group
8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

Re:		
	Patient:	Rooks, Floreen
	SSN:	130-38-8510
	EMP:	Dveal Family and Youth Services
	SIBTF:	SIF10825285
	INS:	CalWORKS
	Claim #:	SAC0000196443
	WCAB #:	ADJ10825285; ADJ7024643; ADJ17024645
	DOI:	CT: 12/30/04 – 04/16/16; 11/10/07; 08/09/07

AGREED MEDICAL EVALUATOR'S ML-104 REPORT SUBSEQUENT INJURY BENEFITS TRUST FUND

Dear Gentlepersons:

The above-named patient was seen for an Agreed Medical Evaluation for determining eligibility for the Subsequent Injury Benefits Trust Fund, pursuant to California Labor Code 4751 on December 21, 2020, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, CA 90048. The information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient.

The evaluation is not intended to ascertain the applicant's current function as it relates to the above captioned industrial injury, but rather determine whether pre-existing disability in combination with impairments arising from the subsequent industrial injury meet the requirements that would qualify the injured worker for SIBTF benefits. 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 in order to determine to what extent the injured worker was disabled, at some time prior to the settled industrial injury noted above. In this report, we will discuss whether or not the injured worker had an industrial injury and whether or not there was an evidentiary basis to determine pre-existing permanent disability. Finally, we will determine whether or not the

applicant preliminarily meets the initial criteria for SIBTF eligibility of 35% permanent disability, or 5% permanent disability to an opposite corresponding member, and whether or not he/she will likely incur a total disability in excess of 70%, subject to additional medical evaluations in various medical specialties.

A request was made by Workers Defenders Law Group for me to evaluate Ms. Rooks, to determine her qualification for the Subsequent Injury Benefits Trust Fund. This evaluation is being performed to address the applicant's pre-existing disability to various body parts, as well as outline additional impairment and disability arising from the injury occurring on a cumulative trauma basis from December 30, 2004 through April 16, 2016 to her eye, upper extremities, back, lower extremities, nervous system; **and from the specific injuries of November 10, 2007 to her ankle and August 09, 2007 to her ankle**, which are the subsequent industrial injuries. I have been authorized to evaluate the industrial injuries and any pre-existing problems. I have been advised to order further evaluations as necessary from other specialists.

This report is billed under ML-104 pursuant to California Code of Regulations 9793(h), and 9795(b)(c). This report is an Extraordinary Comprehensive Medical Legal Evaluation and includes the following complexity factors:

ML104 = Requires 4 of the complexity factors set forth below:

☐ 1) Two or more hours of face-to-face time by the physician with the injured worker;
☐ 2) Two or more hours of record review by the physician;
☐ 3) Two or more hours of medical research by the physician (must provide a list of citations to the sources reviewed and excerpt or included copies of medical evidence relied upon);
☐ 4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;
☒ **5) Six or more hours spent on any combination of three complexity factors (1)-(3)**, which shall count as three complexity factors;
☒ 6) **Addressing the issue of medical causation**, upon written request of the party or parties requesting the report;
☒ 7) **Addressing the issue of apportionment**, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
☐ 8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
☐ 9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under

Actual time spent on this case is as follows:

Face to Face Time	2 hours and 35 minutes
Medical Records Review	23 hours and 00 minutes
Medical Research & Literature Review	2 hours and 00 minutes
Report Preparation & Editing	17 hours and 00 minutes

Total time spent 44 hours and 35 minutes

Upon meeting Ms. Rooks, I introduced myself and discussed with her my role as an evaluator in this SIBTF matter. She expressed no objection to proceeding with the evaluation.

JOB DESCRIPTION(SUBSEQUENT INJURY):

Mrs. Floreen Rooks was employed by DVEAL FAMILY AND YOUTH SERVICES as a Marriage and Family Therapist at the time of the injury. She began working for this employer in December 2004. She worked full time.

Her job activities included coordinating individualized services for clients, including driving to and meeting with clients, performing counseling services to individuals including adults, teens and children, and families, performing phone intake of potential clients obtaining information, entering information on a computer with typing 2-3 hours per day and preparing reports.

During the course of work, the patient was required to perform sitting, walking, standing, flexing, twisting, and side-bending and extending the neck, repetitive hand motions, and bending and twisting at the waist. She was required to climb stairs multiple times on a daily basis as she worked in a two-story building without an elevator.

The patient is a right-hand dominant female, and she would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, pushing and pulling, reaching at shoulder level, reaching above shoulder level and reaching below shoulder level.

The patient was required to lift and carry objects while at work. The patient was required to lift and carry objects weighing up to 10 lbs. occasionally.

The patient was required to drive her personal vehicle to see clients. The patient was not required to operate foot controls or move feet in a repetitive movement activity. The patient was not required to work at heights or walk on uneven ground. The patient was not exposed to dust, gas, fumes, vapors, extreme temperatures or humidity. The patient was not required to use visual or auditory protective equipment.

The patient worked 8 hours per day and 5 days a week. Normal work hours were 9:30 am to 6:00 pm, and sometimes later. She took lunch breaks when she was able.

The last day the patient worked for Dveal Family and Youth Services was April 16, 2006, at which time she was terminated from employment.

OCCUPATIONAL HISTORY:

Prior Work History:

Regarding prior employment, the patient worked at CalTech from 1993 to 2004 as a Senior Assistant and Events Coordinator.

The patient reported she had concurrent employment as a Teacher at University of Phoenix, once a week, for less than six months in 2013

HISTORY OF SUBSEQUENT INJURIES AND TREATMENT ACCORDING TO PATIENT:

Specific Injury:

August 09, 2007: The patient states that on **August 09, 2007**, while working at her usual and customary occupation as a marriage and family therapist for Dveal Family and Youth Services, she sustained a work-related injury **when she slipped and fell and suffered injury to her left ankle/foot**.

November 10, 2007: The patient states that on **November 10, 2007,** while working at her usual and customary occupation as a marriage and family therapist for Dveal Family and Youth Services, she sustained a work-related injury to her **left knee and Right foot/toes**. The patient explains that she fractured two toes in her right foot and suffered a torn meniscus in the left knee. The patient states 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 right foot flipped twist and her left knee hit the ground. She underwent left knee surgery. She was off work for approximately nine months. After the surgery, she used a cane for assistance with ambulation at all times.

CT injuries:

CT: December 30, 2004 – April 16, 2016: The patient states that while working at her usual and customary occupation as a marriage and family therapist for Dveal Family and Youth Services, she sustained a work-related injury to her **eyes, neck, upper extremities, back, lower extremities and nervous system**, which she developed in the course of her employment due to continuous trauma from **December 30, 2004, to April 16, 2016**. She states 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. The patient states the 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 states she had a gradual onset of stiffness in the fingers of both hands, with locking of the right index and middle fingers, and right thumb which she had

experienced over the last several years of her employment. She states that because of the prior injury to her left knee, ankle and foot, she began over-compensating by putting more weight on her right lower extremity and began experiencing pain in her right knee and ankle/foot. She states that 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 states 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 clients home and several times a day at the office. She would type intake reports 2-3 hours per day. She states she developed psyche and eye issues. She states she suffered harassment from the CEO of her company, he would get into her face and pushed a phone to her face. After the aforementioned incident, she was unable to work for the next two days. She states she was paranoid at times if anyone got close to her.

The patient sought legal representation in mid-2017 and was referred to Dr. Nissanoff and Dr. Javid Ghandehari for evaluation and treatment. She was prescribed medication of ibuprofen and gabapentin. Recommendation was made for x-rays, physical therapy, a TENS unit, and psychiatric consultation.

In February 2018, the patient was seen by Gregory T. Heinen, M.D. for a Panel Qualified Medical Evaluation.

COMPLAINTS SECONDARY TO SUBSEQUENT INJURIES OF AUGUST 09, 2007:

Left Foot:

The pain is moderate and the symptoms occur frequently. There is report of swelling of the ankles. The pain is aggravated with standing and walking. She cannot squat or kneel due to the pain. There is radiating pain from the ankles into the toes. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

COMPLAINTS SECONDARY TO SUBSEQUENT INJURIES OF NOVEMBER 10, 2007:

Left Knee:

The pain is moderate and the symptoms occur frequently. 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. There is popping and grinding in both knees and experiences buckling episodes. She has lost her balance as a result of the buckling. There is report of swelling in the knees. She is unable to kneel and squat. She has difficulty ascending and descending stairs and walks with an uneven gait. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Right Foot:

The pain is slight to moderate and the symptoms occur intermittently. The pain is aggravated with standing and walking. There is radiating pain from the ankles into the toes. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

COMPLAINTS SECONDARY TO SUBSEQUENT INJURIES OF CT: DECEMBER 30, 2004 – APRIL 16, 2016:

Eyes:

The patient reports worsening vision of the left eye due to straining while using the computer and compensating for right eye loss of sight.

Neck:

The pain is moderate and the symptoms occur frequently. There is stiffness and restricted range of motion in the head and neck. There is cracking and grinding of the neck with range of motion and twisting and turning the head and neck. The pain is aggravated with flexing or extending the head and neck, turning his head from side to side, prolonged positioning of the head and neck, forward bending, pushing, pulling, lifting and carrying greater than 5-10 pounds, and working or reaching at or above shoulder level. There is radiating pain from the neck into both arms, right greater than left, and down her back down to her legs and his head and she has been experiencing frequent headaches. She is experiencing numbness and tingling or burning sensations in her hands. The patient has difficulty falling asleep and is often awakened during the night by the neck pain. Her pain level varies throughout the day. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Bilateral Shoulders:

The pain moderate and the symptoms occur frequently, right greater than left. The pain radiates to her arms and hands. There is report of clicking and grinding sensations. She experiences weakness and restricted range of motion for the shoulders. She complains of stiffness and experiences increased pain with repetitive motion of the arms/shoulders, the pain is aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting, and carrying greater than 3-5 pounds, and repetitive use of the left/right/bilateral upper extremities. Her pain level varies throughout the day depending on activities. She is not able to sleep on either shoulder due to the pain. She has difficulty falling asleep and awakens throughout the night due to the pain and discomfort. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Bilateral Hands/Wrist:

The patient reports frequent moderate pain with stiffness, numbness and tingling in the right and left wrist and hand and fingers. The pain is aggravated with gripping, grasping, torquing motions, flexion and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the left upper extremity pushing, pulling, and lifting and carrying greater than 2-3 pounds. She has cramping, weakness and loss of grip strength in the hands and wrists and has dropped objects, as a result. There is numbness and tingling in the hands and fingers. Her pain level varies throughout the day depending on activities. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Mid/Lower Back:

The pain is 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. She does not notice numbness or tingling. The pain increases with activities of standing or walking as well as sitting over 15 minutes or forward bending. She is unable to perform activities of kneeling, stooping, squatting, ascending and descending stairs, forceful pushing and pulling, lifting and carrying any weight, going from a seated position to a standing position and twisting and turning at the torso. She complains of muscle spasms. The patient reports frequent urination. She denies bladder or bowel incontinence. She does awaken from sleep as a result of the low back pain. The patient self-restricts by limiting her activities. She uses a cane for assistance with ambulation. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Bilateral Knees:

Left knee pain is moderate to severe and frequent. **Right knee pain is moderate** and intermittent. 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. There is popping and grinding in both knees and experiences buckling episodes. She has lost her balance as a result of the buckling. There is report of swelling in the knees. She is unable to kneel and squat. She has difficulty ascending and descending stairs and walks with an uneven gait. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Bilateral Ankles/Feet:

Left ankle/foot pain is moderate. Right ankle/foot pain is slight to moderate. The symptoms occur frequently in the bilateral ankles and feet. There is report of swelling of the ankles. The pain is aggravated with standing and walking. She cannot squat or kneel due to the pain. There is

radiating pain from the ankles into the toes. Tylenol PM, ibuprofen, and cold packs, provide temporary pain relief.

Psyche:

The patient has continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. She denies suicidal ideation.

The patient has difficulty sleeping, often obtaining a few hours of sleep at a time. She feels fatigued through the day and finds herself lacking concentration and memory at times. She worries over her medical condition and the future.

The patient's condition has worsened due to continued work, lack of medical treatment and activities of daily living

COMPLAINTS AND INJURIES PREDATING THE SUBSEQUENT INJURY:

1) **Left leg injury**–This was a nonindustrial injury that occurred approximately 30 years prior [exact body part was unrecalled (per deposition)].**The patient slipped and fell at 99 Cents Store** as the floor was wet. She reported full recovery from that injury.

2) **Left ankle injury** - In addition, she had sustained a nonindustrial left ankle injury many years prior (in 1992 per 11/20/07 orthopedic report by Michael Hadley, MD). **She reported that she broke her left ankle when she fell down from stairs.** She had undergone surgery (open reduction/internal fixation) to her left ankle and there were screws and plates in place. She had reported that even after the surgery her left ankle had bothered her and she experienced difficulty walking with associated symptoms of swelling (per deposition).

3) **Early degenerative osteoarthritis of the left knee**- (per 09/10/07 comprehensive orthopedic evaluation report by Ralph Gambardella, MD)

4) **Essential hypertension; obesity; smoker; gastroenteritis**- (per 12/13/06 Kaiser Progress Note by Kelly Ching, MD; **Uncertain whether these complaints were present prior to CT: 12/30/04 – 04/16/16.** These complaints were found first documented in the aforementioned Kaiser report)

5) **Heart murmur**- (per 03/17/2011 orthopedic agreed PQME report by Thomas W. Fell Jr., MD) **Patient report being diagnosed since about 7th grade of schooling.**

6) **Right eye loss of sight.**

PAST MEDICAL HISTORY:

Illnesses:

Heart murmur accompanied by shortness of breath, enlarged neck veins, chest pain, dizziness, and fainting.

Other medical conditions included high blood pressure; kidney and bladder dysfunction; extreme loss of vision, right eye is legally blind as she understands; and arthritis.

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 applicant'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.

INJURIES:

The patient denied any prior work-related injuries.

1) **Nonindustrial: about 1992/1993 - Left ankle fracture; had undergone surgery; developed osteoarthritis in the ankle as a result:** The patient suffered a left ankle fracture in approximately 1992/1993, which required surgery, and she developed osteoarthritis in the ankle as a result.

2) **Nonindustrial: Occurred before 1992/1993 (exact date unrecalled) at 99 Cents Store –Left leg: The patient suffered a slip and fall injury** that occurred at a 99 Cents Store when she slipped and fell on the wet floor, with injury to her left leg. Exact date unrecalled.

The patient denied any new injuries.

Please reference "**COMPLAINTS AND INJURIES PREDATING THE SUBSEQUENT INJURY" section for additional information:**

Allergies:

Penicillin, smell of mint, pollens, and certain perfumes.

Medications:

Tylenol PM, Ibuprofen, lisinopril for hypertension for about 10-year duration, nabumetone for musculoskeletal pain for about 10-year duration.

Surgeries:

Left ankle surgery in about 1992/1993 with retained hardware.

Left knee surgery in about 2007/2008.

Hospitalization:

The patient was hospitalized for childbirth in 1971 due to cesarean section & left knee surgery in 2007 or 2008.

REVIEW OF SYSTEMS:

Review of systems is remarkable for trouble sleeping, muscle or joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

ACTIVITIES OF DAILY LIVING:

Self-Care - Personal Hygiene: As a result of the industrially-related injury, the patient states: Difficulty with urination, defecation, bathing by self, dressing by self with a rating of 3.

Communication: As a result of the industrially-related injury, the patient states: Difficulty with writing, typing, seeing, with a rating of 3.

Physical Activities: As a result of the industrially-related injury, the patient states: Difficulty with standing, sitting, reclining, walking and going up and down stairs, with a rating of 4.

Sensory Function: As a result of the industrially-related injury, the patient states: Difficulty with seeing, feeling (tactile feeling) with a rating of 2-3.

Hand Activities: As a result of the industrially-related injury, the patient states: Difficulty with grasping or gripping, lifting and manipulating small items with a rating of 3-4.

Travel: As a result of the industrially-related injury, the patient states: Difficulty with riding in a car, bus, etc., driving a car, traveling by plane, restful night sleep pattern and sexual function, with a rating of 4.

FAMILY HISTORY:

Mother has passed away from cancer.

Father has passed away from an accident when he fell out a window.

The patient had four brothers and one sister, all deceased.

There is no known history of lung cancer.

SOCIAL HISTORY:

Ms. Rooks is a 71-year-old single female with one child.

The patient completed a Master's Degree in Marriage and Family Child Therapy.

The patient consumes alcohol occasionally and smokes occasionally.

The patient does not exercise.

The patient does not participate in any sports activities.

The patient has no hobbies

Physical Evaluation (December 21, 2020) – Positive Findings:

General Appearance:

The patient is a 71-year-old right-handed female who appeared reported age, well-developed, well-nourished, and well-proportioned, alert, cooperative and oriented x3.

Vital Signs:

Pulse:	81
Blood Pressure:	137/90
Height:	5'5"
Weight:	193

Head & Face, Eyes, Ears, Nose and Mouth:

There were no laceration, tenderness, erythema, edema, deformity and swelling of the head, eyes, ears and nose.

Pain at the temporomandibular joints is not present with opening and closing of mouth bilaterally and clicking is not present bilaterally.

There is no tenderness over the temporomandibular joints and masseter muscles bilaterally.

Attrition of the teeth is not present.

Chest and Torso:

Examination of the chest did not reveal erythema, edema, abrasions, laceration, swelling and deformity.

There is no tenderness over the sternum, xiphoid and sternoclavicular joint bilaterally.

Tenderness is not present over the costal cartilage and ribs 1–12 bilaterally. The pectoral muscles are not tender bilaterally.

Abdomen:

Examination of the abdominal area is not remarkable for gross deformities, edema, swelling, erythema and laceration.

There is no obvious diastasis recti, inguinal, or umbilical herniations noted. Tenderness is not present over the upper and lower quadrants, midline, rectus abdominis muscle and oblique muscles bilaterally. There is no tenderness present over the inguinal area bilaterally.

Cervical Spine:

Examination revealed tenderness to palpation with muscle guarding of bilateral paracervical musculature. Tenderness and hypomobility were noted C2 through C7 vertebral regions.

Shoulder depression test is positive bilaterally.

Ranges of motion of the cervical spine were decreased and painful. Please see formal ranges of motion study attached.

Shoulders & Upper Arms:

Examination revealed tenderness to palpation at bilateral supraspinatus musculature with muscle guarding, right worse than left. Tenderness at bilateral subacromial bursa, subdeltoid bursa and bilateral acromioclavicular joints. Tenderness at biceps brachii insertion.

Apprehension test is positive bilaterally. Hawkins test is positive bilaterally.

Ranges of motion for bilateral shoulder decreased and painful, measured as follows.

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	**170**	**160**
Extension	50	**45**	**40**
Abduction	180	**170**	**150**
Adduction	50	**50**	**40**
Internal Rotation	90	**70**	**60**
External Rotation	90	**60**	**50**

Elbows & Forearms:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the elbow bilaterally.

Tenderness is not present over the lateral epicondyle, medial epicondyle and cubital tunnel bilaterally. Tenderness is not present over the flexor muscle group and extensor muscle group of the forearm bilaterally.

Valgus and Varus Stress Tests are negative. Cozens' (resisted wrist extension) and Golfers' (resisted wrist flexion) tests are negative bilaterally.

Tinel's sign at the right elbow and left elbow is negative.

Ranges of motion for the right and left elbows were accomplished without pain and spasm and were as follows:

Elbow Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80
Pronation	80	80	80

Wrists & Hands:

Examination revealed tenderness to palpation at bilateral volar creases, carpal tunnels, carpals, and anatomical snuff box. Tenderness at bilateral thenar regions.

Tinel's sign is positive bilaterally. Finkelstein's test is positive bilaterally.

Ranges of motion for both wrists were within normal limits with pain bilaterally.

Wrist Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	60	60	60
Extension	60	60	60
Ulnar Deviation	30	30	30
Radial Deviation	20	20	20

Finger ranges of motion were performed without pain. Triggering of the digits and mechanical block is not present. Tenderness is not present at the digits. Thumb abduction is 90 degrees bilaterally. Thumb adduction reaches the head of the 5th metacarpal bilaterally **with the exception of pain at both thumbs at end ranges of range of motion.**

Finger Range of Motion Testing						
Digits	MCP Joint		PIP Joint		DIP Joint	
	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
Thumb	60	60	80	80	N/A	N/A
	0	0	0	0	N/A	N/A
Index	90	90	100	100	70	70
	0	0	0	0	0	0
Middle	90	90	100	100	70	70
	0	0	0	0	0	0
Ring	90	90	100	100	70	70
	0	0	0	0	0	0
Little	90	90	100	100	70	70
	0	0	0	0	0	0

Grip Strength Testing:

Grip strength testing was performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 5 attempts and produced the following results:

Left: 5/5/5, average 5 kilograms
Right: 5/2/5, average 4 kilograms

For individual of the same age, sex, and body habitus for right dominant upper extremity expected average is 22.3 kilograms, thus rendering right upper extremity having 82% strength loss index. For left minor upper extremity expected average is 18.2 kilograms, thus rending left upper extremity having 72% strength loss index.

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid (C5), Biceps (C5), Triceps (C7), Wrist Extensor (C6), Wrist Flexor (C7), Finger Flexor (C8) and Finger Abduction (T1) motor testing is normal and 5/5 bilaterally, **with the exception of deltoid bilaterally 4/5, other myotomes 5/5.**

Deep Tendon Reflex Testing of the Cervical Spine and Upper Extremities:

Biceps *(C5, C6)*, Brachioradial *(C5, C6)* and Triceps *(C6, C7)* deep tendon reflexes are normal and 2/2 bilaterally.

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel **with the exception of hypoesthesia at both hands median nerve distributions.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**30.5**	**31**
Forearms	**19.5**	**20**

Thoracic Spine:

Cyst-like mass was noted 1 cm x 1 cm over spine around T4.

Tenderness to palpation with muscle guarding of bilateral parathoracic musculature. Tenderness and hypomobility at T4 through T10 vertebral regions.

Kemp's test is positive bilaterally.

Ranges of motion for thoracic spine were decreased and painful. Please see formal ranges of motion study attached.

Lumbosacral Spine:

Examination revealed tenderness to palpation with myospasm of bilateral paralumbar musculature. Tenderness at sacroiliac joints and sciatic notches. Tenderness and hypomobility at L2 through L5 vertebral regions.

Milgram's test, patient is unable to perform due to pain. Sacroiliac compression joint test is positive bilaterally.

Straight Leg Raising Test (supine) was positive for back pain:

Right: 60 degrees.
Left: 60 degrees.

Ranges of motion for lumbar spine were decreased and painful. Please see formal ranges of motion study attached.

Hips & Thighs:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the hips and thighs.

Tenderness and spasm is not present over the greater trochanteric region, hip bursa, hip abductor, hip adductor, quadriceps, biceps femoris musculature and femoroacetabular joint bilaterally.

Patrick Fabere test elicited increased pain at the low back bilaterally.

Hip ranges of motion were performed without pain and spasm.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	45	45
Internal rotation	45	45	45

Knees & Lower Legs:

Examination revealed healed post-arthroscopic surgical scar at left knee.

Tenderness at bilateral patella. Tenderness at bilateral medial and lateral joint lines.

McMurray's test is positive bilaterally.

Range of motion for both knees decreased and painful. Please see formal ranges of motion study attached.

Ankles & Feet:

Left: Examination revealed healed surgical scar over the medial and lateral malleolar regions of left ankle.

Tenderness to palpation at left distal tibia, distal fibula, and left sinus tarsi.

Orthopedic testing for the left ankle was not performed secondary to post-surgical status and retained hardware as per the patient.

Right: Unremarkable examination.

Ranges of motion for the ankles, right normal, left decreased and measured as follows with pain bilaterally.

Ankle Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Metatarsophalangeal joint (MPJ) Extension	60	**30**	60
MPJ Flexion	20	**10**	20
Ankle Dorsiflexion	20	**10**	20
Ankle Plantar Flexion	50	**25**	50
Inversion (Subtalar joint)	35	**17**	35
Eversion (Subtalar joint)	15	**7**	15

Motor, Gait & Coordination Testing of The Lumbar Spine and Lower Extremities:

Ankle Dorsiflexion *(L4)*, Great Toe Extension *(L5)*, Ankle Plantar Flexion *(L5/S1)*, Knee Extension *(L3, L4)*, Knee Flexion, Hip Abductor and Hip Adductor motor testing was normal and 5/5 **with the exception of left knee extension & flexion 4/5, left ankle dorsiflexion & ankle plantar flexion 4/5, all other myotomes 5/5.**

Patient is unable to perform squatting due to pain at bilateral knees, left worse than right.

Unable to perform heel and toe walking due to left ankle pain.

Antalgic gait favoring left lower extremity.

Deep Tendon Reflex Testing of The Lumbar Spine and Lower Extremities:

Ankle *(Achilles-S1)* and Knee *(Patellar Reflex-L4)* deep tendon reflexes are normal and 2/2.

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel.

Girth & Leg Length (Anterior Superior Iliac Spine to Medial Malleoli) measurements were taken of the lower extremities, as follows in centimeters:

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**57**	**57.5**
Calf - at the thickest point	**38**	**37.5**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**98**	**98**

REVIEW OF RECORDS:

Please see Addendum 1 section of this report.

PAIN AND ACTIVITIES OF DAILY LIVING QUESTIONNAIRES

1. **12/21/20 Beck Anxiety Inventory Score: 45.**
   Comment: Which equals potentially concerning levels of anxiety.

   Reference: Beck, A.T., Epstein, N., Brown, G., Steer, R.A. (1988) Journal of Consulting and Clinical Psychology, 56, 893-897.

2. **12/21/20 Patient Health Questionnaire PHQ 9 Score: 18.**
   Comment: Indicating moderately severe depression.

   Reference: Journal of General Internal Medicine. 2001. September; 16(9): 606-613

3. **12/21/20 Epworth Sleepiness Scale (ESS) Score: 8**
   Comment: Deferred to neurologist Lawrence Richman, M.D.

   Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. Sleep. 1991; 14:50-55.

4. **12/21/20 Headache Disability Index Score: 84**
   Comment: Indicating Significant Adverse Effect on Quality of Life and Performance of Work/ADL

Reference: Jacobson GP, Ramadan NM, et al. The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.

5. **12/21/20 Neck Disability Index Score: 66%.** According to the authors of this questionnaire, a score of 66% indicates significant disability secondary to neck pain. This is consistent with the patient's complaints.

Reference: The Neck Disability Index (NDI) was developed in 1989 by Howard Vernon. Vernon and Mior published the results of a study of reliability and validity in the Journal of Manipulative and Physiologic Therapeutics, 1991.

6. **12/21/20 Modified Oswestry Low Back Pain Questionnaire Score: 66%.**
Comment: According to the authors of this questionnaire, a score of 66% indicates significant disability secondary to back pain. This is consistent with the patient's complaints.

Reference: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. Physical Therapy. 2001;81:776-788.

7. **12/21/20 Upper Extremity Functional Scale Score: 30%.**
Comment: Indicating significant/greater than moderate difficulties in performing activities of daily living.

Reference: Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001; 259-266, 281.

8. **12/21/20 Lower Extremity Functional Scale Score: 5%.**
Comment: Indicating significant (more than moderate) difficulties in performing activities of daily living.

Reference: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

See Addendum 3 for scoring details.

Diagnostic Impressions:

1. Cephalgia, G44.099.
2. Vertigo, R42.
3. Vision problems/cataracts, H53.9/ H25. 9.
4. Cervical spine myofasciitis, M79.1.

5. Cervical facet-induced versus discogenic pain, M53.82.
6. Thoracic spine myofasciitis, M79.1
7. Thoracic facet-induced versus discogenic pain, M54.6.
8. Cyst over thoracic spine, M71.38.
9. Lumbar spine myofasciitis, M79.1.
10. Sacroiliac joint dysfunction, sprain/strain, M53.3.
11. Lumbar facet-induced versus discogenic pain, M47.816.
12. Bilateral shoulder tenosynovitis/bursitis, M75.51.
13. Bilateral shoulder rotator cuff tear, rule out, M75.101.
14. Bilateral shoulder impingement syndrome, rule out, M75.41.
15. De Quervain's stenosing tenosynovitis of the thumb, bilateral, M65.4.
16. Bilateral carpal tunnel syndrome, G56.03.
17. Left knee status post surgery, Z96.652.
18. Bilateral knee internal derangement, M23.92.
19. Left ankle status post surgery, arthritis, Z96. 662, M13.80
20. Right ankle sinus tarsi syndrome, arthritis, M25.579.
21. Hypertension, R03.0.
22. Urinary frequency, R35.0.
23. Anxiety, depression, and insomnia, F41.9, F34.1, G47.00.
24. Per Babak Kumar, O.D- Optometrist: 1) Glare sensitivity. 2) History of amblyopia, associated with exotropia, right eye. 3) Exotropia, right eye. 4) Regular Astigmatism both eyes. 5) Myopia, bilateral. 6) Presbyopia both eyes.

25. Per Lawrence Richman, M.D. – Neurologist: 1) Blindness in the right eye. 2) History of post-traumatic head syndrome, nonindustrial causation. 3) Post-traumatic headaches, nonindustrial causation. 4) Bilateral cervical radiculopathy, nonindustrial causation. 5) Gait instability, nonindustrial causation. 6) Lack of depth perception, nonindustrial causation. 7) Heart murmur and hypertension, nonindustrial causation. 8) Anxiety and depression, nonindustrial causation. 9) Multiple orthopedic complaints.

26. Per Kouron Daldalyan, M.D – Internist: 1) Musculoskeletal injuries involving cervical spine, thoracic spine, lumbar spine, bilateral shoulders, elbows, and hands, left hip, bilateral knees, right ankle and bilateral feet. 2) Carpal tunnel syndrome, bilateral wrists. 3) Cognitive dysfunction secondary to anxiety, depression and chronic pain. 4) Chronic pain syndrome. 5) Epicondylitis bilateral elbows. 6) Internal derangement bilateral shoulders. 7) Cervical spine sprain/strain. 8) Lumbar spine sprain/strain. 9) Myospasms of cervical, thoracic and lumbar spine. 10) Abnormality of gait due to left lower extremity weakness. 11) Use of assistive device (cane). 12) Left knee internal derangement, status post-surgical repair. 13) Fracture of left hallux, status post medical treatment. 14) Bilateral plantar fasciitis. 15) Internal derangement, bilateral ankles. 16) Hypertension (2000) exacerbated by workplace injury. 17) Myopia, right eye (pre-existing). 18) Blurry vision, right 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.

Discussion:

With regards to the eyes, she had **extreme loss of vision; right eye was legally blind.** She had significant loss of vision from her childhood and was legally blind on her right eye from the high school time. Also, in 2015, Dr. Terre Jay Watson, OD (Kaiser Permanente) had recommended her to **self-restrict driving to daytime and street (rather than right or freeway) due to the concerns about best corrected visual acuity for each eye and limitations in peripheral vision.**

With regards to the cervical spine, the patient had multiple complaints including **neck pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist**. She was diagnosed with multiple complaints including **cervical pain**. Also, she had complained of on and off **neck pain with radiation down her back** due to the same injury and was diagnosed with **cervical spine degenerative arthritis; cervical spine degenerative arthritis without radicular symptoms; and cervical spine strain/pain**.

With regards to the shoulders, the patient had sustained work injury on **08/09/07** after a **slip and fall onto her left hip from ground level**. She had injured her multiple body parts and there was **pain in the right shoulder** as well. Also, she had multiple complaints including **right shoulder pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist**. She was diagnosed with **right shoulder pain**

and rotator cuff tendonitis. October 23, 2017 dated Nurse Note by Leilani Rebancos Macaseib, RN had documented that this patient had **upper left shoulder pain since the prior night with pain rated at 3-4/10** (no information was found in the report regarding the etiology or suspected etiology). In addition, she had multiple complaints including **bilateral shoulder pain,** which she attributed to the CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist. She had reported **constant aching to the top of her shoulders, which was radiating down to her elbows. She was diagnosed with bilateral shoulder degenerative arthritis right greater than left.**

With regards to the right elbow/upper arm, the patient had multiple complaints including **right upper arm pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist.** She was diagnosed with multiple complaints including **right elbow pain.**

With regards to the right hand/wrist/thumb, the patient had multiple complaints including **right hand/wrist/thumb pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist.** She was diagnosed with multiple complaints including **right wrist pain.**

With regards to the left hand/forearm, the patient had complained of **left hand and forearm constant tingling x 2 weeks involving all fingers.** She was right-hand dominant. She admitted to leaning and sleeping on hands all the time. She was diagnosed with multiple complaints including **paresthesias and osteoarthritis** [per the October 19, 2011 dated Progress Note by Kelly Ching, MD (Kaiser Permanente)

With regards to the bilateral hands, she had pain with stiffness and locking. She was unable to move them due to the stiffness. She was diagnosed with multiple complaints including **bilateral hand carpometacarpal joint mild degenerative arthritis/numbness.** Also, there was a Kaiser Call documentation (December 16, 2013) regarding her **left arm tingling** and back pain. She had reported that there was **tingling in left arm from the wrist up for more than one month.**

With regards to the thoracic spine, the patient had multiple complaints including **back pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist.** She was diagnosed with **thoracic spine degenerative arthritis** [per February 28, 2018 dated Comprehensive Orthopedic PQME Report by Dr. Gregory T. Heinen, MD]

With regards to the lumbosacral spine, the patient had multiple complaints including **low back pain,** which she attributed to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist.** She was diagnosed with multiple complaints including **low back pain** [per June 21, 2017 dated Orthopedic Followup Evaluation by Jonathan Nissanoff, MD]. Also, for the back, she had reported that **the pain was debilitating and she was unable to move when back gets stuck. She could have this shoot down her back and occasionally, she was unable to walk due to increased pain.** She was diagnosed with **lumbar**

spine degenerative arthritis with radicular symptoms [per February 28, 2018 dated Comprehensive Orthopedic PQME Report by Dr. Gregory T. Heinen, MD]

With regards to the left hip, August 09, 2007 dated Progress Note from Dreamweaver Medical Group indicated that the patient had sustained work injury on **08/09/07** after a **slip and fall onto her left hip from ground level**. She had injured her multiple body parts including **left hip and there was pain in left hip as a result**. She was diagnosed with multiple complaints including **left hip pain.**

With regards to the left knee, August 09, 2007 dated Progress Note from Dreamweaver Medical Group indicated that the patient had sustained work injury on **08/09/07** after a **slip and fall onto her left hip from ground level**. She had injured her multiple body parts including **left knee and there was pain in left knee as a result.** She was diagnosed with multiple complaints including **left knee pain.** Per June 21, 2017 dated Orthopedic Followup Evaluation by Jonathan Nissanoff, MD, she was diagnosed with multiple complaints including the followings: **1) Left knee nonindustrial meniscectomy. 2) Rule out arthrosis, aggravated by work.** She claimed that her injuries were secondary to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist**. August 24, 2020 dated Vocational Expert SIBTF Report by Madonna R, Garcia, MRC, VRTWC, had documented that per patient **left knee and left 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 located medially and laterally.**

With regards to the bilateral knees, per August 11, 2011 dated Progress Note by Kelly Ching, MD, Kaiser Permanente, the patient was seen **status post fall after tripping on pavement two days prior with the complaint of pain in her knees. She had scraped over bilateral anterior knees.** Also, per February 28, 2018 dated Comprehensive Orthopedic PQME Report by Dr. Gregory T. Heinen, MD, she had **stiffness and constant ache in her knees. She was unable to walk at times. This was more frequent and was feeling instability in both knees. She reported that her balance was an issue.**

With regards to the left foot/ankle, June 21, 2017 dated Orthopedic Followup Evaluation by Jonathan Nissanoff, MD had documented that, she was diagnosed with multiple complaints including the followings: **1) Status post nonindustrial left ankle fracture. 2) Status post open reduction internal fixation, left ankle. 3) Aggravation of work-related injury for left ankle.** She claimed that her injuries were secondary to the **CT: 12/30/04 – 04/16/16 that occurred during the employment period with Dveal as a Therapist**. Also, August 24, 2020

I recommend the following diagnostic studies to further evaluate nature, extent and causation of injuries:

- MRI
  - Cervical spine
  - Lumbar spine

- Bilateral shoulders
- Left knee.

- NCV/EMG studies.
  - Upper extremities to assess weakness of shoulder versus cervical radiculopathy.

AMA Impairment, 5th Edition Analysis, Causation, Pre and Post Subsequent Injury Apportionment, Maximum Medical Improvement, Work Restrictions and Discussions:

Cervical Spine

Impairment Rating: Patient qualifying for DRE method and is placed in DRE category II and given 6% **whole person impairment** by referencing Table 15-5 on page 392 due to asymmetric loss of range of motion.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for cervical spine injury is industrial due to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for cervical spine 100% to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to cervical spine as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.

B) **Following Subsequent Work Injury:** No lifting over 10 pounds.

Thoracic Spine

Impairment Rating: Patient qualifying for DRE method and is placed in DRE category II and given **5%** whole person impairment by referencing table 15-4 on page 392 due to asymmetric loss of range of motion.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for thoracic spine due to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for thoracic spine 100% to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to thoracic spine as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.

B) **Following Subsequent Work Injury:** No lifting over 10 pounds. No repeated bending or twisting.

Lumbar Spine

Impairment Rating: Patient qualifying for DRE method and is placed in DRE category II and given 7% whole person impairment by referencing table 15-3 on page 384 due to history and physical examination compatible with mechanism of injury, asymmetric loss of range of motion, muscle guarding on the physical exam.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for lumbar spine injury is secondary to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section" I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for lumbar spine 100% to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to lumbar spine as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling

B) **Following Subsequent Work Injury:** There are work restrictions following the Orthopedic Subsequent Injury subsequent injury CT 12/30/04 to 4/16/16 of no lifting over 10 lbs, no repeated bending and twisting

Spine total impairment 17% whole person impairment by combining 6% cervical spine with 5% thoracic spine with 7% lumbar spine impairment.

Right Shoulder

Impairment Rating: Right shoulder range of motion is 6% upper extremity impairment by referencing figures 16-40, 16-43 and 16-46 on pages on page 476-477, 479 or 4% whole person impairment.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for right shoulder injury is secondary to subsequent injury CT 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation 100% to subsequent injury CT 12/30/04 to 4/16/16 injury as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to right shoulder as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling

B) **Following Subsequent Work Injury:** No overhead work with right arm. No lifting, pushing or pulling over 10 pounds with right arm.

Right Wrist, Hand& Thumb

Impairment Rating: Right wrist/hand major grip strength impairment is 30% upper extremity impairment by referencing table 16-32 and 16-34 on page 509 due to 82% SLI or **18% whole person impairment.**

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for right wrist injury is secondary to continuous trauma 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for right wrist 100% to subsequent injury continuous trauma from 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to right wrist as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.
B) **Following Subsequent Work Injury:** No repeated or forceful use of right hand for pulling, pushing, grasping, torqueing. No prolonged writing and typing.

Right upper extremity total impairment, 34% by combing 30% wrist impairment with 6% shoulder impairment or 20% whole person impairment by referencing Table 16-3.

Left Shoulder

Impairment Rating: 3% upper extremity impairment by referencing figures 16-40, 16-43 and 16-46 on pages on page 476-477, 479 or 2% whole person impairment by referencing table 16-3 on page 439.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for left shoulder injury is secondary to subsequent injury CT 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for left shoulder 100% to subsequent injury CT 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to left shoulder as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.

B) **Following Subsequent Work Injury:** No repeated overhead work with left arm.

Left Wrist, Hand & Thumb

Impairment Rating: Left wrist/hand minor grip strength impairment is 30% upper extremity impairment by referencing table 16-32 and 16-34 on page 509 due to 72% SLI or **18% whole person impairment** by referencing table 16-3 on page 439.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for left wrist injury is secondary to continuous trauma 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for left wrist 100% to subsequent injury continuous trauma from 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to left wrist as the patient is expected to have reached maximum medical improvement one year from the date of injury.

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.
B) **Following Subsequent Work Injury:** No repeated or forceful use of right hand for pulling, pushing, grasping, or torqueing. No prolonged writing and typing.

Left upper extremity total impairment 32% by combing 30% wrist impairment with 3% shoulder impairment or 19% whole person impairment by referencing Table 16-3.

Bilateral upper extremity total impairment is 55% by combining 34% right with 32% left upper extremity impairment **or 33% whole person impairment** by referencing Table 16-3 on page 439.

Left Knee

Impairment Rating: 1). Left knee range of motion is 10% lower extremity impairment by referencing Table 17-10 on page 537. 2) Left knee muscle function deficit impairment is 24% lower extremity impairment by referencing tables 17-7 and 17-8 on pages 531-532 due to grade IV strength deficit of extension, flexion of the knee. 3) Left knee is best represented by muscle function deficit impairment of 24% lower extremity impairment or 10% whole person impairment by referencing table 17-3 on page 527.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for left knee injury is secondary to subsequent injury of 11/10/07 and continuous trauma from 12/30/04 to 4/16/16 and due to aberrant gait secondary to left ankle fracture/surgery as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: It is within reasonable medical probability to conclude that the left knee condition was affected by aberrant gait secondary to left ankle fracture and surgery. I apportion causation for left knee 60% to 11/10/07, 10% to continuous trauma and 30% to 1992 left ankle fracture/surgery injury as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to left knee as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's conditions were labor disabling. No prolonged standing and walking.
B) **Following Subsequent Work Injury:** No prolonged standing or walking. No squatting, kneeling or climbing.

Left Ankle/Foot

Impairment Rating: Left ankle range of motion is 30% lower extremity impairment by referencing arthritis table 17-31 on page 544 due to 0 mm of joint space or 18% whole person impairment.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for left ankle/foot injury is secondary to 1992 fracture and subsequent injury of 08/09/07 and continuous trauma from 12/30/04 to 04/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for left ankle/foot 80% to 1992 fracture and sequelae, 20% to 08/09/07 subsequent injury and continuous trauma combined as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to left ankle/foot as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's conditions were labor disabling. No prolonged standing, walking, no repeated climbing.
B) **Following Subsequent Work Injury:** The patient's conditions were labor disabling. No prolonged standing, walking, no repeated climbing, must be able to work predominantly in a seated position.

Left lower extremity total impairment is 47% by combing left ankle 30% and left knee impairment 24% **or 19% whole person impairment** by referencing Table 17.3.

Right Knee

Impairment Rating: Right knee range of motion is 10% lower extremity impairment by referencing table 17-10 on page 537 or 4% whole person impairment.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for right knee injury is secondary to subsequent injuries continuous trauma from 12/30/04 to 4/16/16 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for right knee 90% to continuous trauma and 10% to prior injury to the left ankle in 1992 and aberrant gait secondary to that as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to right knee as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's condition was not labor disabling.
B) **Following Subsequent Work Injury:** No prolonged standing or walking. No squatting, kneeling or climbing.

Right Foot

Impairment Rating: Right foot range of motion is 4% lower extremity impairment by referencing table 17-33 on page 544 due to mid-foot deformity, avascular necrosis of talus without collapse or 3% whole person impairment.

Causation: As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation for right foot injury is secondary to subsequent injury of 11/10/07 as discussed within this report and summarized in the "discussion section. I reserve the right to change my opinions should additional medical records come forward.

Apportionment: Based upon currently available information, I apportion causation for right foot 100% to subsequent injury of 11/10/07 as discussed within this report and summarized in the "discussion section". I reserve the right to change my opinions should additional medical records and diagnostic studies come forward.

Maximal Medical Improvement: It is reasonable to declare this patient has reached maximum medical improvement with regards to right foot as the patient is expected to have reached maximum medical improvement one year from the date of injury

Work Restrictions:

A) **Pre-existing The Subsequent Work injury:** The patient's conditions were not labor disabling.
B) **Following Subsequent Work Injury:** No prolonged standing or walking. No walking over uneven ground. No climbing.

Right lower extremity total impairment is 14% by combining right knee 10% with right ankle/foot impairment 4% **or 6% whole person impairment** by referencing Table 17.3.

Bilateral total lower extremity impairment is 54% by combining right 14% and left 47% lower extremity impairment **or 22% whole person impairment** by referencing table 17-3 on page 527.

Total Orthopedic Impairment is 57% whole person impairment by combining 17% spinal total impairment with 33% upper extremity total impairment, with 22% lower extremity total whole person impairment.

Impairment as per AMA Imairment as per Internist Dr. Koruon Daldalyan:

Prior to CT 12/30/04 – 4/16/16; 8/9/07; 11/10/07:
Left ankle: 4% WPI.
Aggravated hypertension: 10% WPI.
Right eye:10% WPI.
Her whole-body impairment was 22% = (10% + 10% + 4%).

After CT 12/30/04 – 4/16/16; 8/9/07; 11/10/07:
Cervical spine: 5% WPI.
Lumbar spine: 5% WPI.
Upper extremities (right and left shoulders): 4% WPI.
Left hip: 3% WPI.
Right knee: 3% WPI.

Left knee:10% WPI.
Left ankle:6% WPI.
Right foot:3% WPI.
Right eye: 15% WPI.
Aggravated hypertension:29% WPI.
Cognitive dysfunction:20% WPI.
Urinary frequency: 14% WPI.
Cephalgia:5% WPI.
Sleep impairment:5% WPI.
Vertigo: 4% WPI.
Whole-body impairment was 77% = (29% + 20% + 15% + 14% + 10% + 6% + 5% + 5% + 5% + 5% + 4% + 4% + 3% + 3% + 3%).

Undersigned's conclusion:

Apportionment of hypertension:
Pre Subsequent injuries (10% WPI) / Subsequent Injury (29% WPI) = 34% apportioned to Pre-existing and 66% apportioned of WPI apportioned to Subsequent Injuries.

Apportionment of Right Eye:
Pre Subsequent injuries (10% WPI) / Subsequent Injury (15% WPI) = 67% apportioned to Pre-existing and 33% of WPI apportioned to Subsequent Injuries.

AMA Imairment as per Neurologist Dr. Lawrence Richman.

With respect to her nonwork related injuries, she had qualified for a 12% whole person impairment due to a class 1 mental status impairment (Table 13-6) with 100% apportionment of permanent disability due to her nonindustrial motor vehicle accidents.

For her post-traumatic headaches, 3% whole person impairment per chapter 18, with 100% apportionment of permanent disability to the injury of her two nonindustrial motor vehicular accidents.

For cervical radiculopathy, the patient qualified for a Diagnosis-Related Estimate Category III rating from Table 15-5 with a 17% whole person impairment and 100% apportionment of permanent disability to long standing degenerative arthritis of the cervical spine.

For her visual loss of the right eye, as well as loss of visual fields, both impairments were addressed from Tables 13-9 and 13-10 for visual acuity loss of the right eye. Practically speaking, the right eye was blind and qualified for a Class III rating of 49%, which was also taken into consideration of her visual field loss.

For her gait disturbance, Dr. Richman opined that it was related to loss of depth perception. She had qualified for a 5% whole person impairment from Table 13-15. He added, given the magnitude of her impairments and synergistic effect addition, rather than combined values as allowed for by the Kite case should be utilized to address her visual disturbance, cognitive disturbance and headaches, as well as gait disturbance, all of which could impact each other. 49% plus 12% equals 61%. 61% plus 5% equals 66%. 66% plus 3% equals 69%. 69% was combined with 17%, which equals 73%. Her final whole person impairment was 73%.

AMA Imairment as per Optometrist Dr. Babak Kumar:

The visual impairment was 100% apportioned to natural causes. Impairment: Visual impairment rating: 24.34%. Individual adjustment related to glare sensitivity and poor binocularity: 15%. Total impairment: 39.34%.

Total Calculated Whole Person Impairment Rating:

Please note I have reviewed 3 SIF evaluation reports from different evaluating doctors in different specialties. It is important to note that the evaluating doctors have overlapped each other with respect to assignment of impairments to injuries that include eyes, cognitive/mental and orthopedic. In the following total impairment analysis, I have utilized the impairment ratings from each evaluator that I believe best represents the patient's injuries and current condition.

Total calculated whole person impairment is 91% by combining 17% spinal impairment with 33 upper extremity whole person impairment with 22% lower extremity whole person impairment with 49% right eye impairment with 20% cognitive/mental status impairment with 4% vertigo impairment with 5% cephalgia impairment with 5% sleep impairment with 29% hypertension impairment per internist with 14% urinary frequency impairment per internist with 5% gate impairment as per neurologist.

Permanent and Stationary Status:

The patient's condition is permanent & stationary.

Subjective Factors of Disability:

The subjective factors of disability consist of:

1) Vision, worsening vision of the left eye due to straining while using the computer and compensating for right 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) Bilateral Shoulder pain, the pain is moderate and the symptoms occur frequently, right greater than left. The pain radiates to her arms and hands. There is report of clicking and grinding sensations.

4) Bilateral Hands/Wrist pain, frequent moderate pain with stiffness, numbness and tingling in the right and left wrist and hand and fingers.

5) Mid/Lower Back pain, 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) Bilateral Knee pain, 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) Bilateral Ankles/Feet pain, pain is slight to moderate. The symptoms occur frequently in the bilateral ankles and feet. There is report of swelling of the ankles. The pain is aggravated with standing and walking.

8) Sleeping difficulty, anxiety & depression, the patient has continuous episodes of anxiety, stress, and depression due to chronic pain and disability status.

Objective Factors of Disability:

With regards to cervical spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Muscle guarding on the exam.
4. Tenderness and hypomobility.
5. X-ray (imaging studies)

With regards to bilateral shoulder, objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal orthopedic testing.
4. Decreased muscle strength.

With regards to bilateral wrists, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal neurological examination findings.
4. Decreased grip strength.

With regards to thoracolumbar spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal orthopedic testing.

With regards to knees & lower legs, the objective factors of disability consist of:

1. Healed post-arthroscopic surgical scar at left knee

2. Palpatory tenderness.
3. Painful ranges of motion
4. Abnormal orthopedic testing.

With regards to ankles & feet, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Painful ranges of motion.
3. Status post surgery with retained hardware in left ankle.

Vocational Rehabilitation Benefits:

In my opinion the patient is a qualified injured worker, however based on review of records including the Vocational Expert Madonna R. Garcia's report dated August 24, 2020, 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.

OVERALL SUMMARY OF IMPAIRMENTS

	Total Whole Person Impairment
Cervical Spine	6%
Thoracic Spine	5%
Lumbar spine	7%
Upper Extremities	33%
Lower Extremity	22%
Cognitive/Mental Status	20% Per Internist report
Cephalgia	5% Per neurologist report
Sleep	5% Per neurologist report
Vertigo	4% Per neurologist report
Urinary frequency	14% per internist report
Eye	49% Per Neurologist Report
Hypertension	29% whole person impairment from internist report
Gate	5% per Neurologist
Total	91%

1

RECOMMENDED MEDICAL SPECIALTY EVALUATIONS:

- I recommend this patient undergo a psychiatric versus psychological evaluation for further assessment of additional Psych impairment:

CONCLUSIONS:

I have reviewed Labor Code 4751 and there appears to be adequate evidence to conclude, with reasonable medical probability, that Ms. Rooks meets initial SIBTF criteria.

1. There does appear to be adequate evidence to conclude with reasonable medical certainty that Ms. Rooks had previous partial disability as per the work restrictions outlined by the undersigned.

2. 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%.

3. 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 for Labor Code 4751.

REASONS FOR OPINIONS:

1. The consistency of the mechanism of injury with the patient's complaints and the consistency of the patient's description of injuries in relation to the submitted medical records.

2. Review of available medical records.

3. Perceived credibility of Ms. Rooks and her internally consistent statements and physical action.

4. My experience in treating similar patients and injuries over the past 20 years.

LC 4751 Compensation for specified additions to permanent partial disabilities

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 percent 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 percent 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 percent or more of total.

DISCLOSURE STATEMENT

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (b)): I declare that the history was taken by Kim Smith and I personally reviewed the history with the patient (essentially the history was taken twice), I performed the physical examination, reviewed the document and reached a conclusion. The names and qualifications of each person who performed any services in connection with the report are Dr. Mayya Kravchenko, D.C., who assisted with assembly of components of this report which was transcribed by Acu Trans Solution, LLC, edited for formatting, grammar and spelling by Kim Smith, Medical Editor and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (j)): "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 I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues

regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer. I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manuel Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 19th day of January 2021, in Los Angeles, California.

Eric E. Gofnung Chiropractic Corp
6221 Wilshire Blvd Suite 604
Los Angeles, CA 90048
United states

Phone (323)933-2444
Fax (323)933-2909

Evaluator

Date

Summary/Discussion

Calibration Certificate

Date of Examination	Device Type	Device ID
12/21/2020	Muscle Tester	19EE89

Last Factory Calibration

Date
5/28/2014

Last Full Calibration

Date & Time	Drift from Factory Calibration	JTECH Recommended Drift Limits
1/9/2019 5:14:15 PM	2.0%	±20%

Last Zero Calibration

Date & Time	Drift from Factory Calibration	JTECH Recommended Drift Limits
1/9/2019 5:14:25 PM	2.5%	±20%

Range of Motion - Inclinometry

Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

Cervical ROM	Norm	Result	Difference	% Norm
Cervical Flexion	50°	21°	29°	42%
Cervical Extension	60°	18°	42°	30%
Cervical Lateral Left	45°	18°	27°	40%
Cervical Lateral Right	45°	22°	23°	49%
Cervical Rotation Left	80°	42°	38°	53%
Cervical Rotation Right	80°	41°	39°	51%

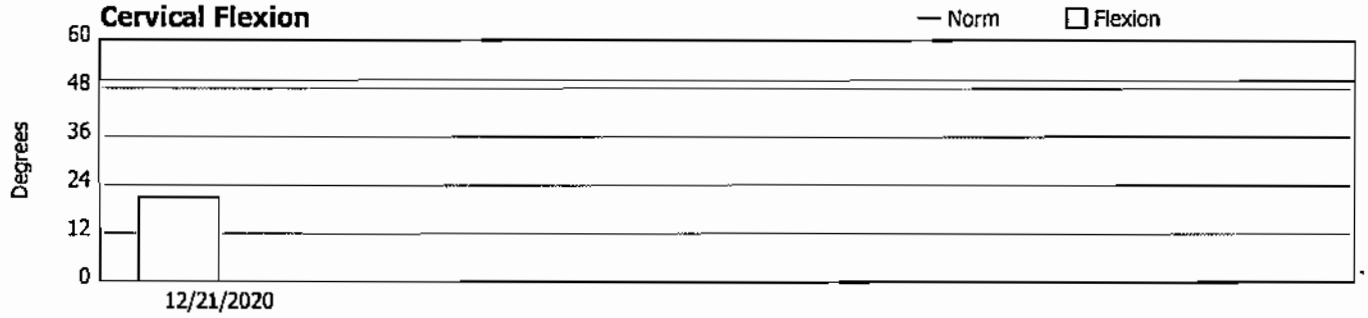
Thoracic ROM	Norm	Result	Difference	% Norm
Thoracic Minimum Kyphosis	–	1°	–	–
Thoracic Flexion	45°	25°	20°	56%
Thoracic Rotation Left	30°	18°	12°	60%
Thoracic Rotation Right	30°	18°	12°	60%

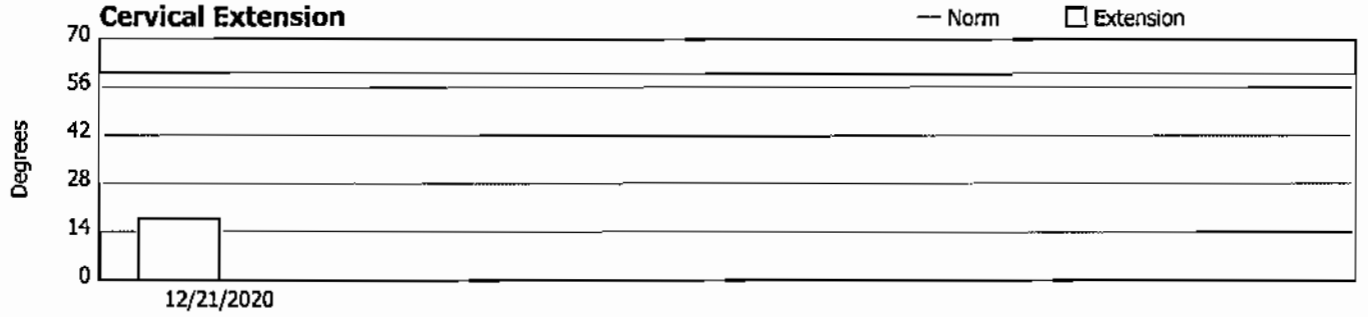
Lumbar ROM	Norm	Result	Difference	% Norm
Lumbar Flexion	60°	35°	25°	58%
Lumbar Extension	25°	15°	10°	60%
Lumbar Lateral Left	25°	17°	8°	68%
Lumbar Lateral Right	25°	15°	10°	60%

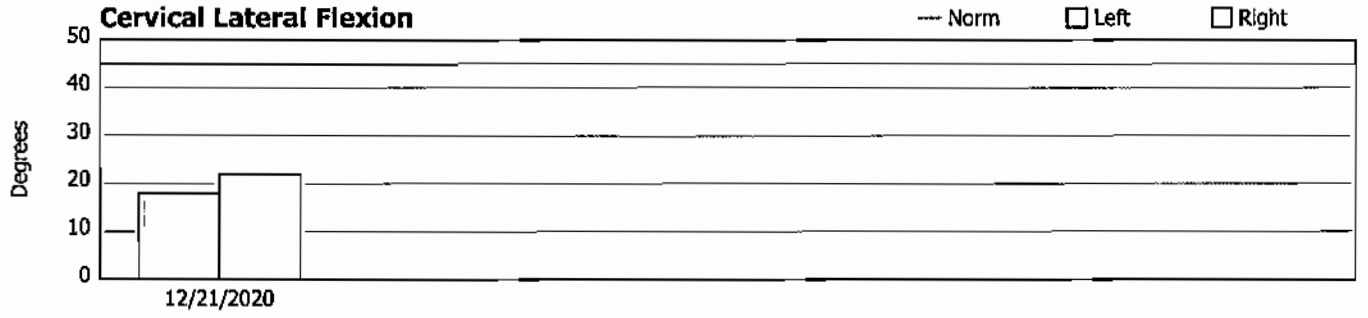
According to the AMA Guides, "An accessory validity test can be performed for lumbosacral flexion and extension... If the straight-leg-raising angle exceeds the sum of sacral flexion and extension angles by more than 15°, the lumbosacral flexion test is invalid. Normally, the straight-leg-raising angle is about the same as the sum of the sacral flexion-extension angle... If invalid, the examiner should either repeat the flexion-extension test or disallow impairment for lumbosacral spine flexion and extension."

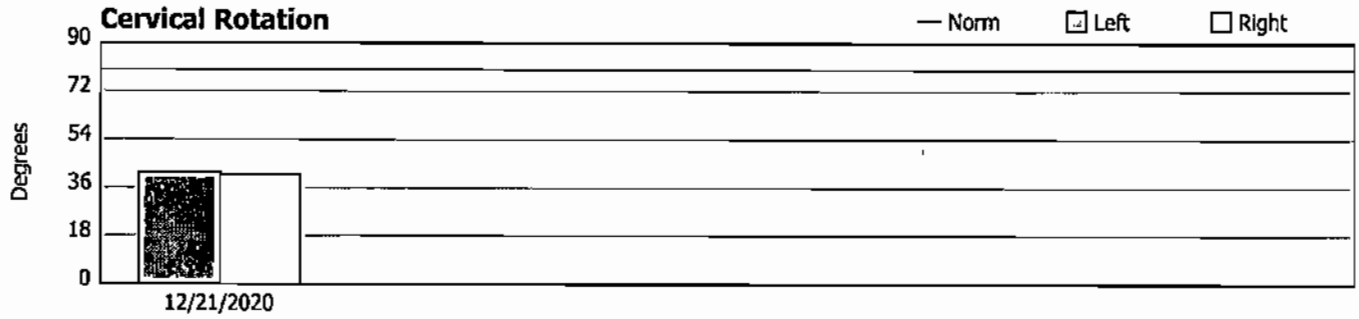
Unless otherwise noted, the table(s) above show current test results compared to American Medical Association normative values.

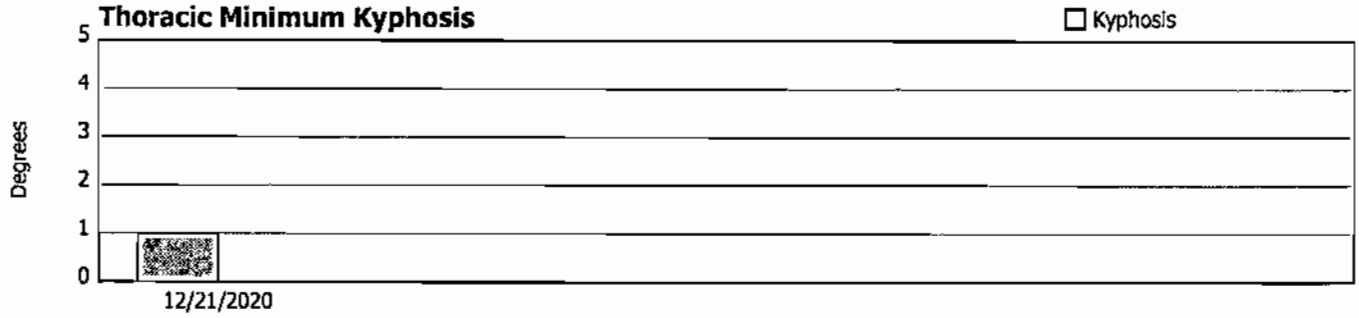
Spine Range of Motion Progress

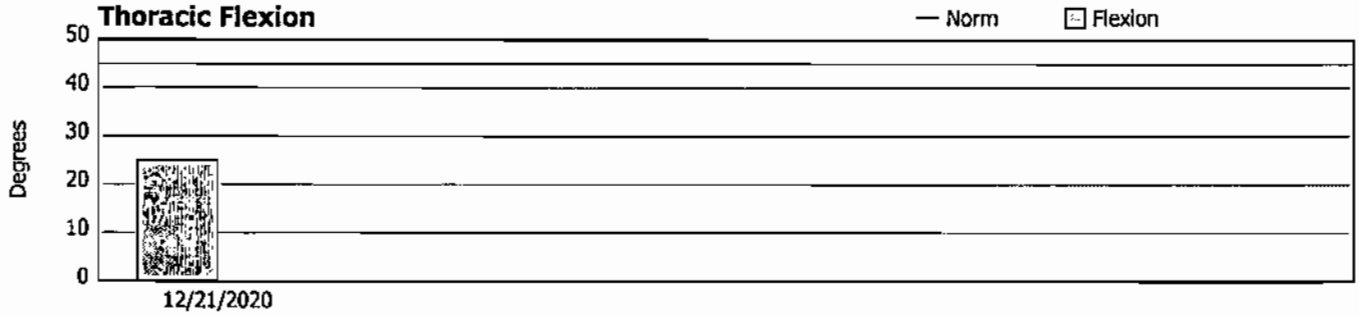


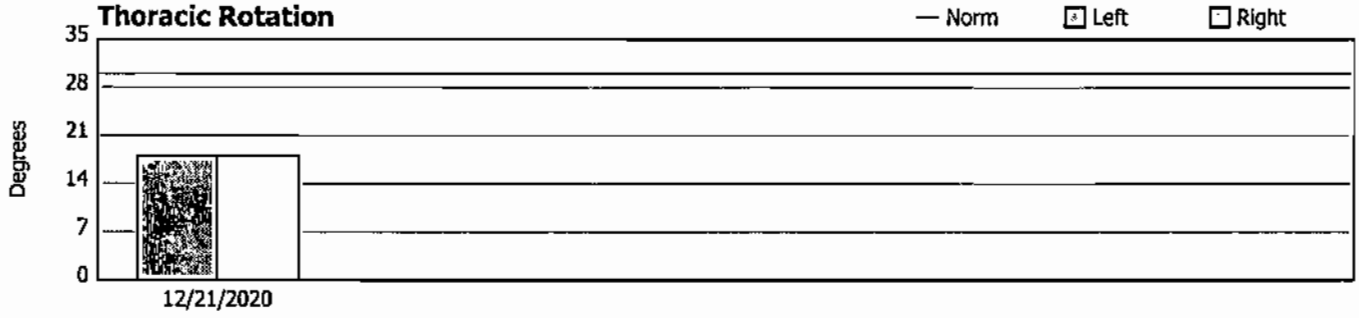


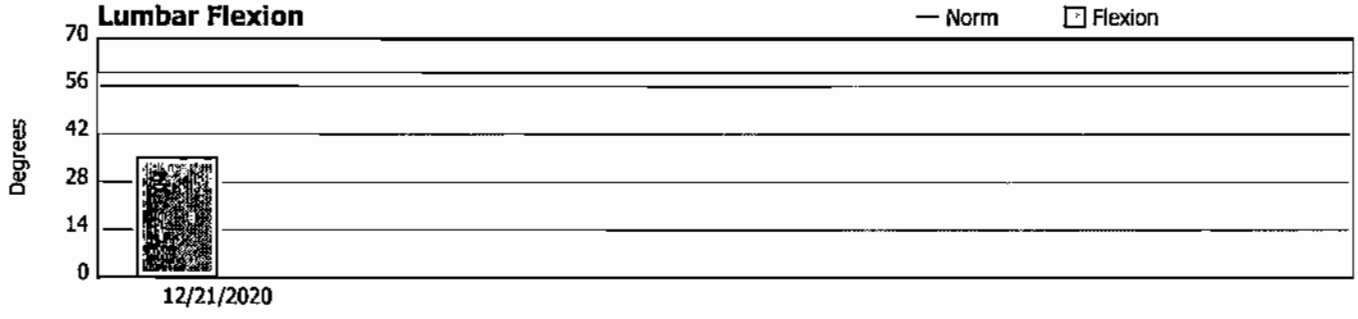


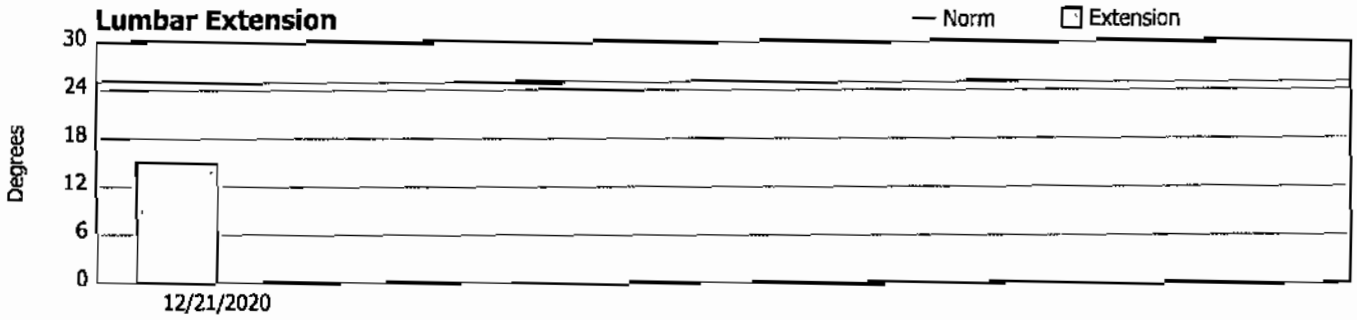

Cervical Rotation
— Norm
Left
Right
Degrees
90
72
54
36
18
0
12/21/2020

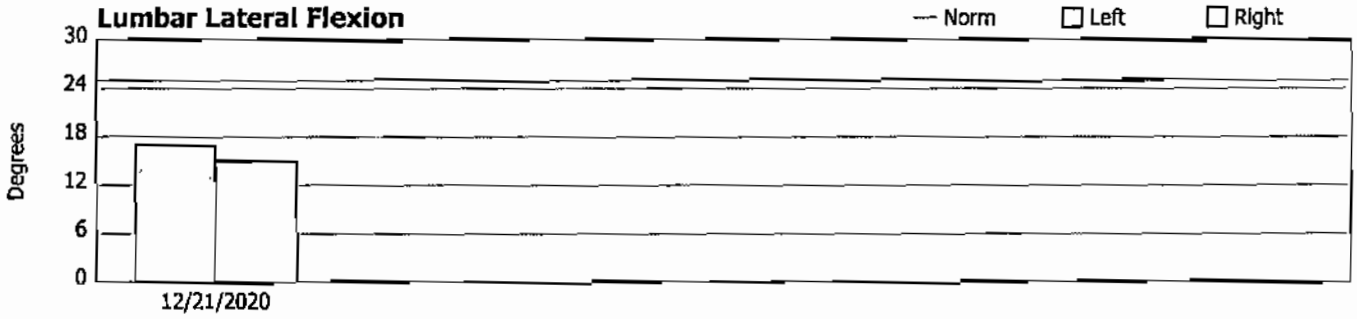

Thoracic Minimum Kyphosis
Kyphosis
Degrees
5
4
3
2
1
0
12/21/2020


Thoracic Flexion
— Norm
Flexion
Degrees
50
40
30
20
10
0
12/21/2020


Thoracic Rotation
— Norm
Left
Right
Degrees
35
28
21
14
7
0
12/21/2020


Lumbar Flexion
— Norm
Flexion
Degrees
70
56
42
28
14
0
12/21/2020





Custom Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using dual inclinometry protocols.

Custom Spine Range of Motion Progress

Extremity Range of Motion

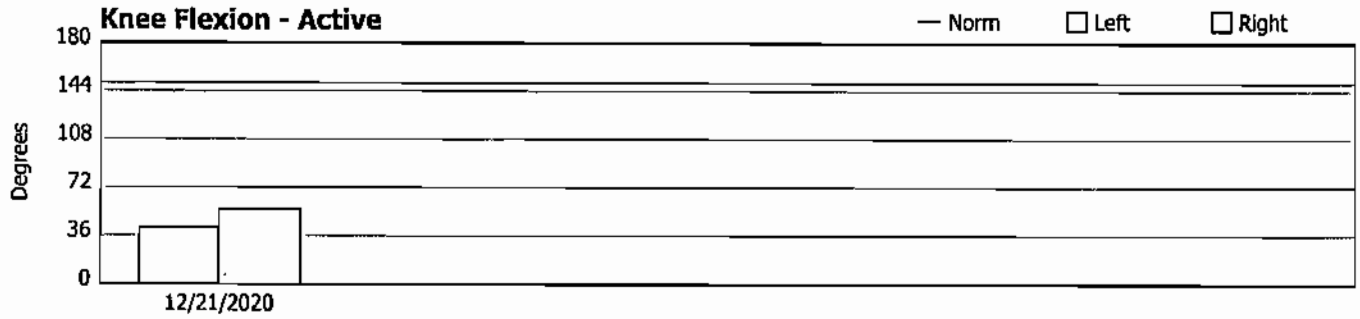
The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the single and dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

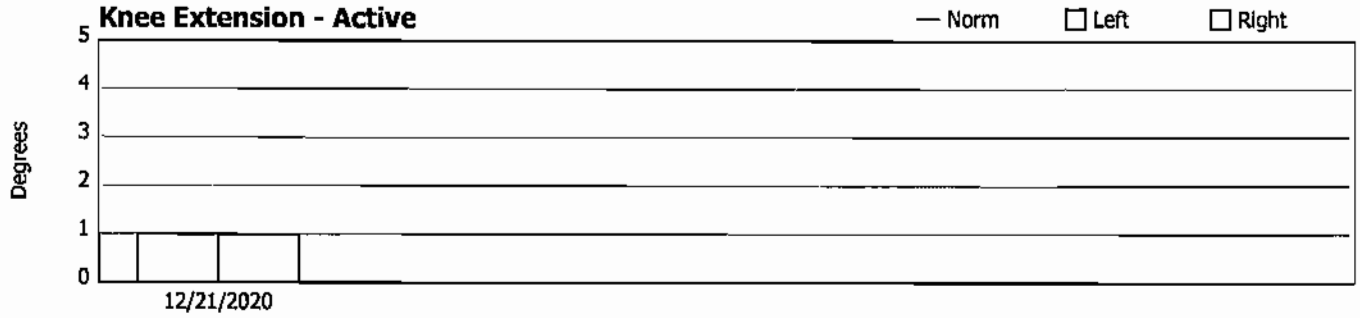
Lower Extremity ROM - Left Active	Norm	Result	% Norm
Knee Flexion	150°	42°	28%
Knee Extension	0°	1°	–

Lower Extremity ROM - Right Active	Norm	Result	% Norm
Knee Flexion	150°	56°	37%
Knee Extension	0°	1°	–

The table(s) above show current test results compared to American Medical Association normative values.

Extremity Range of Motion Progress





Custom Extremity Range of Motion

The patient's range of motion was objectively evaluated with Tracker ROM from JTECH Medical using single and/or dual inclinometry protocols.

Custom Extremity Range of Motion Progress

Patient Information

Name: Floreen Rooks
Gender: Female
Birth Date: 6/20/1949
Dominant Hand: Right

Primary Insurance

Secondary Insurance

Employer

Referral

Attorney

Care Providers

ADDENDUM 1 - REVIEW OF MEDICAL LITERATURE

Review of Medical Literature:

1) **https://pubmed.ncbi.nlm.nih.gov/25144599/**

Karli E Dill 1, Rebecca L Begalle, Barnett S Frank, Steven M Zinder, Darin A Padua

Altered knee and ankle kinematics during squatting in those with limited weight-bearing-lunge ankle-dorsiflexion range of motion

ABSTRACT

Context: Ankle-dorsiflexion (DF) range of motion (ROM) may influence movement variables that are known to affect anterior cruciate ligament loading, such as knee valgus and knee flexion. To our knowledge, researchers have not studied individuals with limited or normal ankle DF-ROM to investigate the relationship between those factors and the lower extremity movement patterns associated with anterior cruciate ligament injury.

Objective: To determine, using 2 different measurement techniques, whether knee- and ankle-joint kinematics differ between participants with limited and normal ankle DF-ROM.

Design: Cross-sectional study.

Setting: Sports medicine research laboratory.

Patients or other participants: Forty physically active adults (20 with limited ankle DF-ROM, 20 with normal ankle DF-ROM).

Main outcome measure(s): Ankle DF-ROM was assessed using 2 techniques: (1) nonweight-bearing ankle DF-ROM with the knee straight, and (2) weight-bearing lunge (WBL). Knee flexion, knee valgus-varus, knee internal-external rotation, and ankle DF displacements were assessed during the overhead-squat, single-legged squat, and jump-landing tasks. Separate 1-way analyses of variance were performed to determine whether differences in knee- and ankle-joint kinematics existed between the normal and limited groups for each assessment.

Results: We observed no differences between the normal and limited groups when classifying groups based on nonweight-bearing passive-ankle DF-ROM. However, individuals with greater ankle DF-ROM during the WBL displayed greater knee-flexion and ankle-DF displacement and peak knee flexion during the overhead-squat and single-legged squat tasks. In addition, those individuals also demonstrated greater knee-varus displacement during the single-legged squat.

Conclusions: Greater ankle DF-ROM assessed during the WBL was associated with greater knee-flexion and ankle-DF displacement during both squatting tasks as well as greater knee-varus displacement during the single-legged squat. Assessment of ankle DF-ROM using the WBL provided important insight into compensatory movement patterns during squatting, whereas nonweight-bearing passive ankle DF-ROM did not. Improving ankle DF-ROM during the WBL may be an important intervention for altering high-risk movement patterns commonly associated with noncontact anterior cruciate ligament injury.

J Athl Train . Nov-Dec 2014;49(6):723-32. doi: 10.4085/1062-6050-49.3.29.

2) **https://pubmed.ncbi.nlm.nih.gov/31420276/**

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Neck disability in patients with cervical spondylosis is associated with altered brain functional connectivity

ABSTRACT

Cervical degenerative disease is a major cause of neck disability, but it has been understudied in patients with cervical spondylotic (CS), largely due to the fact that the neurological impairment associated with this condition tends to be the primary treatment focus. This observational study examined the cerebral functional alterations occurring in advanced cervical spondylosis and myelopathy using resting state functional MRI. Associations between functional connectivity (FC) and neck disability using the Neck Disability Index (NDI) were assessed. Results of the study demonstrated an increase in FC with increasing in neck disability in regions associated with sensorimotor system (both postcentral gyri and precentral gyri, bilaterally, with the SMA; bilateral precentral gyri and the left postcentral gyrus, with the left superior frontal gyrus; bilateral SMA and the left putamen, with the superior frontal gyri). Accounting for the difference in neurological function (mJOA score), strong connectivity between the precentral gyri and the SMA associated with the neck disability. Consistent with studies in chronic pain conditions, these findings suggest neck disability is associated with altered cerebral FC in cervical spondylosis patients.

J Clin Neurosci, . 2019 Nov;69:149-154. doi: 10.1016/j.jocn.2019.08.008. Epub 2019 Aug 13.

3) **https://pubmed.ncbi.nlm.nih.gov/20062970/**

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Risk factors for a contralateral anterior cruciate ligament injury.

ABSTRACT

Contralateral anterior cruciate ligament (ACL) injuries are together with the risk of developing osteoarthritis of the knee and the risk of re-rupture/graft failure important aspects to consider after an ACL injury. The aim of this review was to perform a critical analysis of the literature on the risk factors associated with a contralateral ACL injury. A better understanding of these risk factors will help in the treatment of patients with unilateral ACL injuries and in the development of interventions designed to prevent contralateral ACL injuries. A Medline search was conducted to find studies investigating risk factors for a contralateral ACL injury, as well as studies where a contralateral ACL injury was the outcome of the study. Twenty studies describing the risk of a contralateral ACL rupture, or specific risk factors for a contralateral ACL injury, were found and

systematically reviewed. In 13 of these studies, patients were followed prospectively after a unilateral ACL injury. The evidence presented in the literature shows that the risk of sustaining a contralateral ACL injury is greater than the risk of sustaining a first time ACL injury. Return to a high activity level after a unilateral ACL injury was the most important risk factor of sustaining a contralateral ACL injury. There was inconclusive evidence of the relevance of factors such as female gender, family history of ACL injuries, and a narrow intercondylar notch, as risk factors for a contralateral ACL injury. Risk factors acquired secondary to the ACL injury, such as altered biomechanics and altered neuromuscular function, affecting both the injured and the contralateral leg, most likely, further increase the risk of a contralateral ACL injury. This literature review indicates that the increased risk of sustaining a contralateral ACL injury should be contemplated, when considering the return to a high level of activity after an ACL injury.

PMID: 20062970, DOI: 10.1007/s00167-009-1026-3

ADDENDUM 2 - REVIEW OF RECORDS

The total length of time for review of these records was 23 hours.

1) I reviewed the entire medical file with all pertinent patient information. I have reviewed my initial history, examination and medical file.

2) October 06, 2020, Cover Letter for AME Evaluation in Chiropractic Specialty, From Natalia Foley, Esq (Workers' Defender's Law Group) to Eric Gofnung, DC: In this letter the Ms. Foley indicated that Dr. Gofnung had been selected to act in the capacity of a Qualified Medical Evaluator in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty. He was specifically asked to provide a medical legal evaluation in his area of expertise as a chiropractic doctor. He was also provided with the medical records (dated from 10/02/15 to 08/24/20) in this case for his review.

   Ms. Foley requested Dr. Gofnung to address the following issues:

   A) Please provide a medical legal evaluation and address the issue of causation (Arising Out of Employment and occurring in the Course of Employment) of any injury within your area specialty. Specifically it is requested that a determination be made regarding any pre-existing medical issues and disability within your area of specialty that were present at the time of the subsequent industrial injury.

   B) Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment. Specifically, it is requested that you provide a determination as to the percentage of cause of disability to a pre-existing condition present at the time of the subsequent industrial injury, any contribution from the industrial injury(ies) and any further natural progression, which occurred after the industrial injury.

3) October06, 2020, Request for AME Appointment and Comprehensive Report In Chiropractic Specialty, Natalia Foley, Esq (Workers' Defender's Law Group): The patient had been scheduled for an AME evaluation with Dr. Gofnung on 12/21/20.

4) October 06, 2020, Comprehensive Review of this Case, Natalia Foley, Esq (Workers' Defender's Law Group): The patient was working as a Therapist for Dveal Family and Youth Services for about 12 years from 2006 to 2018. During this time she was injured at several occasions and had filed 3 (three) Workers' Compensation claims as follow:

DOI	ADJ	Body parts
12/30/04 – 04/16/16	ADJ10825285	Eye, upper extremities, back, lower extremities, nervous system.
11/10/07	ADJ7024643	Ankle
08/09/07	ADJ7024645	Ankle

ADJ7024643 and ADJ7024645 were related to the specific injury at work where the patient fractured her lower extremities. Both cases were settled in one C&R (Compromise and Release) dated 3/12/12. In 2017 she claimed cumulative injury complaining to the pain accumulated due to repetitive movements over period of time to her upper and lower extremities, upper and lower back, eyes, and nervous system. On 2/28/18, she was evaluated by PQME Gregory T. Heinen, MD, orthopedic specialty. Dr. Heinen evaluated her neck, both shoulders/wrists/hands, mid back, left knee, right ankle, and left foot. Per his report, she had final 52 PD (permanent disability) before apportionment. There was no medical evidence indicating that any of the above injuries were present prior to the employment with Dveal Family and Youth Services.

Pre-existing debilitating injuries and conditions:

Prior to her employment with the subject employer she had the following partially totally disabling pre-existing conditions:

1) Heart murmur accompanied by shortness of breath, enlarged neck veins, chest pain, dizziness and fainting.
2) High blood pressure
3) Severe allergies
4) Asthma
5) Kidney and bladder dysfunctions
6) Extreme loss of vision, right eye was legally blind
7) Arthritis
8) Sever depression and other psychopathologies caused by parents' divorce, personal difficult relationship with domestic violence, death of all members of the family due to

violent crimes and serious diseases, necessity to give up the patient's own daughter for several years, and other tragic personal life circumstances.

Ms. Foley indicated that psychological issues of the patient had caused her to experience the following symptoms:

- Cognitive: a) Memory Issues. b) Confusion. c) Difficulty concentrating. d) Light and/or sound sensitivity. e) Difficulty communicating.

- Physical: a) Headache. b) Dizziness. c) Nausea/vomiting. d) Loss of coordination/balance. e) Chronic pain. f) Poor vision.

- Emotional: a) Irritability. b) Sadness. c) Anxiety. d) Denial. f) Lack of self-efficacy.

Ms. Foley added that due to her very difficult life circumstances, she did not have health insurance for many years and was not properly evaluated in regard to her many health issues, yet it was reasonable to anticipate that she had at least 35 % of a ratable disability related to her pre-existing conditions, and that these conditions caused her to be partially totally permanently disabled prior to her last employment with the subject employer. By the time she was employed by Dveal Family and Youth Services (hereinafter – "Dveal") as a Therapist, she already had a lot of arthritis related pain, she had to run to the bathroom almost every hour, she was unable to control her emotions while in communication with the team of coworkers, she had difficulties in driving and working with the computer screen. Yet her job at Dveal created a unique opportunity for her to be gainfully employed because of the specific duty assigned to her, that she was able to perform even with all her pain and issues related to her physical disability.

Industrial injuries: The patient worked for Dveal for over a decade, and during that time she sustained industrial injuries rated at 52% PD before apportionments. Thus, it was the patient's contention that within a reasonable medical probability her 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, was equal to 35% or more of total.

Additional subsequent compensable injuries causing additional permanent partial disability and inability to compete in a labor market: Important to mention here that because of the patient's significant loss of vision, difficulties in mainlining balance, difficulty in working with the computer screen for prolonged hours, difficulties in communication, difficulties in prolonged sitting, difficulties in driving, significant irritability, constant headaches, constant need to visit a bathroom, she was already largely unemployable prior to her last employment, yet she was using her best efforts to compete in a labor marker. Her last employment; however, resulted in additional subsequent compensable injuries causing

additional permanent partial disability rendering her 100% permanently disabled and incapable of competing in a labor market.

70% or more of permanent disability total: It's therefore the patient's contention that the degree of disability caused by the combination of both (prior and subsequent) disabilities was 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 was a equal to 70% or more of permanent disability total, and 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, was equal to 35% or more of total.

35% standard rating: It was her contention that should the patient be evaluated and rated by all applicable PQMEs in regard to her claimed industrial injuries, inducing but not limited to neurologist specialty, psychologist, orthopedic surgeon, and internist, her total final PD before being adjusted for the occupation or age of the patient would be equal to or greater than a 35% standard rating.

5% standard rating in an equal and opposite **extremity**: The patient had significant loss of vision from her childhood and was legally blind on her right eye from the high school time. She further claimed that she had significant industrial injury and reported her loss of vision on left eye that was opposite and corresponding injury to her pre-existing disability to the right eye. She claimed that her poor vision was significantly affected by her work at her last employer, due to intense work with the computer screens and a necessity to drive during the dark time of the day. Eventually, she was unable to drive and work with the computer screen that prevented her from properly performing her duty. In addition, she had fractured her left ankle in 1993 that affected her gate, and subsequently, while working at Dveal, she injured her right knee, thus her previous disability affected her leg, and the permanent disability resulting from the subsequent injury affected 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, was equal to 5%or more of total.

Pre-existing mental disability: The patient further claimed that she had a pre-existing disabling condition to her mental disability that caused her memory loss, significant cognitive diminishing ability, inability to concentrate, constant irritability, sadness, depression for many years of her life.

Conclusion: Since her last employment ended, the patient had attempted to return to work, searching for positions that she could perform but her pain, her inability to drive or walk **without** support, her inability to see clearly around her, irritability, constant need to go to the bathroom, inability to work with the computer screen were effectively disqualifying her from the labor market.

Based on the hereinabove, she believed that she qualifies for SIF benefits under Labor Code 4751 because:

1) Prior to her past employment she had pre-existing conditions that rendered her permanently partially disabled.
2) Her subsequent industrial injury was equal to or greater than a 35% standard rating before being adjusted for the occupation or age.
3) That industrial injury affected her left eye and its ratable disability was equal to or greater than a 5% standard rating and that the patient had pre-existing disability in an equal and opposite right eye.
4) The degree of disability caused by the combination of both disabilities was greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previousdisability or impairment was a permanent disability equal to 70% or more of total.

5) October 02, 2015, Ophthalmology Letter Regarding Work Limitations, Terre Jay Watson, OD, Kaiser Permanente: In this letter Dr. Watson indicated that the patient was under her care for vision same day. Due to concerns about best corrected visual acuity for each eye and limitations in peripheral vision, Dr. Watson had recommended that she self-restrict driving to daytime and street (rather than right or freeway).

6) June 21, 2017, Orthopedic Followup Evaluation, Jonathan Nissanoff, MD: DOI: CT: 12/30/04 – 04/16/16. Chief complaints: The patient complained of pain in her neck/low back, right shoulder/upper arm/hand/foot, wrist/thumb, and left ankle. HPI: She worked for Dveal Family and Youth Services as a Marriage and family counselor therapist. She worked there for approximately 12 years and claimed that she had sustained cumulative trauma injury during this period. She reported that she had pain from repetitive use of her arms, neck, and low back as well as due to the continuous sitting, standing, and walking. She had numbness in her right upper extremity with associated stiffness and swelling. Also, she reported having 9/10 pain and numbness in her fingers. Her pain was constant, worse with standing, walking, stooping, twisting, lifting, kneeling, and bending. She did have bladder and bowel dysfunction sometimes. She was currently not working secondary to pain. She has had surgery on her left ankle that she sustained from a nonindustrial accident. She was currently wearing a brace on the left ankle and she was feeling that her pain had got aggravated since the cumulative trauma injury. She also claimed that she had been traumatized from work by her boss who had threatened her and she would be like to have a psychiatric evaluation. Allergies: Penicillin. ROS: General: Fatigue, weight gain, arthritis. Heart: High BP. Psychological: Anxiety, depression. Neurologic: Numbness. Social history: Alcohol: Socially. Tobacco: Three cigarettes per day.

PE: Lumbar spine: Palpation: Noted positive tenderness and spasming in the lower lumbar region. ROM: Noted restricted ROM with pain. Cervical spine: Palpation: Tenderness to palpation was present. ROM: Noted restricted ROM with pain. Left knee: Palpation: Noted positive medial/lateral joint line tenderness. Left ankle/foot: Palpation: Noted positive medial/lateral joint line tenderness. Assessment: 1) Status post nonindustrial left ankle fracture. 2) Status post open reduction internal fixation, left ankle.

3) Aggravation of work-related injury for left ankle. 4) Left knee nonindustrial meniscectomy. 5) Rule out arthrosis, aggravated by work. 6) Low back pain. 7) Cervical pain. 8) Right shoulder pain. 9) Rotator cuff tendonitis. 10) Right elbow and wrist pain. Plan: The patient at this point was indicated for treatment including Naprosyn 550 mg, Prevacid, and PT (2/week for 3 weeks). Pain management consultation and x-rays of the ankle, knee, back, and neck were also recommended. She was indicated for a psychiatric evaluation as well. Work status: As of same day's date, she was TTD. Causation: Dr. Nissanoff opined that the causation was industrial.

7) October19, 2017, Deposition Summary: **Page 1-11**: Examination by Rudy R. Grob, Esq (Defense Attorney, Pearlman, Borska & Wax):This is a 75-page deposition transcript. The proceedings lasted for 2 hours. The Deponent spent approximately 45-60 minutes with her attorney regarding this deposition. She was driven here by her attorney. She testified that she had deposed before (approximately 30 years prior, exact date unknown) and she was the party to that case. She was born on June 20, 1949. Her full name was Floreen Sharon Rooks and Rooks was her maiden name. She was previously married and had used her husband's name, Sparks. She was unsure when she had used that name but possibly it was in 1988. She was married once again after her marriage with Mr. Sparks and went by the name Lespierre for one year when she worked at Cal Tech, possibly in 1999. She testified that currently, she is living in following address: 125 North Allen Avenue, Unit 321 in Pasadena. Her highest educational qualification was Master's Degree in Marriage and Family Child Therapy that she obtained from Pacific Oaks College in Pasadena (approximately between 2002 and 2003). Regarding her prior deposition, she testified that she was bringing a claim regarding a slip and fall injury occurred at 99 Cents Store (she slipped and fell on the wet floor).

Page 12-21: Regarding that injury, she further explained that she had injured her left leg (exact part unrecalled) and reported full recovery from that injury. Currently, her insurance provider was Medicare **(Part A and B)**. Her current personal medical physician was Dr. Ching (Kaiser in Pasadena, California; first name unrecalled) and she had been the Deponent's private physician for approximately 10 years. Regarding the employment with Dveal Family Youth Services, she testified that she had started working in December 2004 and had worked there until April 16, 2016. After that she hadn't been employed anywhere to date. Her job title at Dveal was Marriage and Family Child Therapist and she had worked at the following address for almost 12 years: 855 Orange Grove Boulevard, Pasadena [when she started her employment she was on Fair Oaks Avenue address (exact address unrecalled), then she was switched over to 855]. She also stated that when she last worked there in 2016, her annual salary was close to $70,000 (gross salary before taxes or other deductions). She added that at that time her Supervisor was Rafaela Velgado (she was not sure about the exact spelling; and this was her Supervisor for approximately four years). When started asking about this Supervisor, the Deponent testified, "This is terrible" Regarding her working hours she testified that, she had worked from Monday to Friday and 9:30 am to 6:00 pm (sometimes, she would stay later). She further testified that she was predominantly working in the intake department (screening department of potential

clients who would require mental health services). After the screening process, she would be assigned actual clients by her Supervisor. She added that when she last worked there in April of 2016, she did have approximately five to seven clients (per the best of her recollection). She also testified that as part of her job occasionally she would travel to client's homes or offices (for intake as well as to give therapy). In addition to that she testified about a 4 months concurrent employment that she had done simultaneously while working for the subject employer. She stated, "I worked at the University of Phoenix Teaching a Class." She took class about family therapy and intakes and work location was in Pasadena (year of employment unrecalled). Coming back to her employment with Dveal, she reported that she stopped working in April of 2016 because she was terminated.

Page 22-33: The Deponent further testified that prior to her employment with the subject employer she was not having any chronic pain in her neck, back, right shoulder/hand/foot, or left ankle. Regarding her claimed work related pains and injuries she testified, "I started having headaches. My shoulder started hurting. My arms and my, my fingers would get stiff (indicating) in both hands. I would get a lot stress in my back, my upper/mid/lower back. It's hard to bend down and I think that - - so those are my body parts. And then as far as my right foot, no my right foot but my right leg is concerned, like on the right side of my body, I just found out recently - - well, I know now that because of the strain that I have of my left side of my legs, it's causing more pain on my right side because that's where my weight, you know, that's what I know now." **When she was asked about the indication of right foot pan in the 06/21/17 report of Dr. Nissanoff, she clarified that the pain was actually in the left foot and due to weight bearing issues it was also shifted to right foot**. When she was asked about what problem did she had on the left side that caused her to shift weight onto her right, she replied, "I have nuts and bolts in my left ankle. My left ankle hurts and so, like I said, now I am finding out because I'm experiencing more stress because of that, I am having more stress on the right side of my body." She further explained that she had injured her left ankle/foot previously while working for the same employer. She added that it was happened approximately in 2006 and she broke her left toe in two places and ended up having a torn meniscus in her left knee after a work-related accident.

In addition to the physical problems to the aforementioned body parts, the Deponent also testified having psychological issues due to the mistreatment and harassment by the CEO of Dveal. She stated that because of that she had noticed developing post traumatic stress disorder symptoms. She testified, "I really feel like I suffered, because of what he did to me, like post traumatic stress disorder symptoms. I could not, now I am totally easily startled. I have nightmares every time, I think about this man. I had to leave my job for a couple of days before I came back to work. I don't know. I got scared, you know, and now it's - - like now I am, like I am afraid sometimes." The Deponent further explained about the vision problems that she suffered while working for Dveal. She indicated that her vision had changed tremendously since she had been working there. She attributed this to the prolonged computer work involved in her duties and she added that a couple of years prior she was feeling like she would not be able to do night driving anymore. She stated

that she had seen in Kaiser Permanente, Pasadena due to her eye problem. She believed that all of the above mentioned problems were work-related because she was not having any of those problems before joining Dveal.

Page 34-45: Regarding the mechanism of her 2006 left foot injury, the Deponent explained, "I was in the process of transporting clients to an event. And then my car was rolling, getting ready to roll into the street. So I had to jump in my car and pull up the brake more then, when I was doing that, I felt my left foot flipped over and my knee hit the ground." **She also testified that she did not sustain any other specific orthopedic injuries while working for the subject employer.** When she was asked about her physical duties and she indicated that the time spent in the office at a desk and her time outside of the office would vary on a week to week basis. She did use her personal vehicle to visit clients. Item lifted during the course of a day included books and files, which varied in sizes (but indicated that those were not heavy). Also, she was required to climb stairs (almost daily) at work since the two-story building she worked in did not have an elevator, although her office was on the ground level. She added that she would have to take files upstairs to different departments and would have to climb the stairs. At times, she would ask for help when she needed to take something upstairs. She testified that she would have to type notes and reports all the time. She basically typed every day. Also, regarding her back symptoms, she testified that she noticed it within the last couple of years. And in the same time period she had also noticed difficulty bending down. She confirmed that she did not recall any specific work accidents that she believed as triggered these symptoms. She stated that she was unable to even bath due to her inability to bend. Regarding her neck pain, she testified that it had started gradually through the last two years (approximately) and she believed that it would be due to the prolonged computer work that she had to do daily. She recalled that she had complained about her pain to her colleagues (approximately between 2014 to 2016). She added that she had noticed pain in her shoulders as well along with the neck pain and she agreed with the defense attorney's statement that 'all these pains had an insidious onset.'

Page no **46-57**: The Deponent stated that she had also noticed stiffness in her fingers and she was unable to move them (onset of exact time period unrecalled). She testified having these "locking up' symptoms over her right middle/index fingers and thumb (she was right handed). She reported that the similar symptom were present in her left hand fingers as well and had been going on for several years before she was terminated. In addition to that she testified having achy symptoms over her bilateral upper arms and stated, "It aches like hell." She added that as she indicated earlier, the onset of symptoms in her left foot came on first following the accident in 2006. Regarding her right foot symptoms she was not able to indicate when exactly she began having pain in that area. She could not pinpoint actually what she was feeling in her right foot and where it was hurting exactly. She was feeling like "off balance" on the right side and was having difficulty walking/standing and performing ADLs. She testified, "I used to walk like dancing. It's hard for me to even walk down the street, like one block. It's just hard to do things, like. I mean, like before." She also reported having weakness in her right leg. When she asked whether the right leg

pain was the radiating pain from her back, she replied that she was actually unclear about the etiology of the onset of right leg pain. Furthermore, the Deponent recalled that other than the left knee surgery in 2006, she had undergone left ankle surgery as well (long years prior, before joining Dveal). She added that even after the surgery her left ankle had bothered her and had experienced difficulty walking with associated symptom of swelling.

Page no 58-68: The Deponent testified that occasionally, she was walking with a cane due to her balance issues. She added that she started using the cane after the 2006 accident. Going back to her left knee surgery, she reported that it was done probably by a Workers' Compensation doctor (exact provider/facility name unrecalled; however, she testified, "I think it was Monterey Park, Monterey or Montebello or someplace like that, Monterey, something like that." She was asked, between 2004 and April 2016 (when she was still employed by Dveal) whether she went to a doctor for treatment for her back/neck/shoulders, she responded, "All I could say about that is like when I would visit my doctor, sometimes I would complain about 'stress'. Okay? And that's all I can say about that." However, it was noted that when she was referring to 'stress', she was referring the condition of her body and stated that "it was all related" and that was how she felt about it. She indicated that the 'stress' would accumulate in her neck, shoulder and back. Actually, she was pointing out her symptoms in those particular body parts as 'stress.' She confirmed that she referred to 'stress' as both emotional and physical. She stated, "And the emotional part comes, the way I see it, is because of the physical 'stress', because now you are emotional about it; that's just how I see it." Also, when she was asked "Did you ever see a doctor while employed by Dveal complaining of problems with the right side of your body?" She replied, "No." She further explained that as noted earlier she had reported her back complaints in terms of 'stress' to her regular physician but the physician whom she had initially reported 'back pain' was Dr. Nissanoff. She did report her back pain to this provider without highlighting a particular side of her body. When she was asked about the treatment she received for her stiffness and locking of fingers (while employed for the Dveal) she responded, "No. I was just told that, you just need to drink more water" (she could not recall who had given that advice). In addition, she reported that she had received Workers' Compensation settlement for her 2006 injury.

Page no 69-75: She was asked, before she was fired from Dveal whether she had ever notified her employer of her physical complaints related to her job, including back, neck, eyes, shoulders, hands, fingers, and feet; she replied 'yes.' **She reported it to be a verbal notification to her Supervisor, Rafaela Velgado.** The Deponent had complained about her vision and showed the management a letter from her eye doctor and indicated that she had complained out loud (she had notified this months before her termination). The doctor had given the restrictions of "no night driving and no driving at freeways."

Examination by Natalia Foley, Esq (Deponent's attorney): Earlier, the Deponent was questioned at which point she started experiencing painful symptoms and she had mentioned "couple of years" and now she clarified that, with this response she was not indicating the time from when she left her job but was **the time period during her**

employment, she testified "during the course - - like over the years." She further confirmed that she had complained about her pain to her coworkers, indicating the back pain, and not being able to walk up the steps. She added that it was approximately within a five year range that she had been verbally complaining to coworkers about her pain.

8) February 28, 2018, Comprehensive Orthopedic PQME Report, Gregory T. Heinen, MD: DOI:CT: 12/30/04 - 04/16/16. Job description: The patient was working for Dveal Corporation as a Marriage and family therapist. She had worked for 12 years and the physical demands of her job duties included walking, standing, driving to clients, repetitive hand motions, significant typing, and climbing. She stopped employment in April 2016. She had worked in the intake department over the last couple of years that included working on a computer 2-3 hours/day. HPI: She stated that she had sustained a cumulative trauma injury from her 12 years of employment. She was unable to recall specific date when she first noticed symptoms. She claimed that she developed pain from repetitive use of her upper extremities and lower extremities. She drove significantly to clients homes going in and out of the cars [(on average <5 times per week) (intake department) over the last 3 years…prior to this approximately 6-7 times per day)]. She estimated 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 to clients home (1-2 short flights of steps per day). She would have to type intake reports everyday (2-3 hours/day). She stated that she also developed psyche issues (awaiting psyche evaluation and was looking forward to this). She stated that she had also seen a doctor for her eyes. She did not remember when she started developing these symptoms. She had never sought care for any of these issues prior to Dr. Nissanoff. She reported that she would change her daily practice and did not like driving freeway as eyesight changed. She was getting nervous about this and joined carpools. She added that she had suffered harassment from the CEO of her company. She stated that he got into her face and pushed a phone to her face. She was unable to work for the next two days. She was paranoid at this time if anyone got close to her.

The patient's attorney sent her to see Dr. Nissanoff in June 2017. She has had ongoing care with this doctor once a month. She also had ongoing care with Dr. Javid Ghandehari for medication refills (this was also sent by her attorney). She was seeing this provider once a month for refill for Ibuprofen and Gabapentin. Requests were sent for x-rays, PT, TENS units, and psychiatrist referral but had not been approved. She has not had any care up to this point. Chief complaints: 1) For neck, she had on and off pain with radiation down her back. She added that she had to turn her neck slowly. 2) For back, she stated that the pain was debilitating and she was unable to move when back gets stuck. She could have this shoot down her back and occasionally, she was unable to walk due to increased pain. 3) For bilateral shoulders, she had constant aching to the top of her shoulders, which was radiating down to her elbows. 4) For bilateral hands, she had pain with stiffness and locking. She was unable to move them due to the stiffness. 5) For bilateral knees, she had stiffness and constant ache. She was unable to walk at times. This was more frequent and was feeling instability in both knees. She reported that her balance was an issue. PSH: Eye surgery at 20 years, left ankle, left knee meniscectomy. Current medications:

Ibuprofen 800 mg, Gabapentin 100 mg. ROS: Eyes: Early cataracts. Psychiatric: Trauma related anxiousness.

Review of records: Dr. Heinen reviewed the patient's medical/nonmedical records dated from 12/13/06 to 11/01/17.

Dr. Heinen's ROR included following medical records that were not provided for Dr. Gofnung's review:

a) **December 13, 2006, Progress Note, Kelly Ching, MD, Kaiser Permanente: Subjective complaints: The patient presented with nausea and vomiting 2 x days, aches, chills, neck pain, diarrhea and cramping. Assessments: Essential hypertension; obesity; smoker; gastroenteritis.**

b) **August 09, 2007, Progress Note, Dreamweaver Medical Group, *unidentified provider/illegible handwriting*: DOI: 08/09/07. HPI: Handwritten notes indicated that the patient had sustained work injury on this date after a slip and fall onto her left hip from ground level. She had injured her left hip, left knee and left ankle (reported worst pain in the ankle). There was pain in the right shoulder as well. Assessments: Left hip, knee and ankle pain. Plan: Prescribed Naprosyn; x-rays were ordered. Work status: Off work.**

c) **August 09, 2007, Doctor's First Report of Occupational Injury or Illness, Dan Le, DO: HPI: The patient slipped on a piece of cucumber and fell onto concrete ground. She fell onto her left hip from ground level. She complained of pain in the left hip, left knee and left ankle. There was increased pain in the left ankle. Diagnoses: Left hip, knee and ankle pain. Treatment rendered: Naprosyn 500 mg for pain, and ice packs. Followup: Three days. Work status: Modified work.**

d) **August 09, 2007, Initial Orthopedic Consultation Report, Kenneth Jung, MD: HPI: Remained unchanged. Prior injury history: The patient recalled sustaining a nonindustrial left ankle injury 14 years prior. She reported that she broke her left ankle when she fell down from stairs. She had undergone surgery (open reduction/internal fixation) to her left ankle. Impression: 1) Left ankle post-traumatic arthritis, status post open reduction/internal fixation ankle fracture. 2) Industrial injury secondary to fall. 3) Ankle pain after industrial fall. Plan: No acute injuries after recent fall. Likely exacerbation of pre-existing condition, post-traumatic arthritis. A lace-up ankle brace was recommended.**

e) **August 10, 2007, X-Ray of Left Ankle, Richard Chao, MD: Impression: 1) Old post-traumatic changes of the malleoli status post prior open reduction/ internal fixation. 2) Secondary deformity and secondary osteoarthritic changes at the distal tibia and talus.**

f) **August 10, 2007, X-Ray of Left Knee, Richard Chao, MD: Impression: 1) Generalized demineralization. 2) Suspect small loose body within the central joint. 3) No acute fracture or subluxation demonstrated.**

g) **August 10, 2007, X-Ray of Anteroposterior Pelvis and Lateral Left Hip, Richard Chao, MD: Impression: 1) No acute fracture or hip dislocation demonstrated. Joint spaces appeared preserved. No pelvic fracture identified.**

h) **August 14, 2007, Progress Note, *unidentified provider/illegible handwriting*, Dreamweaver Medical Group: Interim history: The patient was feeling moderately better; however, there was continued left ankle swelling. Assessments: 1) Left ankle sprain. 2) Left knee (*illegible handwriting*). 3) Left hip pain. Plan: 1) Prescribed Ultram; 2) Referred for PT. 3) MRI of the *left knee was ordered (body part is not indicated in report)*.Work status/Restrictions: She was given work restrictions in relation to the left ankle sprain and left knee pain, as well as left hip pain*(not indicated in report what those restrictions were)*.**

i) **August 27, 2007, Progress Note, *unidentified provider/illegible handwriting*, Dreamweaver Medical Group: Interim history: *Handwritten notes were somewhat illegible*. The patient was seen for followup of her left knee, ankle and hip symptoms. She continued to have pain and swelling in her left knee. Assessments: Left knee sprain with swelling. Plan: 1) MRI of left knee to rule out meniscal tear. 2) PT. Work status: TTD until 09/04/07.**

j) **September 04, 2007, Medical Record Review, Kenneth Jung, MD: Medical records were reviewed in relation to the 08/09/07 industrial injury.**

k) **September 10, 2007, Comprehensive Orthopedic Evaluation, Kerlan Jobe Orthopedic Clinic, Ralph Gambardella, MD: Reason for visit: The patient had sustained a work-related injury to her left knee on 08/09/07, and was still having persistent left knee discomfort and swelling. HPI: Remained unchanged. Occupational history: She was employed by Dveal. PE: There was diffuse tenderness to palpation over the medial side of the left knee. Impression: 1) Synovitis of the left knee with underlying early degenerative osteoarthritis of the left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees. 2) Pes bursitis, left knee. Recommendations/Discussion: The patient had evidence of underlying pre-existing early degenerative osteoarthritis of the left knee and further sustained a work-related injury that resulted in a flare-up of her arthritis. She denied having symptoms prior to the work injury. Pre-existing disease was present on x-rays. Diagnostic testing was not recommended. Physical therapy was advised. Prescribed Voltaren. Work restrictions: The patient was restricted to sedentary work.**

l) **November 12, 2007, ED Provider Notes, Kaiser Permanente, Kristen Duyck, MD: DOI: 11/10/07. HPI: The patient reported that she was experiencing right foot and left ankle pain since 11/10/07 when she tried to prevent a car from rolling into street and tried to jump in the driver's seat at which time she twisted the ankle and turned foot under. Subjective complaints: She complained of moderate right foot pain and swelling, which was constant and aggravated by walking. PE: BP: 175/107. Diagnostic studies: X-rays of left ankle/right foot were performed and reviewed. Assessment: Right foot fracture. Plan: Followup with orthopedics. Keep moonboot on as recommended. She was taken to ortho cast room. She was transferred from ED in stable condition.**

m) November 12, 2007, X-Ray of Right Foot, Matthew Tan, MD, Kaiser Permanente: Impression: 1) Fracture at the right fourth and fifth metatarsal bone. 2) Spiral fracture.3) No significant displacement. 4) Moderate soft tissue swelling of right foot.

n) November 12, 2007, X-Ray of Left Ankle, Matthew Tan, MD, Kaiser Permanente: Impression: 1) No osseous fracture. 2) Status post open reduction/internal fixation of the left distal fibula and the tibia. 3) Severe degenerative joint disease of the left ankle.

o) November 12, 2007, Orthopedic Consultation, Jennifer Graham, MD, Kaiser Permanente: Subjective complaints: The patient presented with ankle injury (date of injury was 11/10/07). She complained of right foot pain (9/10).There was left ankle pain as well. PE: There was minimal tenderness over the left ankle anterior talofibular ligament. Assessment: Right foot fourth/ fifth fracture - metatarsal neck and bilateral ankle sprain. Plan: Postop shoe applied. Weightbearing as tolerated. Followup: 1 week.

p) November 16, 2007, X-Ray of Right Foot, Matthew Tan, MD, Kaiser Permanente: Impression: 1) Fracture of the right fourth and fifth metatarsal bone. 2) Spiral fracture.3) No significant displacement. 4) Moderate soft tissue swelling.

q) November 16, 2007, X-Ray of Left Ankle, Matthew Tan, MD, Kaiser Permanente: Impression: 1) No osseous fracture. 2) Status post open reduction/ internal fixation of the left distal fibula and the tibia. 3) Severe degenerative joint disease at the left ankle. Severe joint space narrowing at the tibiotalar joint.

r) November 20, 2007, Doctor's First Report of Occupational Injury or Illness, Michael Hadley, MD: DOI: 11/10/07. HPI: Remained unchanged. Diagnoses: 1) Contusion, left knee. 2) Fracture, right foot. 3) Sprain, left knee. Treatment rendered: 1) X-rays of right foot and left ankle/knee were performed. 2) Walker boot/cam walker dispensed. 3) Dispensed Motrin 800 mg and extra strength Tylenol. 4) Referred to orthopedic surgeon. Work status: Placed on modified duty. *Restrictions: None indicated.*

s) November 20, 2007, X-Ray of the Right Foot, Michael Vo, MD: Impression: 1) Fractures of the fourth and fifth metatarsals. 2) Abnormal report. Preliminary report sent to Dr. Hadley on 11/21/07.

t) November 20, 2007, X-Ray Left Ankle, Michael Vo, MD: Impression: Postoperative findings in the distal tibia and fibula. There is significant degenerative narrowing of the ankle mortise.

u) November 20, 2007, X-Ray of Left Knee, Michael Vo, MD: Impression: 1) Mild osteoarthritis in the left knee.

v) November 26, 2007, Permanent and Stationary Report, Ralph Gambardella, MD:DOI: 08/09/07. HPI: Remained unchanged. Interim history: The patient no longer had any type of significant discomfort in the left knee; however, there were

some aches and minimal irritability. She felt that her left knee had improved enough to return back to regular work. In interim, she sustained a new work injury to the right lower extremity that resulted in a fracture to the right foot. She was ambulating with the assistance of a cane and moon boot. She was being seen separately for this right lower extremity injury. She agreed that in the absence of her right foot condition, she would be able to return to back to regular work relative to her left knee. Diagnostic studies: Reviewed the x-ray of left knee *dated 11/20/07*. Impression: Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral malalignment, left knee; status post post-traumatic synovitis and pes bursitis, left knee. Disability status: The patient was permanent and stationary for the left knee. Causation: Dr. Gambardella opined that the causation was industrial. Apportionment: There was no apportionment indicated as there was no residual disability. There was definite evidence of pre-existing osteoarthritis. Impairment rating: 7% lower extremity impairment for 1 mm joint space narrowing of the knee. Additional 10% lower extremity impairment added for patellofemoral joint. There was a total of 17% lower extremity impairment, which converted to 7% Whole Person Impairment for the left knee. Permanent work restrictions: None indicated for the left knee. She was released to regular work activities effective 11/26/17. Future medical care: Antiinflammatory medication, PT and/or cortisone injection and/or arthroscopic surgical intervention.

w) **November 29, 2007, Orthopedic Consultation Report, Tomas Saucedo, MD:DOI: 11/10/07. HPI: Remained unchanged. Interim history: The patient was seen at Kaiser and was treated with a cane walker with significant improvement in the right foot. She continued to have left ankle pain and to a lesser extent to left knee. She had been off work. Impression: 1) Right foot fourth and fifth metatarsal fractures. 2) Left ankle post-traumatic degenerative osteoarthritis. 3) Left knee sprain. Discussion: Continue with use of cam walker for the right foot. Continue off work. Continue use of Motrin. X-rays requested to assess healing of the right foot.**

x) **December 20, 2007, Orthopedic Supplemental Report (PR-2), Tomas Saucedo, MD: Interim history: The patient was using cam walker for right foot fractures, with steady improvement in pain. Still there were complaints of pain and discomfort in the left knee and left ankle but reported improvement since the last visit. Impression: 1) Healing right fourth and fifth metatarsal fractures. 2) Left knee sprain.2) Left ankle sprain. Discussion: The patient to continue off work. Encouraged to continue with use of cam walker. A knee immobilizer was to be provided. Weightbearing as tolerated with assistive devices.**

y) **December 20, 2007, X-Ray of the Right Foot, Michael Vo, MD: Impression: Healing fractures of the fourth and fifth metatarsals.**

z) **January 17, 2008, Orthopedic Supplemental Report (PR-2), Tomas Saucedo, MD: Interim history: The patient's right foot pain was steadily improving. Also, she continued to complain of pain in the left knee with swelling and effusion. She complained of left ankle soreness as well. She was continuing off work. Impression: 1) Healing right fourth and fifth metatarsal fractures. 2) Left knee internal derangement. 3) Left ankle sprain. Discussion: Right foot fracture appeared to be**

healing well. Continue conservative measures/use of cam walker and off work. An MRI of the left knee was requested. For the left ankle, the patient was to continue aggressive exercises, and use of Tylenol.

aa) **January 17, 2008, X-ray of the Right Foot, Michael Vo, MD: Impression: 1) No significant interval change. 2) Continued healing of fracture involving fourth and fifth metatarsals.**

bb) **January 28, 2008, DEXA Scan, Kaiser Permanente, Hao Sun, MD: Impression: T-score 0.9.**

cc) **January 28, 2008, Bilateral Screening Mammogram, Christian Yi, MD, Kaiser Permanente: Impression: Normal study.**

dd) **February 21, 2008, Orthopedic Supplemental Report (PR-2), Tomas Saucedo, MD: Interim history: The patient had sustained a right foot fracture of the fourth and fifth metatarsals. She had also sustained a left ankle sprain and left knee injury. Left knee pain had progressively worsened and appeared to be the result of favoring the right lower extremity and putting all of her weight on the contralateral extremity, and that pain had steadily become worse as a result of the initial injury, as well as the underlying degenerative osteoarthritic changes from which the patient already suffered. Impression: 1) Healing right fourth and fifth metatarsal fractures.2) Left knee internal derangement. Discussion: The patient developed increased pain in the left knee as a result of favoring the right lower extremity. Now this pain was more painful even though she had injured her left knee previously. An MRI of the left knee was recommended. The right foot appeared to be healing well; noted continued healing of fractures involving the fourth and fifth metatarsals.**

ee) **March 19, 2008, MRI of the Left Knee, Anthony Bledin, MD: Findings: Minimal osteoarthritic changes in the knee joint predominantly involving the medial compartment. Fraying and irregularity of the apex of the posterior horn of the medial meniscus. Tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appeared normal and the lateral meniscus demonstrated no significant abnormality. Knee joint effusion was present with fluid in the suprapatellar bursa with the volume of the effusion less than 5 cc. No significant popliteal cyst. Impression: 1) Tear, posterior horn, medial meniscus (grade III). 2) Early osteoarthritic changes of the medial compartment of the knee joint. 3) Knee joint effusion.**

ff) **March 20, 2008, Orthopedic Re-Examination Report, Tomas Saucedo, MD: Interim history: The patient had no pain or discomfort in the right foot. She had no significant pain in the left ankle. She complained of left knee pain. Previous day's MRI of the left knee revealed a tear of the posterior aspect of the medial meniscus and evidence of mild early osteoarthritic degenerative changes. Impression: 1) Left knee internal derangement with evidence of medial meniscus tear. 2) Right fourth and fifth metatarsal fracture, healed. 3) Left ankle sprain. Plan: Remain off work due to persistent left knee pain. Requested authorization for left knee surgery.**

gg) March 20, 2008, X-Ray of Right Foot, Health Care Partners, Michael Vo, MD: Impression: Continued healing of fourth and fifth metatarsal fractures.

hh) April 17, 2008, Orthopedic Supplemental Report (PR-2), Tomas Saucedo, MD: Interim history: The patient was treated for a right foot fracture, which had completely healed and was currently asymptomatic. However, she continued to have left knee pain. She had minimal soreness of the left ankle as well. Left ankle pain was increasing with prolonged periods of standing. Impression: 1) Healed right foot fourth and fifth metatarsal fracture. 2) Left knee internal derangement with evidence of medial meniscus tear. 3) Left ankle postop degenerative osteoarthritic changes with limited range of motion. Discussion: Left knee surgery was scheduled for 04/24/08. The right foot would continue to be treated conservatively. She was to remain off work.

ii) April 24, 2008, Operative Report, Plaza Surgical Center, Tomas Saucedo, MD: Preoperative diagnosis: Left knee internal derangement. Postoperative diagnoses: 1) Evidence of left knee complex 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) Left knee diagnostic and surgical arthroscopy. 2) Left knee partial medial and partial lateral meniscectomy. 3) Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral, and tibial plateau cartilage.

jj) June 06, 2008, Orthopedic Supplemental Report (PR-2), Tomas Saucedo, MD: Interim history: The patient's left knee pain had significantly improved following arthroscopic surgery. She was six weeks status post-surgery to the left knee. She reported that the postop PT was beneficial. Impression: Status post left knee arthroscopy. Discussion: Continue PT and aggressive home exercise program. Continue Vicodin/off work as well.

kk) June 18, 2008, July 16, 2008, Physical Therapy Progress Reports, *unidentified provider/illegible handwriting*, Associated Sport Therapy: *Handwritten notes are mostly illegible.* The patient attended PT sessions on 06/18/08 and 07/16/08. Knee pain was rated at 2-3/10 as of 7/16/08.

ll) July 30, 2008, Progress Notes, Kelly Ching, MD, Kaiser Permanente: The patient was seen for blood pressure. *She was only eating once per day.* Complained of hot flashes x 15 years. *No other information was found reviewed from this report.*

mm) August 28, 2008, Orthopedic Supplemental Report Signature *unidentified provider/illegible handwriting:* Subjective complaints: *Handwritten notes were mostly illegible.* There was severe electrical type pain over the left lower extremity. No low back pain. Plan: Continue Motrin/strengthening exercises.

nn) September 05, 2008, Orthopedic Supplemental Report, Tomas Saucedo, MD: Interim history: The patient underwent left knee arthroscopy surgery on 04/24/08 and was placed on aggressive physical therapy, as well as a home exercise program. She

indicated that her pain had improved significantly. She complained of associated pain in the lower back and some radiculopathy of the left lower extremity. Impression: 1) Status post left knee arthroscopy. 2) Lumbosacral spine strain. 3) Left lower extremity radiculopathy. Discussion: Advised to continue strengthening program for the left lower extremity and Ibuprofen for pain. Work restrictions: The patient was given work restrictions of no prolonged standing and walking, no squatting, climbing or pivoting activities. Followup: Four weeks.

A handwritten orthopedic supplemental report from the same date was noted and was illegible.

oo) **October 10, 2008, Orthopedic Supplemental Report, *unidentified provider/Illegible handwriting*: *Handwritten notes were mostly illegible.* Plan: Modified work. Home exercise program. Further treatment was indicated.**

pp) **November07, 2008, Orthopedic Supplemental Report, *unidentified provider/Illegible handwriting*: *Handwritten notes were somewhat illegible.* Chief complaint: The patient complained of left knee pain. Plan: Prescribed Motrin 800 mg, Vicodin, and Prilosec. Home exercise program. Modified work.**

qq) **December 05, 2008, Orthopedic Permanent and Stationary Report, Tomas Saucedo, MD: DOI: 11/10/07. Interim history: The patient was under the care of this physician for the left knee. She underwent left knee surgery on 4/24/07. Her pain had improved but was not completely resolved. She had some continued mild discomfort in the left knee. Physical examination was performed. Impression: 1) Status post left knee arthroscopy with partial meniscectomy. 2) Status post left knee abrasive chondroplasty. Discussion: The patient was permanent and stationary. Subjective factors of disability: Intermittent minimal discomfort in the left knee (not exceeding that level). Objective factors of disability: Partial meniscectomy and abrasive chondroplasty with favorable response. Impairment rating: 1% WPI for based on the partial meniscectomy. Work status: Usual and customary job duties with no restrictions. Future medical care: Physician care, medications, PT and coverage should an aggravation or recurrence of the same similar symptoms as a result of the initial injury.**

rr) **January 23, 2009, Orthopedic Supplemental Report, Tomas Saucedo, MD: Discussion: Regarding the left knee, Dr. Saucedo had declared the patient as permanent and stationary as of 12/05/08. Previously, regarding her 08/09/07 injury she was seen by Dr. Gambardella and a permanent and stationary report was generated on 11/26/07. Dr. Gambardella had awarded her 7% lower extremity impairment for the pain based on joint space narrowing of the left knee and 10% lower extremity impairment as a result of the patellofemoral joint space narrowing, and that sums up to a total of 17% left lower extremity impairment, which was equivalent toa7% whole person impairment. It appeared that the patient did in fact have a preexisting underlying degenerative osteoarthritis of the left knee with previous pain that had improved or resolved at the time she had a recurrence of the same problem. Dr. Saucedo apportioned this to at least 50% to the present industrial**

injury of 11/10/07 and would be apportioned to her prior injury of the left knee as noted by Dr. Gambardella.

ss) March 06, 2009, Progress Notes, Kelly Ching, MD, Kaiser Permanente: Subjective complaints: The patient was seen for help with smoking cessation. She was requesting for Zyban. She had been disabled due to left knee surgery; residual left lower extremity swelling was present. Plan: Prescribed Bupropion, Ibuprofen and Lisinopril.

tt) May 01, 2009, Bilateral Screening Mammogram, Morley Slote, MD, Kaiser Permanente: Impression: Negative study.

uu) September 04, 2009, Orthopedic Re-Examination Report, Tomas Saucedo, MD:DOI: 11/10/07. Interim history: At this time, the patient presented reporting an aggravation of her left knee symptoms due to a recent incident. She explained that in the past week, she was getting out a friend's car and had twisted her left knee, which caused pain and discomfort. She was concerned about possible reinjury to the left knee and was seen for evaluation. Diagnostic studies: X-ray of the left knee (same dated) revealed evidence of mild medial joint space narrowing. Impression: 1) Left knee re-injury. 2) Left knee evidence of mild degenerative osteoarthritis. Discussion: Prescribed Motrin for pain and inflammation. It appeared this injury was nothing more than a strain to the left knee. She was to continue working.

vv) October 22, 2009, Eye Examination Report, Anna Montenegro, *unidentified credential*, Kaiser Permanente: Reason for visit: The patient was seen for routine eye examination. She had a history of strabismus.

ww) October 22, 2009, Stipulation with Request for Award, *unidentified signing person*: This was in relation to the date of injury of 8/09/07. Body parts involved were the left knee and left ankle. The injury caused temporary disability for the period 8/22/07 through 9/16/07. The injury caused permanent disability of 6% payable in the sum of $4140. This stipulation was based on the permanent and stationary report of Dr. Gambardella, dated 11/26/07.

xx) October 22, 2009, Stipulation with Request for Award, *unidentified signing person*. This was in relation to the date of injury of 11/10/07 (case no. ADJ7024643). The injury caused permanent disability of 1% for which indemnity was payable at $230/week beginning 09/15/08 in the sum of $690, less credit for such payments previously made. An *informal* rating had not been issued in this case. There was a need for medical treatment. This stipulation was based on the permanent and stationary report of Dr. Saucedo, dated 12/05/08 and supplemental report dated 01/23/09.

yy) November 09, 2009, Progress Note, Khine Win, MD, Kaiser Permanente: Subjective complaints: The patient presented with chest pain that began same day, as well as upper and lower back pain xl month. Upper and lower back pain was aggravating with work. Also, there was worsening neck muscle pain ongoing for past few months. In addition, she reported stress at work. *Other complaints: Ankle and knee pain*. ROS:

Myalgias, joint pain. Assessments: Myofascial pain syndrome; counseling on smoking cessation; chest wall pain; muscle spasm. Plan: Discussed fibromyalgia and vitamin deficiency; trial Robaxin; suggested use of Icy hot. Followup: With PCP in one week.

zz) August 30, 2010, Progress Note, Sabrina Villalba, MD, Kaiser Permanente: Reason for visit: The patient presented for annual physical and blood pressure check. Relevant history: She was not taking BP medications and did not like taking medications. ROS: Occasional left ankle pain. PE: Blood pressure this visit was 166/91; weight 217 pounds. Assessments: Counseling on smoking cessation; essential hypertension. Plan: Labs were ordered. Prescribed Lisinopril.

aaa) January 06, 2011, Order Suspending Action, *unidentified signing person*: Case no: ADJ7024643, ADJ7024645:Action suspended due to the stipulation not adequately addressing the two injuries, in particular apportionment claimed between the two events, in particular the left ankle and right foot. Dr. Saucedo did not perform an examination or report for all the parts of the body and issue adequate support to the proposed stipulated awards or be rated by the DEU*(Disability Evaluation Unit)*. Abdominal pain was unsupported by the medical record.

bbb) March 17, 2011, Orthopedic Agreed Panel QME Evaluation, Thomas W. Fell, Jr., MD: DOI: 08/09/07; 11/10/07. HPI (of both injuries): Remained unchanged. Interim history: The patient had returned to Dr. Saucedo a couple months prior due to left knee pain and inability to use the clutch in her car. She was provided with a cortisone injection to the knee, which was of significant benefit. She subsequently developed a burn to the skin from the topical applied to freeze the knee prior to receiving injection. She was told by Dr. Saucedo that she had bone-on-bone laterally and would need a total knee replacement in the future. She denied left knee symptoms prior the injury of August 2007. Present complaints: 1) Right foot was asymptomatic. 2) Left knee and left ankle symptoms had 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. There was diffuse peripatellar pain in the left knee. Also, there was associated stiffness in the left knee. PMH: Heart murmur/history of hypertension. Medications: Lisinopril, Hydrochlorothiazide, Ibuprofen, Vicodin. Diagnoses: 1) Sprain/strain of the left knee aggravating degenerative arthritis of the left knee. Status post arthroscopic partial lateral and medial meniscectomies. 2) Sprain of the left ankle temporarily aggravating significant preexisting arthritis of the left ankle. 3) Fracture of the right foot, fourth and fifth metatarsals, healed.

Discussion: Dr. Fell indicated that the patient had done well in regard to her left knee with preexisting arthritis until she suffered the injury in August 2007 and again in November 2007. She had left ankle pain prior to the two work incidents due to the injury to the left ankle in the mid-90s that required open reduction/internal fixation. She had a temporary increase in left ankle pain due to the work incidents. It was expected that the majority of her symptoms were now residuals of her arthritis given the fact that she had significant limitation of motion of the ankle as an ankle sprain would not cause the type of limitation she had but instead would cause excessive

motion. The slightest motion of the ankle caused pain with all of the pain coming from the ankle joint. She agreed that the arthritis of the knee was what was really aggravated by the work incidents and the left knee "really wasn't hurting her" and the left ankle had always caused her problems since the prior ankle surgery. The previous right foot fractures of 11/10/07 had healed completely without residuals. It was stated that the patient had a flare-up of symptoms that precipitated a lot of her symptoms. An injection calmed the knee down but it remained symptomatic. Dr. Fell indicated, "Fortunately, individuals with valgus knees, that is, arthritis in the lateral aspect of the knee can tolerate a lot of arthritis without need for total knee replacement." Disability status: The patient had reached MMI status. Impairment rating: The left ankle was rated based on the Arthritis Table 17-31 with 30% lower extremity impairment due to 0 mm of joint space. A total of 30% lower extremity impairment was indicated for the left based on the Table 17-31 and 17-33 *(incomplete report/missing pages).*

ccc) May 14, 2011, Eye Exam Report, Kris Lum, OD, Kaiser Permanente: Interim history: The patient was seen for a routine eye examination. She did not fill prescription from last visit. Assessments: 1) Presbyopia. 2) Strabismic amblyopia, right eye. 3) Anisometropia. 4) Cataracts, left eye.

ddd) August 11, 2011, Progress Note, Kelly Ching, MD, Kaiser Permanente: Visit summary: The patient presented for routine Pap smear. She was status post fall after tripping on pavement two days prior and was complaining of pain in her knees. She had scraped over bilateral anterior knees. Plan: Mammogram and routine lab tests were ordered. Recommended rest, ice and nonsteroidal antiinflammatories for soft tissue trauma due to fall. Continue Lisinopril and Ibuprofen.

eee) October 19, 2011, Progress Note, Kelly Ching, MD, Kaiser Permanente: Subjective complaints: The patient presented with left hand and forearm constant tingling x 2 weeks involving all fingers. She was right-hand dominant. She admitted to leaning and sleeping on hands all the time. Assessments: Paresthesias; osteoarthritis; essential hypertension; obesity; smoker; menopausal symptoms. Plan: Routine vaccinations given. Rx ibuprofen 800 mg and Lisinopril.

fff) March 05, 2012, Compromise & Release: Case no: ADJ7024643; ADJ7024645. The parties agreed to settle the above claims on account of the injuries by the payment sum of $62,000 with $16,435.14 deducted from the settlement amount for permanent disability advances through 02/28/12 and continuing, leaving a balance of $45, 564.86.

ggg) September 27, 2013, Eye Examination Report, Terre Watson, OD, Kaiser Permanente: Interim history: The patient was seen for routine eye exam. Felt like right eye strabismus was increased.

hhh) December 16, 2013, Call Documentation, On Call Nurse, RN, Kaiser Permanente: Call summary: The patient called regarding left arm tingling and back pain. Tingling in left arm from the wrist up more than one month. Back pain was located on the left side. Plan: Referred to appointment center.

iii) **December 17, 2013, Progress Note, Kaiser Permanente, Kelly Ching, MD: Subjective complaints: The patient complained of constant left upper extremity tingling including all fingers x 1 month. Possibly related to how she slept. Assessment: Left arm paresthesia. Plan: Routine labs were ordered. Consider steroids if paresthesia persisted. Restart blood pressure medication.**

jjj) **October /29, 2014, Call Documentation - Message to Dr. Watson, Kaiser Permanente: Call summary: The patient stated that she needed urgent appointment. She reported having problems with lenses and a new vision exam was needed.**

kkk) **November 11, 2014, Eye Examination Report, Terre Watson, OD, Kaiser Permanente: Interim history: The patient was seen for routine eye examination. Constantly had to remove glasses to see. Plan: New prescription given. Right exotropia and amblyopia (longstanding) and dilation discussed.**

lll) **December 31, 2014, Call Documentation, Elaine Ravare, LVN, Kaiser Permanente: Call summary: The patient called regarding work note for days missed from work, 12/29/14 and 12/30/14. She missed work due to cold symptoms. Appointment given.**

mmm) **December 31, 2014, Progress Note, Jamie McKinney, MD, Kaiser Permanente: Visit summary: The patient presented for work note for days missed from work, 12/29/14 and 12/30/14. She missed work as she was having chills/rhinorrhea x 4 days. She was not taking BP medications.**

nnn) **January 09, 2015, Progress Note, Paul Reehal, MD, Kaiser Permanente: Subjective complaints: The patient presented with cough and upper respiratory infection symptoms x 1 week. Her BP noted to be low after starting new medication. Assessments: Cough; upper respiratory infection. Plan: Prescribed Cheratussin AC; saline nasal spray.**

ooo) **January 09, 2015, X-Ray of Chest, Fernando Torres, MD, Kaiser Permanente: Negative chest x-ray.**

ppp) **October 02, 2015, Eye Exam Report, Terre Watson, OD, Kaiser Permanente: Reason for visit: Patient seen for routine eye exam.** ***No other information was found reviewed from this report.***

qqq) **March 01, 2016, Progress Note, Daniel Lin, DO, Kaiser Permanente: Reason for visit: The patient presented with cough x 4 days and worsening upper respiratory infection symptoms. PE: BP 134/72.***No other information was found reviewed from this report.*

rrr) **March 08, 2016, Progress Note, Sandra Montes, MD, Kaiser Permanente: Interim history: The patient presented with cough x2 weeks. She also complained of myalgias and headache. Plan: Medications prescribed.**

sss) April 26, 2016, Mammogram/Amendment, Paul Didomencio, MD, Kaiser Permanente: Findings: Additional imaging needed. Cluster of coarse heterogeneous calcifications in the right breast.

ttt) October 14, 2016 Telephone Appointment Visit, Kaiser Permanente, Kelly Ching, MD: Reason for call: The patient needed refill of Motrin for ankle pain and swelling x2 weeks. She declined Meloxicam (*no further information regarding the ankle was indicated)*

uuu) November 07, 2016, Progress Note, Kevin Bromage, MD, Kaiser Permanente: Subjective complaints: The patient was sent by dentist for high BP, which was 198/122. She indicated that she had smoked a cigarette before going into the dentist's office. She stated she was unsure if the BP cuff was the correct size. She was also very anxious regarding dental appointment. She had high BP in the past but no longer needed medication after significant lifestyle changes. BP came down to normal limits while in urgent care without intervention. On exam, it was 136/102 and 136/88. Assessments: Elevated BP; vaccination influenza and pneumonia; smoker. Plan: Smoking cessation; diet and weight loss discussed; home BP monitoring.

vvv) December 09, 2016, Telephone Appointment Visit, Kelly Ching, MD, Kaiser Permanente: Call summary: The patient called to followup on smoking cessation. Smoked ¼ pack per day. Patient to stop her own; declined assistance/medications.

www) January 25, 2017, Telephone Appointment Visit, Kelly Ching, MD, Kaiser Permanente: Interim history: The patient called and was adamant about needing Motrin refilled for her chronic ankle pain. She had not been seen by this physician in three years. She did not get lab work done as requested. She reported that she was still smoking 3 cigarettes per day. Assessments: Left ankle joint pain; smoker; atherosclerosis of aorta. Plan: Patient advised she needed to be seen for evaluation and for lab work. She was instructed to use Tylenol over-the-counter as needed.

xxx) January 30, 2017, Progress Note, Kelly Ching, MD, Kaiser Permanente: Interim history: The patient was seen for follow-up. Requested refill of Motrin. Using Motrin twice a week. PE: BP: 143/86. Assessments: Osteoarthritis; tobacco smoker; vitamin D deficiency; medication refill; elevated blood pressure reading without hypertension diagnosis; smoking cessation counseling; atherosclerosis of aorta; menopausal symptoms; obesity. Plan: Routine screenings and vaccinations indicated. Prescribed Wellbutrin, Vitamin D3, Calcium and Ibuprofen 800 mg.

yyy) February 09, 2017, Eye Examination Report, Richard Gin, OD, Kaiser Permanente: Reason for visit: The patient was seen for a routine eye examination. *No other information was found reviewed from this report.*

zzz) October 05, 2017, Nurse Visit, Lizette Cespeds, LVN, Kaiser Permanente: Reason for visit: The patient was seen for a routine BP check. Current BP level: 197/89. Weight: 203 pounds. Pulse: 84.

aaaa) **October 11, 2017, Progress Note, David Shaw, MD, Kaiser Permanente: Subjective complaints: The patient presented with complaint of dizziness intermittently for the past 2 weeks. She was worried she had a left facial droop and might have had a stroke. Assessment: Vertigo. Plan: Prescribed Meclizine.**

bbbb) **October 23, 2017, Progress Note, David Morris, MD, Kaiser Permanente: Reason for visit: The patient was seen for a BP check. She was currently asymptomatic. At this time BP was 92/57; had started BP medication on 10/05/17. Plan: She was advised to hold off on medication for the night and followup with titration nurse the next day.**

cccc) **October 23, 2017, Nurse Note, Leilani Rebancos Macaseib, RN, Kaiser Permanente: Subjective complaints: The patient indicated that she had upper left shoulder pain since the prior night with pain rated at 3-4/*10 (no information was found in the report regarding the etiology or suspected etiology)*. She was able to speak clearly. Nurse and MD consult.**

dddd) **October 24, 2017, Progress Note, Mi Pham, LVN, Kaiser Permanente: Reason for visit: The patient was seen for a BP check. Current reading was 88/57.**

eeee) **October 24, 2017,Mammogram, Eric Lee, MD, Kaiser Permanente: Findings: Incomplete study. Additional views needed. 6 mm area of grouped heterogeneous calcifications in the right breast; appeared indeterminate. Possible ultrasound and additional reviews recommended.**

ffff) **November 01, 2017, Progress Note, Kelly Ching, MD, Kaiser Permanente: Subjective complaints: The patient not feeling well; intermittent vertigo x 3 weeks. Current BP reading was 134/69. Assessments: Benign paroxysmal positional vertigo; smoker; obesity; atherosclerosis of aorta; vitamin D deficiency; left ankle joint pain. Plan: Diclofenac topical gel prescribed to be applied to affected areas. *No other treatment recommendations were found reviewed from this report.***

PE: BP: 148/88. Height: 6'5". Weight: 213 lbs. Cervical spine: Palpation: She did have tenderness to her bilateral trapezii muscles. ROM: Noted restricted ROM. Right shoulder: General: The patient had minimal weakness of the rotator cuff. Palpation: There was tenderness over the coracoacromial arch. ROM: Noted restricted ROM. Orthopedic tests: Hawkins/Neer's Impingement signs were positive. Jobe's test for supraspinatus tendinopathy was positive. Left shoulder: ROM: Noted mildly restricted ROM. Wrists: Palpation: She reported minimal volar tenderness about the bilateral wrists. ROM: Noted mildly restricted ROM bilaterally. Thoracic spine: Palpation: Noted tenderness to palpation over the T8-T10. Lumbosacral spine: Palpation: Noted tenderness at the sacroiliac joint and lumbosacral junction. There was mild spasm. ROM: Noted moderately restricted ROM with pain. Bilateral knees: ROM: Noted mildly restricted ROM (worse on the left). Palpation: Noted tenderness to palpation over the patellofemoral joint as well as medial > lateral joint lines. Orthopedic tests: Patellofemoral Compression test was positive. The Compression/Rotation test was positive for a meniscal tear. Left ankle: Palpation: There was medial and lateral tenderness, and swelling. ROM: Noted

severely restricted ROM. Stiff ROM with crepitation. Orthopedic test: There was no Lateral ligamentous laxity but did elicit some pain.

Impression: 1) Cervical spine degenerative arthritis. 2) Cervical spine degenerative arthritis without radicular symptoms. 3) Reported cervical spine strain/pain. 4) Bilateral shoulder degenerative arthritis right greater than left. 5) Bilateral hand carpometacarpal joint mild degenerative arthritis/numbness. 6) Thoracic spine degenerative arthritis. 7) Lumbar spine degenerative arthritis with radicular symptoms. 8) Bilateral knee degenerative arthritis left greater than right. 9) Left ankle severe degenerative arthritis status post fracture, status post-surgical intervention and fixation. 10) Right ankle mild degenerative changes. 11) Status post right foot metatarsal fractures. 12) Reported stress reaction-stress associated pain. 11) Reported visual changes. Discussion/Causation: Dr. Heinen indicated that several issues of the patient had to be addressed. He noted that she was making reference to having a lot of stress and this was causing her issues. This was a psychological issue and was deferred to the appropriate specialists. He added that similarly all issues regarding her visual changes were deferred to the appropriate expert. He would be addressing only the physical orthopedic issues and he did not feel that her exposure to visual changes and/or stressful situation had caused any of her physical orthopedic diagnoses.

It was noted that the patient previously had a significant left ankle fracture and this was estimated approximately in 1993 (14 years prior to her 2007 injury per the records). She was treated with surgical intervention and had returned back to work; however, she had developed severe osteoarthritis. This was noted at the time of her 2007 injury by Dr. Gambardella, Dr. Saucedo and ultimately Dr. Fell. The patient at that time also had a foot injury in 2007 with significant limping, gait abnormality, and degenerative arthritis to the left knee. It was felt at that time by several of these doctors that her gait abnormality from her ankle fracture was a contributing factor. Ultimately, she had surgery to her knee with a meniscectomy and chondroplasty. She was off wok for this combination of injuries for greater than a year. She then had a compromise and release including both ankles, her right foot, in her left knee based on Dr. Fell's report (of which Dr. Heinen's did not have a complete copy). She; however, received a rather significant settlement amount, which appeared to have taken into consideration of her arthritis issues. Clearly the arthritis and issues to these body parts were preexistent to the reported cumulative trauma. It was noted that she had diffuse arthritis throughout her body. This even in places that were unlikely to develop that, such as her shoulders. Dr. Heinen noted her body habitus and per him that was a significant contributing factor to development of arthritis. Her preexistent arthritis, associated limp and resultant malalignment was also a further contributing factor due to her lower extremities. She was unable to give Dr. Heinen a specific mechanism of injury to cause further injury to her bilateral lower extremities or spine at work.

Dr. Heinen further indicated that he had reviewed the patient's job duties and kept trying to identify the physical stressors that she placed on her body on a daily basis. She kept relating that she felt everything was due to cumulative trauma that had developed with

time. She denied any specific injury to the body parts except for her initial ankle fracture and **references her fracture that occurred in 2007 to her foot and injury ankle and left knee.** He also indicated that this was consistent with the deposition. In reviewing her job duties with the description she provided to Dr. Heinen, he was not impressed that this was very physical. He indicated that those physical activities (as noted earlier) were no greater than those activities of a typical day for most people at home. He opined that a formal job description might be helpful to further delineate this. He added that in the face of such arthritis, and absent a mechanism, it was more likely than not the genetic and habitual factors such as her weight were caused of her problems. He indicated that merely her stating that she had pain at work, did not make this a work-related injury. Furthermore, he indicated that according to the records and deposition, there was no clear documentation that she reported the injury previously. Also, per her job description it was noted that she did go out the office periodically but on a very limited basis. There was no overwhelmingly repetitive job activity or significant lifting that could account for her issues. For people with arthritis, limitation ambulation and sitting job duties such as that described by her, were the usual modifications given by physicians.

Consequently, Dr. Heinen did not have a mechanism to account for her cervical/thoracic/lumbar spine arthritis except for those things that were specific to the patient and her personal lifestyle and unrelated to her work activities. The exception to this would be the limp that she mentioned due to her ankle arthritis. He added that this was subject to the previous compromise and release, and other than this previously settled case he did not recognize a mechanism of her issues to her spine except her body habitus and genetics. He further indicated that, the patient's job duties were not substantial from an ambulatory point of view. The natural history of her ankle/knee arthritis was one of progression with time. This in fact had occurred and this was subject to her previous injuries. He did not recognize a cumulative trauma or new specific injury to cause these issues. Consequently, care for her bilateral ankles, right foot and knees should be treated directly as result of her 2007 injury that had been settled by compromise and release. She reported pain into her trapezial areas and shoulders and Dr. Heinen indicated that he was surprised to see significant arthritis on the right glenohumeral joint and some on the left. There was no mechanism to explain this as a result of her work-related activities per the given job description. He did not recognize her shoulder injuries as result of a cumulative trauma. He also noted that she did have reported stiffness and numbness in her hands that had been documented in the Kaiser records for a period of time. She had some early degenerative changes to her carpometacarpal joint and a history of numbness. It was unclear whether this was radiated from her neck or localized carpal tunnel finding. She stated that she did do several hours of paperwork in computer per day. Dr. Heinen did believe that this was a reasonable mechanism to contribute to both carpometacarpal joint arthritis as well as the possibility of carpal tunnel syndrome to her hands. Clinically, at this time, she did not have proactive testing for the carpal tunnel syndrome. If the Trier of Fact feels it was reasonable, Dr. Heinen did believe that her job activities could reasonably have contributed to her bilateral hands on a work-related cumulative trauma basis. Daily

activities and using ambulatory aids might also contribute and hence, apportionment would also be considered.

Further comments: Treatment for the hands would include a short course of PT and antiinflammatory medications. A nerve study might be indicated. Based on her current clinical findings, Dr. Heinen did not see any requirement of surgery. Also, he did not see any indication for restrictions beyond that outlined below for her hands since the onset of her complaints. Work restrictions: Hands and wrists: Precluded from very forceful use of her the bilateral hands. Shoulders: Precluded from very heavy work. Lower extremity: Precluded from prolonged standing and walking; no squatting and kneeling or climbing. Impairment rating: Cervical spine: 6% WPI. Lumbar spine: 7% WPI. Left shoulder: 3% WPI. Right shoulder: 5% WPI. Left knee: 11% WPI. Right knee: 12% WPI. Total WPI: 38%. Apportionment: Shoulders, spine, knees, ankles, feet: 100% due to nonindustrial factors or were the result of her previous injuries and subsequent compromise and release. Hands: 70% due to her work activities and 30% due to her personal nonindustrial issues. Vocational rehabilitation: If the above restrictions for the hands could not be met, she would be considered as a Qualified Injured Worker. Future medical care: She should have future medical care with an evaluation from an orthopedic surgeon, medications, injections, PT, diagnostic studies, and possible surgical intervention.

9) March 08, 2019, Compromise and Release: a) DOI: CT: 12/30/14 to 04/16/16. Case number: ADJ10825285. Injured body parts: Eye, upper extremities, back, lower extremities, nervous system. The parties agreed to settle the above claim(s) on account of the injury(ies) by the payment of the sum of: 24,000$.

10) August 24, 2020, Vocational Expert SIBTF Report, Madonna R, Garcia, MRC, VRTWC (Vocational Return to Work Counselor): Ms. Garcia indicated that she had been requested by Attorney Natalia Foley to perform a forensic vocational analysis and report addressing the patient's ability to compete in the open labor market based upon her subsequent industrial injury as well as pre-existing illnesses and injuries that had created labor disabling conditions that would diminish her ability to compete in the open market. Due to Covid-19, assessments and reports were delayed. Introductory comments: The Ms. Garcia's assignment included a face to face interview with the patient, a review of her occupational history, medical history and records, physician assessment of her medical conditions and labor disablement, and apportionment involving percentage of disability apportioned to the subsequent injury, and pre-existing injuries and illnesses, vocational assessments, transferable skills, the labor market analysis, and whether she was amenable to vocational rehabilitation. A thorough evaluation was conducted of the patient through vocational testing, research through the **OASYS** system, the Employment Development Department (EDD), the Dictionary of Occupational titles, the Social Security Administration (SSA), the Occupational Employment Quarterly (OEQ), and pertinent case law to determine her pre-injury labor disablement, as well as the post-injury labor market access and ability to compete in the open labor market.

Ms. Garcia explained to the patient, her position as an Applicant Vocational Expert and informed the patient that she would not be providing ongoing vocational counseling. Ms. Garcia informed her that the information derived during the evaluation would not be considered confidential and that her findings and opinions would be summarized in a report that would be provided to her attorneys and the Subsequent Injuries Benefits Trust Fund. Ms. Garcia had prepared an index with an overview of her evaluation, with demarcations of each section delineated in the index.Review of records: Ms. Garcia reviewed the patient's medical/nonmedical/miscellaneous records dated from 12/13/06 to 11/01/17. HPI: Remained unchanged. Present Complaints: The right foot was asymptomatic. Left knee and left 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 located medially and laterally. ADLs: ADLs were reviewed. Current medications: Meloxicam, Trazodone 50 mg, Atenolol 25 mg. Effects of medication on full time employment: She was taking prescription medication as indicated above that was severely limiting her ability to function in a full-time work setting. Medication usage could limit an employer from fully considering her from full time gainful employment. Commonly, her current medications had following side effects: a) Meloxicam: Upset, nausea, dizziness, or diarrhea. b) Trazodone 50 mg: Blurred vision, dizziness, drowsiness, headache, nausea, vomiting, and xerostomia. Other side effects included: Syncope, edema, ataxia, confusion, diarrhea, hypotension, insomnia, sedated state, and tachycardia. c) Atenolol 25 mg: Cardiac failure, bradycardia, dizziness, fatigue, and cold extremity.

Physical requirements for Marriage and family therapist:
Strength: Sedentary work.
Lifting, carrying, pushing, pulling 10 lbs - occasionally
Mostly sitting, may involve standing or walking for brief periods of time

Reaching: Occasionally
Extending hand(s) or arm(s) in any direction

Handling: Occasionally
Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers were involved only to the extent that they were an extension of the hand, such as to turn a switch or shift automobile gears.

Fingering: Occasionally
Picking, pinching, or otherwise working primarily with fingers rather than with the whole hand or arm as in handling

Talking: Constantly
Expressing or exchanging ideas by means of the spoken word to impart oral information to clients or to the public and to convey detailed spoken instructions to other workers accurately, loudly, or quickly.

Hearing: Constantly

Perceiving the nature of sounds by ear.

Near acuity: Occasionally
Clarity of vision at 20 inches or less.

Considering the above noted functional limitations resulting from the patient's pre-existing non-industrial and industrial functional limitations, combined with the functional limitations resulting from her industrial injury, because Ms. Garcia believed that the patient, in all vocational probability, did not possess the ability to return to work, in a suitable gainful basis in the current open labor market.

Conclusion: Ms. Garcia indicated that a person had a functional limitation when he or she, because of a disability, could not meet the strength, stamina, endurance or psychological stresses of a job regardless of the work skills possessed by the person; or could not tolerate the physical environment of the workplace. In this case, the patient was significantly restricted in ability to meet typical physical employment requirements to perform previous job or usual line of work such 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 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.

The patient's opportunities to return to work were slim because of all the accommodations the employer would need for the job. Her job as Marriage and Family Therapist would require an adjustment to her job or work environment, which makes it impossible for an individual with a disability to perform the essential functions of her job. She would need accommodations and modifications to the work environment and even adjustments to her work schedules or responsibilities due to her physical limitations. Ms. Garcia had determined that the patient was not amenable to any form of vocational rehabilitation. Her functional limitations combined with the intensity, duration, and nature of her chronic and disabling pain would preclude her pre-injury skills and academic accomplishments. Ms. Garcia did not believe that the patient was amenable to any form of rehabilitation and thus had sustained a total loss in her capacity to meet any occupational demands.

11) October 22, 2020, Subsequent Injury Benefit Trust Fund Report (Occupational/Internal Medicine), Marvin Pietruszka, MD, MSc, FCAP/Koruon Daldalyan, MD: History of injury: Remained unchanged. Prior treatment: The patient was treated by Dr. Nissanoff and Dr. Heinen. Previous work descriptions: Prior to working at D'Veal Family and Youth Services, she had worked at California Institute of Technology. Occupational exposure: She was exposed to excessive noise during the course of her work. Past medical history: She was diagnosed with hypertension in 2000. She had undergone left knee surgery in

2007, ocular surgery in 1973, and cesarean section in 1971. Allergies: She was allergic to Penicillin. Prior injuries: She had suffered a burn to her right hand from a motorcycle. She had sustained a left ankle injury in 1993, which required surgical intervention. Subjective complaints: 1) Headaches. 2) Dizziness. 3) Lightheadedness. 4) Visual difficulty. 5) Sinus problems. 6) Cough. 7) Postnasal drip. 8) Chest pain. 9) Palpitations. 10) Shortness of breath. 11) Nausea. 12) Vomiting. 13) Weight gain. 14) Urinary frequency. 15) Cervical spine pain. 16) Thoracic spine pain. 17) Lumbar spine pain. 18) Bilateral shoulder pain. 19) Bilateral elbow pain. 20) Bilateral hand pain. 21) Bilateral knee pain. 22) Right ankle pain. 23) Bilateral 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.

Review of systems (prior to her work injury): Prior to her work injury, the patient related having some memory problems, which had worsened since sustaining her industrial injuries. Her left knee symptoms had worsened since her 2007 work injury. She related complaints of vision difficulty in her right eye. Review of systems (after her work injury): She complained of headaches, dizziness, light headedness, visual difficulty, sinus problems, cough, postnasal drip, chest pain, palpitations, shortness of breath, nausea, vomiting, weight gain, and urinary frequency. Her musculoskeletal complaints involved cervical spine pain (8/10), thoracic spine pain (7/10), lumbar spine pain (8/10), bilateral shoulder pain (8/10), bilateral elbow pain (8/10), bilateral hand pain (7/10), bilateral knee pain (8/10), right ankle pain (8/10), and bilateral foot pain (8/10). There was a complaint of peripheral edema and swelling of the ankles. Her psychosocial complaints included anxiety, depression, difficulty concentrating, difficulty sleeping, difficulty making decisions, and forgetfulness. There were dermatologic complaints as well. There was intolerance to excessive heat. Current medication: She was taking Lisinopril 20 mg daily, Meloxicam 7.5 mg daily Trazodone 50 mg **HS**, and Tylenol 500 mg **HS**.PE: BP 186/97. Musculoskeletal: There was tenderness and myospasm of the cervical, thoracic and lumbar paraspinal musculature. There was tenderness of bilateral shoulders/elbows/hands. There were post-surgical scars noted of the left knee.

There was tenderness of the bilateral knees/lower extremities. There was +1 pitting edema of bilateral lower extremities. ROM: Cervical/thoracic/lumbosacral spine, bilateral shoulders/elbows/wrists/forearms/knees/ankles/feet: Noted mildly restricted ROM.X-rays (performed same day): 1) Chest: Noted increased bronchial markings bilaterally. 2) Cervical spine: Moderate to severe degenerative changes noted. 3) Lumbar spine: Noted multilevel degenerative changes, more specifically at L3-4 and L4-5. There was straightening of the normal lordosis. 4) Right shoulder: Noted decreased joint space of the acromioclavicular and glenohumeral joint. There was severe arthritic changes noted. 5) Left shoulder: Noted decreased joint space of the acromioclavicular and glenohumeral joint. There was severe arthritic changes noted. 6) Left knee: Noted mild to moderate degenerative changes and decreased joint space. 7) Left ankle: Findings consistent with an operative repair of the tibia and fibula head. Special diagnostic tests: 1) A pulmonary

function test was performed revealing an FVC (Forced Vital Capacity) of 2.45 L (52.3%), an FEV (Forced Expiratory Volume) 1 of 1.90 L (63.3%), and an FEF (Forced Expiratory Flow) of 1.73 L/s (105.3%). There was a 22.3% increase in FVC, a 16.7% increase in FEV 1, and a 21.2% increase in FEF after the administration of Albuterol. 2) A 12-lead electrocardiogram was performed revealing normal sinus rhythm and a heart rate of 68 per minute. 3) A pulse oximetry test was performed that was recorded at 98%. Laboratory testing: A random blood sugar was performed and was recorded at 97 mg/dL. The urinalysis performed by dipstick method, which was reported as 1+ protein. ADLs (pre and post-injury): ADLs were reviewed. Review of records: Dr. Daldalyan reviewed the patient's medical/nonmedical records dated from 11/20/07 to 11/07/20.

Diagnoses: 1) Musculoskeletal injuries involving cervical spine, thoracic spine, lumbar spine, bilateral shoulders, elbows, and hands, left hip, bilateral knees, right ankle and bilateral feet. 2) Carpal tunnel syndrome, bilateral wrists. 3) Cognitive dysfunction secondary to anxiety, depression and chronic pain. 4) Chronic pain syndrome. 5) Epicondylitis bilateral elbows. 6) Internal derangement bilateral shoulders. 7) Cervical spine sprain/strain. 8) Lumbar spine sprain/strain. 9) Myospasms of cervical, thoracic and lumbar spine. 10) Abnormality of gait due to left lower extremity weakness. 11) Use of assistive device (cane). 12) Left knee internal derangement, status post-surgical repair. 13) Fracture of left hallux, status post medical treatment. 14) Bilateral plantar fasciitis. 15) Internal derangement, bilateral ankles. 16) Hypertension (2000) exacerbated by workplace injury. 17) Myopia, right eye (pre-existing). 18) Blurry vision, right 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 factors: Objective findings: 1) Chest increased bronchial markings bilaterally, per x-rays (10/22/20). 2) Cervical spine moderate to severe degenerative changes noted, per x-rays (10/22/20). 3) Lumbar spine multilevel degenerative changes, more specifically at L3-4 and L4-5. There was straightening of the normal lordosis, per x-rays (10/22/20). 4) Right shoulder decreased joint space of the acromioclavicular and glenohumeral joint. There was severe arthritic changes noted, per x-rays (10/22/20). 5) Left shoulder decreased joint space of the acromioclavicular and glenohumeral joint. There was severe arthritic changes noted, per x-rays (10/22/20). 6) Left knee mild to moderate degenerative changes and decreased joint space, per x-rays (10/22/20). 7) Left ankle findings consistent with an operative repair of the tibia and fibula head, per x-rays (10/22/20). Discussion: The patient related a prior injury to the left ankle, which she sustained in 1993 and required surgical intervention. She related that this injury had worsened since sustaining her industrial injuries while employed at D'Veal Family and Youth Services as she sustained left knee and left toe injuries in 2007. She was also diagnosed with hypertension in 2000. According to the medical records from State Compensation Insurance Fund, her hypertension had indeed worsened since 2007 as her blood pressure had gone from stage 1 hypertension to stage 2 hypertension.

Furthermore, the patient had related complaints of chest pain, palpitations, dyspnea, and headaches. It was within reasonable medical probability that her aggravated hypertension had resulted in mild cerebral atrophy, which had resulted in cognitive dysfunction. She related complaints of difficulty concentrating, difficulty making decisions, and forgetfulness. Dr. Daldalyan opined that she had sustained an aggravation of her hypertension due to her industrial injuries while employed by D'Veal Family and Youth Services. She also related that she had some preexisting memory problems and visual difficulty problems, which had worsened by the subject subsequent industrial injuries. In addition, she had sustained industrial injuries to her cervical spine, lumbar spine, bilateral shoulders, left hip, bilateral knees, and right foot. She also related complaints of urinary frequency, difficulty sleeping, headaches, and vertigo symptomology. Permanent impairment rating: Prior to CT 12/30/04 – 4/16/16; 8/9/07; 11/10/07: Left ankle: 4% WPI. Aggravated hypertension: 10% WPI. Right eye:10% WPI. Her whole-body impairment was 22% = (10% + 10% + 4%). After CT 12/30/04 – 4/16/16; 8/9/07; 11/10/07: Cervical spine: 5% WPI. Lumbar spine: 5% WPI. Upper extremities (right and left shoulders): 4% WPI. Left hip: 3% WPI. Right knee: 3% WPI.

Left knee:10% WPI. Left ankle:6% WPI. Right foot:3% WPI. Right eye: 15% WPI. Aggravated hypertension:29% WPI. Cognitive dysfunction:20% WPI. Urinary frequency: 14% WPI. Cephalgia:5% WPI. Sleep impairment:5% WPI. Vertigo: 4% WPI. Whole-body impairment was 77% = (29% + 20% + 15% + 14% + 10% + 6% + 5% + 5% + 5% + 5% + 4% + 4% + 3% + 3% + 3%).Work restrictions: For the patient's complaints of cervical and lumbar spine pain, she should be precluded from work involving heavy lifting, repetitive pushing, pulling, stooping, or overhead work with the upper extremities. For complaints of bilateral upper extremities 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 bilateral lower extremities 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 stress-aggravated hypertension, she should be precluded from work 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) December 14, 2020, Comprehensive Independent Medical Evaluation in Neurology SIBTF Evaluation Report, Lawrence M. Richman, MD: Initial SIBTF summary: 1) Did the worker have an industrial injury? Answer – Yes. The patient sustained continuous trauma from December 30,2014 through April 6, 2016 to her back, lower extremities and body systems abdomen, liver, and kidneys. She reported that she had slipped on a banana peel in2004 while on a company outing fracturing her left toe and injuring her left knee. 2) Did the industrial injury rate to a 35% disability without modification for age and occupation? Answer - Yes. Per Panel Qualified Medical Evaluator, Dr. Heinen dated February 20, 2018

with a total whole person impairment of 38% for orthopedic injuries. 3) Did the worker have a pre-existing labor-disabling permanent disability? Answer - Yes. She had sustained a fracture to the left ankle in 1993 when she fell down from a staircase, as well as sustaining a slip and fall injury with musculoskeletal complaints when she slipped at a99 Store on spilled water; to be addressed by the Panel Qualified Medical Evaluator in orthopedics. She had been legally blind in her right eye since birth, which was lack of depth perception. She had no visual acuity and had loss of visual fields. She has had a heart murmur since childhood with no known cardiac disease; to be addressed by a board certified internal medicine specialist/cardiologist.

The patient had a history of depression following separation of her parents at the age of 8 that had persisted to the present time. She had a history of anxiety during that same time frame that had persisted to the present. She had a history of two motor vehicle accidents with injuries to the cervical spine resulting in chronic cervical spine pain from both accidents, head injury from both accidents associated with diminished memory and concentration. She believed that her memory/concentration complaints were a derivative of these accidents. She responded to the Clinical Dementia Rating Scale, Table 13-5 from the AMA Fifth Edition. She reported that she forgets what to purchase at a store; had to keep a list of objects to purchase; forgets where she places her personal belongings; loses direction easily, and was forgetting things and people that she should know. She had difficulty figuring out solutions for day-to-day problems; difficulty keeping track of time and time-relationships. She had loss of interest in hobbies, such as playing chess. She reported that these cognitive complaints had been present since both motor vehicle accidents. She reported anxiety, depression, impaired concentration, and dizziness. She believed that this was secondary to anxiety. She reported a history of headaches, rated between a 6 to 7 (out of 10) and was frequently present since both motor vehicle accidents.

4) Did the pre-existing disability affect an upper or lower extremity or eye? Answer -No. 5) Did the industrial permanent disability affect the opposite or corresponding body part? Answer - No. 6) Is the total disability equal to or greater than 70% after modification? Answer - Yes. Her disability was equal to or greater than 70% taking into consideration both her orthopedic complaints, concussive-related complaints and visual impairment. 7) Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together? Answer - No. She was not disabled or unemployable from her pre-existing disability or work duties together. 8) Is the employee 100% disabled from the industrial injury? Answer -No. 9) Additional records reviewed? Answer – Yes. 10) Are evaluations or diagnostics needed? Answer - Yes. She should undergo neuropsychologic testing, an ophthalmologic evaluation, head imaging of the brain or a functional MRI scan of the brain. Chief complaints: She stated that she had ongoing difficulty with memory and concentration. She reported dizziness, occipital tension headaches (7/10), and musculoskeletal complaints, which would be deferred to an orthopedic examiner. She reported frequent tingling and numbness in the right hand and a sensation of weakness in the lower limbs. Current medication: Lisinopril and Nabumetone.

Summary of surgical and medical problems: The patient was a Marriage & Family Therapist, who was previously employed by D'Veal Family & Youth Services for twelve years and four months through April 2016. Her job required frequent climbing, occasional bending, and stooping. She had to do occasional lifting up to 10 pounds. She performed repetitive fine manipulation of the right hand and had to use a computer keyboard. She reported having sustained a slip and fall injury on a banana peel during a company outing. She had sustained a fracture of the left toe and an injury to the left 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, orthopedist, dated February 28,2018 referred to an injury date of April 16, 2006 and continuous trauma for twelve years due to repetitive use of the upper and lower limbs. She related that she had to frequently drive cars. She reported being subjected to harassment from one of her co-workers. She also reported constant aching in her bilateral shoulders and elbows. In addition, there were complaints related to her lower limbs/knees and was unable to walk at times. She added that she was feeling imbalanced. The lumbar spine was found to be tender on examination. She was diagnosed with arthritis of the cervical spine, cervical spine pain, arthritis of the bilateral shoulders, thoracic spine, lumbar spine, lumbar radicular symptoms, arthritis of the bilateral knees, left greater than right, severe degenerative arthritic changes of the left knee, status-post surgery to the left knee, degenerative arthritis of the right ankle and fracture of the right foot.

The patient's shoulder complaints could not relate to continuous trauma. She was provided with 30% whole person impairment for complaints of the bilateral upper limbs, cervical, thoracic, and lumbar spine, bilateral knees and bilateral lower limbs. It was reported that her hands were considered to be work related whereas the other orthopedic injuries were nonwork related. The Panel Qualified Medical Evaluator did mention that there were multiple pre-existing non-orthopedic injuries that predated her employment. Her pre-existing longstanding orthopedic injuries should be addressed by a board certified orthopedic examiner as this was beyond the scope of Dr. Richman's expertise. She did have a pre-existing history of several medical problems preceding her date of hire. She had been legally blind in the right eye since birth and has had lack of depth perception. The cause of her ocular disorder was not known. She had a prior history of a heart murmur since childhood, as well as a history of hypertension. Her heart condition and hypertension should be addressed by a board certified cardiologist/internal medical specialist. She had a longstanding history of anxiety and depression that had persisted to the present, which should be addressed by a board certified psychiatrist. She had 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. The patient did respond affirmatively to the Clinical Dementia Rating Scale consistent with a cognitive impairment. She had a history of headaches after both accidents. There were also a prior slip and fall accident down a staircase in 1993 and another slip and fall incident while in a99Store, which should be addressed by an orthopedist. She reported ongoing

headaches at the back of the scalp; muscle tension in type. As mentioned, she responded affirmatively to the Conventional Rating Scale, which was qualifying her for a rating from Table 13-6. She complained of dizziness associated with anxiety. Past medical history: She had hypertension, anxiety, depression, and a heart murmur since childhood, as well as visual loss in the right eye, and two motor vehicular accidents. ADLs: ADLs were reviewed. Neurological examination: Cranial nerve: Cranial nerves II-XII were serially tested. She showed external strabismus of the right eye. She could barely count fingers over the right superior, inferior, and lateral temporal quadrants. She had no visual acuity/visual fields of the right nasal superior and inferior quadrants. The left eye showed full visual fields and visual acuity of 20/30.

Sensory: The patient showed diminished sensation of the bilateral upper limbs in the C7 distribution. Deep tendon reflexes: All reflexes were 1+. Gait and station: She had a broad-based gait. The gait was mildly unstable. Cervical spine: There was straightening of the cervical lordosis with spasm and tenderness. Examination of the trapezius revealed bilateral spasm and tenderness in the trapezial musculature. Review of records: Dr. Richman reviewed the patient's medical/nonmedical records from 10/02/15 to 11/06/18. Clinical impressions: 1) Blindness in the right eye. 2) History of post-traumatic head syndrome, nonindustrial causation. 3) Post-traumatic headaches, nonindustrial causation. 4) Bilateral cervical radiculopathy, nonindustrial causation. 5) Gait instability, nonindustrial causation. 6) Lack of depth perception, nonindustrial causation. 7) Heart murmur and hypertension, nonindustrial causation. 8) Anxiety and depression, nonindustrial causation. 9) Multiple orthopedic complaints to be addressed by a board certified orthopedist. Discussion and recommendation: The patient with multiple longstanding orthopedic and neurologic complaints, as well as internal medical complaints, unrelated to her employment. The Panel Qualified Medical Evaluator in orthopedic surgery had identified pre-existing nonindustrial complaints related to arthritis of the spine, knees and shoulders.

He stated that the patient had significant visual impairment of the right eye, cognitive complaints from two motor vehicle accidents, in which she sustained concussions, headaches, and the unstable gait. She showed evidence of bilateral C7 radiculopathy, which had qualified for a Diagnosis-Related Estimate Category III rating. Her deposition was reviewed in which she described her employment and job activities. She did admit to a history of headaches, multiple musculoskeletal complaints, and a prior left foot injury from work and emotional distress at work, which should be evaluated by a board certified psychiatrist of the parties choosing. She described shoulder/upper limb pain, and gait difficulty likely related to lack of visual depth perception. She was also evaluated by an orthopedist on June 21, 2017, Dr. Nissanoff, who reported numbness of the right upper limb. She had showed full motor strength. She had a nonindustrial left knee injury as well as a left ankle injury that was aggravated by her work. With respect to her nonwork related injuries, she had qualified for a 12% whole person impairment due to a class 1 **mental status** impairment (Table 13-6) with 100% apportionment of permanent disability due to her nonindustrial motor vehicle accidents. For her post-traumatic headaches, Dr. Richman

opined that she had qualified for a 3% whole person impairment per chapter 18, with 100% apportionment of permanent disability to the injury of her two nonindustrial motor vehicular accidents.

For cervical radiculopathy, he opined that the patient qualified for a Diagnosis-Related Estimate Category III rating from Table 15-5 with a 17% whole person impairment and 100% apportionment of permanent disability to long standing degenerative arthritis of the cervical spine. For her visual loss of the right eye, as well as loss of visual fields, both impairments were addressed from Tables 13-9 and 13-10 for visual acuity loss of the right eye. Practically speaking, the right eye was blind and qualified for a Class III rating of 49%, which was also taking into consideration of her visual field loss. This could further be addressed by a board certified ophthalmologist. For her gait disturbance, Dr. Richman opined that it was related to loss of depth perception. She had qualified for a 5% whole person impairment from Table 13-15. He added, given the magnitude of her impairments and synergistic effect addition, rather than combined values as allowed for by the Kite case should be utilized to address her visual disturbance, cognitive disturbance and headaches, as well as gait disturbance, all of which could impact each other. 49% plus 12% equals 61%. 61% plus 5% equals 66%. 66% plus 3% equals 69%. 69% was combined with 17%, which equals 73%. Her final whole person impairment was 73%. Kite provides a more accurate assessment of the patient's impairments by adding rather than combining.

13) December 22, 2020, Subsequent Injuries Benefits Trust Fund Evaluation, Babak Kumar, OD: Brief history of injury: The patient was working at D'Veal Family and Youth Services as a Therapist from 2004 to 04/16/16. During this period, she had cumulative trauma 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 backward 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 left knee meniscus, fracturing a left toe, and fracturing her right leg. She did not realize the extent of her injuries at first, especially the right 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 Medical Center in San Gabriel showed her injuries. Current ocular symptoms: The ocular complaints included blurry vision, difficulty seeing the periphery, unable to see well for freeway driving, judging distances, and driving in general at night.

The patient was born with a right lazy eye that was turned outward. She was bothered by the cosmetic appearance of her eyes and had a strabismus surgery in her adult life, which did not help significantly. She remained with an obvious right exotropia, or right eye had turned outward. She complained of poor depth perception, which was affecting her activities of daily living. For example, she has difficulty judging distances when trying to pour liquid from one container to another. He had noticed her left eye becoming progressively blurry and had noticed black spots floating in front of her. She has had these

symptoms for the past five years. She had also complained of glare from car headlights and poor night vision for the past five years. Current medications: Lisinopril 20 mg, Nabumetone 500 mg, Ibuprofen 200 mg. Review of records: Dr. Kumar reviewed the patient's medical records dated from 12/13/06 to 11/01/17. Diagnoses: 1) Glare sensitivity. 2) History of amblyopia, associated with exotropia, right eye. 3) Exotropia, right eye. 4) Regular Astigmatism both eyes. 5) Myopia, bilateral. 6) Presbyopia both eyes. MMI status: Her condition had reached MMI status. Subjective factors of disability: 1) Poor vision in her right eye. 2) Poor sense of peripheral vision.

Objective factors of disability: 1) Glare sensitivity. 2) Reduced visual acuity. 3) Reduced visual fields. Causation: The subsequent industrial injury did not cause any ocular impairment in this case. The cause of visual impairment was likely 100% natural. Apportionment: The visual impairment was 100% apportioned to natural causes. Impairment: Visual impairment rating: 24.34%. Individual adjustment related to glare sensitivity and poor binocularity: 15%. Total impairment: 39.34%. Work preclusions: 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 could be hazardous to her and others. Examples include delivery services. Her limited visual acuity and history of eye turn was disqualifying her from numerous positions that required normal or near normal visual acuity in both eyes. Examples included police, military, sports referee, and positions where visual inspections were required. In addition, she had limited depth perception due to poor binocular vision. Jobs where detailed depth perception was necessary were precluded, such as dental assistants, hairdressers, dressmakers, cutlery, glass blowing, carpentry, etc. Future medical treatment: She needed annual eye examinations to manage her refractive and age-related ocular conditions.

Missing Records:

1) Records from Kaiser Permanente starting from December 2006 through November 2017 including the followings:

   a) November 12, 2007 dated ED Provider Notes (Kaiser Permanente) by Kristen Duyck, MD (DOI: 11/10/07)

   b) May 14, 2011 dated Eye Exam Report by Kris Lum, OD (Kaiser Permanente)

   c) October 02, 2015, dated Eye Exam Report by Terre Watson, OD (Kaiser Permanente)

   d) October 23, 2017, dated Nurse Note, Leilani Rebancos Macaseib, RN (Kaiser Permanente; chief complaint was left shoulder pain 3-4/10)

2) Records from Dreamweaver Medical Group starting from August 2007.

3) August 09, 2007 dated Doctor's First Report of Occupational Injury or Illness by Dan Le, DO (DOI: 08/09/07).

4) August 09, 2007 dated Initial Orthopedic Consultation Report by Kenneth Jung, MD.

5) September 10, 2007 dated Comprehensive Orthopedic Evaluation by Ralph Gambardella, MD (as well as other records from this provider including November 26, 2007 dated Permanent and Stationary Report)

6) Orthopedic Consultation/Operative Reports from Tomas Saucedo, MD (including November 29, 2007 dated orthopedic consultation report and April 24, 2008 dated Operative Report): DOI: 11/10/07.

7) October 22, 2009 dated Eye Examination Report by Anna Montenegro, MD.

8) March 17, 2011 dated Orthopedic Agreed Panel QME Evaluation by Thomas W. Fell, Jr., MD (DOI: 08/09/07; 11/10/07)

9) All other relevant records addressing her non-orthopedic complaints (related to her cardio/internal medicine, psyche, ophthalmology, neurology complaints)

ADDENDUM -3 PAIN & ACTIVITIES OF DAILY LIVING QUESTIONNAIRES

Lower Extremity Functional Scale (LEFS)

Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.

The Lower Extremity Functional Scale (LEFS) is a questionnaire containing 20 questions about a person's ability to perform everyday tasks. The LEFS can be used by clinicians as a measure of patients' initial function, ongoing progress and outcome, as well as to set functional goals.

The LEFS can be used to evaluate the functional impairment of a patient with a disorder of one or both lower extremities. It can be used to monitor the patient over time and to evaluate the effectiveness of an intervention.

Scoring instructions

The columns on the scale are summed to get a total score. The maximum score is 80.

Interpretation of scores

- The lower the score the greater the disability.
- The minimal detectable change is 9 scale points.
- The minimal clinically important difference is 9 scale points.
- % of maximal function = (LEFS score) / 80 * 100

$4/80 = 0,05 \times 100$
$= 5\%$

Performance:

- The potential error at a given point in time was +/- 5.3 scale points.
- Test-retest reliability was 0.94.
- Construct reliability was determined by comparison with the SF-36. The scale was found to be reliable with a sensitivity to change superior to the SF-36.

Lower Extremity Functional Scale (LEFS)

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Modified Oswestry Low Back Pain Disability Questionnaire[4]

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the one box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I can manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☒ Pain medication provides me with moderate relief from pain. 3
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☒ It is painful to take care of myself, and I am slow and careful. 2
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☒ I can lift only very light weights. 4
- ☐ I cannot lift or carry anything at all.

Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☒ Pain prevents me from walking more than 1/4 mile. 3
- ☒ I can walk only with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☒ Pain prevents me from sitting for more than 1/2 hour. 3
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want, but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2 hour.
- ☒ Pain prevents me from standing for more than 10 minutes. 4
- ☐ Pain prevents me from standing at all.

Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☒ Even when I take medication, I sleep less than 6 hours. 2
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☒ I have hardly any social life because of my pain. 5

Please complete questionnaire on other side.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☒ My pain restricts my travel to short necessary journeys under 1/2 hour. 4
- ☐ My pain prevents all travel except for visits to the physician / therapist or hospital.

Employment / Homemaking

- ☐ My normal homemaking / job activities do not cause pain.
- ☐ My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming). 3
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

FOR OFFICE USE ONLY

Score: 33 /50 x 100 = 66 % points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 10%points (Change of less than this amount may be attributed to error in the measurement.)

Name: Floreen Rooks Date: 12/21/2020

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy*. 2001;81:776-788.

*Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy*. 1980;66:271-273.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: 12/21/2020

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns 2 + 4 + 12

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: 18

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult ✓ Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Floreen Rooks

Neck Disability Index

Office Use Only
Name _____
Date _____

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

0
- ☐ I have no pain at the moment
- ☑ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

2
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☑ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

0

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☑ I can only lift very light weights
- ☐ I cannot lift or carry anything

5

Section 4: Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☑ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

3

Section 5: Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches, which come infrequently
- ☐ I have moderate headaches, which come infrequently
- ☑ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently
- ☐ I have headaches almost all the time

1

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☑ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

3

Section 7: Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

Section 8: Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

Section 9: Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

x Floreen Rooks

Score: 33/50 Transform to percentage score x 100 = 66% point

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated: 16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 5 points or 10 %points

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics 14, 409-415

Beck Anxiety Inventory (BAI)

tellabllity:

'est-retest reliability (1 week) for the BAI = 0.75 (Beck, Epstein, Brown, & Steer, 198

falidit

ınd mildly correlated with the Hamilton Depression Rating Scale (.25) (Beck et al., 1988).

icorin 'ext

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
li questions				

core of 0-21 = low anxiety

core of 36 and above = potentially concerning levels of anxiety = 45 score

leferences: Beck, A.T., Epstein, N., Brown, G., & Steer, R.A. (1988). An inventory for measuring clinical anxiety:

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3
		5	4	36

EPWORTH SLEEPINESS SCALE (ESS)

Patient Floreen Rooks DOI _____ Today's Date 12/21/2020

How likely are you to doze off in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to answer how you believe they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Chance of Dozing	Situation
0 1 (2) 3	Sitting and reading
0 1 (2) 3	Watching TV
(0) 1 2 3	Sitting inactive in a public place (theater, church or meeting)
(0) 1 2 3	As a passenger in a car for an hour without a break
0 1 (2) 3	Lying down to rest in the afternoon when circumstances permit
(0) 1 2 3	Sitting and talking to someone
0 1 (2) 3	Sitting quietly after a lunch where you did not drink alcohol
(0) 1 2 3	In a car while stopped for a few minutes in traffic
8	Total Score

Patient Signature Floreen Rooks Doctor Signature _____

ESS was developed by Dr. Murray W. Johns as Director of the Sleep Disorders Unit at Epworth Hospital in Melbourne, Australia. The ESS was first published in 1991 (Murray W. Johns. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale, Sleep, 1991; 14 (6): 540-545).

Headache Disability Index

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY)
~~Floreen~~ ROOKS	FLOREEN		06/20/1949
Provider Last Name	Provider First Name	Provider Phone (area code first)	

INSTRUCTIONS:
Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully:
The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
✓			F1.	Because of my headaches I feel handicapped.
✓			F2.	Because of my headaches I feel restricted in performing my routine daily activities.
✓			E3.	No one understands the effect my headaches have on my life.
✓			F4.	I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.
✓			E5.	My headaches make me angry.
✓	✓		E6.	Sometimes I feel that I am going to lose control because of my headaches.
✓			F7.	Because of my headaches I am less likely to socialize.
	✓		E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
	✓		E9.	My headaches are so bad that I feel that I am going to go insane.
✓			E10.	My outlook on the world is affected by my headaches.
✓			E11.	I am afraid to go outside when I feel that a headache is starting.
✓			E12.	I feel desperate because of my headaches.
	✓		F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
	✓		E14.	My headaches place stress on my relationships with family or friends.
✓	✓		F15.	I avoid being around people when I have a headache.
	✓		F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
✓			F17.	I am unable to think clearly because of my headaches.
✓			F18.	I get tense (e.g., muscle tension) because of my headaches.
✓			F19.	I do not enjoy social gatherings because of my headaches.
✓			E20.	I feel irritable because of my headaches.
✓	✓		F21.	I avoid traveling because of my headaches.
	✓		E22.	My headaches make me feel confused.
✓			E23.	My headaches make me feel frustrated.
✓	✓		F24.	I find it difficult to read because of my headaches.
	✓		F25.	I find it difficult to focus my attention away from my headaches and on other things.

68 +16 = 84

OTHER COMMENTS: Score = 84 (4x17)+(2x8)

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature Floreen Rooks Date 12/21/2020

With permission from:
Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.

R051507

HEADACHE DISABILITY INDEX

SCORING

Patient Name Floreen Rooks Date 12/21/2020

Examiner D. Cuff

Scoring

The following responses are given the following values:

Response	Points
Yes	4
Sometimes	2
No	0

Interpretation

A 29 point change (95% confidence interval) or greater in the total score from test to retest must occur before the change can be attributed to treatment effects.

With permission from:
Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (eg from bathtub or chair)	0	1	2	3	4
7	Preparing food (eg peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (eg washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: 24/80

Source: Stratford PW, Binkley, JM, Stratford DM (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada. 53(4):259-267.

24/80 = 30%