GENERAL TEACHING HOSPITAL

Pain Management Center
123 Medical Center Drive, Anytown, ST 12345
Phone: (555) 123-4567 | Fax: (555) 123-4568

⚠️ **FICTITIOUS DATA FOR SOFTWARE TESTING ONLY** ⚠️
NOT A REAL MEDICAL RECORD

PAIN MANAGEMENT CONSULTATION

PATIENT INFORMATION

Name: John A. Doe (FICTIONAL)
DOB: 01/15/1985
Age: 40 years
Sex: Male
MRN: 1234567890
Consultation Date: 09/20/2025

CONSULTATION INFORMATION

Referring Physician: Dr. Amanda Rehab, MD (PM&R)
Consulting Physician: Dr. Patricia Painfree, MD
Date/Time: 09/20/2025, 10:00
Reason for Consult: Multimodal pain management
Duration of Pain: 8 weeks post-MVA

REMINDER: FICTITIOUS TESTING DOCUMENT

HISTORY OF PRESENT ILLNESS

40-year-old male presents for pain management consultation 8 weeks following motor vehicle accident on 07/30/2025. Patient sustained left intertrochanteric hip fracture (surgically repaired 07/31/2025), cervical strain, and lumbar strain. Despite ongoing physical therapy and rehabilitation efforts, patient continues to experience significant multi-site

pain that is limiting his functional recovery and return to work. He describes his pain as follows:

• **Hip Pain:** Deep, aching pain rated 3-4/10 at rest, 6-7/10 with activity. Improved from immediate post-operative period but plateaued over past 3 weeks.
• **Neck Pain:** Constant stiffness with sharp pain on movement, 4/10 baseline, 7/10 with rotation or extension.
• **Lower Back Pain:** Constant burning pain with muscle spasms, 6/10 baseline, 8-9/10 with prolonged sitting or forward bending.

Patient reports pain significantly impacts sleep (awakens 3-4 times nightly), mood (feels frustrated and discouraged), and function (unable to sit at computer for more than 30 minutes for work). Previous treatments include tramadol, ibuprofen, muscle relaxants, and ongoing PT with minimal improvement over past month.

PAIN ASSESSMENT

Current Pain Ratings (0-10 scale):

Hip Rest: 3-4/10	**Hip Activity:** 6-7/10	**Neck Baseline:** 4/10	**Neck Movement:** 7/10
Back Baseline: 6/10	**Back Activity:** 8-9/10	**Average Daily:** 6/10	**Worst Daily:** 9/10

Pain Quality: Hip - deep aching; Neck - sharp, stabbing; Back - burning with spasms
Aggravating Factors: Sitting >30 min, forward bending, neck rotation, walking >200 feet
Alleviating Factors: Lying down, heat application, rest
Sleep Impact: Awakens 3-4x nightly, difficulty finding comfortable position
Mood Impact: Moderate frustration, mild depression (PHQ-9 score: 12)
Functional Impact: Unable to work, limited ADLs, social isolation

CURRENT MEDICATIONS

Pain Medications:
• Tramadol 50mg every 6 hours as needed (taking 3-4 times daily)
• Ibuprofen 600mg three times daily with meals
• Cyclobenzaprine 10mg at bedtime
• Acetaminophen 1000mg twice daily

Other Medications:
• Lisinopril 10mg daily for hypertension

Allergies: No known drug allergies
Prior Opioid Use: None prior to accident; morphine post-operatively only

REVIEW OF SYSTEMS

Constitutional: Denies fever, weight loss. Reports fatigue and sleep disturbance.
Neurological: Intermittent numbness in right thumb/index finger (known C6 radiculopathy). No weakness.
Musculoskeletal: As described in HPI. No joint swelling.
Psychiatric: Moderate frustration, mild depression. No anxiety or panic attacks.
GI: Mild stomach upset with NSAIDs, taking with food. No other concerns.
GU: No issues. Normal urination.
Other: All other systems negative.

PHYSICAL EXAMINATION

Vital Signs: BP 145/90, HR 88, T 98.6°F, Wt 185 lbs
General: Alert, cooperative, appears uncomfortable when sitting/standing
Gait: Slightly antalgic, uses cane for distances >100 feet
Cervical Spine: Limited ROM, tender paraspinals, negative Spurling's test
Lumbar Spine: Visible muscle spasm, limited flexion, positive straight leg raise at 60° on right

Left Hip: Well-healed incision, limited flexion to 90°, tender to palpation over greater trochanter
Neurological: Strength 5/5 except left hip flexors/extensors 4/5. Sensation decreased C6 distribution right hand.

ASSESSMENT AND PLAN

Primary Diagnoses:
1. Chronic post-traumatic multi-site pain syndrome
2. Post-surgical hip pain with functional limitation
3. Post-traumatic cervical strain with C6 radiculopathy
4. Post-traumatic lumbar strain with disc protrusion (L4-L5)
5. Pain-associated sleep disturbance and mood changes

Multimodal Pain Management Plan:
Interventional Procedures:
1. **Lumbar epidural steroid injection (L4-L5)** - scheduled for 09/25/2025
2. Consider cervical epidural injection if neck symptoms persist after 2 weeks
3. Greater trochanteric bursa injection for hip pain if no improvement

Medication Management:
1. Continue tramadol 50mg q6h PRN (will reassess after procedures)
2. Start gabapentin 300mg TID, titrate up to 600mg TID over 2 weeks for neuropathic component
3. Continue ibuprofen with gastroprotection (add omeprazole 20mg daily)
4. Replace cyclobenzaprine with tizanidine 4mg BID for better muscle relaxation
5. Short course low-dose prednisone 20mg daily x 5 days for acute inflammation

Non-Pharmacological Interventions:
1. Continue PT with focus on functional restoration
2. Add occupational therapy for work conditioning
3. Referral to psychologist for pain coping strategies and mood support
4. Consider TENS unit trial

5. Sleep hygiene counseling

Follow-up Plan:
• Return visit in 2 weeks post-epidural injection
• Functional capacity evaluation in 4-6 weeks
• Goal to wean off daily opioids within 8 weeks
• Return to work evaluation in 6-8 weeks

PATIENT EDUCATION

Patient counseled on:
• Realistic expectations for pain improvement (target 50% reduction)
• Importance of multimodal approach vs. relying solely on medications
• Proper use of gabapentin and potential side effects
• Activity pacing and gradual return to function
• When to contact our office for concerns
• Pain diary completion for next visit

PHYSICIAN ATTESTATION

I have personally examined this patient and reviewed all available records. The above represents my assessment and comprehensive pain management plan.

Electronically signed by: Dr. Patricia Painfree, MD
Date/Time: 09/20/2025, 10:00
Pain Management & Anesthesiology
License #: 97531 (FICTIONAL)
DEA #: BP1234567 (FICTIONAL)