EXHIBIT 2

THE NEUROLOGY CENTER

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Gregory Sahagian, M.D.
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Megan Strowd, PA
Phyllis Taylor, NP

Medical Neurology
Medical-Legal Evaluations
Neuro-Diagnostic Testing

Neuro-Ophthalmology
Neurologic Rehabilitation
Sleep Medicine

Botox Therapy
Headache Medicine
Epilepsy Monitoring

July 10, 2015

Lieff Cabraser Heimann & Bernstein, LLP
Attention Alexandra Brilliant
275 Battery Street, 29th Floor
San Francisco, CA 94111-3339

Re:
DOB:
Your Client-Matter No.

Dear Ms. Brilliant:

is a 33-year-old African American male with a nine-year history in the NFL as a defensive lineman playing for multiple teams. At your request, he was evaluated in my office on June 3, 2015 for a medical-legal evaluation.

HISTORY:

can recall that he had three major concussive type injuries over his career plus significant other multiple heavy head blows that would make him momentarily queasy with visual change.

He had a brief episode of loss of consciousness in his rookie year and was out of it for a few minutes. A second impact occurred in 2012 when he had visual disturbance, as well as dizziness lasting 4-5 plays. The third impact occurred in high school with a fall backward during a game that he felt out of and cannot recall the remainder of the day.

Over time he has noted the onset of the following symptoms that are currently present.

1. Memory loss, poor concentration, and mental focus and loss of basic comprehension and impairment in handling complex tasks.
2. Sleep disturbance
3. Anxiety-panic attacks
4. Irritability, extreme mood swings
5. Depression
6. Headaches
7. Fatigue
8. Chronic pain

, his wife of the last nine years, was interviewed separately on July 9, 2015. She describes extreme irritability is present on a daily basis that she has tried to cope with over the last couple of years. His wife has also noted short-term memory loss, extreme anxiety and depression. She notes he has become socially more withdrawn and as an example cites a recent NFL players reunion that he tried to attend but ended up having a panic attack and calling her from the restroom unable to continue. She notes he needs reminders. When she drives with him, he appears to not know his way around as well. He has become less concerned about his personal hygiene and no longer showers regularly and may need a reminder to do so at times.

ROS:
Fatigue, intermittent tinnitus, difficulty with speech in terms of word finding, incoordination at times, imbalance at times, numbness in the left leg and numbness in hands and feet if standing or sitting for prolonged time. No tremors, hallucinations, visual loss.

PAST MEDICAL HISTORY:
1. Multiple orthopedic surgeries2
2. Sleep apnea surgery
3. Multiple concussions
4. Chronic pain

MEDICATIONS:
1. Norco 5/325 PRN occasionally (not using daily)
2. Flexeril 10mg daily
3. Vyvanse 20mg daily
4. Ambien 10mg QHS 3x/week
5. Alprazolam used rarely

ALLERGIES: INDOCIN – RASH

SOCIAL HISTORY:
Born in Jamaica Queens NY
Married x nine years
Retired NFL
Education: Stanford BS in Comparative Studies (GPA 2.5)
Smokes 1-2 cigarettes per day.
ETOH – occasional social only.
Drugs – none.

FAMILY HISTORY:
Maternal aunt with brain aneurysm
Stroke

Brother Bipolar
Heart disease
Cancer

NEUROLOGIC EXAMINATION:

Vital Signs:
BP138/73, P 83, Wt. 333.5, Ht. 75", BMI 41.68

Mental Status examination:
Montreal Cognitive Assessment (V7.1) = 25/30
Alert and oriented.
Short term memory recall 2/5 at 5'.
Moderately impaired attention tasks.
Impaired serial 7 subtractions.
Mood and thought processes appear normal.
Montreal Cognitive Assessment (7.1) = 25/30

Cranial nerves:
Some smell impairment.
Fields full to finger counting.
Fundi normal
Pupils equal, round and reactive to light and accommodation.
Extra ocular muscles intact without nystagmus.
Facial sensation symmetric.
Hearing intact to finger rub.
Face symmetric in all three divisions.
Tongue and palate normal.
Sternocleidomastoid and trapezii intact.

Motor: Normal tone, power, bulk and coordination. Rapid alternating motions symmetric.

Muscle	Right	Left (0-5, 5= normal)
Deltoid	5/5	5/5
Biceps	5/5	5/5
Triceps	5/5	5/5
Infraspinatus	5/5	5/5
Interossei	5/5	5/5
Wrist extensors	5/5	5/5
Finger extensors	5/5	5/5
Finger flexors	5/5	5/5

Illiopsoas	5/5	5/5
Hamstrings	5/5	5/5
Quadriceps	5/5	5/5
Tibialis anterior	5/5	5/5
Gastrocs	5/5	5/5
Tibialis posterior	5/5	5/5
Toe extensors	5/5	5/5

Reflexes	Right	Left (0-4, 2=normal)
Biceps	1	1
Triceps	1	1
Brachioradialis	1	1
Knee	1	1
Ankle	1	1
Plantar responses	Flexor	Flexor
Ankle clonus	Absent	Absent
Finger Flexors	Absent	Absent

Cerebellar function:
Normal finger, nose, finger. Normal heel shin movements.

Sensory: symmetric to pin, touch and vibration as well as position sense.

Gait: Intact casual gait, heel and toe walk and tandem.
Romberg absent.

Vascular:
Normal pulses in both upper and lower extremities. No bruits.

RECORD REVIEW

Stanford Hospital and Clinics
Date: 10/11/00
Fanton, Gary MD
Operative Report: Pre/Postoperative Diagnosis: Anterior instability shoulder. Right shoulder with large Hill-Sachs lesion, bony Bankart lesion and multiple loose bodies with degenerative labrum. Procedure Performed: Arthroscopy of the right glenohumeral joint, removal of loose bodies, open anterior capsule labral reconstruction with capsule shift and debridement of the ossific labral fragment.

Date: 04/02/01
Fanton, Gary S MD

Progress Note: was here for a recheck on his shoulder. He was doing well in the rehabilitation program. Plan: He put a checker on his pads for spring ball.

Date: 04/25/01
Fanton, Gary S MD
Progress Note: They reviewed his X-rays, which showed good position of his radial neck fracture. He continued improving the range of motion. Plan: He was not ready to return to impact until at least 6 to 8 weeks.

Date: 08/17/01
Fanton, Gary S MD
Progress Note: was status post anterior open reconstruction of the right shoulder. He was doing well. On the examination was within normal limits. Plan: He was cleared to play football.

Date: 05/28/09
Nord, Russell, MD
Progress Note: The patient was here for complained of left Achilles pain. He was playing football with the Eagles at practice when he was pushed and felt a pop in his posterior left ankle and had immediate pain forcing him to cease playing. Since that time he had been wearing a TED hose, non-weigh bearing and Cam walker. On the examination showed palpable defect over the upper tendinous portion of the Achilles tendon. The Thompson test was positive. MRI showed an Achilles tendon tear. Plan: Operative repair of the injury. Vicodin.

Date: 06/09/09
Fanton, Gary S MD
Progress Note: was here for a recheck of his ankle. His Achilles was doing very well. The wound looked great. The doctor put him back on posterior splint today. He started a range of motion program in about 2 weeks. He had non-weight bearing and faithful with his crutches. When he came back, then they will put him a postoperative boot with a 1 inch heel lift and keep him in plantar flexion, but allowed him to remove it for gentle range of motion. He stayed non-weight bearing for 8 weeks postop and then progress as weight bearing as tolerated after that.

Date: 06/30/09
Fanton, Gary S MD
Progress Note: was here for a recheck of his Achilles. The wound looked great. It felt that he had good integrity of the tendon. He started a gentle range of motion program now on his own in the sagittal plane only, dorsiflexion and plantar flexion, but he did not put any weight on it, continue the crutch walking. The doctor gave him a boot to wear. The doctor spoke to his trainer in Philadelphia, and they would like him to rehab in San Diego. His Steri Strips had all been removed.

Date: 07/21/09
Fanton, Gary S MD
Progress Note: was here for a recheck of his left Achilles tendon. His cast boot was removed today. He had not been weight bearing today, nor started a rehab program, other than some very minimal range of motion. He had moderate calf atrophy. The doctor would like to wait at least 2 more weeks before we start progressive weight bearing. The doctor allowed him a range of motion as tolerated and a gradual strengthening program and range of motion program. His incision was well healed, but his calf was considerably atrophied. Since he really had not done much weight bearing yet, the doctor would like to hold off on flying him back to Philadelphia for about 2 more weeks because of the risk of deep venous thrombosis. Based on the amount of atrophy he had sustained after his injury and the nature of his tear, it will be at least until January before he can return to football. These injuries take a minimum of 6 months and typically longer in larger players.

Date: 10/15/09
Fanton, Gary S MD
Progress Note: was here for a recheck of his ankle. His Achilles repair looked excellent. He had no pain. He can easily toe lift on one side and he can essentially fully dorsiflexion and plantar flexion. They started him on a treadmill with some incline now, and for the next 2 weeks they did some light treadmill work, starting with walking, and then a light running program. In 2 weeks they let him run a little bit outside on a track, with his ankle taped to avoid twisting or forced dorsiflexion. That will put him 6 months postop and he could start increasing his strength and training as tolerated to try out for other NFL teams. He continued his strength, endurance program. Range of motion was excellent. He had excellent bulk and no tenderness at the Achilles tendon side, and a well-healed incision. The doctor did renew his ketoprofen cream, and also prescribed some 5-pound ankle weights to work out independently.

Date: 03/26/10
Fanton, Gary S MD
Progress Note: was here for a recheck of his ankle. His Achilles tendon repair was doing fine. He was 10 months postop. He had been running, doing all his workouts. He had no pain, no limitation of motion. There was no tenderness at all at his Achilles tendon and excellent calf circumference. He was clear to return to full activities and play as tolerated.

Date: 05/22/13
Lowenberg, David W MD
Medical Evaluation: The doctor had been asked by the NFL Players Association to obtain a history and examine in regard to injuries he sustained while playing as a football player in the National Football League. The patient now

stated his major problem was his left shoulder and left hip pain. The patient cannot sleep on his left side due to his left shoulder pain. He had pain with reaching behind him and pain with reaching across his body and with any overhead lifting. The pain was present to some extent on a daily basis, and he noted loss of shoulder motion as well. He did not occasional clicking about his left shoulder, which tends to occur with shoulder activity. He had been advised to undergo a left shoulder Arthroscopy with repair of his labral tear. He had not been able to do so at this point. In regard to his left hip, he had been advised to undergo a left hip Arthroscopy to address his left labral tear and possible micro-fracture to a possible chondral injury of the acetabulum. The patient stated that he had pain in his left groin with any prolonged sitting. He could walk distances, but was limited in any activity further than walking. He could jog short distances, but was unable to run due to left hip pain. He noted a popping about his left hip and specific pain with flexion and internal rotation as he describes it. In regard to his left hip, his exam and history of relief of pain with an intra-articular local anesthetic was consistent with intra-articular pathology of the hip. This was consistent with a left hip labral tear; and, in fact, his exam was consistent with a left hip Labral tear. Provided this was the case, this would also best be treated by a left hip Arthroscopy. It was possible he could also have a control problem in his left hip, although the doctor did not know the answer to this without seeing the MRI. I do feel a left hip Arthroscopy, addressing the labral tear and probably repairing this; versus trimming this out and addressing any possible chondral lesion could help him relieve his left hip symptoms. The doctor did feel if these 2 were undertaken, there would probably be at 2 separate operative settings. He would then have to rehabilitate from these after this and let a labral repair heal. The doctor did feel factoring in separating these 2 surgeries out of several weeks and then accounting for physical therapy and rehabilitation, he could then return to play professional football as a lineman, which was the position he played for the Kansas City Chiefs, 12 weeks after initiation of treatment beginning with the 1st surgery.

Cleveland Browns, Clinic
Date: 04/30/04
Dimeff, Robert J. MD
Progress Note: 22 year-old was here for a physical. He had an allergy to Naprosyn, which causes a rash, had previous right shoulder Bankart repair after shoulder dislocation in 10/00. He did report taking Ambien intermittently for difficulty sleeping. Examination was within the normal limits. Impression: Healthy 22 year-old. Plan: Routine preseason screening, updated TB and tetanus, checked hepatitis B surface antibody titer. Chest x-ray was normal.

Date: 05/01/04
Jani, Mihir MD
Progress Note: The patient denied any issues with cervical/thoracic/lumbar spine and had a normal exam. Shoulders: Right shoulder subluxation in 2000 and underwent

Arthroscopy and open Bankart repair in 10/00. He had a significant decrease in external rotation, he went only to about 10-15° on the right vs. 40° on the left. The shoulder was stable to load-and-shift exam. He demonstrated full forward elevation. Normal rotator cuff strength was present. X-rays of right shoulder revealed glenohumeral moderate arthritis and an inferior osteophyte. Arms/elbows: Fracture of his radial neck in 4/01. Hands/fingers: left side index metacarpal fracture in 9/02, treated conservatively. Feet/toes: He had some problems with plantar fasciitis in the past back in January 2004. He wore orthotics and now completely resolved. Impression: Normal exam.

Date: 08/01/04
Dimeff, Robert J. MD
Progress Note: The patient sustained an eversion injury to his right ankle with his ankle plantar flexed. He was complaining of continued medial ankle pain. There was a point tenderness of the medial malleolus. He had pain with passive ankle inversion and eversion. Impression: Possible medial malleolus fracture. Plan: Continued analgesics, ice, were placed in a boot, and obtained an x-ray after this study.

Date: 08/01/04
Dimeff, Robert J. MD
Progress Note: The patient was complaining of a few weeks of sinus congestion and non-productive cough. He reported mild congestion in his ears. He was given a Z-pack and Entex LA with only minimal improvement. At the examination, he presented with fever, nasal hyperemia. The lungs revealed mild coarse rhonchi bilaterally. Impression: Upper respiratory infection. Plan: He was placed on Amoxicillin, Advil Cough & Cold, and general supportive measures.

Date: 01/03/05
Donley, Brian MD
Progress Note: noted he had a right ankle sprain and has had no symptoms or problems. He had played without pain or limitation. On the examination, his right ankle had a good range of motion.

Date: 06/09/05
Gubanich, Paul MD
Dimeff, Robert J. MD
Progress Note: The patient was here for Cleveland Browns pre-season physical examination. In the off season patient had developed some left foot plantar fasciitis, which was mild in nature. He had been exercising with a frozen juice can and also stretching and taking Advil. This helped and barely notices the pain. The examination was within normal limits. Impression: Healthy and history of minor plantar fasciitis. Plan: Routine pre-season testing.

Date: 08/26/05
Miniaci, Anthony MD
Progress Note: was seen for follow up on his left knee. He had experienced some swelling after Wednesday night's practice, they rested him, and obtained an MRI. Today he was feeling much better and was not feeling as much pressure on his knee with very little discomfort. On the examination, the effusion was gone at this time. He still had some very mild lateral joint line discomfort, but had been walking on this without difficulty. The doctor reviewed the MRI, which showed signal changes in the posterior horn of his lateral meniscus and this appears to be a horizontal-type tear of his meniscus. This was small in nature and non-displace fragment. In the posterior aspect of the lateral femoral condyle there was a small condyle defect with some loss of the articular cartilage in this area. The doctor explained to him that because he had these findings that it did not mean it necessitates immediate surgical management. Conservative management had settled down the swelling considerably and had very little pain today. He rested him for tonight's game, however, on Sunday started him back into limited activities at practice and attempt to get him ready for next week's game. They would give consideration to surgical management at some point in the form of a meniscectomy and debridement. This was not an infrequent finding in the NFL in the focal areas of arthrosis. He asked that they send his MRI to Dr. Russell Warren for a second opinion.

The Hospital for Special Surgery
Date: 09/15/05
Warren, Russell, MD
Initial Consultation: This patient played at Stanford. He noticed this summer at camp that he jammed his knee. He felt a pop with some discomfort. He had some pain, swelling and discomfort. Apparently he had an MRI that showed him having a hole in the bone. On the examination, His knee was tender medially, mostly laterally. X-rays showed preservation of the joint space. The meniscus looks frayed. There was a degenerative tear. There was a chondral defect in the lateral side. Impression: Chondral defect. Plan: They discussed the issues of a micro-fracture vs. Mosaic. If the defect was small, which the doctor hope then they'll be doing the Mosaic especially around his lateral compartment. His meniscus looks like it has some degeneration. With the meniscus being injured, it puts more pressure on trying to put material in.

Date: 09/16/05
Warren, Russell, MD
Operative Report: Pre/Post-operative Diagnosis: Left knee pain and meniscal tear and Osteochondritis dissecans lesion. Procedure Performed: Left knee debridement of meniscal tear lateral side and micro-fracture of lateral Osteochondritis dissecans. Procedural Findings: Exploration demonstrated that he had a degenerative lateral meniscus with a horizontal split. The femoral lesion was overlying the meniscus.

The doctor thinks it was probably injured the same time his meniscus was torn. It had distinct horizontal and slightly vertical tear in the back part. It was trimmed back, but at least 60 to 70% of the meniscus remains.

Date: 09/19/05
Warren, Russell, MD
Progress Note: The patient was status post micro-fracture debridement with lateral meniscus. He was actually doing well. He had nice motion. He was going to use the CPM out in San Diego. They will see him back here in four to five weeks.

Date: 10/28/05
Warren, Russell, MD
Progress Note: This patient was evaluated today regarding his knees. He was doing well. He had full range of motion. He was going to go from partial to full weight bearing. Hold off on heavy weights until 10 weeks. He will get a T-2 weighted MRI of his micro-fracture in January. At the present time he had some obstructive like urinary complaints. They checked his urine. They will have him see an urologist when he gets back home.

Date: 01/05/06
Warren, Russell, MD
Progress Note: This patient was seen today regarding his knee. He was a status post micro-fracture. He was doing well. There was full motion. MRI was ordered. He was to try to progress to running in the beginning of March and work on his weights and strength.

Scripps Mercy Hospital, Sleep Disorder Center
Date: 12/14/05
Spinweber, Cheryl L. PhD
Sleep Disorder Medicine
Consult because of snoring and difficulty sleeping. The patient snored very significantly. Snoring ranged from mild to loud and was, at times, associated with mild sleep fragmentation. Mild obstructive events were noted during REM sleep. The overall Respiratory Disturbance Index was quite low at 3.8, but the REM index was elevated at 11.7.
The examiner was also working with the patient to improve his sleep scheduling and ability to fall asleep more readily to help him obtain adequate sleep. The patient had very significant difficulty falling asleep at night and his total sleep time was greatly reduced.

Hillcrest Head and Neck Associates
Date: 01/31/06

Rivet, Pierre G. MD, FACS
Otolaryngology
Consultation Report: a 24-year-old, NFL football player for the Cleveland Browns. He stated that he has had a significant snoring with sleep interruption. He had also stated that his bed partner has noted sleep apnea. Polysomnography revealed a respiratory disturbance index of 3.8 with his REM index elevated at 11.7. Also, he complained of constant, right greater than left nasal airway obstruction, which had affected his occupation and airway at night. He had allergy testing was found to be positive for ragweed and multiple pollens.
On examination of the nose, there was significant right inferior turbinate hypertrophy with moderate right middle turbinate hypertrophy. The left inferior turbinate also impinges somewhat on the left, but not as much as the right. On examination of the mouth and throat, there was a very long palate and uvula with heavy palatal tissues and moderate tonsil hypertrophy.
It was the doctor's opinion that had turbinate hypertrophy, which caused airway obstruction in association with his allergic rhinitis. He also had mild sleep apnea with snoring and sleep interruption. Recommendation: Sub-mucosal resection of the right inferior turbinate as well as laser reduction of his palate and uvula with intracapsular partial tonsillectomy.

Date: 02/14/06
Rivet, Pierre G. MD, FACS
Otolaryngology
Operative Report: Pre/Postoperative Diagnosis: Bilateral inferior turbinate hypertrophy, right greater than left with nasal airway obstruction and snoring with observed sleep apnea.
Procedure Performed: Sub-mucosa resection of the right inferior turbinate with left inferior laser turbinate reduction and C02 laser palatoplasty with partial uvulectomy and intra capsular tonsillectomy.

Date: 02/21/06
Rivet, Pierre G. MD, FACS
Otolaryngology
Progress Note: The patient complained of pain. The throat was well healed. Recommendation: Percocet and Ibuprofen. Return in a week.

Date: 03/01/06
Rivet, Pierre G. MD, FACS
Otolaryngology
Progress Note: The patient's snoring improved, nasal airway better and throat was well healed. Plan: Return in 3 weeks.

Date: 02/12/07

Rivet, Pierre G. MD, FACS
Otolaryngology
Progress Note: The patient presented much better with nasal cough and increased nasal drainage. On the examination, there was postnasal exudate. Impression: Acute sinusitis. Plan: Sinus XR and antibiotic.

Date: 02/06/10
Rivet, Pierre G. MD, FACS
Otolaryngology
Progress Note: The patient presented with recurrent snoring and his sleep had been worse. On the examination, there was nasopharyngeal tissue hypertrophy with 80% of airway obstruction. Impression: Left nasopharyngeal tissue hypertrophy. Recommendation: handwritten illegible.

Denver Broncos Football Club
Date: 03/23/06
Schlegel, Theodore F. MD
Progress Note: 24-year-old defensive lineman from the Cleveland Browns, who was seen today for a pre-signing physical. Of significance, this player had recently undergone an arthroscopy with partial lateral meniscectomy and micro fracture of the lateral femoral condyle in September of 2005 by Dr. Russ Warren. He had followed through with the rehab program as outlined. He was recovering nicely, and he had no major setbacks. He had an MRI, which showed the defect is filled with fiber cartilage. Overall, he did well. He had not had an opportunity to return to play at this point. He still would be a risk since he had not returned to competitive play.

Date: 08/12/06
Charron, Kevin MD
Progress Note: The patient in last night's game thigh sustained a left proximal-medial strain. The patient stated that it feels like a muscle pull. On physical examination, the patient had tenderness to palpation in the medial proximal thigh over the adductor longus. Impression: Left adductor strain. Plan: PLAN: The patient was going to continue a course of ice, stretching, and NSAIDS.

Date: 09/15/06
Boublik, Martin MD
Progress Note: a 24 year-old defensive lineman who injured his right knee in practice yesterday, 09/14/06. He was engaged with another player and sustained what he thinks was a hyperflexion, twisting type injury to his right knee. He felt a 'pop' in his knee and had primarily lateral pain. He finished practice with some mild soreness. He iced and elevated his knee. He woke up this morning with a stiff, swollen right knee. The pain was diffuse but it is primarily lateral. The patient did have left knee surgery by Dr. Russell Warren, 09/16/05 with left knee debridement of meniscus tear and

microfracture lateral compartment Osteochondritis desiccants. On the examination, gait mildly antalgic right.
Right knee with a mild effusion. Range of motion 0-110 with lateral and posterior-lateral discomfort at both extremes. The patient was tender over the lateral joint line. He has lateral pain with lateral McMurray's. Lateral pain with medial McMurray's. He was tender to palpation laterally over his posterior-lateral corner in the LCL. At 30 degrees of flexion, he had mild varus stress laxity with pain. Impression: Left knee presumed lateral compartment, injury with possible lateral meniscal or lateral chondral injury and possible lateral collateral ligament sprain. Plan: MRI of the right knee.

Date: 09/19/06
Boublik, Martin MD
Operative Report: Pre/Postoperative Diagnosis: Right knee lateral meniscus tear. Right knee lateral collateral ligament sprain. Right knee plicae. Procedure Performed: Right knee arthroscopic partial lateral meniscectomy. Right knee arthroscopic debridement. Arthroscopic Findings: Right knee, mild diffuse synovitis. Patellofemoral joint with intact articular cartilage on the patella and minimal grade I chondromalacia on the opposing trochlea. Grade II medial shelf plica with small focus of grade II chondromalacia distal extreme medial trochlea. Grade II infrapatellar plica. Mild grade I chondromalacia on the medial tibial plateau, the intact articular surface of the medial femoral condyle, and intact medial meniscus. In the lateral compartment, the patient had mid third of posterior third white-white moderate degenerative lateral meniscus tear with two fairly significant unstable flaps at the anterior and posterior aspect of the tear. The posterior flap was noted to be reflected under the posterior third of the lateral meniscus at the time of entering into the joint. The tear was white-white and degenerative. It involved approximately 25% of the total surface area of the lateral meniscus. The articular surface of the lateral tibial plateau was grade I. The articular surface of the lateral femoral condyle was intact. Plan: The patient had partial weight bearing for one week. Passive Full range of motion. He had a protected in the hinged knee brace to reduce stress to his lateral collateral ligament.

Date: 09/20/06
Boublik, Martin MD
Progress Note: was post op day one from right knee arthroscopic debridement and partial lateral meniscectomy, 09/19/06. Routine follow-up. States, he was fairly sore around his portals last night, but felt better this morning. On the examination, right knee: benign portals x2. Mild effusion. Passive range of motion quite comfortably. Plan: Patient began a rehab program with our physical therapists today and then transition back to the Denver Broncos training staff. Partial weight bearing in one week. They protected his LCL in a hinged knee brace.

Date: 09/25/06
Boublik, Martin MD

Progress Note: was postop day six from right knee arthroscopic partial lateral meniscectomy. He had been working on rehabilitation with the training staff. He was using one crutch and a brace. He stated that his knee feels quite good. On the examination, right knee had traces of effusion. Range of motion 0-135 with mild anterior and posterior tightness on forced flexion. The patient had traced lateral joint line tenderness. He had mild tenderness postero-laterally in the region of his LCL. With gentle varus stressing at 30 degrees of flexion, he had no gross instability and the fibular ligament is palpable. Plan: Upgrade rehab with the transition to a functional brace as the swelling and comfort allows. Progress weight bearing as tolerated. Sutures out later this week.

Date: 10/04/06
Lind, Charles MD
Progress Note: was 2-3 weeks status post right knee Arthroscopy with partial lateral meniscectomy for a lateral meniscus tear and fibular collateral ligament sprain. at this point still had some very mild pain along the lateral aspect of his knee but was doing his rehab comfortably. On physical examination, there was no significant effusion in his knee. He was mildly tender over the lateral joint line. The fibular collateral ligament is non-tender to palpation and intact. He had 1+ instability to varus stress with the knee flexed to 30 degrees. Lachman's 1+ with a firm end point. Impression: Approximately 2 weeks status post right knee Arthroscopy with partial lateral meniscectomy. Fibular collateral ligament sprain. Plan: continued to progress his rehab as he tolerates and continued bracing his knee.

Date: 10/10/06
Lind, Charles MD
Progress Note: was 3 weeks status post right knee Arthroscopy with partial lateral meniscectomy and isolated fibular collateral ligament sprain. He had been returning to practice with the functional brace. He had some pain in the area of the fibular collateral ligament of his right knee. However, he was tolerating his rehab well. On physical examination, there was no significant effusion of his knee. His knee came to full extension, 140 degrees of flexion without pain. There was no significant tenderness to palpation along the lateral joint line or the medial joint line. He had 1+ Lachman with a firm end point. 1+ posterior drawer with a firm end point. However, with his knee flexed 30 degrees, he did have 3 mm of opening to varus stress with a painful end point. In the figure-four position the fibular collateral ligament can be palpated down to its insertion on the head of the fibula, however, it was tender in this area. Impression: Three weeks status post right knee Arthroscopy with partial lateral meniscectomy. Grade 2 fibular collateral ligament sprain. Plan: They continued to allow to progress his activity as tolerated in the functional knee brace and rehabilitation. No real restrictions at this point, and he could return to play as tolerated.

Date: 10/16/06
Boublik, Martin MD
Progress Note: The player was status post right knee Arthroscopy with partial lateral meniscectomy 9/19/06. He also had a high grade fibular collateral ligament sprain. He had been progressing well with rehab. He still had some mild occasional aching in his knee and this can be posterior and at times even medial. He had been fitted for a Townsend brace. He had already done a fair bit of functional activity. On the examination, Right knee was within normal limits. Plan: He continued to upgrade his activities with hopefully return to practice in a brace later this week.

Date: 12/12/06
Geraghty, John S. MD
Progress Note: The patient presented with headaches and right maxillary pain. On the examination, the patient had occasional cough, purulent discharge for the nostril with mild redness of the mucous and mild right maxillary tenderness. The lungs had soft wheeze throughout. Assessment: Acute sinusitis. Bronchospasm.

Date: 05/17/07
Lind, Charles F. MD
Progress Note: A 25-year-old defensive tackle. With history of right shoulder bony Bankart injury and repair in October of 2000. There was a history of some early degenerative change on x-ray. The patient had a history of right elbow radial neck fracture in April of 2003 and left index finger metacarpal fractures in September 2003 treated nonoperative. Left thumb proximal phalanx fracture in September 2005. Left knee meniscus repaired and microfracture in September 2005. Right knee, partial lateral meniscectomy on September 18, 2007. Also at the time of the injury, he sustained a grade II lateral collateral ligament sprain. He was treated in the brace after the injury. Approximately, five to six games were missed. He returned to play in the brace. Currently asymptomatic with no residual symptoms. Examination of the upper extremities were normal with the exception of lack of approximately 15 degrees of external rotation on the right compared to the contralateral shoulder. Both knees examined normally with no significant effusions, joint line tenderness, or instability. Impression: No ongoing orthopedic issues. Fit to play professional football.

Select Physical Therapy
Date: 09/03/08
Munson, Susan E. PT
Evaluation Note: The patient was presented with complained of mild tenderness and swelling over the lateral portion of left knee. On the examination, there was mild tenderness and swelling over the lateral portion of left knee and mild swelling over lateral portal when contracts quad. Plan: The patient required skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as

outlined in the problems and goals section of this evaluation. The overall rehabilitation potential was excellent.

Date: 09/11/08
Munson, Susan E. PT
Progress Note: The patient had mildly improvement today, less tenderness to the palpation and active motion. The therapy decreased the point of tenderness.

Date: 09/15/08
Schleicher, Eric A. PT
Progress Note: The patient had minimal complaints with all stretching, manual resistance and pool running. His upper quad still slightly tender to the touch.

Date: 09/24/08
Munson, Susan E. PT
Evaluation Note: The patient was able to complete a full workout but felt mildly sore post exercises and stated that his quickness off the ball was limited by his hip pain. He had soft tissue work done, which helped to decrease the pain.

Date: 09/30/08
Schleicher, Eric A. PT
Progress Note: The patient stated that his hip had been feeling good with the rest and with ADL's, however, he reported mild discomfort with running and changing direction last week.

Date: 10/02/08
Schleicher, Eric A. PT
Progress Note: The patient was slight soreness post running, cutting with agility work yesterday but minimal soreness today. He had a very slightly tenderness in the middle belly region.

Date: 07/22/09
Schleicher, Eric A. PT
Evaluation Note: The patient was here post repair of the rupture of left Achilles tendon. He presented with severe restriction of his left gastrocnemius and Soleus. He had severe limitation of the left Achilles tendon and had a weakness in the left ankle plantar flexion. Plan: He required skilled physical therapy for decreased pain, improve function, increased range of motion and strength.

Date: 07/29/09
Schleicher, Eric A. PT
Progress Note: The patient presented moderate restriction of the gastrocnemius and Soleus muscle. There was a moderate limitation of the mobility of the left Achilles

tendon. He still had weakness plantar flexion and limitation of the range motion of the left ankle.

Date: 08/07/09
Schleicher, Eric A. PT
Progress Note: The patient's overall condition was improving. He had tolerated weight bearing pressure with pool activities. There was moderate tenderness with soft tissue mobilization. Plan: continued current rehabilitation.

Date: 08/14/09
Schleicher, Eric A. PT
Progress Note: The patient was doing better with the gait but was getting mild burning sensation with prolonged walking at the incision site. Best dorsiflexion today. His calf strength was improving but was unable to heel raise without upper body support and significant forward lean at waist. Plan: continued current rehabilitation.

Date: 08/21/09
Schleicher, Eric A. PT
Progress Note: The patient had mild muscular soreness from increased eccentric work. He still had mild restriction of the calf and weakness of dorsiflexion of the ankle.

Date: 08/27/09
Dehulsters, Valerie K. PT
Progress Note: The patient had made range of motion gains since his initial evaluation, however, he still lack of significant strength with both concentric and eccentric plantar flexion. Plan: continue with skilled physical therapy.

Date: 09/18/09
Munson, Susan E. PT
Progress Note: The patient had minimally decreased push off with gait and slightly antalgic gait. He was unable to perform single heel raise. There was a mild increase in soreness from pool HEP work yesterday, but gait and overall function increased post pool work. The patient tolerated today's treatment intervention with minimal complaints of pain. Plan: Continue with current program.

Date: 09/25/09
Munson, Susan E. PT
Progress Note: The patient's pain was worse after a workout and he had swelling in medial region the Achilles at night and stiffness after ride a car more than 1 hour. He presented a limited range of motion of the left ankle. The patient tolerated today's treatment intervention with mild complaints of pain. Plan: add a pool.

Date: 10/02/09

Munson, Susan E. PT
Progress Note: The patient's overall condition was sore at the plantar fascia at the heel. There was a mild restriction in the gastrocnemius and slight restriction of the Soleus. His balance was fair with one leg and eye closed bilateral. There was a limitation of the range of motion in the left ankle. Plan: Continued with the current plan.

Date: 10/09/09
Munson, Susan E. PT
Progress Note: The patient's condition was improving, there was no limitation of the left gastrocnemius and Soleus. His left ankle range of motion was within normal limits.

Date: 10/12/09
Schleicher, Eric A. PT
Progress Note: The patient had mildly achy at the incision area, but no complained to all ADL's including stairs. He was able to heel raise without upper extremity assistance. Plan: Continued with the same plan.

Date: 10/15/09
Munson, Susan E. PT
Progress Note: The patient runs well in his initial treadmill run. He had slight limitation with the heel strike and toe of the left leg, but overall his gait was fairly good. Plan: Continued strength and jogging program as tolerated.

Date: 10/30/09
Munson, Susan E. PT
Reevaluation Note: The patient remained with decreased strength into plantar flexion but within normal limits for inversion/eversion/dorsiflexion. He required skilled physical therapy to address this problem.

Date: 11/04/09
Schleicher, Eric A. PT
Progress Note: The patient felt fairly good with the initial running outside yesterday, but got stiff and sore later that day. The soreness improved with the therapy. Plan: continued with the current plan.

Date: 11/11/09
Munson, Susan E. PT
Progress Note: The patient felt really good with running and had minimal soreness. He was running at ¾ speed and striding was improving. Plan: continued with the current plan.

Date: 11/20/09
Munson, Susan E. PT

Progress Note: The patient stated was tired, but Achilles was doing well. Did get off with running program yesterday, no soreness, but felt mildly awkward. The patient tolerated today's treatment intervention without complaints of pain or difficulty.

Date: 11/18/09
Munson, Susan E. PT
Progress Note: The patient continued to improve steadily and was running at near full speed without complaints. The patient tolerated today's treatment intervention with minimal complaints of pain. Plan: Continue with current program. To start doing get off with running drills tomorrow.

Date: 11/13/09
Munson, Susan E. PT
Progress Note: The patient was doing well, no complaint with running the program, but moderately fatigued today from workouts this week. Limited gym program today due to general fatigue. Overall Achilles was doing very well.

Date: 11/27/09
Munson, Susan E. PT
Progress Note: The patient with no new Complaints. His overall condition was improving. The patient tolerated today's treatment intervention without complaints of pain or difficulty. There was weakness in the ankle plantar flexion. Plan: Continue with current program. Begin cutting program w/ running work next week.

Date: 12/02/09
Munson, Susan E. PT
Progress Note: The patient tore his Achilles in football mini-camp 5/21/09 and had it surgery repair on 5/26/09; started progressive weight bearing as tolerated in 2 weeks. He was unable to work secondary to dysfunction. Plan: It was recommended that the patient attend rehabilitative therapy for 1x a week x 4 weeks. Therapeutic Contents: aerobic conditioning, functional activities, interval athletic program, Home Exercise Program, joint mobilization techniques, neuromuscular Re-education, proprioceptive/closed kinetic chain activities, stretching/flexibility activities and soft tissue mobilization techniques.

Date: 12/04/09
Schleicher, Eric A. PT
Progress Note: The patient complained of stiffness only after car rides. He was doing well and could run S's and get offs off both hands down without complaining about now. He's running at near full speed. The patient tolerated today's treatment intervention without complaints of pain or difficulty. Plan: Continue 1x week until end of the month and then discharge to gym program.

Date: 12/09/09
Schleicher, Eric A. PT
Progress Note: The patient was progressing well with cutting and running program. He felt that he was doing equally well with cutting to his left and right. He had no complaints with getting offs bilaterally. The patient tolerated today's treatment intervention without complaints of pain or difficulty.

Date: 12/16/09
Schleicher, Eric A. PT
Progress Note: The patient was very pleased with the progress and wants to increase functional running and training at this time. The patient tolerated today's treatment intervention with minimal complaints of pain.

Date: 01/06/10
Munson, Susan E. PT
Discharge Note: Based on this patient's clinical presentation, it was the therapist's opinion that the patient was discharged at this time with an excellent prognosis.

Rothman Institute
Date: 05/21/09
Marchetto, Paul MD
Progress Note: The patient was here complained of left ankle pain and inability to plantar flex against resistance. He had tenderness to the distal 3rd at the junction of the Achilles and the calcaneus, approx. 3 inches from the insertion. Thompson sign was positive. The active plantar flexion was abnormal. Impression: left Achilles tendon rupture. Plan: Boot immobilization and follow up for further evaluation.

Seattle Seahawks
Date: 08/18/10
McAdam, Michael MD
Physical Evaluation: He had a history of a number of different injuries in both his collegiate and pro career. He had a right shoulder dislocation treated with an open stabilization while he was at Stanford in 2000 by Dr. Gary Fanton. He also had a nonoperative treated radial neck fracture and left thumb fracture during that time frame as well. He had a high ankle sprain in the past of his right ankle and then recently in May of 2009 had an Achilles repair on the left ankle while he was with the Jets. He also had a microfracture of his lateral femoral condyle of his left knee and a lateral meniscectomy of his right knee. He did not report any current problems with any of these things. He reported that his training and activities were full. On the examination, his shoulder range of motion showed slight limitation of his maximal forward elevation. There was mild crepitus in the joint. He had pseudovarus and valgus laxity in both of his knees. He had a scar over his Achilles with a little bit of fusiform swelling over the Achilles itself but good strength on plantar flexion. X-rays: On bilateral knees, he had

moderate lateral joint space narrowing of the right knee and fairly advanced of the left knee with only 1-2 mm of joint space still remaining. There was some irregularity in the lateral femoral condyle consistent with the microfracture. His right shoulder also has moderate joint space narrowing, but no osteophyte formation. His right elbow appeared completely normal, as do his left thumb x-rays. His ankle x-ray showed very minimal spurring in the medial gutters on both sides. Impression: Bilateral knee lateral compartment arthritis status post meniscectomy and microfracture. Right shoulder arthritis status post opens stabilization in 2000. Right radial head fracture. Left thumb fracture. High ankle sprain on the right and Achilles repair on the left ankle. Plan: The doctor discussed with that he did have some significant issues that did not prevent him from playing football and he was cleared from a physical standpoint to play, but the doctor had discussed with him and recommended to the waivers by the team on his knees and his shoulder given the significant arthritis that was present in all of these that could cause missed time.

Date: 08/26/10
Drezner, Jonathan MD
Progress Note: complained of trouble sleeping. He had a good result with Ambien in the past. He came late to training camp and had a lot on his mind. Plan: Ambien.

Date: 09/02/10
McAdam, Michael MD
Progress Note: During the fourth quarter became entangled during a pileup and felt some pain in his left Achilles. He was examined both on the sideline and afterwards. He did had some tenderness in the area of the slight thickening below his prior Achilles repair on the left side. Impression: Left Achilles tendon strain. Plan: reevaluated in the morning and continued to practice and play as tolerated.

Date: 12/16/10
McAdam, Michael MD
Progress Note: noted at the end of practice being involved in a play in which he was driven back and hyperflexed his right knee. He noticed some numbness in the lateral aspect of his leg and dorsum of his foot. On the examination, he had fairly significant diminished sensation subjectively in both the deep peroneal and superficial peroneal distributions. He was fairly exquisitely tender in the area just medial to his biceps femoris in the area of the common peroneal nerve, although none over the fibular neck. Impression: Impression: Compressive injury to the common peroneal nerve behind the posterior-lateral aspect of the knee. Plan: He was instructed to monitor his symptoms during the meetings and come and report to us afterwards to let us know how it is doing. If it did seem to be getting worse, they may start him on a prednisone Dosepak but likely this will improve with no intervention treatment.

Date: 12/20/10
McAdam, Michael MD
Progress Note: was seen for follow-up on his right leg. The neurologic symptoms resolved pretty quickly, but then he started having some pain in the deep lateral portion of his calf. The examination was within normal limits. Impression: Significant improvement status post his right calf strain. Plan: Progression of his rehab regimen as tolerated with excepted ability to participate in practice Wednesday.

Orthopaedics, Sports Medicine Clinic Kansas City, PA
Date: 01/03/12
Barnthouse, Cris D. MD
Progress Note: The patient was seen today, the day following his physicals for his left shoulder and bilateral knees. Indicates with regards to his left shoulder, most of his soreness was posterior shoulder soreness without radiating down his arm. Exam today revealed nearly full motion of his left shoulder without significant restrictions. He had a painful arc of motion in the scapular plane and forward flexion plane from approximately 90 to 150 degrees. Right knee was 1+ effusion. Motion O to 125. Mild lateral joint line pain. Mild very trace asymmetric varus laxity at 30 degrees of flexion. Left knee exam with mild asymmetric 1+ retro-patellar crepitance noted, particularly between 60 and 20 degrees of flexion. Mild diffuse lateral joint line soreness. Previous lateral meniscectomy and microfracture on the involved left knee. MRI showed on the left shoulder primarily low to moderate grade articular surface supraspinatus tendon tear with some mild AC joint edema. Right knee showed prior lateral meniscectomy with full thickness defect lateral femoral condyle. Left knee MRI primarily showed significant prior lateral meniscectomy with again full thickness chondral defect lateral femoral condyle and some mild to moderate lateral facet chondrosis. Recommendation: At this point, the doctor would suggest attempts at non-surgical treatment for all three areas. The RPR type injection had been outlined. Rehabilitation.

Date: 05/09/12
Barnthouse, Cris D. MD
Progress Note: The patient participated as a professional football player for the Kansas City Chiefs. Previously seen and evaluated for his right knee. He recently noted onset of soreness in his postero-lateral knee associated with increased workouts on turf. Significantly, he had a soreness in this area in previous season treated effectively with appropriate active rest and treatment. On the examination, he had a mild effusion. His motion today was approximately full extension to 130 degrees of flexion. His soreness was demonstrable with palpation on the very posterior aspect of his fibula near the direct heads of both short and long heads of the biceps. Impression: Right knee pain insertional tendinosis of the distal biceps. Recommend: Recommend modification of activities, appropriate local treatment in this area as he was currently receiving.

Date: 09/03/12
Barnthouse, Cris D. MD
Progress Note: Today, he denied any other specific injuries that were limiting. He indicated that at this point, none of these injuries would restrict his ability to participate in NFL football. The form as presented to him from the Kansas City Chiefs, he completed the area of injury, signed, and indicated that he thought he could participate in football. On the examination today of his back revealed some minor soreness to palpation in the right side just right of the midline at approximately the L5 region. Forward flexion reproduced minimal symptoms. Extension reproduced some minor soreness in that same location. The right knee revealed minimal- swelling. Motion was O to approximately 130 compared to O to 132 opposite knee. He had a grade I retro-patellar crepitance. Minor soreness to palpation over the lateral aspect of the knee. Exam today of his right Achilles tendon revealed mild soreness approximately 4 to 5 cm proximal to the attachment site. Very minimal thickening of the tendon was identified. Recommendation: Discussed with him options of treatment, and at this point, he would like to undergo additional radiographs of his back, and these will be arranged in communication with the team trainer.

Scripps Carmel Valley
Date: 09/21/12
Rachna, Jafri A. MD
Family Medicine
Progress Note: The patient was here regarding to difficulty sleeping as he was waived from the Kansa City NFL team. Any little thing made him irritable and sets him off. He was frustrated and didn't want to snap. He also had sinus pain. On the physical examination, there was facial pressure in his sinus, and it hurt his face to bend over. Assessment: Adjustment disorder with anxiety and sinusitis. Plan: Clonazepam, Azithromycin and mental health consultation.

Medical Evaluation
Date: 06/11/13
Young, Shaun PA
Evaluation Report: 31-year-old gentleman who presented to the clinic for evaluation of multiple body parts. The patient was a former defensive lineman in the NFL. The patient played a total of 9 years for multiple teams, including the Cleveland Browns, Denver Broncos, Baltimore Ravens, Tennessee Titans, Philadelphia Eagles, Northern Patriots, Seattle Seahawks, Tennessee Titans, Houston Texans, and Kansas City Chiefs. The patient presented to the clinic for evaluation of multiple body parts that he either had single injuries to or cumulative injuries to over the course of his career. The patient complained of pain, weakness, decreased range of motion, decreased strength, and multiple body parts following his career in the NFL including C-spine, L-

spine, left shoulder, right shoulder, right elbow, right wrist, left hip, bilateral knees, right ankle, and left Achilles.
On the examination and reviewed of the Imaging they found; had evidence of lumbar spine sprain, strain with mild degenerative changes and mild disc bulge at L4-L5. He had evidence of left shoulder labrum tears, left shoulder instability, and impingement syndrome acromio-clavicular joint arthrosis right shoulder. As well as there was evidence of right shoulder SLAP labrum tear, impingement syndrome, and acromio-clavicular joint arthrosis. had evidence of right elbow previous fracture with near-normal right elbow examination. There was evidence of right wrist sprain, strain early degenerative joint disease. had evidence of a left hip labrum tear with Cam type impingement. He also had evidence of bilateral knee degenerative joint disease and had evidence of right ankle multiple sprains and early degenerative changes. He was doing well, status post opens left Achilles tendon repair with occasional tendinitis pain and some atrophy.
Using the combined values chart, they combined the 17% whole person for the left lower extremity with 12% for the right lower extremity with 11% for the left upper extremity plus 11% for the right upper extremity plus 5% for the L-spine, plus 5% of the C-spine does come out to total combined value of 48% total whole person impairment.
The medical opinion on impairment was of the highest degree of medical certainty. The patient did sustain multiple injuries during his NFL career, which did cause continued pain, orthopedic impairments, his cervical spine, lumbar spine both upper and lower extremities.
The patient should be afforded future medical care for the above-listed body parts including the cervical spine, lumbar spine, right shoulder, right elbow, right wrist, left shoulder, left hip, right knee, right ankle, left knee, and left Achilles. The patient's future medical care may include occasional physician office visits, anti-inflammatory medication, physical therapy, injections, bracing, and/or ultimately he may require surgeries as well.

Amen Clinics
Date: 01/05/15
Tucker, Lawrence MD
Initial Note: previously played football in the NFL and sustained many head injuries. He currently exhibits memory loss, cognitive concerns, sleep problems, and chronic pain. played football for almost two decades. He had MRI's performed in 2013, which indicated he had left frontal lobe damage and two iron deposits on both of his hemispheres. He has had other MRI's on his spine, which showed he was losing curvature of his spine, and was dehydrating the discs in his lower back L5 and his neck. had recognized cognitive deterioration over the years. He had periods of spaces and confusion, including daydreaming when he was driving and losing his train of thought intermittently. He often forgets what he was going to say. He felt more disoriented when navigating, which never used to pose a problem. finds it

difficult to perform basic activities and he often felt fatigued. His reading comprehension had been lacking and his reading speed had slowed down. had to do a lot of reading and it was difficult and struggled more with receiving auditory directions. The mental status examination was within normal limits. Plan: SPECT Study.

Date: 04/01/15
Tucker, Lawrence, MD
Progress Note: The Patient presented with problems falling asleep at night, continued to have fatigue during the day. He was having a lot of stress to the family and had a hard time driving long distance, because his hands fall asleep. The patient continued to have bad headaches and light sensitivity. His mood had been better overall, however, some frustration transitioning. Wife had noticed decreased mood swings. He continued to have some anxiety and used breathing techniques to help him. The wife noticed that the patient had been forgetting things. He had poor concentration and focusing throughout the day. Mental Status Examination: His affect was congruent with mood without liability. The mood was euthymic. Behavior was normative. Thought Process was linear and insight/judgment was good. Diagnoses: Brain injury NEC, encephalopathy NOS, frontal/temporal lobe disorder/dysfunction, attention-deficit and hyperactivity disorder and anxiety disorder. Recommendations: Continue current treatment plan; start on Vyvanse. Patient follow-up in 1 Month.

HealthSouth
Date: 09/30/05
Munson, Susan E. PT
Initial Evaluation: The patient presented left knee derangement medial meniscus and left wrist metacarpal base fracture. He was no weight bearing with limited ADL's function. He had a moderate loss of motion and stiffness, minimal pain and mild swelling. There were limitations of the left thumb opposition, abduction, abduction, flexion and left knee range of motion. Plan: Exercises, manual intervention, cryotherapy, electric stim and home exercise program. Overall his rehabilitation potential was good.

Date: 10/26/05
Munson, Susan E. PT
Reevaluation Note: The client tolerated treatment and therapeutic activity with minimal complaints of pain and difficulty. His hand had a full active range of motion, no pain and good strength, including normal grip strength. He still in no weight bearing for 1 ½ more weeks. There was a limitation of the range of motion in the left knee and weakness of the hamstring and quadriceps. Plan: Home exercises program, manual range of motion, strength/flexion activities, soft-tissue mobilization, gait training, cryotherapy and aerobic conditioning.

Date: 12/12/05
Munson, Susan E. PT
Reevaluation Note: The patient was now full weight bearing with the left knee; however, still had stiffness and loss motion. He was unable to run. The patient gained strength of his hamstring and quadriceps. There was minimal swelling of the left knee. Plan: Home exercises program, manual range of motion, strength/flexion activities, soft-tissue mobilization, gait training, cryotherapy and aerobic conditioning. They will discuss the advancement to running with the physician.

Date: 01/31/06
Munson, Susan E. PT
Discharge Note: The patient still was unable to run. He presented medial soreness with a pool running and agility work. The patient had all strength in the hamstring and quadriceps. Plan: The patient was being discharged due to insurance, and new chart will be started.

Date: 03/02/07
Stanton, Valerie K. PT
Initial Evaluation: The patient presented post right ankle sprain. He had pain with ambulation and pushing off of the foot. There was a weakness of the dorsiflexion, plantarflexion, eversion and inversion. His gait was abnormal with the decreased of the push off. There was a limitation of the range of motion. Plan: Home exercises program, passive/ active assistive range of motion, stretching/flexibility activities, aerobic conditioning, soft-tissue mobilization, cryotherapy and ultrasound.

Date: 03/30/07
Stanton, Valerie K. PT
Discharge Note: The patient had minimal pain with ambulation and pushing off of the foot. He increased range of motion in plantar flexion, eversion and inversion as well as increased on the strength while was ankle dorsiflexion, plantarflexion, eversion and inversion. Plan: Discharge secondary to the patient was returning to Denver and stated he was doing very well. He continued with a home exercise program.

The Center for Headaches, Spine and Pain Medicine
Date: 02/05/14
Fink, Ezekiel, MD, QME
Independent Medical Evaluation: was evaluated in my office on February 5, 2014 for an IME of the neurologic sequelae that resulted from prolonged participation in football. He participated in football play for two decades, was experiencing ongoing cognitive impairment, headaches, hearing loss, dizziness, tinnitus and behavioral/mood symptoms after retiring from football play. The examiner was going to address the various neurological symptoms below; this patient did have

cognitive impairment affecting multiple areas of function and should undergo neuropsychological screening. did have other symptoms suggesting injury to his nervous system; headaches, tinnitus, dizziness and hearing loss. Plan: The examiner will produce a supplemental report after getting the results of the neuropsychological testing. Further studies, including neuroimaging, may also be required in the patient's case.

The Crosby Center
Date: 12/16/14
Paxton, Venus C. MD
Psychiatric Evaluation: 33-year-old male presented for evaluation. He stated his mood varied and affected by pain. The patient also struggled with depression and anxiety. He as well had poor sleep. In his mental status, his mood was stable with reactive affect, alert and oriented x 3. His memory was grossly intact. DSM-4TR Diagnosis: Axis I: insomnia. Axis III: chronic pain status post multiple injuries. Axis IV: Moderate. Axis V: 60. Recommendation: The patient continued with current medication and followed up in 1-2 weeks.

Confidential Psychological Report
Date: 12/24, 29 and 30/14
Hopper, Laura PhD
Report Note: overall intellectual ability falls within the average range; however, notable strengths and weakness were discovered by analyzing his performance. While he performed well on a number of sub-tests, performance on several sub-tests and measures suggested the presence of auditory memory and processing deficits. These problems can be associated with temporal and frontal damage. performed better than his peer on the task of verbal comprehension. His general fund of knowledge was broad and intact. He was articulated and well educated. It was due to this strength that could appear a problem free. He performed similarly to peers on tasks of perceptual reasoning and working memory, but performed significantly lower on tasks involving processing speed. He took longer than others his age to process information and produce a response. This was a particularly important finding when relating his score in this area to scores in other areas. In fact, the difference between his scores on processing speed and all other areas was so large that it was not often seen in the general population. When differences such as these were seen, it was sometimes associated with a traumatic brain injury.

demonstrated difficulty with both auditory and visual memory. He had difficulty recalling verbally presented information. He demonstrated the ability to learn and improve when provided with multiple trials; however, he was still not able to perform as well as his peer on these tasks. His performance on this subtest measuring auditory memory was below what would be expected given his level of intellectual functioning. also struggled with visually presented information. He could

reproduce designs presented to him with an average degree of accuracy. However; the time in which he took to complete these designs was far longer than his peers. It indicated that he did not feel there was enough time for him to look at the designs. This could be influenced by his deficits in both speed of processing and memory. His performance on memory tasks was significantly lower than what would be expected given his overall level of cognitive functioning. Again, differences such these were suggestive of damage to the brain, particularly in the temporal and frontal areas. endorsed a high number of physical and psychological symptoms, which the MMPI-2-RF indicated was indicative of over-reporting. The SIRS-2 was administrated in order to discern whether his reporting was genuine. reported experiencing symptoms associated with somatic and cognitive dysfunction, anxiety, aggression, helplessness/hopelessness, and idea of percussion, malaise, gastrointestinal issues, head pain and neurological difficulties. He also expressed feeling uncomfortable in social situations and remarked that he had difficulty with social cues. The SIRS-2 indicated that responses were consistent within an individual who was experiencing a genuine disorder and was not attempting to exaggerate the symptoms. Recommendation: The examiner recommended an SPECT scan, neuro feedback program, group therapy, individual therapy and consult a physician.

Diagnostic Testing
Nova Tech EEG
Date: 07/03/15
Sherlin, Leslie PhD, CC-AASP, QEEGD, BCN, BCB
EEG → analysis indicated atypical frequency maxima distribution due to the presence of delta diffusely presented across the cortex. The posterior dominant rhythm in the eyes closed condition was in the 4-6 Hz range. The theta/beta power ratio at site CZ in the eyes closed condition was 3.0. The alpha/beta power ratio in the parietal cortex in the eyes closed condition was 0.6. Normative database comparison analysis indicated decreased absolute power with the exception of increased delta in the central and parietal sites bilaterally. Relative power comparisons illustrate increases of slow activity and the deficits of the alpha maximal in the occipital cortex. There were no clinically significant asymmetries noted. The findings were consistent within both the eyes closed and open condition. However, it should be noted the theta/beta power ratio in the eyes open condition increases to 12.0.

Stanford Hospital and Clinics
Date: 09/29/00
Beaulieu, Christopher F MD
Upper extremity joint MRI → Complex tear of the anterior, inferior labrum with a small chondral fragments. Edema within distal clavicle with fluid in the acromio-clavicular joint noted. Small Hill-Sachs lesion of the humeral head.

Date: 04/10/01
Beaulieu, Christopher F MD
Right elbow XR → showed elevation of the posterior fat pad and a fracture involving the radial neck, presumably this crosses the radial head articular surface as well, but these view did not show it well.

Date: 04/24/01
Lane, Barton MD
Right elbow XR → nondisplaced radial head fracture.

Date: 06/03/01
Lang, Phillip K MD
Right shoulder XR → changes consistent with a healing radial head fracture were seen. There was some mild callus formation.

Date: 11/26/01
Strome, Glenn M. MD
Right shoulder XR → Opacities project over the glenohumeral joint and inferior to the glenoid. These may represent intra-articular bodies. There may be a Hill-Sachs deformity dislocation at this time. There was a suggestion of prior dislocation with possible ossific bodies projecting over the glenohumeral joint which may be related to prior avulsion or impaction. MRI was considered.

Date: 04/19/02
Kane, Peter E. MD
Right ankle XR → no evidence of fracture. No significant soft tissue swelling was identified.

Date: 08/28/02
Jones, Henry H MD
Left elbow XR → there was no displacement of the fat pads of the elbow. There was minimal soft tissue swelling.

Date: 09/17/02
Beaulieu, Christopher F MD
Left hand XR → the left index finger demonstrated an oblique fracture at the mid-shaft of the first metacarpal bone with no displacement or angulation. The soft tissue swelling was noted around the area of the fracture.

Date: 10/08/02
Beaulieu, Christopher F MD
Left hand XR → the oblique fracture of the second metacarpal mid-shaft showed no change in alignment and there was formation of the callus. Slight irregularity of the 2nd

metacarpal head was unchanged. There was soft tissue fullness along the lateral aspect of the hand.

Date: 10/24/02
Stevens, Kathryn L. MD
Left hand XR → There was oblique fracture through the mid shaft of the second metacarpal. Moderate surrounding callus formation. The fracture appeared in good alignment. There was some very minor irregularity of the second metacarpal head with early osteophytosis, this may be represent sequelae of the prior trauma.

Date: 09/11/03
Gold, Gary E. MD
CXR → negative.

Cleveland Browns Clinic
Date: 04/30/04
Bradford, Richmond MD
Right shoulder XR → Narrowing of the glenohumeral joint space with osteophyte formation. There was a 7 mm corticated density consistent with an intercapsular body seen on the AP view just distal to the inferior aspect of the glenoid. Findings were consistent with degenerative changes of the glenohumeral joint with intercapsular body.
CXR → Peri-bronchial cuffing about the hilum. Lungs were free of focal infiltrates and consolidations.

Date: 08/01/04
Belhobek, George MD
Right ankle XR → no acute fracture or dislocation.

Date: 04/21/05
Moon, Doksu MD
Sinuses CT → minimal inflammatory changes in the maxillary sinuses.

Date: 08/25/05
Ilaslan, Hakan MD
Left knee MRI → lateral meniscal tear. Full thickness chondral defect in the lateral femoral condyle with underlying subchondral bone marrow changes.

Date: 09/02/05
Bradford, Richmond MD
Left hand and thumb → Inter-articular, corner fracture of the proximal phalanx of the first ray on the radial side consistent with a collateral ligament avulsion versus a direct blow. Less than 1 mm displacement of the fracture fragment. Deformity of the medial

side of the base of the proximal facets consistent with a remote injury. Remote healed fracture of the second metacarpal with hypertrophic callus remaining. Soft tissue swelling at the first CMC joint.

Date: 09/14/05
Wu, Yee Tu Peter MD
Left thumb XR → avulsed fracture, base and proximal phalanx.

Scripps Mercy Hospital Sleep Disorder Center
Date: 12/09/05
Spinweber, Cheryl L. PhD
Polysomnography → Obstructive sleep apnea syndrome (REM related, mild: respiration is within normal limits when the patient is in non-REM sleep)

The Hospital for Special Surgery
Date: 01/05/06
Potter, Hollis MD
Left knee MRI → demonstrated effects of the microfracture lateral femoral condyle with overall good coverage by reparative fibrocartilage discrete fissure at the interface with native cartilage and degenerative changes lateral compartment.

Denver Broncos
Date: 06/20/07
Loyell, Mark MD
Collins, Micky MD
ImPACT Report: Memory composite (verbal) 74%, Memory composite (Visual) 58%, Visual motor speed composite 43.30%, Reaction time composite 0.56%, Impulse control composite 18% and Total symptom score 27.

Jefferson Outpatient Imaging
Date: 05/22/09
Hobbs, George MD
Left ankle MRI → Extensive mucoid degeneration throughout the Achilles tendon with a superimposed full thickness tear at the distal aspect of the musculotendinous junction. Chronic tear of the anterior talofibular ligament. Chronic medial bundle plantar fasciitis.

Heartland Health Radiology
Date: 08/06/11
Alvarez, Jose F MD
Cervical spine XR → Straightening of the usual cervical lordosis. This may be related to muscle spasm. This was otherwise a negative examination of the cervical spine.

Date: 08/06/11
Bridges, Jack MD
Left ankle XR → normal.
Right elbow XR → normal.
Right shoulder XR → Mild osteoarthrosis of the acromio-clavicular (AC) joint and glenohumeral joint. Possible old avulsion injury to the inferior portion of the glenoid process.
Right knee XR → there was a calcified loose body in the patellofemoral joint space. There was small osteophytes of the medial and lateral femoral condyles.
Left knee XR → Chronic-appearing osteochondral defect of the left lateral femoral condyle. There was a small left knee joint effusion. There was a calcified loose body near the medial tibial spine. A calcified loose body was seen in the patellofemoral joint on the right as well.
Left thumb XR → Mild osteoarthrosis of the metacarpophalangeal (MCP) joint of the left thumb. Small calcifications along the margins of the joint capsule, possibly due to old trauma. There was an old, well-healed fracture of the metacarpal of the index finger.

CDI, St. Louis Park outside Read
Date: 01/03/12
Fritts, Hollis M. MD
Left Knee MRI → Residua of full-thickness vertical radial tear/disruption of the junction of middle and posterior thirds of the lateral meniscus, and expected superimposed residua of partial lateral meniscectomy. Chondromalacia and mild towards moderate osteoarthritis of the lateral joint compartment with mild subjacent reactive bone marrow edema. Expected relatively chronic residua of sprain injury of the proximal fibular collateral ligament. 2.0 x 1.5 cm irregular Grade II to Grade III chondromalacia of the central femoral trochlea without subjacent reactive bone marrow edema.
Right knee MRI → Residua of complete vertical radial tear which disrupts the junction of middle and posterior thirds of the lateral meniscus with surrounding meniscus attenuation expected to represent residua of partial meniscectomy. Ongoing reactive changes of moderate osteoarthritis of the lateral joint compartment. Incomplete nondisplaced 1.5 x 1.0 cm horizontal fracture of subcortical marrow of the lateral rim of the lateral tibial plateau, expected to be associated with lateral symptoms. Findings suspicious for residua of incomplete sprain injury of the proximal ACL. Moderate knee effusion.
Left shoulder MRI → Up to 1.5 cm intrasubstance partial tear/delamination the distal infraspinatus tendon with smaller, up to approximately 7 mm segment of deep surface partial tear extension of the distal infraspinatus tendon. Shallow deep surface tendinopathy and perhaps minor attenuation of the distal superior leading edge of the subscapularis tendon without larger or more well-defined partial or full-thickness tear. Moderate inferior hypertrophy of the acromio-clavicular joint, mild subchondral spur/enthesophyte and mildly thickened coraco-acromial ligament contribute to

borderline encroachment upon the subacromial space. Relatively complex appearing tear of most of the anterior labrum.

Alliance Radiology, PA
Date: 09/03/12
Gorantla, Kavita MD
Right knee MRI → Changes of the prior partial lateral meniscectomy. Stable full thickness chondral loss involving the posterior peripheral weight-bearing surface of the lateral femoro-tibial compartment. New 7.0 mm focus of the cartilage delamination involving the central aspect of the trochlea. New bone contusion involving the anterior periphery of the lateral femoral condyle.

Orthopaedics Sports Medicine Clinic Kansas City, PA
Date: 09/04/12
Voos, James E. MD
Lumbar spine XR → revealed a chronic L5-S1 spondylosis without listhesis.

Advanced Physician MRI & Imaging Center
Date: 02/25/13
Smith, Michael MD
Brain MRI → Small nonspecific finding of the 3 mm focus of signal alteration in the left frontal white matter, consistent with a small focus of gliosis most likely, possibly related to small vessel ischemic event in the past. 2 small low signal foci only on the FLAIR sequence, one on the left and one on the right, in the basal area region, both of which were in line in the same plane. An additional gradient echo sequence in the coronal plane might helpful to exclude the possibility of hemosiderin deposition, which could be seen with tiny foci of prior punctate hemorrhagic traumatic event, if this was clinically relevant. Mild chronic paranasal sinusitis was noted.
Cervical spine MRI → very minimal beginning disc bulge at C4-C5, C5-C6 but no stenosis or focal disc herniation.

MHS
Date: 01/02/15
Conners, C. Keith, Ph.D. and MHS Staff
Conners' Continuous Performance Test II (CPT II V.5)→ The Conners' Continuous Performance Test II (CPT II) is a valuable assessment tool that can reveal important information about an individual's functioning. The instrument is helpful when a diagnosis of ADHD is being considered. had clinically significant Attention Problem, Confidence Index = 77.68%. The CPT discriminant function indicates that the results better match an ADHD clinical profile than non-clinical profile. The Confidence Index can be described in the following way. The chances are 77.68 out of 100 that a clinically significant problem exists.

Brain Health Score
Date: 01/03/15
Brain Health Score → 4.4 low end of expected range 24.3% of individuals.

Amen Clinics
Date: 01/05/15
Tucker, Lawrence MD
Brain SPECT scan → Diffuse and focal increased thalamic tracer activity seen on both studies more intense with concentration. Increased left basal ganglia tracer activity seen at rest, and increased right basal ganglia tracer activity seen on both studies. Patchy increased tracer activity seen on both studies. Decreased right temporal lobe tracer activity seen on both studies, more severe with concentration, and decreased left temporal lobe tracer activity seen on both studies.

DIAGNOSES:

1. **MULTIPLE CONCUSSIVE INJURIES**
2. **TRAUMATIC BRAIN INJURY DUE TO ABOVE**
    a. **COGNITIVE IMPAIREMNT**
        i. **MEMORY LOSS**
        ii. **IMPAIRED PROCESSING AND EXECUTIVE FUNCTION**
        iii. **IMPAIRED ATTENTION AND CONCENTRATION**
        iv. **TINNITUS**
        v. **ABNORMAL BRAIN IMAGING**
    b. **MOOD DISTURBANCE**
        i. **DEPRESSION**
        ii. **ANXIETY**
        iii. **IRRITABILITY**
3. **POST-TRAUMATIC HEADACHES**
4. **SLEEP APNEA**
5. **CHRONIC PAIN**

DISCUSSION:

has a progressive history of cognitive impairment with loss of executive function complicated by the development of depression and the appearance significant anxiety, irritability and panic attacks.

He has had abnormal neuropsychological testing by Dr. Hopper in December 2014 demonstrating diminished memory and processing. I have evaluated Dr. Hopper's report in detail dated December 24, 29 and 30, 2014. The evaluation and scoring of tests includes the use of standardized neuropsychological testing that is generally consistent with diagnostic criteria in Exhibit 1 and Exhibit 2, of the proposed NFL Settlement Agreement, including the use of adequate measures of performance validity and an estimate of premorbid intellectual ability. The testing meets the criteria

of Level 1.5 based on test scores in the domains of learning/memory and executive functioning (processing).

He has been evaluated psychiatrically in December 2014 and found to have significant depression and anxiety for which he is on antidepressant medication, tranquilizers and sleep medication.

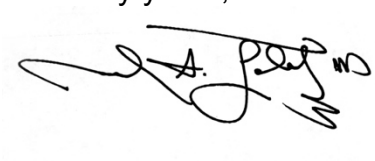
I find that there is concern by there has been a moderate decline in cognitive function and the report of , as well as the neuropsychological findings and other records of the Amen Clinic, Dr. Fink and the Crosby Center document evidence of functional impairments, depression and anxiety that are generally consistent with the criteria set forth in the National Alzheimer's Coordinating Center's Clinical Dementia Rating Scale (CDR) 1.5 (Neurocognitive impairment) in the areas of Community Affairs, Home and Hobbies and personal care.

The cognitive deficits documented in this case for have clearly not occurred exclusively in the context of a delirium, acute substance abuse, or as a result of medication side effects.

I am a board certified neurologist and a copy of my curriculum vitae is attached.

If you have any questions regarding this evaluation please let me know.

Sincerely yours,



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System Medical Director, Scripps Health Neurosciences
Medical Director Scripps Rehabilitation & Traumatic Brain Injury Programs
Vice President Medical Affairs, Scripps Health