

ASSESSMENT PROTOCOLS

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What are Assessment Protocols?

Welcome to Assessment Protocols. This course is designed to teach you the components of Assessment and how to use them. “Why would I need them?”, you may ask. As a massage therapist we are faced with situations on a daily basis that require us to use critical thinking and deductive reasoning to solve our clients’ problems. You may or may not work in a doctor’s office. You may or may not consider yourself as a medical massage therapist. It does not matter where you work. Your clients will have everyday aches and pains that will need to be addressed if you expect them to stick around. For example:

A 25-year-old female comes to your office with complaints of constant bilateral neck pain, with numbness in her right hand. She works as a clerical assistant for a prominent law firm. There is a history of whiplash injury 7 years earlier that was treated by an Orthopedist. The neck pain has been really bad for 2 or 3 months but has bothered her off and on for the last 5 years. The hand numbness started about 3 months ago.

This is a very common type of injury that will be seen by a therapist in all types of work settings. What do you do? Where do you start?

First and foremost, **Massage Therapists Do Not Diagnose.** It is not within the scope of practice of a massage therapist to diagnose any condition. The term “Diagnose” can be defined as the ability to determine the identity of (a disease, illness, etc.) by a medical examination; to give a name or put a label to a disease or syndrome. Diagnosing can only be performed by licensed professionals that have the legal authority to do so (MD, DC, DO, PT). One of the best mottos to follow is “when in doubt, refer out”. If you are presented with a situation that you are either unfamiliar or uncomfortable with, the best course of action is refer the client to the resource that can help them the most.

Although a massage therapist cannot diagnose, they can however, perform assessments of a client’s current condition. “Assessment” can be defined as “an appraisal or evaluation of a client’s condition, which comes from client history, subjective information, and objective findings”. Basically, an assessment deals with finding then “signs” and “symptoms” of a client’s current condition. Signs can be seen, heard, measured or felt by a therapist. Examples of signs include redness, swelling, and bruises. Unlike signs, a symptom can only be recognized and reported by the client. Examples include numbness, weakness, and pain.

A therapist has many tools on hand to help assess a client’s current condition. There are eight different components a massage therapist should become proficient in.

Components of Assessment:

1. Health History Form
2. Client Interview
3. Visual inspection
4. Postural evaluation
5. Muscle palpation
6. Passive and Active Range of Motion
7. Strength/Weakness testing
8. Documentation

Subjective Information

The first tool used to gather subjective information is the **Health History Form**. This form is very important because it informs the therapist many possible contraindications for massage before the session ever begins. Important items on this form are:

- a. Has the client ever had any surgeries? If so, what kind?
- b. Is the client on any current medication that could impair their judgement or sensation to touch?

After the Health History Form has been completed, the therapist will still need to fill in some of the “blanks” that are not covered by the health history form. The **Client Interview** is the next step in gathering subjective information. The Health History Form may include the client’s occupation, but it does not cover the details of their work day. Important questions to ask your client include:

- a. What is their type of work environment? Mostly sitting? Mostly standing?
- b. How long is the commute, as well as what type of traffic? An hour drive in bumper to bumper traffic has a completely different impact than one with little to no traffic.
- c. Are there any repetitive motions or positions required with their work? This could lead to many types of biomechanical dysfunctions that would need to be considered when it came time to develop a treatment plan.
- d. Is there anything that makes your problem better or worse?
- e. Where is your problem are? Be specific. Have the client point to the area, not just say it. Many times, I have had a client tell me their “low back” was hurting, but when I had them point to it, they pointed to their hip.
- f. Are there times of the day that the problem is better or worse?

Objective Information

The next step in Assessment is to gather **Objective Information**. Gathering objective information will be done with and without the client's assistance. We will start with the **Visual Inspection**. When conducting a visual inspection, the therapist is looking for physical and emotional expressions of their complaints. A therapist should compare their client to previous visits. Do they sound and act the same? If this is the initial visit, look for signs of impairment within their speech and gait. As therapist, when should know when a client is in no condition to receive a massage. We should also be looking for signs that we need more information. For example, if the client comes in on crutches and in a cast and we ask them, "How are you today?", and their answer is "Fine.", we are going to need a little bit more information. Sometimes our clients are not very forthcoming or have just gotten use to their everyday issues that they fail to inform the therapist. Without prying into personal information, we should strive to gather as much information that can help us create the best treatment plan possible.

After the brief **Visual Inspection**, we can begin a detailed **Postural Evaluation**. During a postural evaluation, we will look at our client from all sides. We are looking for any asymmetries or postural distortions. These distortions could be structural or muscular. At this point, knowing which one is not crucial. For this portion of the assessment, we are looking at how they relate to gravity and their plumb lines. The next section will list each area to inspect and what to look for in each of the four views.

Anterior View

Feet - When analyzing the feet, look to see if they are directly under the shoulders and pointed straight ahead. Make any notations if they are rotated in any direction (inversion, eversion, lateral, medially) or if they are abducted or adducted. If their feet are laterally rotated, you need to find out if it is coming from the knees or the hips. Have your client sit down. If the feet point forward while seated but rotated while standing, the rotation is in the hip. If they are rotated seated and standing there is a rotation in the knee.

Knees – Look to see if the patellas are the same height on each leg. If one patella is higher than the other, either the quadriceps are hypertonic or they may have one leg shorter than the other. To be properly diagnosed with an anatomically short leg, the client would need to see their physician. If one patella is more medial than the other, check the vastus lateralis. If the knee is more lateral than the other, check vastus medialis.

Pelvis – Check the level of the Anterior Superior Iliac Spine(ASIS) on both sides. If the ASIS are uneven, it is either the hip is elevated or rotated.

Hands – When looking at the hands, they should be by their sides with the thumbs pointed forward. If the dorsal part of the hand is showing, it is either medial rotation of the shoulder or pronation of the forearm. If the crease of the elbow is pointed towards the body, the shoulder is medially rotated. If the crease of the elbow is pointed forward, the forearm is pronated.

Shoulders – Check to see if the shoulders are level or if they are uneven. If they are uneven, then either one shoulder is elevated or the other is depressed. You can use the clavicle as a guide. If the acromion is higher than the sternal head of the clavicle, then the shoulder is elevated. If the acromion is lower than the sternal head, then the shoulder is depressed.

Head – Check the head for either left or right rotation or lateral flexion.

Posterior View

Feet - When looking at the feet in this view, you are focusing on the calcaneal tendons. Check to see if one of the tendons is thicker than the other. If so, this could show compensation on one side of the body.

Knees – Look to see if the popliteal lines are the same height on each leg. If one line is higher than the other, either one hip is elevated or they may have one leg shorter than the other. To be properly diagnosed with an anatomically short leg, the client would need to see their physician. Checking the popliteal line acts as a conformation if you found any difference on the anterior side.

Pelvis – Check the level of the Posterior Superior Iliac Spine(PSIS) on both sides. If the ASIS are uneven, it is either the hip is elevated or rotated.

Scapula – Check the position of the inferior angles of the scapula. Check not only their level, but also their distance from the spine. Distortions you are looking for are if one scapula is elevated or depressed or if the scapula is rotated. You can also use this data as a double check for the anterior view.

Shoulders – Check to see if the shoulders are level or if they are uneven. If they are uneven, then either one shoulder is elevated or the other is depressed.

Head – Check the head for either left or right rotation or lateral flexion.

Lateral View

Feet - When analyzing the feet, they should be directly under the hips. If visually one looks more forward or backwards than the other, check the plumb line. If the ankle is in front of the hip, then the hip is flexed. If the ankle is behind the hip, then the hip is extended.

Knees – Look to see if the knees are hyperextended or in a locked position. A good sign that the knees are locked is if they are located posterior to the hip.

Pelvis – Check the relationship between the Anterior Superior Iliac Spine(ASIS) and the Posterior Superior Iliac Spine (PSIS). The pelvis should have a small degree of tilt, approximately 10°. If the ASIS and PSIS has a tilt greater than this, it will cause excessive pressure in the lumbar spine. This condition is called Anterior Pelvic Tilt. If the ASIS and the PSIS has a tilt less than 10°, it is called Posterior Pelvic Tilt.

Hands – When looking at the hands, they should be by their sides with the thumbs pointed forward. Check to see if either the elbow or shoulder is flexed.

Shoulders – Check to see if the shoulders are in line with the head and the hip. Check to see if the scapula is protracted (abducted). A protracted scapula can cause excessive pressure on the posterior cervical and entrapment of the brachial plexus in the chest.

Head – Check the head to see if it is line with the shoulder. If the head is in front of the shoulder, Forward Head Posture, this can cause compression on the cervical nerves.

Palpation

Completing a postural evaluation gives you an idea of where to start. The body did not pull itself out of alignment. Hypertonic muscles are the cause. Start with one side of the body and begin testing the muscles for tenderness.

Range of Motion

The next Assessment tool is **Range of Motion**. When conducting Range of Motion test, the therapist is looking for limitation in normal movement. There are two types of Range of Motion, **Active** and **Passive**. When conducting either type of range of motion test, we are looking for specific data and feedback. Data and feedback includes the following:

1. Note when and where the onset of pain occurs.
2. Note whether movement increases the intensify and quality of pain.
3. Note the reaction of the client to pain.
4. Note the amount of observable restriction.
5. Note the pattern of movement.
6. Note muscular splinting or guarding.
7. Note movement of associated joints.
8. Note nature of movement on uninvolved side.
9. Note willingness of client to move injured area.
10. Note quality of movement.

We will first discuss **Active Range of Motion**. Active Range of Motion engages both agonist (contractile) as well as antagonist (passive) tissues. The primary focus in active range of motion is on the agonist tissues, which are for movement.

Procedure for Testing Active Range of Motion

1. Demonstrate the movement to be performed.
2. Test the uninvolved side first.
3. If there are movements that you suspect are going to be painful, do them last.
4. Ask and make note of any reported pain or discomfort. (Be specific)

After you have completed the active range of motion tests, you need to determine if any passive range of motion tests are necessary. If you find that there are range of motion issues, you need to determine whether the limitation came from the agonist muscles or from the antagonist muscles. When it comes to the motion of a joint, there are different reasons why range of motion will cease. The first reason is because the muscles responsible for the motion have hit their contraction limit. They merely cannot contract any more. This is a common occurrence with over used muscles. An example would be a weight lifter that has worked out to the point of fatigue. Another reason range of motion stops is because the antagonist muscle cannot stretch any farther. The relationship between agonist and antagonist is like a tug-of-war. One side can only take what the other side gives up.

For example, a client complains of shoulder pain. You then test the injured shoulder with Active Range of Motion and see it hurts their shoulder to raise their arm higher than parallel to the ground. Which muscles are causing the restriction? Is it the shoulder flexors are too tight, or is it the extensors will not stretch any farther? One way to find out is through **Passive Range of Motion**.

Passive Range of Motion does not engage the agonist muscles of a joint. So by testing the same joint where you found restrictions with active range of motion, you are eliminating the possibility of the agonist contracting and reducing range of motion. If you have the same restrictions with passive range of motion as you did with active range of motion, you will know the problem is with the antagonist muscles. If the restriction is less with passive range of motion than with active range of motion, the agonist muscles were the culprits. Passive range of motion can also help determine if there are any issues with the ligaments and joint capsule.

Procedure for Passive Range of Motion Testing

1. Demonstrate the movement that will be performed.
2. Get the client to relax as much as possible.
3. Test the uninvolved side first.
4. Ask and make note of any reported pain or discomfort. (Be specific)

Muscle Testing

Muscles generally move in one plane of action at a time. The three planes are: **Sagittal, Frontal, and Transverse**. The Sagittal Plane divides the body into left and right parts. Movements in the Sagittal Plane include flexion and extension. The Frontal Plane divides the body into front and back parts. Movements in the Frontal Plane are: lateral flexion, abduction, and adduction. The Transverse Plane divides the body into top and bottom sections. Movements in the Transverse Plane are: rotation, supination, pronation, inversion, and eversion.

With muscle testing, you need to assess two things. First, note if there is any weakness or loss of strength in the muscles. Second, have the client inform you if they experience any pain or discomfort while the muscles are being tested. During the muscle test, if you encounter any positives for weakness, you must then determine if the “positive” is a result of **true weakness** or from **false weakness**.

The term “**true weakness**” means that the client’s muscle is not strong enough to resist the pressure. This could be a result of some form of injury, trauma, or atrophy. The term “**false weakness**” refers to a muscle that is fatigued and cannot resist the pressure applied. Go back to the earlier example of the weight lifter. If after a long work out, you tested their muscles, they would not have a good result. Their muscles are exhausted and would not resist against your pressure like they would if they were rested. Why is this important? The results would completely change your treatment plan. If muscles are “true weak”, the client would need a strengthening rehabilitation program. However, if the muscles are “false weak”, the client would need a stretching rehabilitation program. A strengthening program at this point would only cause more damage to the tissues.

Procedure for Muscle Testing

- a. Determine which muscles are the primary movers
- b. Test unaffected side first
- c. Position yourself to test the muscle in the same plane of action
- d. Make sure client is READY
- e. Only use enough pressure to engage the muscle being tested.
- f. Make note of any weakness and/or reported pain or discomfort
- g. Determine if weakness is true or false

To determine between false weakness and true weakness, you would need to retest the muscles after you treated the muscles. Once the affected muscles have been treated, then repeat the same muscle test. If the results are stronger, then they had a positive for false weakness.

Cervical Muscle Testing

Cervical Flexion

1. Testing Sternocleidomastoid, Longus Colli/ Capitus
2. Client is seated with head looking forward
3. Therapist is positioned at the side of the client
4. Therapist places hand on client's forehead and support hand on client's back
5. Therapist applies pressure posteriorly as client resists

Cervical Extension

1. Testing Upper Traps, Splenii, Suboccipitals
2. Client is seated with head looking forward
3. Therapist is positioned at the side of the client
4. Therapist places hand on the back of client's head and support hand at sternum
5. Therapist applies pressure anteriorly and client resists

Cervical Rotation

1. Testing Sternocleidomastoid, Splenii, Levator Scapulae
2. Client is seated with head looking forward
3. Therapist is positioned behind the client
4. Therapist puts hands on opposite corners of client's head
5. Therapist applies pressure clockwise as client resists
6. Therapist then applies pressure counterclockwise as client resists

Cervical Lateral Flexion

1. Testing Splenii, Levator Scapulae, Upper Traps, SCM
2. Client is seated with head looking forward
3. Therapist is positioned behind the client
4. Therapist crosses their arms and puts one on the side of the client's head and a support hand on the client's shoulder
5. Therapist will apply pressure away from testing side as client resists
6. Test both sides

Upper Extremities Muscle Testing

Shoulder Flexion:

1. Testing Anterior Deltoid, Biceps
2. Client is seated.
3. Therapist stands facing the client on the side to be tested.
4. Therapist flexes the client's shoulder of side to be tested to 45° and flex the elbow to 90°.
5. Therapist's active hand overlies the biceps muscle and stabilization hand overlies the shoulder joint.
6. Therapist directs pressure with active hand posteriorly in same plane of action.
7. Client is instructed to hold shoulder firm against this pressure.

Shoulder Extension:

1. Testing Posterior Deltoid, Long Head Triceps
2. Client is seated.
3. Client extends shoulder 45 degrees with elbow flexed at 90 degrees
4. The therapist stands behind and alongside client's arm to be tested.
5. The therapist's active hand is placed on the triceps muscle and the stabilization hand is on the shoulder joint.
6. Therapist directs pressure with active hand anteriorly against posterior humerus
7. Client resists against this pressure.

Shoulder Abduction 90°:

1. Testing Middle Deltoid
2. The client is seated.
3. Therapist stands facing the client's side to be tested
4. Therapist puts client's shoulder to 90° of abduction with elbow flexed to 90°
5. Therapist's hand is placed above the client's elbow with the stabilization hand over the client's shoulder joint.
6. Therapist directs pressure to push client's elbow inferiorly while client resists

Shoulder Abduction 15°:

1. Testing Supraspinatus
2. The client is seated.
3. Therapist brings client shoulder to neutral position and elbow to 90° flexion.
4. The therapist stands facing the client's side to be tested
5. The therapist's active hand cups the client's elbow with the stabilization hand over the shoulder joint.
6. Therapist passively abducts client's shoulder 15°.
7. Therapist directs pressure to push client's elbow to their side while client resists

Shoulder Adduction:

1. Testing Latissimus Dorsi, Teres Group, Pectoralis Major
2. The client is seated.
3. Therapist stands facing the client's side to be tested
4. Client's shoulder is in neutral position with elbow flexed at 90°
5. Therapist's hand cups the client's elbow with the stabilization hand over the shoulder joint.
6. Therapist directs pressure trying to pull client's elbow away from their side while client resists

Shoulder Lateral Rotation:

1. Testing Infraspinatus, Teres Minor
2. The client is seated.
3. Therapist stands facing the client's side to be tested
4. Client's shoulder is in neutral position with elbow flexed at 90°
5. Therapist holds the lower arm proximal to the wrist with the stabilization hand cupping the elbow.
6. The elbow should stay close to client's side and becomes the pivot point of movement
7. Pressure is exerted medially to rotate their shoulder internally.
8. Client is instructed to resist against this pressure.

Shoulder Medial Rotation:

1. Testing Latissimus Dorsi, Teres Major, Subscapularis
2. The client is seated.
3. Therapist stands facing the client's side to be tested
4. Client shoulder is in neutral position with elbow flexed at 90°
5. The elbow should stay close to client's side and becomes the pivot point of movement
6. Pressure is exerted laterally to rotate the client's shoulder externally.
7. Client is instructed resist against this pressure.

Elbow Flexion:

1. Testing Biceps brachii, Brachialis, Brachioradialis
2. Client is seated with their elbow flexed to 90°.
3. Therapist stands in front and stabilizes at the elbow and the testing hand exerts downward pressure at the distal forearm.
4. Client resists by trying to flex their arm further.

Elbow Extension:

1. Testing Triceps and Anconeus
2. Client is seated with their elbow flexed to 90°.
3. Therapist stands in front and stabilizes at the elbow and the testing hand exerts upward pressure at the distal forearm.
4. Client resists by trying to extend their arm further.

Forearm Supination:

1. Testing Supinator and Biceps Long Head
2. Client is seated with their elbow flexed to 90° and the thumb pointing upward.
3. Therapist stands in front and stabilizes at the distal forearm.

4. Pressure is exerted against the dorsum of the hand and resists the client trying to further supinate the hand.

Forearm Pronation:

1. Testing Pronator Teres, Pronator Quadratus
2. Client is seated with their elbow flexed to 90° and the thumb pointing upward.
3. Therapist stands in front and stabilizes at the distal forearm.
4. Pressure is exerted against the palmar surface of the hand and resists the client trying to further pronate the hand.

Wrist Flexion:

1. Testing Flexors of the Wrist
2. Client holds their loose fist in flexion while the therapist exerts pressure to extend the wrist.

Wrist Extension:

1. Testing Extensors of the Wrist
2. Client holds their loose fist in extension while the therapist exerts pressure to flex the wrist.

Opposition of Thumb and 5th Digit:

1. Testing Thenar and Hypothenar pads
2. Client touches the tip of their thumb and 5th digit together.
3. Therapist applies force trying to separate the fingers.

Lumbar/Lower Extremities Muscle Testing**Trunk Flexion**

1. Testing Rectus Abdominis, External and Internal Oblique
2. Client rests supine with knees bent and feet on the table.
3. Client crosses arms and raises off the table.
4. Therapist supports client's knees and applies pressure to client's torso.

5. Client resists pressure.

Hip Flexion

1. Testing Rectus Femoris, Sartorius, and Adductors
2. Client lying supine having one leg with hip and knee flexed at 90°
3. Therapist stands above knee and faces client's feet.
4. Therapist adds pressure to distal femur and client resists.

Iliopsoas

1. Testing Iliacus and Psoas
2. Client is supine with both legs straight.
3. Therapist will flex, lateral rotate and abduct the testing leg
4. Therapist will support opposite hip
5. Therapist will apply pressure 45° away from client as they resist

Hip Medial Rotation

1. Testing Adductors, Semimembranosus, Semitendinosus
2. Client is supine with hip and knee at 90°
3. Therapist will support the knee so it doesn't move
4. Therapist will push ankle toward midline as client resists

Hip Lateral Rotation

1. Testing Deep 6 Rotators, Iliopsoas, Biceps Femoris, Glut Max
2. Client is supine with hip and knee flexed at 90°
3. Therapist will support the knee so it doesn't move
4. Therapist will pull the ankle away from midline as client resists

Hip Adduction

1. Testing Adductors, Iliopsoas, Glut Max
2. Client is supine with legs together
3. Therapist stands on testing side
4. Therapist supports opposite leg

5. Therapist pulls testing leg lateral as client resists

Hip Abduction

1. Testing Gluteal Group, TFL, Sartorius
2. Client is supine and has leg abducted about 45°
3. Therapist stands contralateral to testing leg
4. Therapist supports non-testing leg
5. Therapist pulls toward the midline on testing leg as client resists

Hip Elevation

1. Testing Quadratus Lumborum
2. Client is supine with legs together
3. Client elevates one hip
4. Client resists as therapist pulls inferiorly

Trunk Extension

1. Testing Erector Spinae and Quadratus Lumborum
2. Client is prone and lifts chest off the table.
3. Therapist supports lumbar and adds pressure between scapulae

Hip Extension (Leg Straight)

1. Testing Gluteus Maximus, Hamstrings
2. Client is lying prone with legs together
3. Therapist lifts leg off the table into extension keeping it straight
4. Therapist applies pressure above the knee toward table as client resists

Hip Extension (Leg Bent)

1. Testing Gluteus Maximus
2. Client is prone with knee bent 90°
3. Therapist lifts leg off the table into extension keeping it bent
4. Therapist applies pressure above the knee toward table as client resists

Knee Flexion

1. Testing Hamstrings
2. Client is prone with knee bent 90°
3. Therapist applies pressure inferiorly at the ankle toward the table as client resists

Knee Extension

1. Testing Quadriceps
2. Client is prone with knee bent 90°
3. Therapist applies pressure superiorly at the ankle toward the gluts as client resists

Plantar Flexion

1. Testing Gastrocnemius, Soleus, Peroneals
2. Client is supine with foot in neutral position
3. Therapist exerts pressure against the ball of the foot superiorly as client resists

Dorsiflexion

1. Testing Tibialis Anterior, Extensor Digitorum Longus, Extensor Hallucis Longus
2. Client is supine with foot in neutral position
3. Therapist exerts pressure against the top of the foot inferiorly as client resists

Reasons for Documentation

1. Serves as a tool to aid in providing quality care
2. Promotes professionalism
3. Creates a historical record
4. Can be used to educate our clients
5. Provides the therapist and client with a proof of progress
6. Inspires client trust
7. Promotes safety

Explaining the Evaluation form

Listed below is a key for all the different symbols on the assessment form.

Range of Motion

- N stands for normal range of motion.
- L stands for limited range of motion
- P stands for any pain present with motion

The blank after “P” – use this space for anything descriptive including pain scale

Palpation

- N stands for normal muscle tone.
- H stands for hypertonic muscle tissue. This tissue excessively tight but is not painful.
- TeP stands for tender point. Tissue that hurts but does not refer pain to another location.
- TrP stands for trigger point. This is a tender point that refers pain to another location.

The blank after the “P” – this space is use to indicate the side of dysfunction, area of tender point for larger muscles, pain scale, and/or areas trigger points referred to.

Muscle Testing

- N stands for normal. When tested the muscle held firm.
- L stands for mild or limited weakness. When tested the muscle held, but showed some signs of straining.
- M stands for moderate weakness. When tested the muscle initial held, but gave out.
- S stands for severe weakness. When tested the muscle could not resist the pressure given.
- P stands for pain. Pain can be felt with or without weakness present.

Learning Experience #1

Please answer the following questions:

1. List the eight components of a soft tissue assessment
 - a)
 - b)
 - c)
 - d)
 - e)
 - f)
 - g)
 - h)
2. What is the difference between a diagnosis and an assessment?
3. What is the difference between a sign and a symptom?
4. Give an example of a sign and a symptom.
5. Describe the value of a soft tissue assessment to the massage therapist.

6. What types of questions would be asked when performing a health history that may not be on the form?

7. What is the importance of touching the site of the client's complaint?

8. What things should the therapist observe during the visual inspection?

9. The client complains of pain in the shoulder with elevation of the arm to their side. Which two muscles allow abduction of the arm?

Learning Experience #2

An example of an assessment for is on the following pages. The form covers range of motion, palpation, and muscle testing for every joint in the body. Your assignment is to complete one assessment evaluation on someone of your choosing. Submit your forms as well as the answers to the questions for **Learning Experience #2** at the end of this packet.

ONCE YOU HAVE COMPLETED BOTH ACTIVITIES PLEASE SEND TO:

Knowlesrehab@gmail.com

With the subject: **Assessment Protocols Homework**

CERVICAL EVALUATION

CERVICAL RANGE OF MOTION

Flexion	N	L	P	_____
Extension	N	L	P	_____
Left Lateral Bending	N	L	P	_____
Right Lateral Bending	N	L	P	_____
Left Rotation	N	L	P	_____
Right Rotation	N	L	P	_____

MUSCLE PALPATION - SUPINE

Suboccipitals	N	H	TeP	TrP-> _____
Occipitalis	N	H	TeP	TrP-> _____
Lamina groove	N	H	TeP	TrP-> _____
Temporalis	N	H	TeP	TrP-> _____
Masseter	N	H	TeP	TrP-> _____
SCM	N	H	TeP	TrP-> _____

MUSCLE PALPATION – PRONE

Suboccipitals	N	H	TeP	TrP-> _____
Lamina groove	N	H	TeP	TrP-> _____
Upper trapezius	N	H	TeP	TrP-> _____
Levator Scapulae	N	H	TeP	TrP-> _____
Erector Spinae	N	H	TeP	TrP-> _____

CERVICAL MUSCLE DYSFUNCTION TESTING

TEST

STRENGTH

Flexion	N	L	M	S	Pain_____
Extension	N	L	M	S	Pain_____
Left Rotation	N	L	M	S	Pain_____
Right Rotation	N	L	M	S	Pain_____
Left Lateral Flexion	N	L	M	S	Pain_____
Right Lateral Flexion	N	L	M	S	Pain_____

UPPER EXTREMITY EVALUATION

SHOULDER RANGE OF MOTION

Flexion	(RT)	N	L	P_____
	(LT)	N	L	P_____
Extension	(RT)	N	L	P_____
	(LT)	N	L	P_____
Abduction	(RT)	N	L	P_____
	(LT)	N	L	P_____
Adduction	(RT)	N	L	P_____
	(LT)	N	L	P_____
Internal Rotation	(RT)	N	L	P_____
	(LT)	N	L	P_____
External Rotation	(RT)	N	L	P_____
	(LT)	N	L	P_____

MUSCLE PALPATION- SEATED

Supraspinatus	N	H	Tep	TrP->_____
Infraspinatus	N	H	Tep	TrP->_____
Teres Minor	N	H	Tep	TrP->_____
Teres Major	N	H	Tep	TrP->_____
Posterior Deltoid	N	H	Tep	TrP->_____
Middle Deltoid	N	H	Tep	TrP->_____

MUSCLE PALPATION – SEATED (CONT.)

Anterior Deltoid	N	H	Tep	TrP->	_____
Rhomboid	N	H	Tep	TrP->	_____
Serratus Anterior	N	H	Tep	TrP->	_____
Latissimus Dorsi	N	H	Tep	TrP->	_____
Trapezius	N	H	Tep	TrP->	_____
Levator Scapulae	N	H	Tep	TrP->	_____
Pectoralis Major	N	H	Tep	TrP->	_____
Pectoralis Minor	N	H	Tep	TrP->	_____
Coracobrachialis	N	H	Tep	TrP->	_____
Subscapularis	N	H	Tep	TrP->	_____

SHOULDER MUSCLE DYSFUNCTION TESTING

TEST

STRENGTH

Flexion	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Extension	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Abduction	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Adduction	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____

SHOULDER MUSCLE DYSFUNCTION TESTING (CONT.)

Medial Rotation (RT) N L M S P _____
 (LT) N L M S P _____
 Lateral Rotation (RT) N L M S P _____
 (LT) N L M S P _____

ELBOW RANGE OF MOTION

Flexion (RT) N L P _____
 (LT) N L P _____
 Extension (RT) N L P _____
 (LT) N L P _____
 Supination (RT) N L P _____
 (LT) N L P _____
 Pronation (RT) N L P _____
 (LT) N L P _____

MUSCLE PALPATION SITTING

Biceps Brachii N H TeP TrP-> _____
 Brachialis N H TeP TrP-> _____
 Brachioradialis N H TeP TrP-> _____
 Triceps N H TeP TrP-> _____
 Anconeus N H TeP TrP-> _____
 Supinator N H TeP TrP-> _____
 Pronator Tern N H TeP TrP-> _____
 Pronator Quadratus N H TeP TrP-> _____

ELBOW MUSCLE DYSFUNCTION TESTING

Flexion	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Extension	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Supination	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____
Pronation	(RT)	N	L	M	S	P	_____
	(LT)	N	L	M	S	P	_____

WRIST RANGE OF MOTION

Flexion	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Extension	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Ulnar Deviation	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Radial Deviation	(RT)	N	L	P	_____
	(LT)	N	L	P	_____

MUSCLE PALPATION – SITTING

Wrist Flexors	(RT)	N	H	TeP	TrP >	_____
	(LT)	N	H	TeP	TrP >	_____
Wrist Extensors	(RT)	N	H	TeP	TrP->	_____
	(LT)	N	H	TeP	TrP >	_____
Thenar Eminence	(RT)	N	H	TeP	TrP->	_____
	(LT)	N	H	TeP	TrP >	_____
Hypothenar Eminence	(RT)	N	H	TeP	TrP->	_____
	(LT)	N	H	TeP	TrP >	_____

WRIST AND HAND MUSCLE DYSFUNCTION TESTING

Wrist Flexion	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Extension	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Ulnar Deviation	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____

WRIST AND HAND MUSCLE DYSFUNCTION TESTING (CONT.)

Radial Deviation	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Thumb Abduction	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Thumb Adduction	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____

LUMBAR EVALUATION

THORACOLUMBAR RANGE OF MOTION

Flexion.	N	L	P	_____
Extension	N	L	P	_____
Left Lateral Bending	N	L	P	_____
Right Lateral Bending	N	L	P	_____
Left Rotation	N	L	P	_____
Right Rotation	N	L	P	_____

MUSCLE PALPATION - PRONE

Erector Spinae	N	H	TeP	TrP->_____
Quadratus Lumborum	N	H	TeP	TrP->_____
Multifidus	N	H	TeP	TrP->_____
Gluteus Maximus	N	H	TeP	TrP->_____
Gluteus Med \ Min	N	H	TeP	TrPr>_____
Piriformis	N	H	TeP	TrP->_____
Deep Rotators	N	H	TeP	TrP->_____
Sacrobuterosus	N	H	TeP	TrP->_____
Hamstrings	N	H	TeP	TrP->_____
Popliteus	N	H	TeP	TrP->_____
Calves	N	H	TeP	TrP->_____

MUSCLE PALPATION - SUPINE

Psoas	N	H	TeP	TrP->	_____
Iliacus	N	H	TeP	TrP->	_____
Rectus Abdominus	N	H	TeP	TrP->	_____
Obliques	N	H	TeP	TrP->	_____
TFL	N	H	TeP	TrP->	_____
Quadriceps	N	H	TeP	TrP->	_____
Adductors	N	H	TeP	TrP->	_____
Iliotibial Band	N	H	TeP	TrP->	_____
Peroneals	N	H	TeP	TrP->	_____
Feet	N	H	TeP	TrP->	_____

THORACOLUMBAR MUSCLE STRENGTH TESTING

TEST

STRENGTH

Trunk Flexion	N	L	M	S	Pain_____
Trunk Rotation	N	L	M	S	Pain_____
Trunk Extension	N	L	M	S	Pain_____
Elevation of Pelvis	N	L	M	S	Pain_____
Iliopsoas	N	L	M	S	Pain_____

LOWER EXTREMITY EVALUATION

HIP RANGE OF MOTION

Flexion	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Extension	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Internal Rotation	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
External Rotation	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Abduction	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Adduction	(RT)	N	L	P	_____
	(LT)	N	L	P	_____

MUSCLE PALPATION - SUPINE

Iliacus	N	H	TeP	TrP->	_____
Psoas	N	H	TeP	TrP->	_____
Rectus Femoris	N	H	TeP	TrP->	_____
Sartorius	N	H	TeP	TrP->	_____
Adductor Longus	N	H	TeP	TrP->	_____
Adductor Brevis	N	H	TeP	TrP->	_____
Adductor Magnus	N	H	TeP	TrP->	_____
Gracilis	N	H	TeP	TrP->	_____
TFL	N	H	TeP	TrP->	_____
Iliotibial Band	N	H	TeP	TrP->	_____

MUSCLE PALPATION - PRONE

Gluteus Maximus	N	H	TeP	TrP-> _____
Gluteus Medius	N	H	TeP	TrP-> _____
Gluteus Minimus	N	H	TeP	TrP-> _____
Piriformis	N	H	TeP	TrP-> _____
Hip Rotators	N	H	TeP	TrP-> _____
Hamstrings	N	H	TeP	TrP-> _____

HIP MUSCLE DYSFUNCTION TESTING

<u>TEST</u>	<u>STRENGTH</u>					
Flexion	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Extension	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Internal Rotation	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
External Rotation	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Abduction	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____
Adduction	(RT)	N	L	M	S	P_____
	(LT)	N	L	M	S	P_____

KNEE RANGE OF MOTION

Flexion	(RT)	N	L	P	_____
	(LT)	N	L	P	_____
Extension	(RT)	N	L	P	_____
	(LT)	N	L	P	_____

MUSCLE PALPATION – SUPINE

Rectus Femoris	N	H	TeP	TrP->	_____
Vastus Medialis	N	H	TeP	TrP->	_____
Vastus Laterails	N	H	TeP	TrP->	_____
Sartorius	N	H	TeP	TrP->	_____
Gracilis	N	H	TeP	TrP->	_____
Iliotibial Band	N	H	TeP	TrP->	_____

MUSCLE PALPATION - PRONE

Hamstrings	N	H	TeP	TrP->	_____
Gastrocnemius	N	H	TeP	TrP->	_____
Soleus	N	H	TeP	TrP->	_____
Popliteus	N	H	TeP	TrP->	_____
Plantaris	N	H	TeP	TrP->	_____

KNEE MUSCLE DYSFUNCTION TESTING

TEST

STRENGTH

Flexion	(RT) N	L	M	S	P_____
	(LT) N	L	M	S	P_____
Extension	(RT) N	L	M	S	P_____
	(LT) N	L	M	S	P_____

FOOT/ANKLE RANGE OF MOTION

Dorsiflexion	(RT) N	L	P_____
	(LT) N	L	P_____
Plantarflexion	(RT) N	L	P_____
	(LT) N	L	P_____
Inversion	(RT) N	L	P_____
	(LT) N	L	P_____
Eversion	(RT) N	L	P_____
	(LT) N	L	P_____

MUSCLE PALPATION - SUPINE

Tibialis Anterior	N	H	TeP	TrP->_____
Tibialis Posterior	N	H	TeP	TrP->_____
Peroneus Longus	N	H	TeP	TrP->_____
Peroneus Brevis	N	H	TeP	TrP->_____
Peroneus Tertius	N	H	TeP	TrP->_____
Ext. Hallicis Long.	N	H	TeP	TrP->_____
Ext. Digitorum Long.	N	H	TeP	TrP->_____

MUSCLE PALPATION – PRONE

Gastrocnemius	N	H	TeP	TrP-> _____
Soleus	N	H	TeP	TrP-> _____
Plantaris	N	H	TeP	TrP-> _____
Flex. Hall. Long.	N	H	TeP	TrP-> _____
Flex. Digit. Long.	N	H	TeP	TrP-> _____
Plantar Fascia	N	H	TeP	TrP-> _____

ANKLE MUSCLE DYSFUNCTION TESTING

<u>TEST</u>	<u>STRENGTH</u>					
Dorsiflexion	(RT)	N	L	M	S	P _____
	(LT)	N	L	M	S	P _____
Plantarflexion	(RT)	N	L	M	S	P _____
	(LT)	N	L	M	S	P _____
Inversion	(RT)	N	L	M	S	P _____
	(LT)	N	L	M	S	P _____
Eversion	(RT)	N	L	M	S	P _____
	(LT)	N	L	M	S	P _____