

ISM Clinical Reasoning Reflection Form for Finding Drivers

46 y/o male presenting with right posterior hip pain, insidious onset over the last 3-4 months, no previous injuries in the area. The pain is present after running 5 km with minimalist shoes and with yoga poses that require single leg balancing on right leg (warrior III and tree)

Meaningful complaint: pain in right posterior hip
 Meaningful task: right single leg stance

Phenotype of pain: nociceptive

Start Screen Position: standing

Screening Task: weight shift to right leg

Do you need to find a driver in FU#1 or not? Yes
 FU #1

	Start Screen Findings <i>Position:</i> Partially/fully corrected, no change, worse) Put a * next to incongruences	Screening task findings (Partially/fully corrected, no change, worse) Put a * next to incongruences	Corrections <i>Only complete the boxes where the body region was a site of impairment in the screening task.</i>			
Pelvis	L TPR with IPT (no unlocking of SIJ)	Increased TPR	Impact of correcting pelvis on:			
			Pelvis:	Hip: Did not correct	Thorax: Did not correct	Experience: No change
Hips	R hip ant to L	Anterior translation of the femoral head relative to acetabulum	Impact of correcting R hip on:			
			Pelvis: Corrects pelvis	Hip: (Fill in if needed for other side R/L)	Thorax Corrects TR6	Experience: Leg feels more stable, less pain in the hip
Thorax	TR9 L rotated TR6 R rotated*	TR6 translation increased	Impact of correcting thorax on:			
			Pelvis: Did not correct the pelvis	Hip: Did not correct the hip	Thorax: TR6 corrects TR9	Experience: No change
Lumbar Spine	No relative rotation between pelvis and TR9		Impact of correcting FU1 Driver(s) on Lumbar spine			
			No change			

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Driver(s) for FU #1: R hip

FU# 2

What information from either the story, or from the FU#2 quick screen test with FU#1 driver corrected suggest you need to even assess FU#2?
 I did not assess FU#2, but I did a quick screen test to confirm that correcting TR6 did not change head and neck rotation range.

	Start Screen Findings <i>Same Position as FU#1</i>	Screening task findings <i>Same Task</i>	Corrections <i>Only complete the boxes where the body region was a site of impairment in the screening task.</i>				
Cranial: Cranium (OA,AA)			Impact of correcting cranium on:				
			Cervical	Shoulder Girdle	TR1 & 2	Cranial	Exp
Cervical: C2-C7			Impact of correcting cervical spine on:				
			Cervical	Shoulder Girdle	TR1 & 2	Cranial	Exp
Shoulder girdle: Scap & Clavicle			Impact of correcting shoulder girdle on:				
			Cervical	Shoulder girdle	TR1 & 2	Cranial	Exp
Thorax: TR1 & 2			Impact of correcting TR1, 2:				
			Cervical	Shoulder girdle	TR1 & 2 (Fill in the rings that were corrected)	Cranial	Exp

Driver(s) for FU#2:

Relationship of driver(s) FU#1 & FU#2:

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FU #3 – Lower Extremity

What information from either the story, or from the FU#3 lower extremity quick screen test with FU#1 or #2 driver corrected, suggest you need to even assess FU#3 lower extremity?

The MT involved the function of the entire lower extremity so any suboptimal biomechanics could influence the FU#1 driver

R knee normal position in standing (tibial external rotation), no change in screening task

R foot: lateral talar tilt increasing in screening task

Correcting the R foot corrected the R hip anterior translation and improved the subjective experience of single leg stance

FU #3 – Upper Extremity

What information from either the story, or from the FU#3 upper extremity quick screen test with FU#1 or #2 driver corrected, suggest you need to even assess FU#3 upper extremity?

No need to test upper extremity

Final Driver(s):

Primary: R Foot

Secondary:

Co-drivers:

Further Assessment of the Driver:

Active mobility: lateral talar tilt still present in open chain, slight restriction of plantar flexion

Passive mobility: restriction of end range plantar flexion, articular mobility restriction of the first ray: talo-navicular and naviculocuneiform joints (articular vectors) as well as a neuro-muscular vector (tibialis posterior) felt at end range dorsiflexion

Passive stability: did not test as there is no history of trauma

Active stability: tested after releasing the vectors above, no lateral talar tilt in MT, noted slight pronation (on and off with maintaining the single leg stance) that could benefit from foot intrinsic muscle retraining considering his activities (especially running).