

1st PHASE – PATIENT SUPINE

The Lower Extremity and Pelvis

1 + 2 go together

4 + 5 go together

No .	Focus Area(s) Tissues	D.O. Body Position:	D.O. Hand Positions: R/L or Cephalic/ Caudal	Patient Notes LE=lower extremity UE=upper extremity	Sequence Description & Notes OS=oscillations Where is greatest rigidity? POB = point of balance IR/ER= int & ext rotation CIR=circumductio n	Picture

1	Lower Leg	Thighs against plantar surfaces	Contact distal tibia/ Talocrural join	Feet just off table, neutral (not ER/IR)	<p>DO leans forward to oscillate in dorsi-flexion. Can treat with this sequence, also used to assess most rigid limb (to begin on this side).</p> <p>Rotate body to test each leg Do oscillations in both first Emphasize more rigid side If pain-slow and small amplitude Be in spring Knees bent Use body Keep moving to rigid spots to work out Pillow under knees Easier for osteo less weight of leg</p>	
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2	Lower extremity .	Facing patient	One hand on top at talus, navicular, cuboid. Other under at calcaneus. Switch to specific arch contacts.	Supine, pillow under distal thigh to support L/E.	<p>1.Traction lower limb & gradually change vector to engage ankle, knee, hip, pelvis and treat according to resistance felt.</p> <p>Lower extremity in general</p> <p>Flex/ext to get to target structures</p> <p>Look for orientation with most resistance (abd/add, flex/ext)</p> <p>E.g. Increase flex-targets more psoas, kidney</p> <p>Lean back with body to increase reciprocal tension</p> <p>Can do in compression modification if first oscillation not working</p> <p>Hip abduction-targets more SI joint</p> <p>Hip adduction targets more hip</p>	
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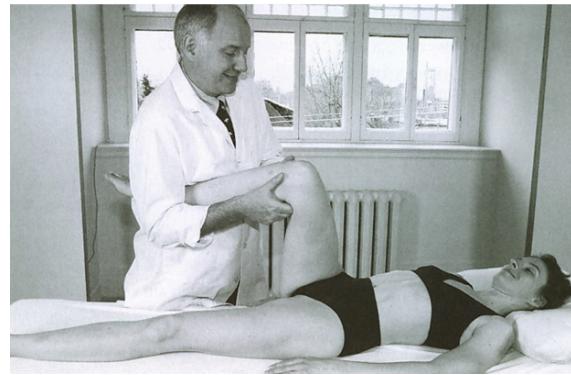
					<p>2. arches: Maintain L/E tension, and layer in spreading of arches in spring (medial, lateral, anterior, central).</p> <p>Accumulate longitudinal tension by leaning back, then “open apple” down the foot, using oscillations with body</p> <p>1-mid, 2-external, 3 internal arch</p> <p>Stay on most rigid spots</p> <p>Keep longitudinal tension</p> <p>Oscillate and spread local</p> <p>Stay at place where there is most resistance</p> <p>Spread internal and external arch, spread thumbs</p> <p>Look for points of tension and restriction and treat as needed</p>	
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					<p>p. 24 turns away to increase tension, initial stable hand and then moves in rolling motion,</p> <p>second sequence significance-global support to walk/stand helps with interosseous membranes of LE, SI joint, L2-L3, c-spine especially C1</p> <p>internal arch: increase adapts to vertical posture and balance</p> <p>external arch-more involved in adapting to weight distribution when walking</p>	
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3	Hip Knee Ankle	Front of body facing/nea r hip	Hip flexed, Knee against abdomen Sole of foot against hand/forear m Foot dorsiflexed	At edge of table with hip, knee, ankle in full flexion	<p>DO flexes knee and hip toward abdomen in spring. OS in direction of shoulder hold LE in ER and IR adduction/abduction can also be used to release complementary muscles</p> <p>Stay within the spring/rebound Global lower leg Work into resistance until full release Inside spring of mm barrier Body forward and back</p> <ul style="list-style-type: none"> a) Check ER/IR b) Abd/add c) Try adduction if can't do IR <p>Triple effect: Inside 3 springs-ankle, knee, and hip, whole lower extremity</p>	 
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					<p>Feel restrictions/treat there</p> <p>1 unit Oscillate front to back 1-A-P 2-can also add circumduction CW and CCW As own spring motion</p> <p>can't bend knee, just work hip</p> <p>Work into resistance until full release Inside spring of motor barrier</p> <p>Local knee-release Regional benefits-hams, plantar flexors, hip, legs etc.</p> <p>Side bend trunk caudally to pick up knee flexion</p>	
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4	Knee: Cruciate ligaments & capsule	Edge of table facing or sitting on knee	Full hold with both hands around knee joint	Knee in flexion with foot resting on table	<p>Anterior Drawer Test</p> <ul style="list-style-type: none"> -Pull knee toward DO -Traction by leaning R/L to test -Test knee cruciate ligaments ant/post rotation of knee -Assess spring at different angles as per above to find POB <p>knee joint look for restriction-oscillate in spring local effect of knee but also helps hip/SI/l-spine</p> <p>anterior drawer back and forth (abd/add) look for point of restriction and treat</p> <p>sit on foot for pull ACL</p>	

					<p>stand up and push for PCL fingertips meet superior tibias</p> <p>can also add circumduction CW/CCW rotation great for knee, hip, shoulder</p>	
5	Knee	<p>Patient's side, facing patient</p> <p>Full hold on upper part of lower leg (under knee)</p> <p>Index fingers are positioned around the hamstring tendons</p> <p>Knee approx. 90-100 degrees of flexion</p>	<p>Foot under DO's axilla</p>	<p>-CIRs in both directions to find rigidity</p> <p>-add IR and ER with CIR</p> <p>Lift up with body-so tension in femur</p> <p>Start crouching and then lift up towards ceiling so tension in femur</p> <p>Oscillate within circumduction</p> <p>Thumbs just before joint line</p> <p>Patient close to you on table</p> <p>Adduct creates ER in tibia</p> <p>Abduction creates IR in tibia</p>	 	

					Oscillate in both directions With abd/add of hip find rigid point and treat Effects Knee, hip, SI, proximal tib/fib, whole leg pelvis	
6	Hip & Sacral Area (IRers & ERers)	Patient's side at hip region	Under pelvic region /thigh area with arm around leg Page 27	Hip and knee flexed -points on: -retro-troch anteric -above trochanter - press pt @ ilio-lumbar & SI (PSIS/PIIS or sides of L4/L5 SP) Or muscle belly piriformis, gluts etc.	-DO carries out CIRs in both directions -subjects IRs and ERs to tension in turn (caudal hand/arm) -palpates points with cephalic fingers around glutes, piriformis, IT, fascia lata, internal obturator to determine which one has more tension -flared elbows -post part greater trochanter=insertion of piriformis (tender spot) -with 3 fingers on insert of piriformis Circumduction both directions	 

					<p>a) Retro-trochanteric-piriformis post part of trochanter</p> <p>b) Point situated above the trochanteric-cervical axis for movement around</p> <p>c) Pressure points on ilio-lumbar and SI ligaments Could add more if more tender spots...iliac crest All over glut area</p> <p>Good for prep before lower lumbar or SI OA adjustment</p> <p>SI ligaments-spread fingers on ligament-accumulate</p>	
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					<p>parameter, oscillate around</p> <p>-fingertips or thumb on specific points SI, hip, iliolumbar between L4/L5 and ilium</p> <p>Fingers on table to fix Piriformis, gluts mm bellies</p> <p>-p. 33-contact sulcus to impact the SI ligaments -iliolumbar ligaments joint above sacrum between L5/PSIS</p>	
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The Upper Extremity and Thorax

7th and 8th sequence go together

9th and 10th go together

15 and 16 go together

17th and 18th go together

No .	Focus Area(s) Tissues	D.O. Body Position:	D.O. Hands Position: Cephalic/Caudal	Patient Notes	Sequence Description & Notes	
7	Sterna-costal region	-Front facing patient's side at shoulder -Feet parallel to axis of arm	Upper extremity/fingers on pts on of thorax region -sternum -cartilage -rib	Forearm under DOs axilla Caudal hand is on ribs/sternum etc.	<ul style="list-style-type: none">-DO directs the UE along vectors to explore tension-DO works with vector of greatest tension-DO varies angle of UE to direct traction towards tense region <ul style="list-style-type: none">Increase arm abduction as work lower ribsAs arm adducts working more superior ribs	 

				<p>Rotate trunk (ER) away</p> <p>Reciprocal tension between arm and sternum</p> <p>Influences Brachial plexus, ..artery</p> <p>Hold their hand/arm against your thorax for more support</p> <p>Usually do one side of the body and then the other</p> <p>Sternum-rigid=often stuck emotions</p> <p>At each level assess and treat as needed - shoulder, heart, lungs, mediastinum, thyroid, diaphragm, esophagus all benefit from this technique</p>	
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					<p>Reciprocal tension between the hands and oscillate</p> <p>Track along upper limb</p> <p>Reference point/axis changes</p> <p>Stay longer on rigid spots</p> <p>Can do 2nd to 6 rib with this, can't access first</p> <p>Arm abduction further as move down to lower ribs</p>	
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8	Scapula, Hemithorax, ribs, their attached myofascial & vertebrae, & pleural dome	-Front facing patient's side at shoulder region	<p>1. 1st sandwich scapula and then one hand anterior aspect of ribs and shoulder</p> <p>2. UE grasping tricep (cephalic hand) area/curved fingers on: -med border scapula -spinous processes from T1 (1st rib) – T10</p> <p>Photo page 31</p>	<p>Forearm in extension under DOs axilla</p> <p>Caudal hand on medial scap border</p>	<p>-Lateral traction in spring, alter vector to isolate tensions.</p> <p>Good for whole dermatome, myotome, sclerotome -soft tissues around</p> <p>-helps to release pathway of Nerve roots to viscera sympathetic ganglion, t-spine and effect of head/neck</p> <p>1. Sandwich: Volume reciprocally, perceive the motion</p> <p>A/P compress by leaning body and then lean back to create lateral distraction Oscillate laterally</p> <p>2. UE versus Reference point-TPs, medial border scap, SPs</p>	  <p>8th Sequence- Hand position, internal surface of the scapula</p> 
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				<p>Fingers just lateral to TPs 3-lateral spring oscillate</p> <p>Hold medial border of scapula</p> <p>Or hold arm versus scapula and move arm in more abduction to be more specific to lower t-spine and adduction to specific to upper t-spine</p> <p>Can also do TVP/facet on contact side</p> <p>2-3 spts at a time</p>	
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	9	Upper thorax & shoulder area	Front facing patient's side at shoulder region	Have patient hold shoulder or trap forearm under upper arm and axilla.	Hand holds DO shoulder, or is trapped under their arm.	<p>-DO draws chest slowly back -leans back and maintains to create vertical/ longitudinal oscillations.</p> <p>- Spreading between thumbs.</p> <p>Second step can then bring chest forward inducing posterior movement and longitudinal tension on the ribs</p> <p>Thumbs under clavicle</p> <p>Holds your shoulder over or under</p> <p>Influencing pathway of Brachial plexus, Brachiocephalic arteries, root internal carotid Cervical plexus</p> <p>Spread with thumbs then oscillate by thorax up and down</p>		
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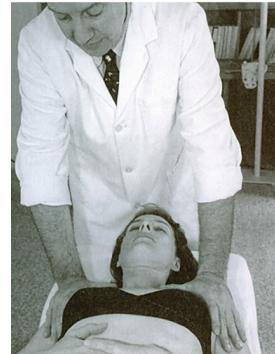
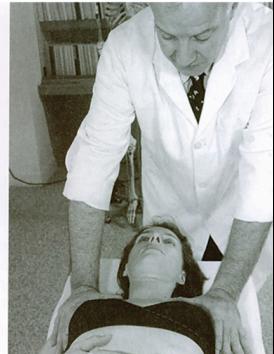
					<p>Can place thumbs just under clavicle to influence subclavius muscle Pumps subclavian vein -frees up path brachial plexus</p> <p>1st subclavius 50/50 spread and traction vertical by leaning back</p> <p>-releases traps to 1st rib/clavicle Can indirect work on 1st rib via ligament between clavicle and 1st rib, car accident</p>	
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10	Upper extremity, shoulder & neck (elbow and wrist)	-Patient's side	-Both hands at hand/wrist. hand – using thumbs to spread carpal bones assessing these and moving up arm	-Arm extended and supported by DO	-Separation (longitudinal traction) to address neck, shoulder, elbow, wrist (carpals). Spreading between hands on carpals for local wrist work. Stack GH into ease ER/IR, forearm into pronation/supination. a) Shoulder (see page 35) b) Oscillate with straight arm hold wrist/shoulder c) Hand-grip lateral/media l arch Oscillate from body GH with arm neutral On humerus, never compress clavicle	  
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				Vary angle look for rigidity Abd/add Both directions clockwise/counter clockwise direction -can also hold at wrist/elbow and work elbow in pronation/supination For right arm, right hand holds wrist Left hand holds lateral elbow Work abd/add ER/IR find rigidity Stand at end of arm Maintain reciprocal tension and spring as you oscillate, 2 parameters here, longitudinal tension and spread between thumbs-open by supinating hands -picks up third parameter automatically stack the 2	
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11	Shoulder; local joint, capsule, ligament, muscles, fascia, and pathways through volume.	-DO's thigh under patient's axilla.	-Caudal hand supports U/E at elbow. Cephalic hand anterior over GH volume. - Avoid posterior shearing. Photo page 37	-Arm with slight bend at elbow held by DO	-DO turns body toward exterior (away from patient) to induce slight traction in upper extremity - then performs circumduction in both directions looking for significant tensions. cho-cho train -secret is in the foot-DO pushes off back foot/raises heel to help create motion 1 st cephalic and caudal Second circumduction using leg to induce circumduction ER trunk to get reciprocal tension	

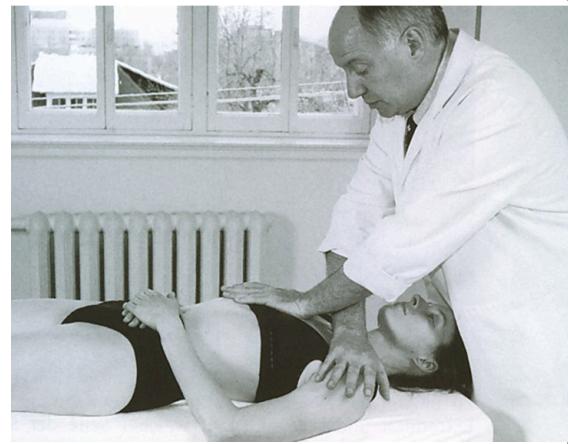
				<p>-in spring using traction Create circumduction around GH joint</p> <p>Vary angle of arm access anterior muscles or posterior muscles</p> <p>Posterior 1st to circumduction tension Oscillate sup/inf cephalic/caudad</p>	
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12	Shoulder region/ Scapular Girdle/ upper thorax	<ul style="list-style-type: none"> -Behind the patient at head -Straight arms to efficiently transmit force 	<ul style="list-style-type: none"> -Hands on shoulders avoiding clavicles - Just below clavicles, on upper ribs. <p>Page 39</p>	<ul style="list-style-type: none"> -Arms resting on abdomen or at sides 	<ul style="list-style-type: none"> -DO generates OS inferior/posterior while maintaining spring. -Use body side to side to alter vectors and search for significant tensions. - Can pick up spreading parameter between 2 hands. Intention move to rigid side, Can pick up transverse parameter between 2 hands End should feel increase amplitude and spring 	  
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13	<p>Cranio-cervical – shoulder – upper thorax.</p> <p>*the SCM and the opposite side's trapezius are subject to tension</p>	<ul style="list-style-type: none"> -Stand at patient head -Draws back his chest and spread hands to create tension to obtain spring effect 	<p><i>Anterior caudal hand:</i> Sternum, upper ribs, shoulder</p> <p><i>Posterior cephalic hand:</i> cup hold under occiput to support volume.</p>	<p>Photo page 43</p>	<p>Hands relaxed on abdomen or at sides</p> <p>- Traction between 2 hands, lean back with body to assist.</p> <p>- Rotate head away from side working.</p> <p>- More flexion in neck local to C2, more neutral into lower c-spine.</p> <p>- Search for significant tensions between cranio-cervical and sternum to GH contacts.</p> <p>-lift head to different heights depending on what induces more tension</p> <p>-do both sides</p> <p>more posterior fascia if head up anterior fascia if head down where most rigid treat there</p>	
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					<p>spread and oscillate</p> <p>If female-fingers open and pointing up</p>	 <p>13th Sequence To induce tension in relation to the sternum. The pericardium is attached to the internal of the thorax, at the level of the sternoclavicular articulation in the S.C.O.M. axis.</p>  <p>Sequence Position to induce tension at level of the superior cartilages</p>
14	Cervical spine	<p>-Standing above the patients' head.</p> <p>-Fingertips overlap. 3rd fingers make contact with spinous processes from C7 to C1.</p> <p>Page 44 photo</p>	<p>Hands relaxed on abdomen</p>	<p>-DO leans back to lift the vertebra into the spring and oscillates to test spring and treat if necessary. Vectors follow an arc from C7 (anterior/inferior) to C1 (anterior/superior).</p> <p>-cradle neck, suspend and oscillate in suspension spring -bend your knees In your own spring to feel their spring</p>	 	

					<p>Start C6/C7/T1 Softer the better Can assess for rotation restrictions</p> <p>Fingers on facets/TPs</p> <p>One side tighter than the other-focus on that side</p> <p>Until even on both sides</p> <p>Lift, traction, then spring, then C5, C4, C3</p> <p>Oscillate rhythmically</p>	
15	Shoulders, scapular girdle, thorax.	Standing above the patients' head.	<ul style="list-style-type: none"> -Hands hold arms below elbows bilaterally. - DO leans body back to oscillate rhythmically. <p>(Variation: ipsi-lateral treatment; e.g. left hand on patient's left arm</p>	<ul style="list-style-type: none"> - Puts U/E's around DO waist and holds.. 	<p>-DO looks for rigidity in scapular girdle/thorax and shoulder. Leans body to opposite side of rigidity to localize oscillations on area of restriction.</p> <p>Work side most rigid</p>	

			& right hand on left hemi-thorax. Good prep for norm of pulmonary parenchyma)		Keep longitudinal tension end in middle Side to side can lean to focus on restriction -hold arms, accumulate tension by leaning back Center of spring and oscillate If no block shoulder goes to feet If blocked work large/slow oscillation towards local and faster	
16	Shoulder/ Thorax	-Stand next to shoulder contact at side of patients' head.	*Arms crossed with: -one hand on shoulder (avoid clavicle). - Other hand on opposite side hemi-thorax; various locations.	-Arms relaxed at sides	- DO induces tension in the thorax obliquely and oscillates. -Addresses thoracic rings, pleura, pulmonary parenchyma, pericardium attachments, the diaphragm & mediastinum.	

					Stand on opposite side Shoulder versus thorax Shoulder versus sternum Arms parallel Osc up and down A/P Regional tension between structures Shoulder versus 1 st 3 ribs, sternum, costal margin	
17	Lower extremities.	-DO stands at patient's feet	-Holds patient's ankles under axillae, supporting calves with hands bilaterally. -Can control hip ER/IR, flexion, extension, and ABD/ADD with contact at calves.	-Supine. Pillow under distal thighs.	-DO draws chest back rhythmically to generate OS. -If one side more rigid, DO leans body to the opposite side of the rigidity to induce more tension and localize treatment. - Can also do semi-supine (sequence 33). -cushion under legs	

					<p>Hold legs under arms Play with hip flexion, extension Psoas, renal fascia=legs higher Pelvis/hips=legs lower Extension affect legs, hip, diaphragm, abs</p>	
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2ND PHASE – PATIENT PRONE

The Lower Extremity

22 and 23 go together

28 and 29 go together

30 and 31 go together

No .	Focus Area(s) Tissues	D.O. Body Position:	D.O. Hands Position: Ce/Ca	Patient Notes	Sequence Description & Notes	Picture
18	Hip/Knee/Ankle	At patients' feet	Global around ankle. See photo page 49	Distal thigh on pillow to support weight of leg.	-DO tractions and OS L/E. Can address ankle, knee, hip, iliac, l-spine, psoas. Change vectors with flex/ext, IR/ER, ABD, ADD – to assess and treat rigidity. More horizontal = ankle, more vertical = hip.	

					<p>Support ankle not just foot Vary abd/add look for rigidity IR/ER, angle that is most restricted Slight traction on psoas, effect iliac, l-spine</p> <p>Abd/add-spring and traction Pillow under distal femur Body oscillates not arms Look for rigidity</p>	
19	Foot	At patients' feet	<p>Thumbs spreading (anterior arch and medial), Support ankle and opposite arch (internal, external), Arms outstretched Photo: 50, 51</p>	Distal thigh on pillow to support weight of leg.	<p>- DO tractions L/E AND spreads arches. OS both parameters. Bowing motion, "breaking bread". -Turn body away from medial and lateral arch to localize tension and specificity. Along midline, medial and lateral arch, distal arch Bowing Long oscillation and local spread Spread volume....not skin</p>	

					<p>1-long tension 2-oscillate 3-spread local in foot Inversion/eversion parameters</p> <p>Maintain spring-traction, spread laterally and oscillate</p> <p>1. Medial, 2. external arch, 3. internal arch and distal arch 4. at ball of foot Pillow under leg to take weight off therapist and better for knee</p>	  
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20 21	Knee	Stand at level of knee on affected side.	-thumb & bent index or 3 rd finger in popliteal fossa - Other hand lower leg/ ankle. 53-20 photo 54-21 photo	-knee flexed	-DO spreads fingers in popliteal fossa (between hamstrings/ pes anserine) and maintains. -Lift lower leg upward (sink in) and flex knee. Body contacts leg. Can adjust hip IR/ER. Oscillate flexion (20), then circumduction; both directions (21). -person close to you -hold leg against body-easier for circumduction	

				<p>1st flexion, 2nd circumduction ER and IR hip-look for rigidity 20-flexion/ext 21-oCW and CCW</p> <p>Make sure not compress medial arteries, vein, lymph 1-spring of spread 2-spring knee flexion 3-circumduction</p> <p>Arteries passing through impact on fascia around -some issues ...arterial compression-release fascia Fingers inside tendons and spread</p> <p>IR/ER of hip to add more parameters to help release</p> <p>This helps with Helping normalize anterior rotation ilium.</p>	  
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22	Hip, glutes, hip rotators, SI joint.	Stand at level of pelvis on affected side.	Cephalic hand thumb on reference point. Caudal hand lower leg/ankle. Page 57 photo	Patient reference pts: Trochanteric & Gluteus Max	<p>Knee flexion 90-130 degrees, Hip CIR in IR/ER.</p> <p>Thumb as reference point retro-trochanteric, supra-trochanteric, gluteus maximus.</p> <p>C-F “trash can” must release Walking, pelvis, leg swing, pivot on hips Foot out-IR at trochanter Foot inward-ER at trochanter</p> <p>Feel circumduction of head of femur, work hip rotators Thumb on reference point and work around it Great to prepare SI adjustment Can move all through gluts in this manner Person is next to you</p> <p>Finger fixed</p> <p>Leg circumduction at knee</p>	
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				<p>IR/ER hip parameters look for rigidity Other hand just below ankle 90-130 knee flexion-depends on patient</p> <p>-also do internal rotation of hip and circle other way In ER Not just knee flexion Rotation Circle away and back to you</p>	   
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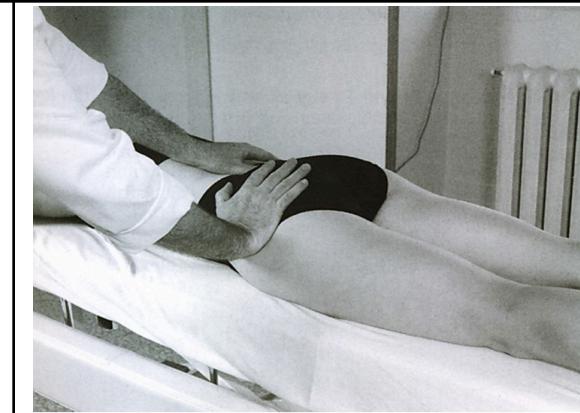
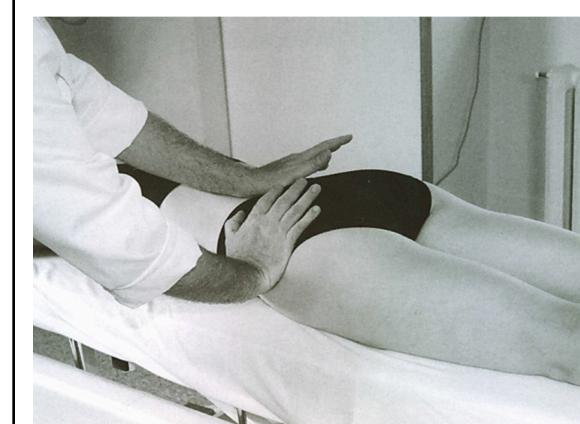
23	Hip/hip flexor, QL, T/L junction, renal fascia.	Standing at level of pelvis on unaffected side.	On affected side; one hand controls pelvis so it touches the table the whole time, other lifts knee on opposite side (hip extension, slight ADD) Hand above knee, very little motion to keep pelvis on table. Will put pressure on low		DO ensures pelvis remains on table, executes OS in direction of hip extension. Stand opposite side and add lift leg at knee, hip extension ADD Oscillate -stabilize pelvis at ilium -ext hip and ADD -side bend trunk (to them) to oscillate Impact psoas, QL dorsal lumbar renal myofascial chain, quads etc. No photo	
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The Vertebral Spine

28 and 29 go together

30 and 31 go together

No .	Focus Area(s) Tissues	D.O. Body Position:	D.O. Hands Position: Ce/Ca	Patient Notes	Sequence Description & Notes	Picture

24	Lumbar spine Pelvis	Standing on affected side at level of pelvis/lumbar spine.	<p>Cephalic hand's thumb (or thenar eminence) on ipsilateral side of SPs from L5 to T12 (can go as high as T9). Caudal hand contacts ipsilateral global posterior pelvis/ CF.</p> <p>See page 59 photo</p>	<p>-DO uses caudal hand to produce rhythmic transversal pelvic movements resulting in OS at lumbar spine & pelvis. Slight delay between 2.</p> <p>pillow under hips so not hyperextending spine</p> <p>Tension in spring Away from you and oscillate Lean in to generate tension Thumb on SP fixed- oscillation from pelvis (PD) Slight delay-one moves before then other</p> <p>Can go up to T9 Load tissues first-lean in then delay</p>		
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					Lateral part of iliac crest at pelvis hand Quick way to assess l-spine	
25	Lumbar Spine/ Ilium/ribs	Standing on unaffected side at level of pelvis/lumbar spine.	Cephalic palm over lumbar TPs (or lower ribs) on opposite side from where standing. Caudal hand volumetric over ASIS/iliac. May use towel between. Refer to page 61 for photo		DO OS iliac towards them in post rotation. Counterforce on lumbar TPs or lower ribs. Induces lumbar rotation towards DO and posterior ilium. Reference point Use hypothenar eminence contralateral TVP to you Iliac crest-oscillate towards you Pull towards in spring and oscillate within spring Stay in tightness/rigidity	 

					Pelvis can do versus lower ribs as well	
26	Pelvis/sacrum	Standing at side of patient at level of pelvis.	Hands/arms crossed in an X pattern. Pisiform contacts at PSIS and opposite inferior aspect of sacral-iliac articulation. Medial PSIS contact versus long arm.		DO rhythmically lowers chest generating OS along oblique axes of the sacrum. Influences SI capsule/ligaments, visceral pelvic structures (utero-sacral ligaments, isthmus etc.) Oscillate A/P in oblique axis Medial PSIS contact versus long arm Do both sides	

27	Sacral & Lumbar Vertabreae	Standing at patient's side at level of lumbar spine.	<p># 1. Arm's crossed in an X Pattern. Caudal hand global sacrum versus cephalic T12 to L5 (pisiform/ hypothenar contact under SP) Fingers are spread hand more oblique than sacrum hand</p> <p># 2. Right SI vs left inferior hemi-thorax (global contact) and vice versa.</p> <p>Page 64 photo</p>		<p>DO rhythmically lowers chest generating longitudinal OS through volume between hands.</p> <p>Where more tension-pelvis/L-spine focus oscillation</p> <p>Can go Up to mid thoracic for #1.</p> <p>focus on tightest side with oscillations</p> <p>Left SI versus right thorax for example</p> <p>Sacrum versus l-spine lean forward</p> <p>Think of a Tie to lean over area of rigidity</p>		
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					#2-SI versus hemi-thorax/lower ribs on opposite side, arms crossed Photos: Can do all from same side =lower chest and oscillate -spread and spring Vary intent a) Central b) Crossed hands c) Same side	
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28	Pelvis, lower extremities, posterior myofascial chains.	Standing at side of patient at level of knees. Feet off table	<ul style="list-style-type: none"> - Cephalic at global sacrum, fingers facing head - Caudal contacts and joins bilateral ankles/calcaneus into unit. 	<p>Do on both sides of patient</p> <p>DO lowers body rhythmically to generate longitudinal OS through volume between hands.</p> <p>The sacrum as a whole legs at ankles as whole and spread both volumes</p> <p>Do on both sides</p> <p>Posterior myofascial chain Tension and oscillation Feet off the table</p> <p>Lean forward-spread between 2 hands Spread and oscillate</p>	 
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29	Thoracic vertebra/ Shoulder	Standing at side of patient at level of shoulder on affected side.	<p>Cephalic hand controls UE just proximal to elbow. Caudal thumb (or thenar eminence) against lateral side of SPs on side standing (fixed reference point).</p> <p>Page 66 is photo</p> <p>The arm is in the axis of the involved vertebrae</p>	Patient head turned to face DO	<p>DO OS via traction U/E vs T1-T7. Increase GH ABD as work lower – vector to level. Can work vs. rib angles/scapulae.</p> <p>Can also use heel of hand-more volume and presence-Phillipe prefers this</p> <p>Open hand fingers volumetric Spread between 2 and oscillate</p> <p>Rotate trunk to oscillate</p> <p>Tuck arm in under your arm against thorax</p> <p>Thumbs contact, fingers flat</p> <p>Increase abduction arm as work lower t-spine</p>	
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					<p>Feet in line with tissue treating</p> <p>Can also do arm versus angle of rib or versus scapula</p> <p>can be used to evaluate if OA or rigidity</p> <p>If SP can't go to left, it can't rotate right, so its rotated left</p>	
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The Upper Extremity

30 and 31 go together

No .	Focus Area(s) Tissues	D.O. Body Position :	D.O. Hands Position: Ce/Ca	Patient Notes	Sequence Description & Notes	Picture
30	Shoulder Region	Standing at level of thorax on opposite side working. Photo page 67	Caudal hand holds anterior lateral shoulder. Entering between patient's torso and arm to go under and then hold in front. Cephalic hand contacts posterior shoulder/scapula. Volumetric.	Looking away DO (increases tension)	<p>DO OS via CIR in both directions; lift shoulder and CIR in spring, maintaining tension. Lean back, use body to lift and CIR.</p> <p>one hand anterior volume of shoulder other hand posterior volume of shoulder whole volume of shoulder</p> <p>head is supposed to be looking away-not like picture</p> <p>spring towards you by leaning away maintain spring-circumduction</p>	 

31	Cervical spine, upper thorax.	Standing at side facing patient between head and shoulder. Photo page 68	Arms crossed: X pattern. Caudal hand superior thoracic TPs and ribs, cephalic cup under cranium (occiput/temporal)	Start with vertebral artery test. -looking toward DO	<p>- DO produces OS between cranial sphere and upper thorax. - Lean forward to have hands spread longitudinally.</p> <p>-Keep spine aligned.</p> <p>-Don't lock elbows.</p> <p>- Gentle, small, no force, in spring.</p> <p>Regions related through anastomosis between the spinal nerves, vagus nerve and sympathetic nerves This normalizes dysfunctions in dermatome, myotome, sclerotome as do others sequence of vertebral spine</p> <p>Scoop under occiput and mastoid</p> <p>Patients Head towards you</p> <p>Upper middle thorax down to T6 with heel of hand</p> <p>Arms at side patients</p> <p>Gentle</p> <p>Crossed hands oscillate, reciprocal tension between hands</p>	
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					Do Not push occiput down-spread One hand under occiput Other hand thorax Slow and without force	
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3RD PHASE – PATIENT RECLINING AND SITTING

No .	Focus Area(s) Tissues	D.O. Body Position:	D.O. Hands Position: Ce/Ca	Patient Notes	Sequence Description & Notes	
32	Thoracic Area/chest	At patient's side	A-Hands crossed on patient's chest B-do hands on lower ribs,	-the photo does not match the description but matches option B. Can do both in supine, semi-sitting or sitting	For all DO executes a posterior traction, pulling his body back rhythmically without releasing the longitudinal tension	
33	Lower Extremities				See description #17, only semi-supine option here . This is already on number 17	

34	Thorax/ chest	<p>Stand next to patient at their side (e.g. right) Control body with cephalic hand (e.g. right) to keep in axis and induce thoracic rotation.</p>	<p>Cephalic hand (e.g. right) reaches across to contact opposite shoulder (e.g. left).</p> <p>Caudal hand thumb contacts TP (e.g. left) or side of SP for vertebra, rib just lateral to TP (for CT joint), and rib angle with pisiform (for CV joint).</p> <p>Page 72</p> <p>CV/CT:</p> <ul style="list-style-type: none"> - right rotation testing right CT and left CV, 	<p>Seated, even, in axis, legs apart, feet touching, arms crossed, holding opposite shoulders.</p>	<p>-DO rotates trunk taking patient's trunk with them (e.g. to the right).</p> <p>Stand right, turn patient right</p> <p>patients head aligned between ischial tuberosities</p> <p>DO body against patient body rotates to induce rotation around axis, pisiform contact</p> <p>Patient edge of table</p> <p>D.O under arms and lift, hold under patient arms so if on right side, the right arm would be under patient's arms</p> <p>Hands just move up level by level</p> <p>T1-T12</p> <p>Work most rigid vertebrae or rib</p> <p>forearm in line with area treating</p> <p>Oscillate</p> <p>For Vertebrae can oscillate in the spring in rotation. Palpating side of SP or on TP.</p>	    
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			testing to see if they are open		<p>Local Posterior to Anterior spring at CT (just lateral to TP) to test and treat.</p> <ul style="list-style-type: none"> - opposite rib angle with pisiform contact for CV. - Evaluate and treat both sides, as required. - Can work T1-T12 levels. <p>Patient even on ischial tuberousities</p> <p>-normalize SNS -big effect on sympathetic chain which is anterior to rib head Very powerful technique vertebrae Works CV/Ct and ganglion Sympathetic ganglion sits just in front of head of rib (CV) Stand right, turn patient right</p>	
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					forearm in line with area treating Oscillate 1 segment blocked-work 1 level below and above, do bilateral	
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