The McKenzie Institute International

CENTRE FOR POSTGRADUATE STUDY IN MECHANICAL DIAGNOSIS AND THERAPY

International Credentialling Exam

Candidate Information Booklet

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INTERNATIONAL CREDENTIALLING EXAM

SECTION ONE
CREDENTIALLING EXAM OVERVIEW

The International Credentialling Exam is the primary level of certification for Clinicians who have completed the Part A – D schedule of MDT courses.

To attain the status and qualification of “Cred. MDT” or “Cert. MDT” you need to undertake an examination to fully demonstrate your thorough understanding of the principles of MDT.

1. PURPOSE

The McKenzie Institute conducts the Credentialling Examination to:

- Establish a standard of minimum competence in the application of the McKenzie Method of Mechanical Diagnosis and Therapy.
- Identify and recognise the clinician who has demonstrated basic competency in the McKenzie Method of Mechanical Diagnosis and Therapy (MDT).
- Develop a referral network of MDT qualified clinicians.

2. ELIGIBILITY

You are eligible to register for the Credentialling Examination if you have completed Parts A - D of the McKenzie Institute International Education Programme, and are a licensed clinician, currently in good standing with your provincial college. Clinicians that did not take all their courses in Canada will need to provide evidence of their attendance at Parts A - D courses.

3. FORMAT OF THE EXAMINATION

Every component of the International Credentialling Examination has been reviewed by The McKenzie Institute International Education Council.

3.1 Content Areas

Since the primary objective of this Credentialling Exam process is the assessment of clinical skills and clinical decision-making processes, the format of this examination is multi-method testing.

Each method has been selected for its perceived suitability in testing one or more of the content areas.

The content areas are as follows:

- *History*
- *Physical Examination*
- *Provisional Classification*
- *Principles of Management*
- *Follow up Evaluation*
- *Prevention of Reoccurrence*
- *Clinician Procedures*

3.2 Methods

The testing methods currently used in the examination are paper-and-pen, chart evaluations, case studies, audio-visual presentation, and performance simulation. A description and goal of each method is given below.

3.2.1 Paper-and-Pen

The written examination is administered in a multiple-choice format that focuses on assessing the candidate's knowledge of all content areas.

3.2.2 Chart Evaluations

Based on an actual patient's records, a patient's history and/or physical examination findings are presented on a McKenzie Institute International Assessment Form. A sample of the version used on the exam is included in this manual. This section focuses on the interpretation of the written history and physical examination form, a principle of management identifying contraindications and the need for additional testing or medical procedures. The testing format is multiple-choice questions.

3.2.3 Case Study

Written case histories are presented on a McKenzie Institute International Assessment Form (sample forms are included in this manual). Multiple-choice questions are asked that focus on evaluating the patient, provisional classification, developing a principle of management, and selecting treatment procedures. This section also focuses on follow up evaluation and reassessment concepts.

3.2.4 Audio-Visual Presentation

A video is presented of a patient undergoing a history, physical examination, and/or a principle of management plus/minus a procedure in a clinical setting. Multiple-choice questions assess the candidate's ability to record, analyse and interpret the History, Physical Examination, including the patient's movements and static postures, conclusions, the clinician / patient communications, and the proposed management plan

3.2.5 Performance Simulation

This section is used to examine the candidate's ability to competently perform MDT clinician procedures. Three procedures are randomly selected for each exam.

PLEASE NOTE:

Any procedures taught on Parts A – D courses, included in the course manuals and demonstrated in the procedure videos (excluding manipulation), can be tested in the exam. Be sure that you are familiar with, and have practised performing, all procedures.

4. PASSING GRADE

The purpose of the Credentialling Examination is to assure the patient, the medical community, and the McKenzie Institute International that the clinician has attained a minimum level of competency in MDT. Because of this philosophy, a predetermined passing grade for the exam has been established based on field testing and on the Anghoff procedure for determining passing points for examinations.

The exam is divided into two sections:

- **Section 1:** Paper and Pen, Chart Evaluations, Case Studies and Audio-Visual Presentation. (In total 80 multiple choice questions).
- **Section 2:** The Performance Simulation. (In total 3 clinician procedures)

A candidate must pass both sections. The passing score for Section 1 is 60 points, and the passing score for Section 2 is a total of 230 points **WITH** a required minimum of 60 points for **each** procedure performed.

A candidate is able to re-take the exam if they do not achieve a pass. If a candidate passes only one section, then they only have to re-take the section they failed. A candidate may retake either or both sections of the exam up to three times. If they are not successful after three attempts, direction for remedial study is strongly recommended and can be provided by the faculty of the Branch conducting the exam. A retake of failed sections of the exam needs to be completed within five years of the date of the initial exam.

If the Performance simulation section is failed, the candidate will be required to retest on at least one of the previously failed techniques plus the selected techniques for that day's exam. At times, this may mean 4 techniques are tested for that candidate.

5. REGULATIONS FOR THE EXAMINATION

You can be dismissed from the examination for:

1. Impersonating another candidate
2. Not following the online examination guidelines provided by MICanada

6. EXAMINATION Guidelines

6.1 Instruction Prior to Exam

1. Exam candidates CANNOT use a CHROMEBOOK or similar, mobile phone, or tablet for the online examination
2. Exam candidates cannot wear a headset or speak during the exam
3. Even though this is an online exam, you cannot play music during the exam as you are being recorded, and it will interfere with the quality of the recording

6.2 Instruction Prior to Exam

Candidates cannot receive any form of instruction or feedback from Institute faculty or examiners, nor can faculty or examiners provide any instruction or feedback relating to any component of the examination including but not limited to the performance simulation within two weeks of the scheduled examination date.

7. SOFTWARE PREPARATIONS FOR THE EXAMINATION

7.1 Set Up Requirements

Equipment:
You will need to use a device that has a **webc**am: A laptop or Mac OS or PC computer with Windows OS is required. You **CANNOT** use a Chromebook, mobile phone or tablet.

System Requirements:
- Windows: 11, 10, 8, 7.
- Mac: MacOS 10.12 or higher.
- Chromebook OS not permitted

Room set up:
You must set your computer up in a quiet, empty room where you will not be distracted or interrupted. You must be alone in your exam environment.

7.2 Schoology

For the purposes of the examination, the MICanada Branch Administrator will supply you with a log in to use. This will be provided approximately 10 days prior to the exam date. You must access the examination site and Test Assessment folder (see below) at least 3 full days before the exam gets underway.

You will also be given details and access to an online TEST assessment. This will not take longer than ten minutes to complete, and it will allow you to test the following:
- Your login for Schoology is correct
- You are able to gain access to the Test Assessment folder & when the time is right the Examination Assessment folders
- The Lockdown Browser is installed correctly and works when you take the assessment
- You are able to access to a test simulation that will help you become become familiar with how the online examination environment, how the

questions will appear, and the format for answering them during the real exam.

It is recommended that you use this time to read through the relevant information about each section in this booklet as well as the helpful tips for progressing through the exam online.

7.3 Lockdown Browser and Webcam Proctoring

The McKenzie Institute International employs the use of Lockdown Browser and Webcam Proctoring software to ensure a fair and secure online testing environment for our candidates. The Respondus software will record your activity on screen and visually throughout the exam and those recordings will be viewed by the branch to ensure all exam candidates follow the examination protocols stipulated throughout this document and outlined in the exam.

You are required to be alone in your selected examination environment. You **CANNOT** share your examination environment with another person. As you are being recorded during the exam, please take your privacy into consideration when selecting your examination setting. Please remove items of a personal nature that you don't wish to be viewed or recorded.

7.4 Non-Disclosure Agreement

This will be sent to you by your Branch Administrator. The Non-Disclosure agreement as well as the candidate instructions should be read and signed by you. This should then be returned to the Branch Administrator at least 3 days before the exam is due to get underway. You will not gain access to the Test Assessment until the non-disclosure agreement is signed.

8. EXAMINATION DAY SCHEDULE

8.1 Examination timetable

MI Canada Credentialing Exam: March 29 & March 31, 2026

Section	Updated Exam Time Allocation
Pen and Paper	**1 hr 40 mins**
Chart Eval/Case Studies	**1hr 20mins**
Audio Visual	**1hr 30mins**
Total Exam	**4 hrs 30mins**

EXAM SCHEDULE PACIFIC TIME (PT):

DATE	EXAM COMPONENT	START	END
29MAR (SAT)	*Registration & Set-up*	7.00AM	7.15AM
29MAR (SAT)	WRITTEN EXAM	**7:15AM**	1.30PM
31MAR(TUES)	PERFORMANCE	Assigned Appointment Time	20 minutes

EXAM SCHEDULE EASTERN TIME (ET):

DATE	EXAM COMPONENT	START	END
29MAR (SAT)	*Registration & Set-up*	10.00AM	10.15AM
29MAR (SAT)	WRITTEN EXAM	**10:15AM**	4.30PM
31MAR(TUES)	PERFORMANCE	Assigned Appointment Time	20 minutes

Below is a breakdown of the exam hourly schedule. This schedule is based on **Eastern Time**, please adjust for your individual time zone. If you finish a section early, then you will have some extended break time between the different sections of the exam.

10.00am ET 10.00am – 10.15am	EXAM WILL OPEN for submissions Registration, Introduction, Exam preparation Open the Paper/Pen Assessment and read through / complete the LockDown Browser/Web monitoring requirements
10.15am – 11.55am	**Paper/ Pen (1 hr 40 mins)**
11.55am – 12.15pm	*Break (20 mins)*
12.15pm – 1.35pm	**Chart Evaluations/Case Studies (1 hr 20 mins)**
1.35pm – 2.30pm	*Meal Break (55 mins)*
2.30pm	*If you logged out of Schoology or closed out of the lockdown browser before lunch, you will need to use the MCKENZIE the MCKENZIE Schoology link to once again access the exam site. The link can be found in the Exam Day Instructions page.*
2.30pm	*Audio-visual folder will appear, you may need to refresh your page to see it.*
2.30pm – 4.00pm *4.00pm – 4.30pm*	**Audio Visual (1.5 hours)** *Additional time allowance is allocated for final submission to account for slow internet speed or content loading. Please note that this extra time allowance does not increase the overall time allocated for each component once the timer begins. Please see below for more information.*
4.30pm	WRITTEN EXAM WILL CLOSE with no further submissions possible

Recommendation: Do not log out or close out of Schoology until you have completed the exam or until the exam is over.

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9. PAPER/PEN

9.1 General Information

This portion of the examination consists of **45 multiple choice questions, plus 1 non-quantifying admin question**. You have **ONE HOUR AND 40 MINS** to complete this section of the examination.

10. CHART EVALUATIONS and CASE STUDIES

10.1 General Information

This section of the examination consists of **24 multiple choice questions plus 1 non-quantifying admin question** related to information on Assessment Sheets that are clearly marked EVALUATION 1, 2, 3 etc.

For the Chart Evaluations, you will have an Assessment form only OR just the History Sheet completed; OR just the Examination sheet completed.

For the Case Studies, you will have a History AND Examination Assessment form completed and Follow Up Visit information.

You have **ONE HOUR 20 MINUTES** to complete this section of the examination.

AUDIO VISUAL PRESENTATION

10.2 General Information

This section of the examination consists of **11 multiple choice questions plus 1 non-quantifying admin question** related to the video.

In this section you will be examined by use of a Video. You will see a Clinician examine and treat a Patient.

You will start with a **blank Assessment sheet and a blank Reassessment Sheet** and you will follow along and complete it with what is being said and done by both the Clinician and the Patient.

IMPORTANT: The Clinician may be doing some things correctly and some things incorrectly, completely or incompletely.

There are question sections for the following areas:

- History
- Examination
- Conclusion
- Principles of Treatment
- Reassessment

You have **ONE HOUR 30 MINUTES** to complete this section of the examination.

10.3 Examination process

In Schoology, you will see a FOLDER called **'AUDIO VISUAL COMPONENT'** which contains 10 separate assessments/folders.

How it the audiovisual section works:

You will begin with a blank assessment form. For each subsequent section, you will be able to view a 'correct' form. You have approximately five minutes to then update your assessment form with any changes before you watch the next video component.

Doing it this way, you will not be penalised and will have the opportunity to answer subsequent sections correctly, even if you answered incorrectly on the previous section.

Each time, refer to the information you have or do not have on your assessment sheet to help you answer the questions.

PERFORMANCE SIMULATION

8.1 OVERVIEW - PERFORMANCE SIMULATION

The second component to the Credentialling Examination is the successful completion of a performance simulation. This is a practical exam where you demonstrate your knowledge about the application of MDT Procedures with **two examiners** who will critique and grade your knowledge. This practical examination may be conducted via Zoom or similar software. It may be on the same day as the online written examination, or on a different date to be advised by your Branch.

This component is completed over the duration of **20 minutes**. In total you will be examined on three procedures selected by the examiner and to gain a PASS in this section you must obtain a total of **230 points, AND a required minimum of 60 points for each technique performed.**

Exam Candidates are required to recruit a patient model for the performance component of the exam.

Patient Models: The practice patient model can be a friend, family member, work colleague or another course registrant. Patient models must be considered adults in the province they are residing. All patient models will be required to sign a consent waiver.

The patient model cannot be another Physiotherapist or Chiropractor. They should be asymptomatic and they must be the legal age of majority in the province/state where you practice. Ideally, the patient model should be no older than 65). The patient model waiver must have been submitted to MICanada at least **7 days before** the exam

8.2 ONLINE PERFORMANCE EXAMINATION PROCESS

On your allotted date and time you should be prepared with the following:

- Computer/Tablet/Phone with a suitable camera that can be placed conveniently so that the examiners will be able to clearly see you perform the procedures.
- A portable or adjustable treatment table
- A straight back chair
- An adult model (as defined by your province or state) to be used as the 'patient'

It is the exam candidate's responsibility to make sure that the camera angle is positioned well prior to the performance testing. As such, we suggest you practice and record yourself in advance to ensure good sight lines. This is also a great tool to help critique your procedure practices. **Without exception, the model cannot be another exam candidate or previously noted clinician.**

You will be asked to perform specific MDT procedures as selected by the examiners. The head examiner will present you with the first procedure, which you will have two minutes to read through.

You will then be asked to perform the procedure (using your model) as if it was going to be the first time you are applying it to a patient. This will be repeated until you have completed all three procedures.

There will be no role-playing required with regard to monitoring any symptoms or pretending the model has a particular diagnosis. The model with perform only the movements you request. The model will not volunteer any information.

If at any time the model experiences any discomfort related to procedures performed, they may terminate the procedure.

Please refer to the following pages for sample examination questions.

10. SAMPLE QUESTIONS AND INFORMATION ABOUT THE EXAMINATION

To familiarise yourself with the format prior to the exam, the following are sample questions for the Paper/Pen, Chart Evaluation and Case Study sections of the Credentialling Exam together with the directions. *(Answer key provided on the last page of this section.)*

10.1 Paper/Pen

Read each question and all answers, and then decide which is the best answer. There is only one correct answer for each question. You will not be given credit for any question for which you indicate more than one answer or for any that you do not answer. There is no penalty for guessing.

1. On the initial assessment of a 27-year-old male patient presenting with intermittent left back and left posterior thigh and calf pain, lumbar ROM shows a moderate loss of flexion and minimal loss of extension. With repeated movement testing Rep FIS produces back and leg pain which is no worse after and has no effect on movement baselines, Rep EIS has no effect during and after, Rep FIL has no effect during and after, Rep EIL produces low back strain which is no worse after and has no effect on movement baselines. Based on the assessment findings your provisional classification is lumbar Adherent Nerve Root. His history is consistent with a derangement six months ago after a lifting injury. He has not received any previous care. He is scheduled for a follow up review in 48 hours. What are the appropriate self-treatment exercise recommendations until his review?

a. Rep FIL 10/2hours, Rep FIS 10/2hours starting at midday, Rep EIL after either Rep FIL and Rep FIS for prevention, postural advice

b. Rep FIS 10/2hours, Rep EIL after the Rep FIS for prevention, postural advice

c. Rep FIL 10/2hours, Rep EIL after the Rep FIL for prevention, postural advice

d. Rep FIS 10/2hours, Rep EIS afterwards for prevention, postural advice

2. A 32-year-old female patient presents with pain located equally across the base of the neck, the right scapula and right upper arm. All symptoms are constant. She reports that during the test movements of repeated retraction her symptoms are felt a bit more with each movement, but are about the same when she returns to the starting position. How should the response to repeated retraction be recorded on the evaluation form?

a. Increase, No Worse

b. Produce, No Worse

c. Increase, Worse

d. Produce, Worse

3. Which of the following symptoms would most strongly indicate consideration of Serious Pathology in a patient presenting with complaint of headache?

a. Associated symptoms of dizziness and nausea when moving the head.

b. Progressive worsening of temporal/occipital headache with visual changes not associated with movement.

c. Headache aggravated with routine activity which worsens as the day progresses.

d. Difficulty sleeping due to being unable to find a comfortable position.

4. A patient with central symmetrical low back pain returns for follow up treatment 24hours after the initial assessment. What should the follow-up evaluation include?

a. Review location, frequency and intensity of symptoms, effect of posture change, and test the response to repeated lumbar flexion and extension.

b. Review symptomatic presentation, adherence to and performance of the home programme; retest all repeated movements for mechanical baselines.

c. Review the symptomatic baselines, functional baselines, mechanical baselines, and the effect of posture change.

d. Review the symptomatic and functional presentation, review adherence with posture recommendations and performance of the home programme. Retest appropriate key physical examination baselines.

10.2 Chart Evaluations and Case Studies

These sections of the examination consist of multiple-choice questions.

1. On the Chart Evaluations, you will have one of the following:

- A completed history and physical examination assessment sheet
- A completed history sheet only
- A completed physical examination sheet

The assessment sheets and questions will be clearly marked ‘Evaluation 1, 2, 3’.

2. With the Case Studies, you will have completed:

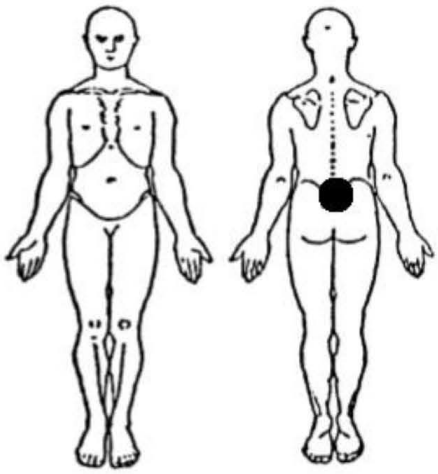
- History
- Physical Examination Sheets, and
- Follow up visits

The Case Studies and questions are clearly marked ‘Case Study 1, 2, 3’ etc.

Please go to next page.

CHART EVALUATION EXAMPLE: HENRY

THE McKENZIE INSTITUTE
LUMBAR SPINE ASSESSMENT



Date

Name Henry Gender M

Address

Telephone

Date of Birth Age 32

Referral: *GP / Orth / (Self) / Other*

Work demands Dentistry student, predominantly sitting

Leisure activities Gym work out 4-5x per week

Walking dog

Functional limitation for present episode Difficulty dressing lower ½

Not been able to go to the gym

Outcome / Screening score

NPRS (0-10) 2-7/10

Present symptoms As per body chart

Present since 7 days *improving / (unchanging) / worsening*

Commenced as a result of Fell backwards off approx. 0.5m (2ft) wall and landed on back no apparent reason

Symptoms at onset: *(back) / thigh / leg*

Constant symptoms: *(back) / thigh / leg* Intermittent symptoms: *back / thigh / leg*

Worse *bending* *sitting* ~~*/ rising*~~ (2 hrs) *standing* (> 20 mins) *walking* (> 20 mins) *lying*

(am) / as the day progresses / (pm) *when still / on the move*

other

Better *bending* *sitting* *standing* *walking* *lying*

am / as the day progresses / pm *when still / on the move*

other

Disturbed sleep *yes / (no)* Sleeping postures: *prone / sup / side R / L* Surface:

Previous spinal history Nil

Previous treatments Nil

SPECIFIC QUESTIONS

~~*Cough*~~ / ~~*sneeze*~~ / ~~*strain*~~ Bladder / Bowel: *(normal) / abnormal* Gait: *(normal) / abnormal*

Medications: Nil

General Health / Comorbidities: Good general health, stressed about exams and being able to sit to do them

Recent / relevant surgery: *yes / (no)*

History of cancer: *yes / (no)* Unexplained weight loss: *yes / (no)*

History of trauma: *yes / (no)* Imaging: *yes / (no)*

Patient goals / expectations: 1. To be able to sit for exams without pain 2. Dress lower ½ 3. Return to the gym

EXAMINATION

POSTURAL OBSERVATION

Sitting: *lordotic / neutral / kyphotic* Change of posture: *better / worse / no effect* _____

Standing: *lordotic / neutral / kyphotic* Lateral shift: *right / left / nil* Shift relevant: *yes / no*

Other observations / functional baselines: _____

NEUROLOGICAL

Motor deficit _____ Reflexes _____

Sensory deficit _____ Neurodynamic tests _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion					
Extension					
Side gliding R					
Side gliding L					
Other					

TEST MOVEMENTS **Describe effect on present pain – During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptomatic response		Mechanical response	
	During testing	After testing	Effect - ↑ or ↓ ROM or key functional test	No effect
Pretest symptoms standing				
FIS				
Rep FIS				
EIS				
Rep EIS				
Pretest symptoms lying				
FIL				
Rep FIL				
EIL				
Rep EIL				
Pretest symptoms				
SGIS - R				
Rep SGIS - R				
SGIS - L				
Rep SGIS - L				
Other movements				

STATIC TESTS

Sitting slouched / erect / lying prone in extension / long sitting _____

OTHER TESTS _____

PROVISIONAL CLASSIFICATION

Derangement Central or symmetrical Unilateral or asymmetrical above knee Unilateral or asymmetrical below knee

Directional Preference: _____

Dysfunction: Direction _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

Chart Evaluation Question (Henry)

5. Based on the information from the history, what provisional classification(s) are still a consideration?

a. Derangement Syndrome, Trauma/Recovering Trauma, Serious Pathology

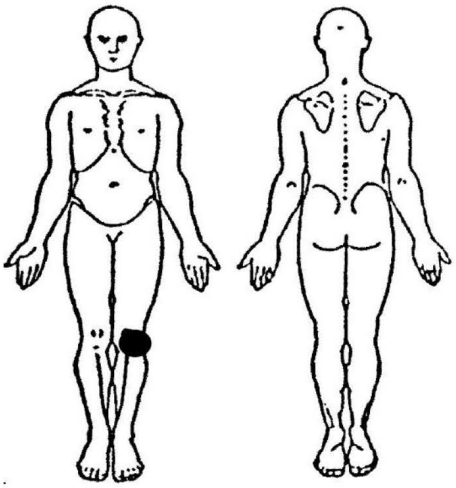
b. Derangement Syndrome

c. Derangement Syndrome, Serious Pathology

d. Derangement Syndrome, Trauma/Recovering Trauma

CASE STUDY EXAMPLE: KHAN – Assessment and Follow-up

THE McKENZIE INSTITUTE
LOWER EXTREMITIES ASSESSMENT



Date

Name Khan Gender M

Address

Telephone

Date of Birth Age 48

Referral (GP) / Orth / Self / Other

Work demands Government administrator 40 hrs/week

Leisure activities Running 5x per week

Functional limitation for present episode: Difficulty with running

Outcome / Screening score

NPRS (0-10) 0-7/10

Present symptoms As per body chart

Present since Four months — improving / (unchanging) / worsening

Commenced as a result of Fell and landed on flexed knee — no apparent reason

Symptoms at onset As per body chart — Paraesthesia: yes / (no)

Spinal history Nil — Cough / Sneeze +ve / (-ve)

Constant symptoms: — Intermittent symptoms: X

Worse: (bending) ~~sitting~~ / rising / first few steps ~~standing~~ walking stairs (squatting / kneeling)

~~am~~ / as ~~the day progresses~~ / ~~pm~~ when still / ~~on the move~~ Sleeping: prone / sup / side R / L

Other getting in and out of car

Better: ~~bending~~ ~~sitting~~ ~~standing~~ walking stairs squatting / kneeling

~~am~~ / as ~~the day progresses~~ / ~~pm~~ when still / ~~on the move~~ Sleeping: prone / sup / side R / L

other Sleeping with pillow under knee sometimes helps

Continued use makes the pain: better (worse) no effect Disturbed sleep yes / no

Pain at rest yes / no Site: back / hip / (knee) / ankle / foot

Other Questions: swelling catching / clicking / ~~locking~~ giving way / ~~falling~~

Previous history No past history

Previous treatments Nil

Medications Initially NSAIDS no effect, so stopped

General health / Comorbidities: hypertension

Recent / relevant surgery: yes / (no)

History of cancer: yes / (no) Unexplained weight loss: yes / (no)

History of trauma: yes / (no) Imaging: (yes) / no

Patient goals / expectations: Running no pain, stairs no pain

EXAMINATION

POSTURAL OBSERVATION

Sitting: *lordotic / (neutral) / kyphotic* Change of posture: *better / worse / (no effect)* Standing: *lordotic / (neutral) / kyphotic*

Other observations: _____

NEUROLOGICAL: (NA) / motor / sensory / reflexes / neurodynamic _____

BASELINES: Pain and functional activity squat 1/2 range NPRS 7/10, descending step NPRS 4/10

EXTREMITIES *hip / (knee) / ankle / foot* _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion			X		knee
Extension			X		knee
Dorsi Flexion					
Plantar Flexion					
Other:					

	Maj	Mod	Min	Nil	Symptoms
Adduction / Inversion					
Abduction / Eversion					
Internal Rotation					
External Rotation					
Other:					

Passive Movement: note symptoms, range and +/- over pressure:	PDM	ERP
Flex min loss +OP		X
Ext min loss +OP		X

Resisted test pain response Knee flexion no pain or weakness, Knee extension no pain but weakness 4/5

Other tests / static positioning McMurray's produces concordant pain

SPINE

Movement Loss Nil

Effect of repeated movements NE

Effect of static positioning _____

Spine testing *(not relevant) / relevant / secondary problem* _____

Baseline Symptoms _____

Repeated Tests	**Symptomatic Response**		**Mechanical Response**	
Active / Passive movement, resisted test, functional test	**During** Produce, Abolish, Increase, Decrease, NE	**After** Better, Worse, NB, NW, NE	**Effect** ↑ or ↓ ROM, strength or key functional test	No Effect
Rep Ext	Produce	NW		X
Rep Flex	Produce	NW		X
Rep Flex with patient OP	Produce	NW	Dec Ext NE Flex/Squat	
Rep Ext with patient OP	Produce	NW		X
Rep Ext with patient OP in standing	Produce	NW	Inc Ext NE Flex/Squat	

PROVISIONAL CLASSIFICATION **Extremities** **Spine**

(Derangement) _____ Directional Preference Extension

Dysfunction: Articular / Contractile _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education Traffic light guide for symptom response

Exercise type Rep knee ext with OP in standing Frequency 10-15 reps every 2 hrs

Other exercises / interventions _____

Management goals 1. To be able to go down stairs no pain 2. To be able to squat no pain 3. Resume running

_____ Signature _____

Case Study Questions (Khan)

History - Khan reports that symptomatically and functionally he feels he is unchanged. He has been consistent with the exercises in terms of repetitions and frequency; they produce knee pain during but are no worse after.

Physical Examination – Baseline symptoms nil. Functional baseline tests as per initial assessment.
Movement Loss - Flexion nil loss ERP with overpressure, extension nil loss ERP with overpressure. Resisted tests - no pain or weakness with flexion or extension. McMurray's produces concordant pain.

6. Based on the information gathered on Day 2, what is the interpretation and how should management proceed?

a. There is a green light response therefore the loading strategy should remain unchanged.

b. There is a green light response, however, to try and change the symptomatic and functional baselines increase the repetitions and frequency of his current exercise.

c. There is a green light response, however, to try and change the symptomatic and functional baselines, explore the force progression of clinician overpressure.

d. There is a green light response, however, to improve the symptomatic and functional baselines, utilise the force progression of knee extension with femoral external rotation.

Day 3 (2 weeks after initial assessment)

History - Khan reports that symptomatically pain is less 0-3/10 but he is still experiencing occasional clicking and sensations of giving way and does not feel confident in his knee to run on it. Stairs are pain free,but squatting and kneeling still produce pain. He has been consistent with the exercises in terms of repetitions and frequency; the exercises have no effect during or after.

Physical Examination – Baseline symptoms nil. Squat and kneeling both produce pain at end range.
Movement Loss - Flexion nil loss ERP with overpressure, extension nil loss no pain with overpressure. Resisted tests no pain or weakness with flexion or extension. McMurray's produces concordant pain.

7. Based on the information gathered on Day 3, how should management proceed?

a. Commence recovery of function with a graded strengthening and running programme.

b. Test the response to knee extension with overpressure combined with lateral forces.

c. Address the cognitive barriers around fear of resuming running.

d. Refer for imaging to rule in/out Structural Compromise.

Answer Key: 1. C; 2. A; 3. B; 4. D; 5. A; 6. C; 7. B

APPENDIX
Abbreviations
MDT Assessment Forms

Guide to Abbreviations and Terminology used
for the Completion of the
Assessment Forms with Mechanical Diagnosis and Therapy®

History: **Page One** *Patient responses are recorded but supplemented by the clinician as appropriate*	
Referral:	GP = General Practitioner Orth = Orthopaedic Specialist
NPRS:	NPRS = Numerical Pain Rating Scale
Better / Worse Section:	am = morning; pm = evening
Disturbed Sleep:	sup = supine; R = right; L = left

Physical Examination: Page Two	
Movement Loss:	Maj = major; Mod = moderate; Min = minimal; Nil = no loss R = right; L = left

Test Movements:	**Describe effect on present pain – During:** · P = Produces · A = Abolishes · ↑ = increases; ↓ = decreases; NE = no effect **LUMBAR:** **Pretest symptoms standing:** · Rep Repeat · FIS Flexion in standing · Rep FIS Repeat Flexion in standing · EIS Extension in standing · Rep EIS Repeat Extension in standing **Pretest symptoms lying:** · FIL Flexion in lying · Rep FIL Repeat Flexion in lying · EIL Extension in lying · Rep EIL Repeat Extension in lying **If required pretest symptoms:** · SG Side gliding · SGIS Side gliding in standing · SGIS – R Side gliding in standing right · Rep SGIS – R Repeat Side gliding in standing right · SGIS - L Side gliding in standing left · Rep SGIS – L Repeat Side gliding in standing left

Test Movements cont.:	**LUMBAR cont.:** **Other tests:** · FISitt Flexion in sitting · Rep FISitt Repeat Flexion in sitting · FISS Flexion In Step Standing · Rep FISS Repeat Flexion In Step Standing **CERVICAL:** **Pretest symptoms standing:** · PRO Protrusion · Rep PRO Repeat Protrusion · RET Retraction · Rep RET Repeat Retraction · RET EXT Retraction Extension · Rep RET EXT Repeat Retraction Extension **Pretest symptoms lying:** As above **If required pretest pain sitting:** · LF – R Lateral Flexion right · Rep LF – R Repeat Lateral Flexion right · LF – L Lateral Flexion left · Rep LF – L Repeat Lateral Flexion left · ROT – R Rotation right · Rep ROT – R Repeat Rotation right · ROT – L Rotation left · Rep ROT – L Repeat Rotation left · FLEX Flexion · Rep FLEX Repeat Flexion **Symptomatic respmnse:** PDM = Pain during Movement ERP = End range pain **Mechanical response:** ↑ **=** increase; ↓ **=** decrease; ROM = Range of movement

Static Tests:	(see below)
Principle of Management:	**Education:** TYOB = Treat Your Own Back; TYON = Treat Your Own Neck

During Loading - Either by repeated movements or sustained postures ***(Static Tests)***		
Produce	P	Movement or loading creates symptoms that were not present prior to the test.
Abolish	A	Movement or loading abolishes symptoms that were present prior to the test.
Increase	↑	Symptoms already present are increased in intensity.
Decrease	↓	Symptoms already present are decreased in intensity.
No Effect	NE	Movement or loading has no effect on the symptoms during the testing.
Centralising	CE'g	Movement or loading moves the most distal pain proximally.
Peripheralising	PE'g	Movement or loading moves the pain more distally.

After Loading - Either repeated movements or sustained postures		
Worse	W	Symptoms produced or increased with movement or loading remain aggravated following the test.
Not Worse	NW	Symptoms produced or increased with movement or loading return to baseline following the test.
Better	B	Symptoms decreased or abolished with movement or loading remain improved after testing. - Or - Symptoms produced, decrease on repetition, remain better after testing.
Not Better	NB	Symptoms decreased or abolished with movement or loading return to baseline after testing.
Centralised	CE'd	Distal pain abolished by movement or loading remain abolished after testing.
Peripheralised	PE'd	Distal pain produced during movement or loading remain after testing.
No Effect	NE	Movement or loading has no effect on symptoms after testing.

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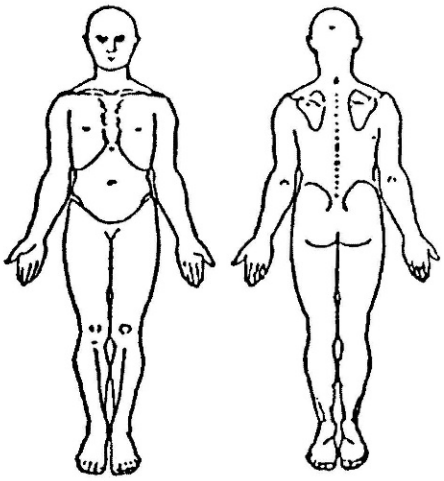
LUMBAR SPINE ASSESSMENT



Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____

Present symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ no apparent reason

Symptoms at onset: *back / thigh / leg* _____

Constant symptoms: *back / thigh / leg* _____ Intermittent symptoms: *back / thigh / leg* _____

Worse *bending* *sitting / rising* *standing* *walking* *lying*
am / as the day progresses / pm *when still / on the move*
other _____

Better *bending* *sitting* *standing* *walking* *lying*
am / as the day progresses / pm *when still / on the move*
other _____

Disturbed sleep *yes / no* Sleeping postures: *prone / sup / side R / L* Surface: _____

_____

Previous spinal history _____

_____

Previous treatments _____

_____

SPECIFIC QUESTIONS

Cough / sneeze / strain Bladder / Bowel: *normal / abnormal* Gait: *normal / abnormal*

Medications: _____

General Health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations: _____

_____

EXAMINATION

POSTURAL OBSERVATION

Sitting: *lordotic / neutral / kyphotic* Change of posture: *better / worse / no effect* _____

Standing: *lordotic / neutral / kyphotic* Lateral shift: *right / left / nil* Shift relevant: *yes / no*

Other observations / functional baselines: _____

NEUROLOGICAL

Motor deficit _____ Reflexes _____

Sensory deficit _____ Neurodynamic tests _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion					
Extension					
Side gliding R					
Side gliding L					
Other					

TEST MOVEMENTS **Describe effect on present pain – During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptomatic response		Mechanical response	
	During testing	After testing	Effect - ↑ or ↓ ROM or key functional test	No effect
Pretest symptoms standing _____				
FIS _____				
Rep FIS _____				
EIS _____				
Rep EIS _____				
Pretest symptoms lying _____				
FIL _____				
Rep FIL _____				
EIL _____				
Rep EIL _____				
Pretest symptoms _____				
SGIS - R _____				
Rep SGIS - R _____				
SGIS - L _____				
Rep SGIS - L _____				
Other movements _____				

STATIC TESTS

Sitting slouched / erect / lying prone in extension / long sitting _____

OTHER TESTS _____

PROVISIONAL CLASSIFICATION

Derangement Central or symmetrical Unilateral or asymmetrical above knee Unilateral or asymmetrical below knee

Directional Preference: _____

Dysfunction: Direction _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

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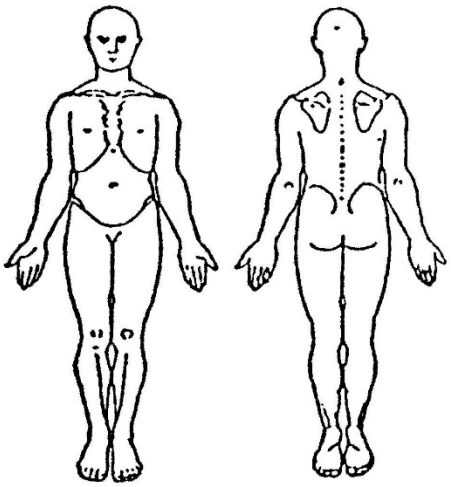
CERVICAL SPINE ASSESSMENT



Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____

Present Symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ no apparent reason

Symptoms at onset: *neck / arm / forearm / head* _____

Constant symptoms: *neck/arm/forearm/head* _____ Intermittent symptoms: *neck/arm/forearm/head* _____

Worse *bending* *sitting* *turning* *lying / rising*

am / as the day progresses / pm *when still / on the move*

other _____

Better *bending* *sitting* *turning* *lying*

am / as the day progresses / pm *when still / on the move*

other _____

Disturbed Sleep *yes / no* Sleeping postures: *prone / sup / side R / L* Pillows: _____

Previous spinal history _____

_____

Previous treatments _____

_____

SPECIFIC QUESTIONS

Dizziness / tinnitus / nausea / vision / speech _____ Gait / Upper Limbs: *normal / abnormal*

Medications: _____

General health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations: _____

_____

EXAMINATION

POSTURAL OBSERVATION

Sitting: *erect / neutral / slump* Protruded head: *yes / no* Lateral deviation: *right / left / nil*

Change of posture: *better / worse / no effect* _____ Lateral deviation relevant: *yes / no*

Other observations / functional baselines: _____

NEUROLOGICAL

Motor deficit _____ Reflexes _____

Sensory deficit _____ Neurodynamic tests _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Protrusion					
Flexion					
Retraction					
Extension					

	Maj	Mod	Min	Nil	Symptoms
Lateral flexion R					
Lateral flexion L					
Rotation R					
Rotation L					

TEST MOVEMENTS **Describe effect on present pain – During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptomatic response		Mechanical response	
	During testing	After testing	Effect - ↑or ↓ROM or key functional test	No effect
Pretest symptoms sitting				
PRO				
Rep PRO				
RET				
Rep RET				
RET EXT				
Rep RET EXT				
Pretest symptoms lying				
RET				
Rep RET				
RET EXT				
Rep RET EXT				
Pretest symptoms				
LF - R				
Rep LF - R				
LF - L				
Rep LF - L				
ROT - R				
Rep ROT - R				
ROT - L				
Rep ROT - L				
FLEX				
Rep FLEX				
Other movements				

STATIC TESTS Pro / Ret / Flex / Other _____ **OTHER TESTS** _____

PROVISIONAL CLASSIFICATION

Derangement Central or symmetrical Unilateral or asymmetrical above elbow Unilateral or asymmetrical below elbow

Directional Preference: _____

Dysfunction: Direction _____ **Postura**l **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

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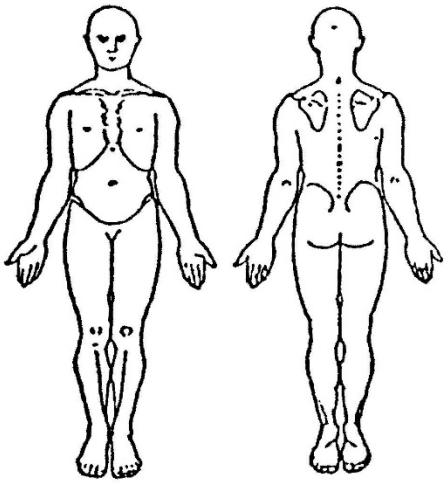
THORACIC SPINE ASSESSMENT



Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____

Present symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ no apparent reason

Symptoms at onset _____

Constant symptoms _____ Intermittent symptoms _____

Worse *bending* *sitting / rising* *turning neck / trunk* *standing* *lying*
am / as the day progresses / pm *when still / on the move*
other _____

Better *bending* *sitting / rising* *turning neck / trunk* *standing* *lying*
am / as the day progresses / pm *when still / on the move*
other _____

Disturbed sleep *yes / no* Sleeping postures: *prone / sup / side R / L* Pillows: _____

_____

Previous spinal history _____

_____

Previous treatments _____

_____

SPECIFIC QUESTIONS

Cough / sneeze / deep breath _____ Gait / Upper Limbs: *normal / abnormal*

Medications: _____

General health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations: _____

_____

EXAMINATION

POSTURAL OBSERVATION

Sitting: *erect / neutral / slump* Protruded head: *yes / no* Change of posture: *better / worse / no effect* _____

Standing: *neutral / kyphotic* _____

Other observations / functional baselines: _____

NEUROLOGICAL (upper and lower limb)

Motor deficit _____ Reflexes _____

Sensory deficit _____ Neurodynamic tests _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion					
Extension					
Rotation R					
Rotation L					
Other					

CERVICAL SPINE REPEATED MOVEMENT TESTING

Rep Pro _____

Rep Ret _____

Rep Ret Ext _____

Rep LF - R _____

Rep LF - L _____

Rep ROT - R _____

Rep ROT - L _____

Rep Flex _____

TEST MOVEMENTS **Describe effect on present pain – During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised

	Symptomatic response		Mechanical response	
	During testing	After testing	Effect - ↑ or ↓ ROM or key functional test	No effect
Pretest symptoms sitting				
FLEX				
Rep FLEX				
EXT				
Rep EXT				
Pretest symptoms lying				
EIL (prone)				
Rep EIL (prone)				
EIL (supine)				
Rep EIL (supine)				
Pretest symptoms sitting				
ROT - R				
Rep ROT - R				
ROT - L				
Rep ROT - L				
Other movements				

STATIC TESTS Flex / Ext / Rotation / Other _____ **OTHER TESTS** _____

PROVISIONAL CLASSIFICATION

Derangement Central or symmetrical Unilateral or asymmetrical

Directional Preference: _____

Dysfunction: Direction _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

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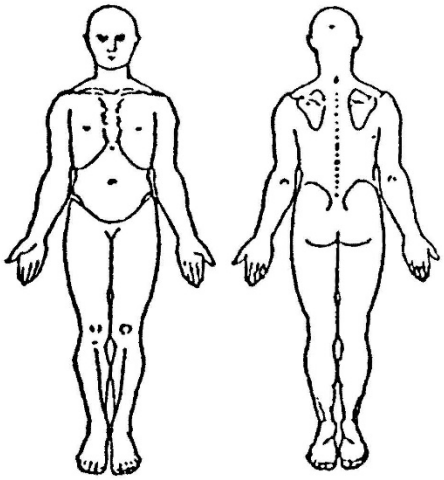
LOWER EXTREMITIES ASSESSMENT



Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____

Present symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ *no apparent reason*

Symptoms at onset _____ Paraesthesia: yes / no

Spinal history _____ Cough / Sneeze +ve / -ve

Constant symptoms: _____ Intermittent symptoms: _____

Worse *bending sitting / rising / first few steps standing walking stairs squatting / kneeling*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
Other _____

Better *bending sitting standing walking stairs squatting / kneeling*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
other _____

Continued use makes the pain: *better worse no effect* Disturbed sleep *yes / no*

Pain at rest *yes / no* Site: *back / hip / knee / ankle / foot*

Other Questions: *swelling catching / clicking / locking giving way / falling*

Previous history _____

Previous treatments _____

Medications _____

General health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations _____

_____

EXAMINATION

POSTURAL OBSERVATION

Sitting: *lordotic / neutral / kyphotic* Change of posture: *better / worse / no effect* Standing: *lordotic / neutral / kyphotic*

Other observations: _____

NEUROLOGICAL: NA / motor / sensory / reflexes / neurodynamic _____

BASELINES: Pain and functional activity _____

EXTREMITIES *hip / knee / ankle / foot* _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion					
Extension					
Dorsi Flexion					
Plantar Flexion					
Other:					

	Maj	Mod	Min	Nil	Symptoms
Adduction / Inversion					
Abduction / Eversion					
Internal Rotation					
External Rotation					
Other:					

Passive Movement: note symptoms, range and +/- over pressure: _____

PDM	ERP

Resisted test pain response _____

Other tests / static positioning _____

SPINE

Movement Loss _____

Effect of repeated movements _____

Effect of static positioning _____

Spine testing *not relevant / relevant / secondary problem* _____

Baseline Symptoms _____

Repeated Tests	**Symptomatic Response**		**Mechanical Response**	
Active / Passive movement, resisted test, functional test	**During** Produce, Abolish, Increase, Decrease, NE	**After** Better, Worse, NB, NW, NE	**Effect** ↑ or ↓ ROM, strength or key functional test	No Effect

PROVISIONAL CLASSIFICATION **Extremities** **Spine**

Derangement _____ Directional Preference _____

Dysfunction: Articular / Contractile _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____

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UPPER EXTREMITIES ASSESSMENT

Date _____

Name _____ Gender _____

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work demands _____

_____

Leisure activities _____

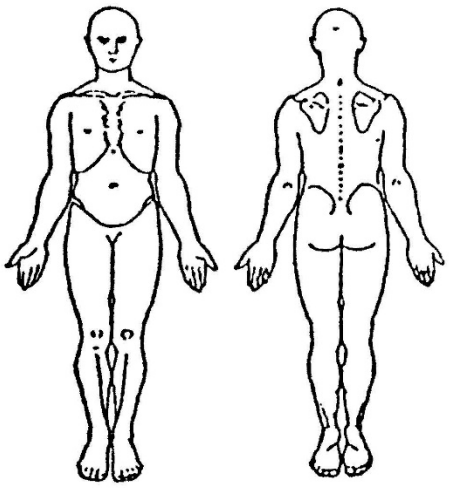
_____

Functional limitation for present episode _____

_____

Outcome / Screening score _____

NPRS (0-10) _____



Handedness: Right / Left

Present symptoms _____

Present since _____ *improving / unchanging / worsening*

Commenced as a result of _____ *no apparent reason*

Symptoms at onset _____ Paraesthesia: yes / no

Spinal history _____ Cough / Sneeze +ve / -ve

Constant symptoms: _____ Intermittent symptoms: _____

Worse *bending sitting turning neck dressing reaching gripping*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
Other _____

Better *bending sitting turning neck dressing reaching gripping*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
other _____

Continued use makes the pain: *better worse no effect* Disturbed sleep *yes / no*

Pain at rest *yes / no* Site: *neck / shoulder / elbow / wrist / hand*

Other Questions: *swelling catching / clicking / locking subluxing*

Previous history _____

Previous treatments _____

Medications _____

General health / Comorbidities: _____

_____ Recent / relevant surgery: *yes / no* _____

History of cancer: *yes / no* _____ Unexplained weight loss: *yes / no* _____

History of trauma: *yes / no* _____ Imaging: *yes / no* _____

Patient goals / expectations _____

_____

EXAMINATION

POSTURAL OBSERVATION

Sitting: *erect / neutral / slump* Change of posture: *better / worse / no effect* Standing: *lordotic / neutral / kyphotic*

Other observations: _____

NEUROLOGICAL: NA / motor / sensory / reflexes / neurodynamic _____

BASELINES: Pain and functional activity _____

EXTREMITIES *shoulder / elbow / wrist / hand* _____

MOVEMENT LOSS	Maj	Mod	Min	Nil	Symptoms
Flexion					
Extension					
Supination					
Pronation					
Other:					

	Maj	Mod	Min	Nil	Symptoms
Adduction / Ulnar Deviation					
Abduction / Radial Deviation					
Internal Rotation					
External Rotation					
Other:					

Passive Movement: note symptoms, range and +/- over pressure: _____	PDM	ERP

Resisted test pain response _____

Other tests / static positioning _____

SPINE

Movement Loss _____

Effect of repeated movements _____

Effect of static positioning _____

Spine testing *not relevant / relevant / secondary problem* _____

Baseline Symptoms _____

Repeated Tests	**Symptomatic Response**		**Mechanical Response**	
Active / Passive movement, resisted test, functional test	**During** Produce, Abolish, Increase, Decrease, NE	**After** Better, Worse, NB, NW, NE	**Effect** ↑ or ↓ ROM, strength or key functional test	No Effect

PROVISIONAL CLASSIFICATION **Extremities** **Spine**

Derangement _____ Directional Preference _____

Dysfunction: Articular / Contractile _____ **Postural** **OTHER** subgroup: _____

POTENTIAL DRIVERS OF PAIN AND / OR DISABILITY Comorbidities Cognitive - Emotional Contextual

Descriptions: _____

PRINCIPLES OF MANAGEMENT

Education _____

Exercise type _____ Frequency _____

Other exercises / interventions _____

Management goals _____

_____ Signature _____