

Neuromuscular Therapy Clinic, LLC
Anne Barber-Shams LMT, CNMT License 1964
Certified Neuromuscular Massage Therapist, St. John Method
Corbett Hill Wellness Center
4425 S W Corbett Ave. Portland, OR. 97239
503 246-0461 FAX 503 225-9039

July 25, 2007

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To: Dr. Rothbart

RE: Frank

Dear Dr. Rothbart,

The following is an addendum to the postural assessment forms which I completed for Frank Cook today:

Full Body Assessments: All standing assessments are taken with the feet positioned heels even, knees evenly extended and weight even on both legs. The sacral measurements are taken in the prone position, following osteopathic technique. The leg length assessments are a combination of standing and supine observations.

Feet: bilateral pronation **standing**, however the talar ligaments appear stable. **Supine** the arches become very high and the toes more flexed. Frank tells me you have films of his feet both weightbearing and non weightbearing. My observations are hypertonicity of the tibialis anterior and flexor digitorum. It is obvious that Frank bears weight on the first three toes only.

Legs: Standing The L patella is raised relative to the right. The L popliteal crease, PSIS and iliac crest are all inferior relative to the R. **Supine** knees bent and feet together, the L fibular head is inferior to the R. Supine the R medial malleolus, greater trochanter and ASIS are all inferior to the L.

Pelvis/Sacrum: Standing there appears to be a R pelvic flexion with the R ASIS inferior and R PSIS superior. However, on the coronal plane, there appears to be the same degree of angle between the bilateral PSIS and ASIS, which usually indicates equal flexion/extension positions of the iliums.

Seated the iliac crests are level.

Prone there is a L deep sulcus and L inferior lateral angle, worse on back extension with L-5 compensatory. This indicates a R sacral extension.

Supine there appears to be a R ilium inflare.

ACJ and Occiput: Standing the ACJ is L superior/R inferior and the occiput L inferior with the head shifted R lateral.

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To: Dr. Rothbart

RE: Frank

Cervical Spine:

Standing and Supine C-1 is WNL. **Standing** there is a slight forward head posture, and the cervical and upper thoracic spines are hypolordotic. (Frank is an ex-marine.) **Supine** the CS is also hypolordotic but somewhat flexible -extension and translation can be induced manually.

Cranium:

Standing The temporal bones are level in the anterior/posterior and superior/inferior dimensions. However the remaining cranial bones are R inferior/anterior, ie the frontal, maxilla and mandible. There is a R temporal inflare.

Supine: All of the cranial bones are level in the superior/inferior dimension. In the anterior/posterior dimension the temporal bones are level at the external auditory meatus, however the mastoid process is R anterior/ L posterior, which may be a relative extension position of the R temporal bone and relative flexion position of the L. The temporal bone is R inflare/L outflare. The sphenoid is R lateral.

Sincerely,

Anne Barber-Shams, LMT, CNMT

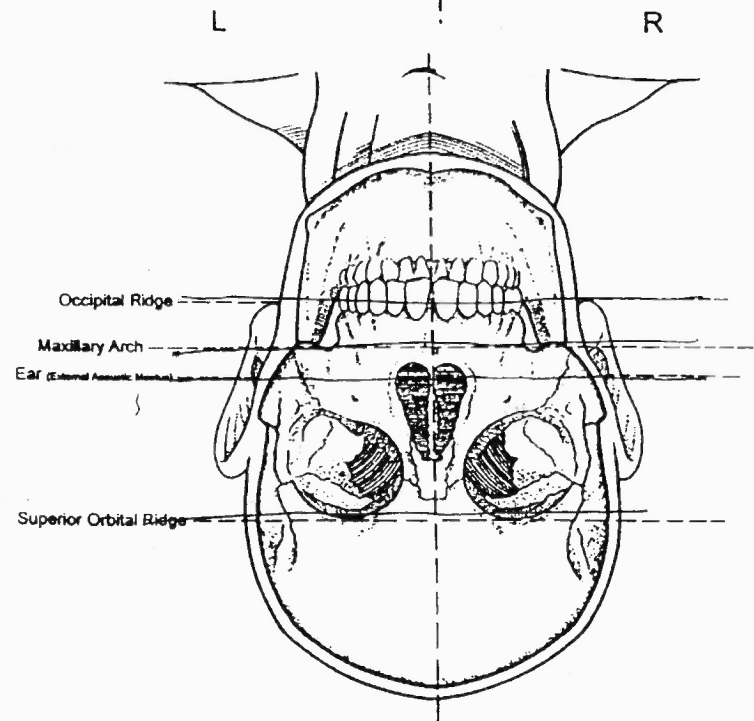
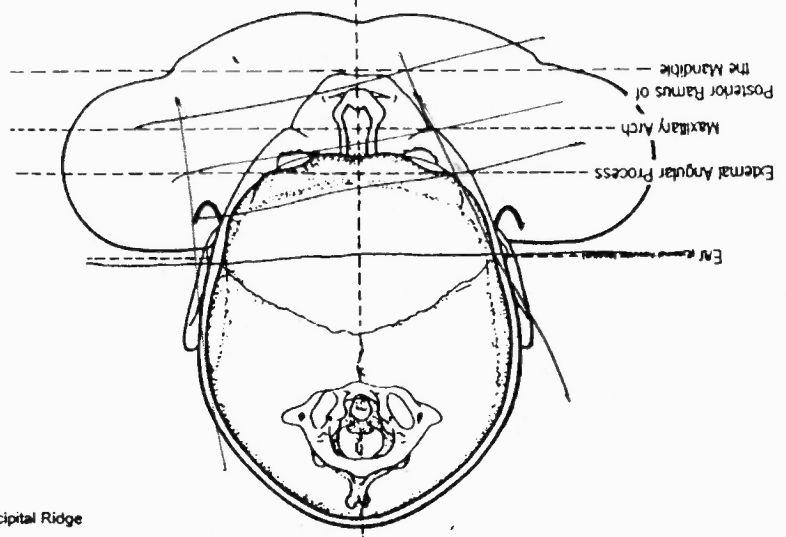
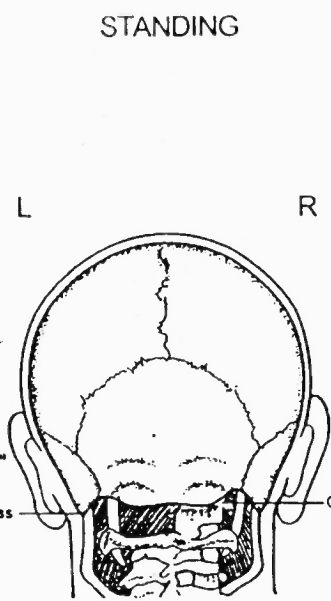
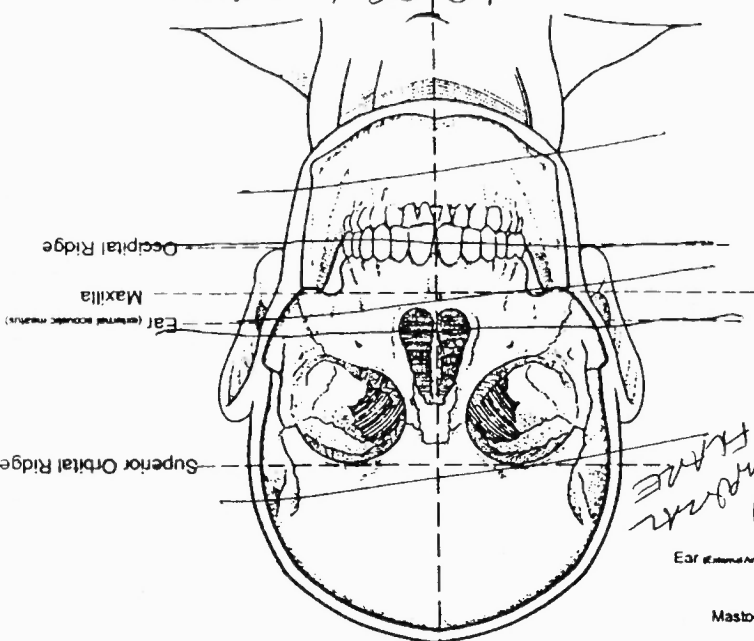
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LE

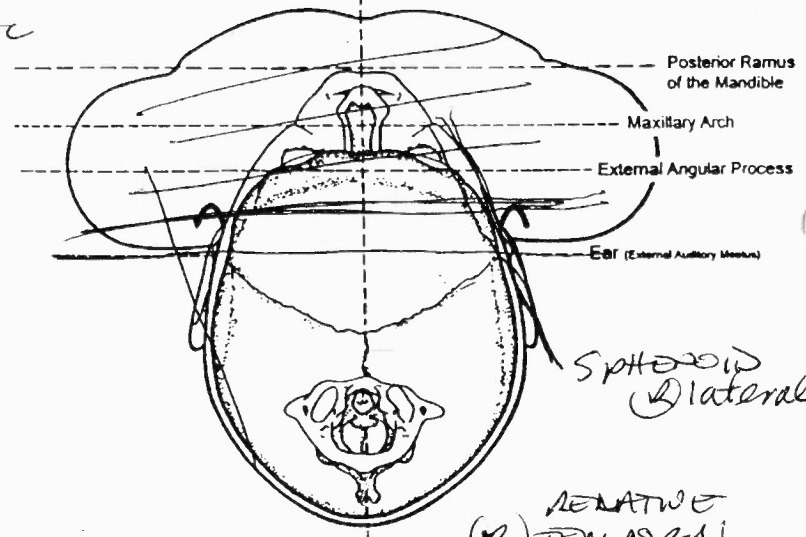
Superior to Inferior
Frank 7.25.07

Therapist: Anne Barber Sham

Anterior to Posterior



C-7 position with
CS hypolordotic
but somewhat
flexible.



SUPINE

Spheroid
② lateral
RELATIVE
② TEMPORAL
EXTENSION
① TEMPORAL
FLEXION

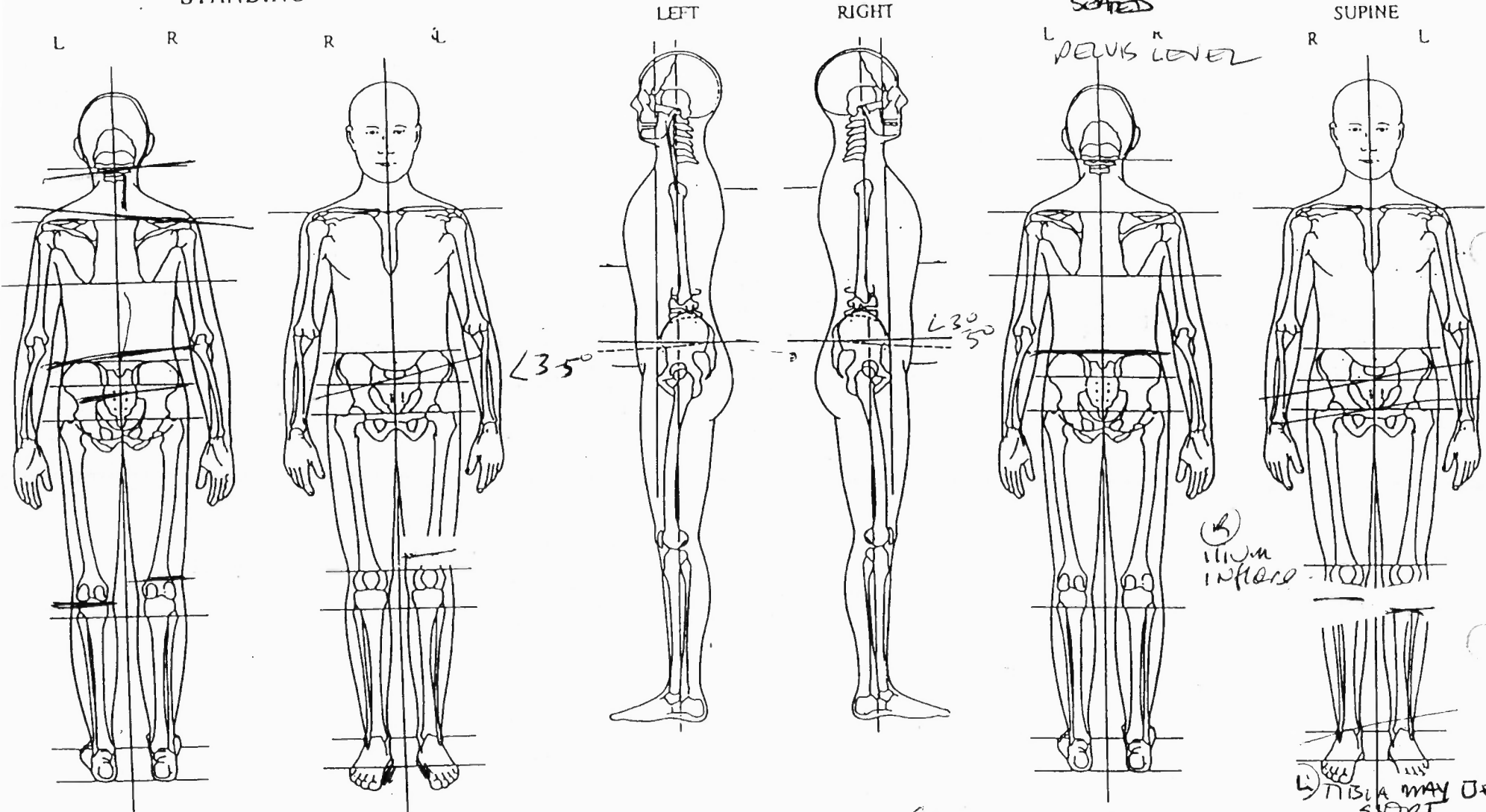
Subject: Frank

NEUROMUSCULAR SEGMENTAL NEUROPATHY EXAMINATION

Therapist: Barber Shams, Anne

Date: 7.25.07

STANDING



CODES:

- ANTERIOR MOVEMENT: Rotation of ASIS, AC Joint, or head.
- Superior/Inferior Deviation of Transverse Plane
- ~~■~~ Muscles in Shortened Contraction
- X Trigger Point
- Reference Zone of Trigger Point

SACRUM MEASURED PRONE
 (B) SACRAL EXTENSION (L DEEP SULCUS; (C) INFERIOR LATERAL ANGLE; WORSE ON BACK BENDING. L-S COMPENSATORY)

(D) TIBIA MAY BE SHORT →