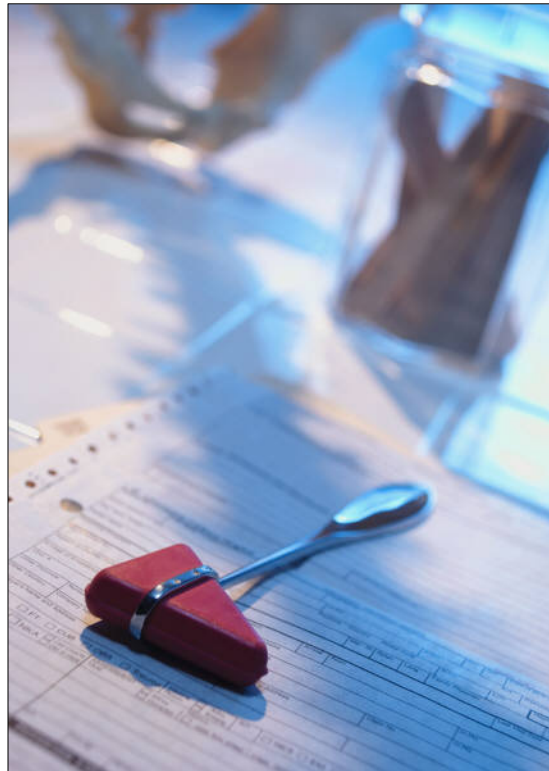


Charting Skills

For Massage Therapists

A Self-Study Workbook



Donald Quinn Dillon, RMT

Review Chapters 1, 2 and case study

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

© 2007, Donald Quinn Dillon. All Rights Reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, recording or otherwise, without the prior written permission of the author.

Published by MTCOach
19 Durham Drive, St. Catharines, ON L2M 1C1 ☎ 905 937 5802
www.MTCOach.com email: coach@MTCOach.com

Library and Archives Canada Cataloguing in Publication

Dillon, Donald Quinn, 1965-

Charting Skills for Massage Therapists: A Self-Study Workbook

Donald Quinn Dillon, author; Manisha Solomon, editor.

ISBN ISBN 978-0-9781193-3-1

1. Massage therapy. 2. Health facilities--Business management.

First edition

Disclaimer:

Although the author and publisher have made every effort to ensure the accuracy and completeness of information contained in this book, we assume no responsibility for errors, inaccuracies, omissions, or any inconsistency herein.

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

Contents

Introduction	- 5 -
Why Chart Anyway?	- 6 -
How to Use this Workbook	- 7 -
Start From Where You Are.....	- 7 -
Chapter One: The Case History.....	- 9 -
Why take a case history?.....	- 9 -
What Are Your Problems in Taking a Case History?	- 9 -
Regulations for Record Keeping.....	- 10 -
The Case History / Intake Template	- 11 -
The Dimensions of Pain.....	- 14 -
The Presence of Yellow and Red Flags	- 16 -
Personal Information Protection and Electronic Documents Act (PIPEDA).	- 18 -
Chapter Two: Performing a Thorough and Comprehensive Assessment.....	- 20 -
Advantages of using the Assessment/Treatment template:.....	- 20 -
Postural Distortion: Charting Made Simple.....	- 22 -
Charting Range of Motion (ROM)Findings	- 23 -
The Short on Short Hand	- 25 -
Assessment / Treatment Template: Completed Example	- 27 -
Chapter 3: Palpation Findings and Forming a Clinical Opinion	
Chapter 4: Treatment Plans / Completing the Treatment Record	
A Framework for Treatment Plans	
Treatments, Outcomes and Recommendations	
Chapter 5: Pain Questionnaires and Special Templates for Insurance	
Chapter 6: Case Studies / Labs	- 28 -
Appendix	- 31 -
Palpation as an Objective, Measurable Finding	- 31 -
About the Author.....	- 36 -
Also by MTCOach	- 37 -

Notes

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

Introduction

When I teach the Charting Skills workshop and ask the question “Why do we chart?” the most common response by registrants is an emphatic “because we have to!” Although it’s true we are required to maintain solid clinical records for regulatory purposes, I suggest it need not be our primary motivation in charting. The ability to skilfully create a symptom picture and formulate a clinical opinion — based on focused inquiry, keen observations, investigative palpation and diagnostic tests — actually can boost the therapist’s ability in administering an effective treatment plan.

I have experienced failure to create the desired results in a treatment plan when I did not ask essential questions in the case history. On other occasions, I did not critically examine all my findings to see where the symptom-picture was pointing. This led to some wasted time and frustration on my part, and sometimes the over-treatment or inadequate intervention of a person’s condition thereby hindering, not helping, their progress. In essence, when I’ve not given the case history and assessment their proper attention, I have sabotaged my efforts and my results.

There have been a few embarrassing moments when I went on a tangent to explore a minor, secondary complaint only to have the patient by treatment-end say “Well my ankle feels much better, but I really came in because my back was sore.” Ouch!

By framing all the information I gather in a concise and structured format, I can create as accurate a picture as possible of the person’s clinical condition today. I can then use this symptom picture to identify barriers to recovery, flag contraindications to treatment, and pose further questions to bring missing pieces together – why the condition is worse in the morning than in the evening. My assessment in combination with the person’s history can help to reveal whether the symptom picture is neuro-musculo-skeletal in nature and will respond to my interventions, or a systemic, neoplastic or inflammatory condition that requires direct referral to the person’s physician.

I think what therapists dislike about charting is the time and effort that goes into documenting one’s findings at the end of the day. It seems so mundane compared to the kinaesthetic interchange of providing treatment and witnessing somatic transformation. This charting system is designed to be effective and efficient: effective in clearly portraying the findings, treatment, results and recommendations of the therapist in a meaningful way; efficient in the time and energy required to record this information.

It is also a fact that, although orthopaedic tests and joint range-of-motion findings are generally uniform and agreed upon, very little is standard regarding the palpatory findings of muscle dysfunction. There exists various classifications and we’ll discuss some excellent models in this book. I think if we could employ this latter part in our regular and daily charting, not only would charting become easier and more clear, it would pave the way to substantiating results when massage therapy efficacy is challenged by third-party payers and research advocates.

Why Chart Anyway?

Of course we chart to meet regulatory requirements, but there are other essential reasons why you should chart effectively. These include:

- Designing better treatment plans
- Improving your treatment effectiveness
- Increasing your business!

How can good charting practices increase your business? By focusing your treatment plan, identifying secondary symptoms that can be remedied, and getting results faster. The greater the solutions you provide to someone's problem, the faster your solid reputation (and practice!) will grow.

The *MTCOach Charting System* is:

Easy to apply

This system builds on what you already know – tension, texture, temperature, and tenderness...the four “T’s” of palpation¹ – with opportunity to record ranges of motion, orthopedic tests and other assessments.

Time-efficient

Once you apply the system a few times, you will find it saves you a substantial amount of time normally dedicated to writing copious amounts of notes. By use of images, prompts and short-hand notation, you will have more time to focus on treating your patients/clients.

Meaningful to Massage Therapists

Learn to measure changes based on myo-fascial, not just orthopedic, parameters. Massage therapists are arguably the best practitioners at palpating and identifying soft-tissue anomalies. I believe it's time we started measuring and recording this information.

Qualifiable and quantifiable

You can expand the system to quantifiably measure soft-tissue findings. Texture, tenderness, tension and temperature can all be measured in a three-grade system of mild, moderate and severe.

Applicable to a variety of workplaces

Whether you work in private practice, in rehab treating auto insurance or WSIB cases, corporate on-site, or spa setting, this system can be modified to work for you.

Compliant with College of Massage Therapists of Ontario (CMTO) standards

You'll find a number of tools to ensure you are compliant with the CMTO standards - some of the highest standards in North America.

¹ The College of Massage Therapist guidelines include a fifth “T” – skin Tonus

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

How to Use this Workbook

This workbook is designed to facilitate learning the Charting Skills material as you read. There are a number of practical exercises placed within the workbook, including two case studies. Feel free to write in the book, highlight, and make notes...whatever you need to do to best learn the material.

Don't I need to keep the book clean so I can photocopy the templates for my own use? No. In fact, all the material in the book is bound by copyright law and is irreproducible. However, once you've completed the exercises in the workbook, you can register your workbook and receive access to the templates on-line.

When you register your workbook, you receive access to the following:

1. Case History template - Female and Male versions
2. Assessment/Treatment template
3. On-going Treatment template
4. Short-hand notation key
5. Pain and Disability questionnaires – Neck and Low Back
6. References to auto insurance and WSIB templates

Two Bonuses!

In addition to the above templates, you will have access to two templates specifically designed for working within the rehab / auto insurance systems:

7. WAD II Assessment – Quick Reference
8. Case History template – auto insurance

Plus! If you've been required to complete this course by your regulatory body to upgrade your record keeping/charting skills, we'll send you confirmation of completing the course. Simply complete the two case studies in the workbook, scan your completed worksheet (available to download when you register your book), and email to coach@mtcoach.com. MTCoach will provide confirmation that you have successfully completed the study course. Completing the case studies, even if you haven't been directed to do so, will give you a sense of completion of the course, and allow you to claim Continuing Education Units (CEUs).

Start From Where You Are

Now, before we get into the “sinew” of the book, please take a few moments to complete the tool provided on the next page to assess your current charting practices.

Compare at least five of your current records to assess what areas of your charting you may wish to improve upon. Note the areas you're currently missing from your charting practices and then utilize the rest of this book to build those weaknesses into strengths!

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCoach—Cultivate Your Massage Therapy Practice www.MTCoach.com

Check-box all fields covered in your current case history template

Health History Particulars Must Include at a minimum

- Date of health history
- General health status
- Client/patient name and address
- Date of birth
- Telephone number
- Occupation and source of referral
- Name and address of primary care physician
- Primary complaint
- Vision or hearing loss
- Loss of sensation
- Current treatment / other practitioners
- Current medications and conditions treated
- Timing & nature of injuries and accidents
- Timing & nature of surgical procedures

Possible Cardiovascular Insufficiency, including:

- High or low blood pressure
- Chronic congestive heart failure
- Heart disease
- History of myocardial infarction
- Phlebitis
- History of cerebro-vascular accident
- Presence of pacemaker or similar device

Known Allergies or Hypersensitivity Reactions:

- Allergies with response of anaphylaxis or skin irritation
- Diabetes, arthritis, cancer, epilepsy, skin conditions
- Presence of infectious conditions including: Infectious skin conditions, Tuberculosis, hepatitis or HIV
- Pregnancy
- Location and nature of soft-tissue and / or joint dysfunction
- Other diagnosed diseases/medical conditions eg: digestive conditions, gynaecological conditions, hemophilia, etc.
- Presence of internal pins, wires, artificial joints or special equipment

Ref: Standard #6 CMTO Standards of Practice 2006

Possible Respiratory Insufficiency, including:

- Chronic cough
- Bronchitis
- Shortness of breath
- Asthma
- Emphysema

Compare at least five records. Check-box all fields you typically include in your assessment

Assessment / Reassessment Particulars Must Include:

- Acute, sub-acute or chronic conditions
- Acute or chronic pain, with location, type, duration, origin, pattern, triggering phenomena, intensity and quality
- Central nervous system injuries and conditions
- Peripheral nervous system injuries and conditions
- Range of motion of joints and muscles (active, passive and resisted)
- Flexibility of the soft-tissues
- Evidence of tenderness, tension, temperature, (skin) tone and texture
- All testing is done bi-laterally
- Identify physical conditions treatable by massage therapy

- Identify conditions that may preclude general or local massage therapy treatment, or require treatment adaptation
- Identification of potential risks associated with treatment in the presence of contraindication
- History of massage therapy care
- Particulars of every needs assessment, examination and treatment performed by the member at each clinical visit
- Every report written re: examination or treatment
- Particulars of all advice given
- Particulars of every referral to another health professional

- A Treatment plan, with treatment goals and focus, body areas to be treated, anticipated frequency and duration of treatment, anticipated patient responses to treatment, schedule for reassessment and recommended remedial exercises or hydrotherapy
- Determination if a treatment plan must be modified/changed/stopped
- Verbal or written consent as required
- Each health record must have a reference identifying the client/patient
- Each health record must clearly identify the date and the member making the entry
- Determination if massage therapy treatment is indicated

Standards #8, 9 and 10 CMTO Standards of Practice

Highlight all fields missing from your case history template, and all fields missing from your typical assessment.

Congratulations! This is a good start.

Chapter One: The Case History

Why take a case history?

There are many good reasons to take a good case history, beyond the requirements of your regulatory body. Health practitioners take a case history to learn and determine:

- the source of symptoms / dysfunction
- contributing factors to the symptoms — environmental, emotional, behavioural, physical or biomechanical
- precautions or contra-indications to the examination or treatment
- Prognosis — how response to intervention is affected by stage of recovery, extent of injury, patient's expectations, personality and lifestyle
- how best to manage and treat the person's condition

What Are Your Problems in Taking a Case History?

Wouldn't it be great if every patient could come in to your office, sit down and tell you every thing you need to know to treat the condition, in a sequential and logical manner? Sometimes taking a case history can be like chasing a scurrying mouse...always just out of reach. Therapists require skills beyond palpation to discern the cause of the problem, why it has manifested in the present pain patterns, and how one can remedy the problem.

What problems have you encountered in taking a case history? Here are common responses from workshop participants:

- The patient shares a great deal about her/his symptoms in an unorganized manner, making it difficult to record essential information.
- The patient doesn't understand medical terms, or doesn't clearly understand what is being asked for.
- The person is not very kinesthetically (body) aware. They have difficulty in describing their symptoms.
- The patient has more than one or two primary conditions, with a multitude of symptoms.

The following suggestions may be helpful:

1. Use leading questions to clarify points and to create a more complete case history picture. "Tell me more about that" and "What does that feel like?" Use gentle cues to bring the person back on track to answer your questions.
2. Ask the person to indicate the area of pain or symptoms. Palpate the area yourself and qualify: "Is this the area right here you were describing as tight?" Your palpation will instil compassion, confidence, and competency in your abilities.

3. If the person's description of the symptoms is vague, they may be challenged to transcribe their kinesthetic experience into a verbal description. Ask them questions to help them re-associate with their body. "When you are in pain, what does it feel like?" or "On your worst days, what activities do you have trouble doing?"
4. Speak slowly and clearly. Ask one question at a time. Use simple and common language, avoiding unnecessary medical jargon when possible. If spoken language is the barrier, ask the person to bring someone who can interpret your questions and the person's responses.
5. Address only the primary symptom for the first session. Ask "of the symptoms you described, what bothers you the most?" Assure the patient you will get to the subsequent symptoms. However, you want to work with them to resolve their primary complaint first.
6. Set goals for each treatment. Remember physiological change is a process, and you don't need to "fix" someone in a single session. Just make sure they feel understood and that you will address their primary symptom.
7. Try role-playing with a fellow therapist to help you hone your case history taking skills.
8. Listen empathetically. Listening well – eye contact, engaging posture and gestures, acting in a non-hurried or agitated way - will often yield all the information you're looking for.

While unconscious creation - animals, plants, crystals - function satisfactorily as far as we know, things are constantly going wrong with man.

— C. G. Jung, *An Answer to Job*

Regulations for Record Keeping

According to the College of Massage Therapists of Ontario (CMTO), each health record must include:

- Name and address
- Date, time and duration of each visit
- Name and address of primary care physician and any referring professional
- Relevant medical history, including relevant massage therapy history
- Particulars of every examination performed by the therapist and particulars of every clinical finding and assessment made by the therapist.
- Every written report received by the therapist in respect to examinations, tests, consultations or treatments performed by any other person
- Particulars of any advice given, and referral to another health care professional
- Fees or other amounts charged
- Copy of every written consent, needs assessment, and treatment plan
- Particulars of each treatment applied, including the name of the therapist who applied the treatment

In addition:

- Every part of the health record must be referenced to the person treated
- Every entry in the record must be dated, with the person entering the information easily identifiable
- Every record must be retained for at least 10 years following the person's last visit
- The therapist must ensure that all records destroyed maintain the person's confidentiality
- A financial record for each person must be kept which contains a) the particulars of the treatment or procedure rendered b) the fee charged for services provided c) a copy or record of the receipt issued for payment of services provided

CAVEAT! Review the CMTO's Code of Ethics / Standards of Practice for updated information and additional requirements. Visit Obtain, Update and Record the Client's Health History <http://www.cmta.com/regulations/standard.htm>

Let's Check Our Learning!

Before you move on, please test yourself with the questions below. If you get stumped, you may wish to go back and review the material before going on to the next section.

- What are the objectives of taking a case history?
- What are problems therapists commonly experience in the intake?
- List solutions you can apply.
- What are the requirements for each record kept?

The Case History / Intake Template

The Case History, or Intake, template which we'll use in this system is illustrated on the next page. This Case History template provides many great features:

1. The one page design increases the likelihood it will be completed accurately.
2. It uses illustrations, checkmarks and short answers to be aesthetically pleasing while gathering the essential information.
3. It copies to the back of the assessment template, ensuring a clear and connected symptom picture at this point in time.
4. It requires a signature up front, confirming the individual is aware of how the information will be used, the fee schedule and cancellation policy.
5. There are female/male versions (I don't care for non-gender humanoid figures)
6. It prompts for the patient's occupation, birth-date, referral source and extended health care coverage. This information can be used for practice statistics, newsletter mailings and identifying referral sources (note: see PIPEDA points on privacy).
7. It contains the essential information the CMTO² requires on the case history form.

² You can find several case history examples at the CMTO website if you prefer not to use this template. Visit <http://www.cmta.com/about/down.htm>

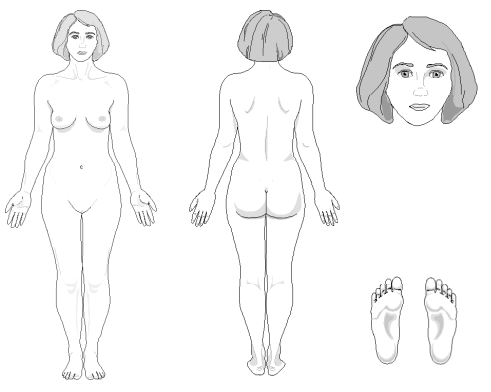
Name _____ Birth date (DD/MM/YYYY) _____
 Street Address _____ City of _____ Postal Code _____
 Home ☎ _____ Work ☎ _____ E-Mail _____
 Your Occupation _____ Who Referred You? _____
 Physician Name / Address _____ Extended Health Care? Yes No
 Symptoms? _____

Please describe your symptoms:
Sensation: sharp dull aching throbbing
 burning "numb" or pins and needles other

Frequency: rarely experience comes & goes
 frequent constant

What is the intensity of this discomfort?
 0 1 2 3 4 5 6 7 8 9 10
 No pain _____ Intolerable _____
This discomfort is affecting your:
 work activity / sports home life sleep

Please mark areas of: symptoms no symptoms



Health History current conditions experienced in the past

<p>Muscle, Skeletal and Nervous Systems</p> <input type="checkbox"/> tension or migraine headaches <input type="checkbox"/> whiplash / motor vehicle accident <input type="checkbox"/> neck & shoulder pain or stiffness <input type="checkbox"/> back or hip pain or stiffness <input type="checkbox"/> upper extremity weakness or tingling <input type="checkbox"/> lower extremity weakness or tingling <input type="checkbox"/> head trauma or concussion <input type="checkbox"/> loss of co-ordination or dizziness <input type="checkbox"/> sleep or personality changes <input type="checkbox"/> light-headedness / fatigue <input type="checkbox"/> epilepsy / seizures <input type="checkbox"/> TMJ or tooth, jaw or ear pain <input type="checkbox"/> vision or hearing difficulty or loss <input type="checkbox"/> degenerating discs <input type="checkbox"/> osteo or rheumatoid arthritis <input type="checkbox"/> osteoporosis or bone disease <input type="checkbox"/> spasm & strain or sprain <input type="checkbox"/> tendonitis, fibrositis or bursitis <input type="checkbox"/> fractures / pins, wires, plates <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> loss of sensation <p>Heart and Circulatory Systems</p> <input type="checkbox"/> blood pressure high low <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart disease / attack or stroke (CVA) <input type="checkbox"/> chest pain or angina <input type="checkbox"/> pacemaker or similiar device <input type="checkbox"/> varicose veins or phlebitis <input type="checkbox"/> cold hands & feet or swelling <input type="checkbox"/> diabetes <input type="checkbox"/> poor healing / bruise easily	<p>Skin and Immune Systems</p> <input type="checkbox"/> open sores, cuts or warts <input type="checkbox"/> contagious skin disease <input type="checkbox"/> tuberculosis or hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> cancer <input type="checkbox"/> allergies (food, environmental) <p>Breathing System</p> <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis or emphysema <input type="checkbox"/> shortness of breath <input type="checkbox"/> frequent colds or sinus <input type="checkbox"/> chronic cough / smoking <p>Digestive System</p> <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> constipation <input type="checkbox"/> rapid weight loss <input type="checkbox"/> appetite changes <input type="checkbox"/> diarrhea <input type="checkbox"/> bad taste in mouth <input type="checkbox"/> irritable bowel <input type="checkbox"/> ulcers <input type="checkbox"/> gall bladder problems <p>Genitourinary System</p> <input type="checkbox"/> painful urination <input type="checkbox"/> unusual colour / odour <input type="checkbox"/> hip or flank pain <input type="checkbox"/> gynecological concerns <input type="checkbox"/> pregnant currently <p>Life Questions</p> <input type="checkbox"/> I exercise regularly <input type="checkbox"/> I feel good about life <input type="checkbox"/> I have good sleeping patterns <input type="checkbox"/> I have poor energy levels <input type="checkbox"/> I suffer from too much stress
---	---

Please rate your overall health
 1 2 3 4 5 6 7 8 9 10
 Poor Moderate Excellent

Prominent family illnesses _____
 Current medications _____ Other treatment _____
 Major injuries or surgeries _____ When? _____
I understand that all information gathered for this treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. I understand I will be asked for written authorization for release of any information outside my circle of care. I have reviewed the fee schedule and cancellation policy, and I understand I must give at least 24 hours notice to reschedule my appointment. I will inform my therapist should anything change regarding my health status.
 Today's Date _____ Signature _____
 We regard your privacy very seriously. Please ask for a copy of our privacy and complaints policy, or visit our website

© Donald Quinn Dillon, R.M.T. 2003

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

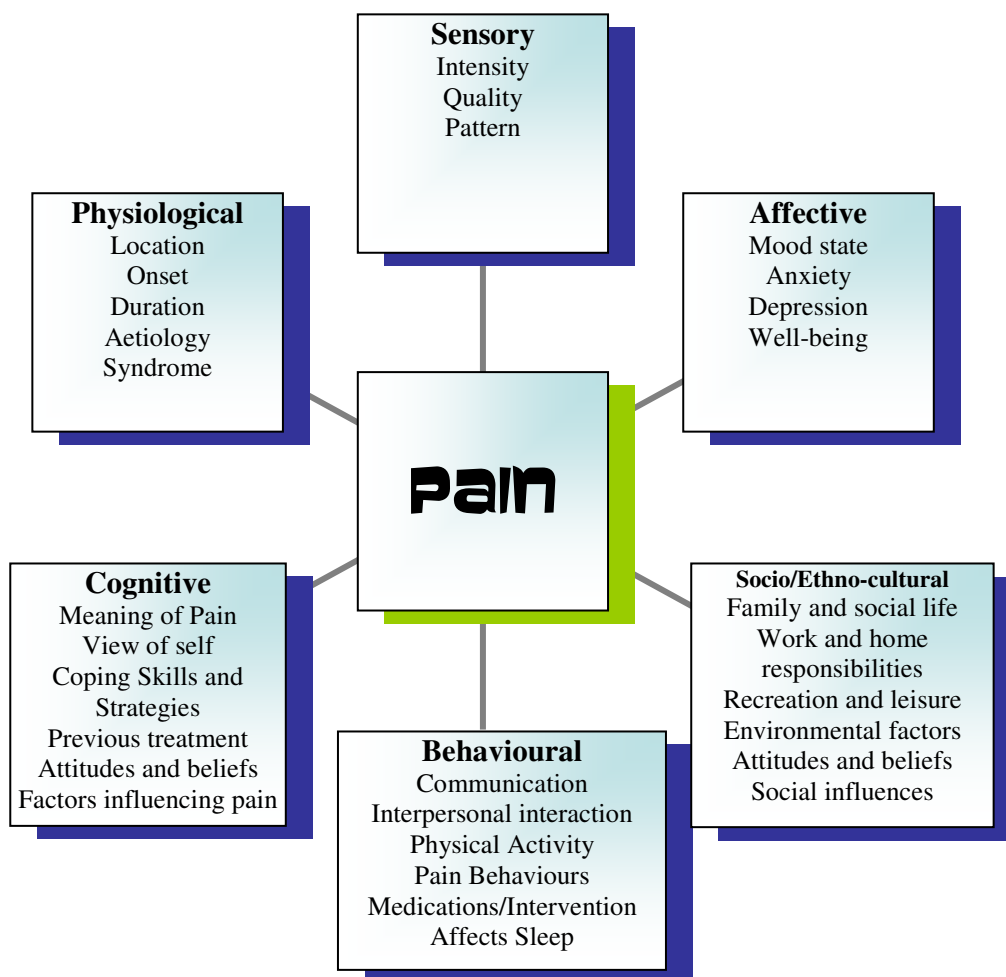
Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

You may wish to fill out the case history/intake template yourself first to get a general sense of the information your patient is being asked. You can then better clarify responses to any questions they may ask about the intake process.

Once the patient has completed the case history, review their responses and ask further clarifying questions to gain the best possible perspective on their case. I highly recommend that you do not write on the case history/intake form, as this is an official document that the patient completes and applies their signature. Rather, summarize the information they have filled out, in addition to the further information you gather from your inquiries, on the Assessment / Treatment template. This template is the subject of our next section. First, however, we need to discuss the dimensions of pain, and yellow and red flags. Briefly, we'll also mention the privacy act as it relates to charting.

The Dimensions of Pain

Pain is complicated. When people show up at our offices and complain of pain, they are talking about a multi-faceted problem that encompasses physiological, sensory, affective, cognitive, behavioural and socio/ethno-cultural parameters.



In an article printed in the *Journal of Bodywork and Movement Therapies*³, Martha Costello, DC, describes the different types of pain:

- *Sharp, well-localized pain*—superficial lesion
- *Sharp, lancinating, shooting pain*—suggests nerve lesion, possibly nerve root compromise
- *Pins and needles, tingling*—ischemia of the peripheral nerves, often due to nerve compression
- *Dull, aching pain*—deep somatic (not visceral) origin
- *Excruciating pain, unrelenting pain, intolerable pain, deep aching pain, boring pain*—underlying localized pathology or systemic disorder
- *Stiff, achy, cramping or grabbing*—typical of musculoskeletal disorders
- *Hot or feverish*—inflammation

Leon Chaitow, DO, describes the enormity of pain this way:

Pain is probably the single most common symptom experienced by humans and, along with fatigue, is the most frequent reason for anyone consulting a doctor in industrialized societies – indeed the World Health Organization (1981) has suggested that pain is ‘the primary problem’ for developed countries.

Within that vast area of pain, musculo-skeletal dysfunction in general, and back pain in particular, feature large. If symptoms of pain and restriction are viewed in isolation, with inadequate attention being paid to the degree of acuteness or chronicity, their relationship with the whole body and its systems (including the musculoskeletal and nervous systems) – as well as, for example, the emotional and nutritional status of the individual and of the multiple environmental, occupational, social and other factors which impinge upon them – then it is quite possible that they will be treated inappropriately.⁴

Physiotherapists Petty and Moore describe the dangers of overlooking the implications of pain.

Since (manual therapists) are now ‘first contact’ clinicians, we have assumed greater responsibilities. While those interested in manipulation and allied treatments energetically improve their competence in the various techniques and applications, we might profitably spend a little time considering what we are doing all this for. ...Pain distribution might confuse unwary or overconfident therapists, who may assume familiarity with a syndrome they recognize and then perhaps find themselves confronting the tip of a very different kind of iceberg.⁵

³ Costello, M.: Low Back and Pelvic Pain. *Journal of Bodywork and Movement Therapies*. April 1998. p 69.

⁴ Chaitow, L: *Muscle Energy Techniques*, 2nd edition. Churchill Livingstone 2001 p 22

⁵ N. J. Petty. A. P. Moore: *Neuromusculoskeletal Examination and Assessment*. Churchill Livingstone 1998 p 28

The Presence of Yellow and Red Flags

In the sports arena, a yellow flag indicates caution when proceeding. A red flag means stop! We use the metaphor of yellow and red flags in healthcare to identify factors which call us to proceed with caution (yellow flags) or to stop (red flags) and immediately refer to the appropriate emergency medical care. As healthcare practitioners, we need, as part of our case history, to carefully screen for yellow and red flags.

The following list is adapted from Petty and Moore's book *Neuromusculoskeletal Examination and Assessment*.⁶

Yellow or Red Flag Questions	Possible Indications
General health—Are you experiencing any feelings of general malaise or fatigue, fever, nausea or vomiting, stress, anxiety or depression?	Feeling unwell or tired is common with neoplastic disease while malaise, lassitude and depression can be associated with rheumatoid arthritis.
Weight loss—Have you noticed any recent weight loss?	If there is no explanation for rapid weight loss, this may be indicative of malignancy.
Rheumatoid Arthritis—Have you or has anyone in your family been diagnosed with Rheumatoid Arthritis?	Collagen necrosis of the cervical vertebral ligaments is a concern in spinal mobilization, or other joints during the acute inflammatory stage. Careful consideration should be taken with movement of the neck.
Drug therapy: a) What medications have you been prescribed? b) Have you been on long term medication or steroids? c) Have you taken anti-coagulants?	a) Medication strength can indicate the degree of pain the individual is experiencing. As well, pain meds may mask or alter reaction to treatment. Side effects of the drug therapy are also a consideration. b) High doses of corticosteroids or Heparin for prolonged periods may lead to osteoporosis—problematic with deep palpation and treatment. c) Take care to avoid tissue trauma and consequent bleeding.
X-Rays and Medical Imaging—Have you received X-rays or other medical tests?	X-rays are useful to diagnose fractures, arthritis and serious bone pathology such as osteoporosis or tumour, and to determine the extent of the injury following trauma. Other imaging includes CT scans, MRIs,

⁶ N. J. Petty. A. P. Moore: *Neuromusculoskeletal Examination and Assessment*. Churchill Livingstone 1998

	myelography and bone scans. The fact that the individual is undergoing such tests should be a yellow-flag to be cautious in approach.
Neurological symptoms—Are you experiencing (symptoms for a) spinal cord compression or b) cauda equina compression)?	a) Spinal cord compression — compression of the spinal cord from the foramen magnum to L1 — can present as bilateral tingling in hands or feet and / or disturbance of gait due to disturbance of sensory and motor pathways of the spinal cord. b) Cauda equina compression — compression below L1 — can present as saddle (perineum) paresthesia and bladder or bowel sphincter disturbance (loss of control, retention, hesitancy, urgency or a sense of incomplete evacuation). This is a red flag and requires prompt surgical attention!
Dizziness—Have you ever experienced any dizziness?	May indicate vertebrobasilar insufficiency (VBI). Ask about aggravating and relieving factors, duration and severity of the dizziness, and association with other symptoms such as visual disturbance, diplopia, nausea, ataxia, ‘drop attacks’, impairment of trigeminal sensation, sympathoplegia, dysarthria, hemianesthesia and hemiplegia. If further investigation reveals VBI is likely, cite a red flag and refer the patient to a physician for further testing.

Martha Costello, DC reiterates the importance of proper screening in the case history.⁷

Bodyworkers should be cautioned—often, when a client/patient has seen a medical professional prior to consultation with the bodyworker, it is assumed that all organic or pathological causes for symptoms have been ruled out.

Unfortunately, this often is not the case, as the prior medical examination may have been cursory, and a thorough history may not have been conducted. It is not uncommon for even a review-of-symptoms questionnaire to have been extremely brief, painting a very incomplete picture of the patient’s current and past health history.

⁷ Martha Costello, DC: Chiropractic Rehabilitation: Journal of Bodywork and Movement Therapy April 1998
Charting Skills for Massage Therapists: A Self-Study Workbook
 © 2007. Donald Quinn Dillon. All Rights Reserved
 Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

Personal Information Protection and Electronic Documents Act (PIPEDA).

There are new rules governing what information we collect, how we use that information and who has access to that information. It's called the Personal Information Protection and Electronic Documents Act (PIPEDA). There's also a sub-document related to health care specifically entitled PHIPA – Personal Health Information Privacy Act. Health practitioners should review both documents to ensure they are in compliance. Following is a summary for your consideration.⁸

- Appoint a “privacy officer” who is responsible for the organization’s compliance with the Act
- Draft a privacy policy that refers to:
 1. The purpose for which the information is used, collected and disclosed
 2. The amount and type of information required
 3. The retention of personal information including minimum and maximum retention periods
 4. The destruction of personal information
 5. A complaint and inquiry process (with contact information of your regulatory body and the privacy officer)
- Safeguards taken to protect personal information such as passwords and encryption (this includes databases and email)
- Implement the privacy policy
- Draft materials such as brochures or memos that contain these policies and providing them to your patients in pamphlets, your website, and as requested
- Draft materials to obtain express written consent and/or ensure that implied consent has been given for the use, collection and disclosure of personal information.
- Train staff in these policies and practises. Have all staff handling records sign a confidentiality agreement
- Implement safeguards such as locked filing cabinets and password encryption.
- Respond in a timely and appropriate manner to complaints and inquires
- Periodically review compliance with your privacy policy and make changes as necessary.

Visit http://www.privcom.gc.ca/legislation/02_06_01_e.asp for more information, or check with your regulatory body and professional association to learn how this legislation applies to you.

⁸ P. Puddy: New Federal Privacy Legislation and Its Impact on RMTs. *The Body Politic*, Vol 1, No. 5

Check Your Learning:

1. What are the advantages of the case history/intake template provided?
2. What are the dimensions of pain?
3. What are the yellow and red flags you should be cognizant of while conducting the case history?
4. Why is it important to screen for yellow and red flags?
5. What is PIPEDA and what do I need to know about it?

For every thought supported by feeling there is a muscle change. Primary muscle patterns being the biological heritage of man, man's whole body records his emotional thinking. - Mabel Ellsworth Todd, *The Thinking Body*

The arrangement of the body is so well proportioned, the symmetry of its parts so beautiful, that it can be doubted whether at its creation utility was more of a determining factor than beauty. - Aurelius Augustinus 354-430 AD

What a piece of work is man,
How noble in reason, how infinite in faculties, in form and moving,
How express and admirable in action, How like an angel in apprehension,
How like a God. The beauty of the world, the paragon of animals.
And yet to me, what is this quintessence of dust?
- William Shakespeare, *from Hamlet*

Chapter Two: Performing a Thorough and Comprehensive Assessment

With case history in hand, it's time to turn over the page to complete a thorough and comprehensive assessment on the **Assessment / Treatment template** (see next page). Once you register your workbook, you can download a version for your own use.

Advantages of using the Assessment/Treatment template:

- Uses prompts to encourage the therapist to ask key questions, and to accurately complete the symptom picture
- Combines written responses with illustrations to appeal both to therapists who enjoy using symbols/visual representation, and those who prefer to write out all observations
- Provides the opportunity to visually represent postural distortion and affected ranges-of-motion in the cervical and lumbar spine
- Prompts key treatment information such as time/length of treatment, treatment number, fee for service, date, informed verbal consent (IVC) and therapist's initials
- Encourages the therapist to identify problematic tissue/mechanics, classify dysfunction and qualify palpatory findings. This may lead to the creation of a better treatment plan
- Can be photocopied on opposite side of case history page, ensuring history completed by patient and symptom picture remain intact

The left side of the template, "Symptom Picture", prompts the user with check-boxes to ask pertinent questions and record essential information. Note the prompts to illuminate potential yellow or red flags. Again, I suggest you not write on the case history the patient has completed. Instead, summarize their responses and merge with any further case history information you gather to the Assessment / Treatment template.

The centre of the template contains anterior and posterior body diagrams to document postural distortions, range of motion and even visual representations of tension or pain if the therapist so desires. The right side of the template includes more check-boxes, prompting you to record your assessment – observations, tests and palpation.

The template then prompts you for your clinical opinion based on your findings, followed by a section for treatment provided. Treatment outcomes and any prescription for remedial exercise or hydrotherapy, or referral to an appropriate health care provider for further assessment are all recorded on the right side under "Findings, Treatment & Prescription (Rx)". Following an illustration of the Assessment / Treatment template, is an examination of how to notate postural distortion and range of motion.

Identifier: _____

Symptom Picture

- Location
- Onset
- 24 hr pattern
- Intensity
- Quality
- Radiation
- Aggravates
- Relieves
- Other symptoms
- Other treatment
- Related History
- Social, Occupational and Recreational

Yellow and Red Flags

- General health
- Weight loss
- Rheumatoid Arthritis
- Drug Therapy:
 - Meds R
 - Long-term Steroids or Anti-coagulants
- X-Ray / Med imaging
- Neurological symptoms
- Dizziness



Findings, Treatment and Recommendations

Observations

- Postural Distortion
- Pallor and respiration
- Guarded movement

Tests

- Range of Motion
- Joint Physiological and Accessory mobility
- Orthopedic and Neurological Tests

Palpation:

Identify (cause of symptoms)

Classify:

- Muscle Spasm/Strain
- Muscle Tension
- Myofascial Pain / Dysfunction
- Postural/Mechanical Chain
- Joint Fixation
- Neuro-Vascular Entrapment
- Outside Scope (refer out)

Qualify:

- Tenderness ☆
- Texture ✱
- Tension +
- Temperature ▲

Treatment:

- Method
- Region
- Focus
- Position
- Modality



Outcomes/Notes:

R - Rem-Ex / Referral & Treatment Plan

Date TX # ② Fee IVC R.M.T. © Donald Quinn Dillon, R.M.T. 2005

Subsequent Treatment: Symptoms increased decreased unchanged

Subsequent Treatment: Symptoms increased decreased unchanged

New History

Findings:

New History

Findings:



Treatment

Method, Region, Focus, Position, Modality

Treatment

Method, Region, Focus, Position, Modality

Outcomes/Notes:

R - Rem-Ex / Referral

Outcomes/Notes:

R - Rem-Ex / Referral



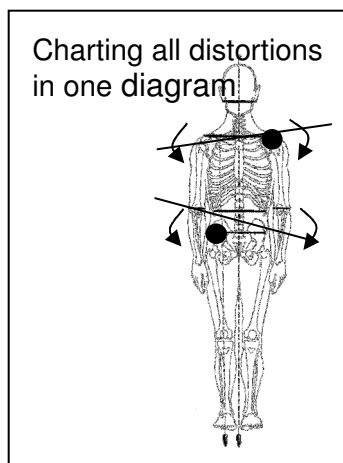
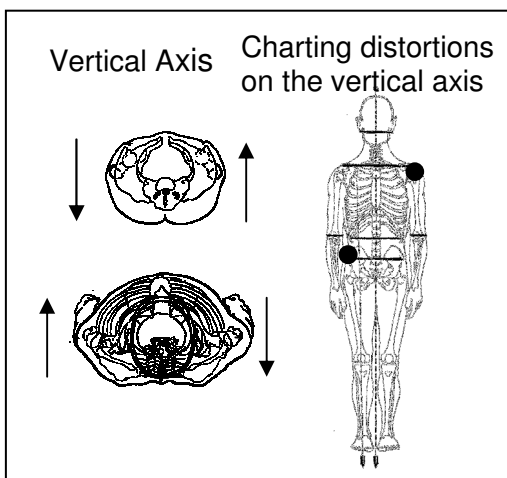
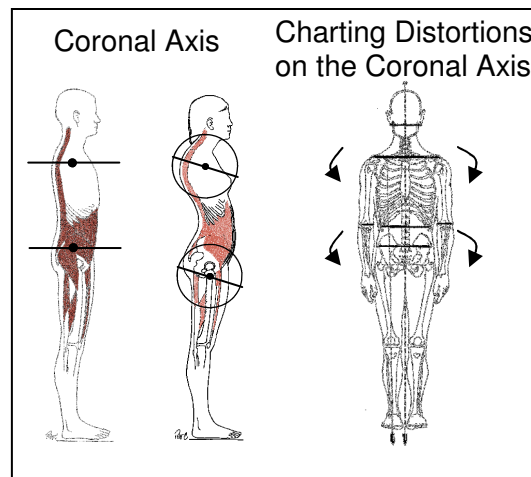
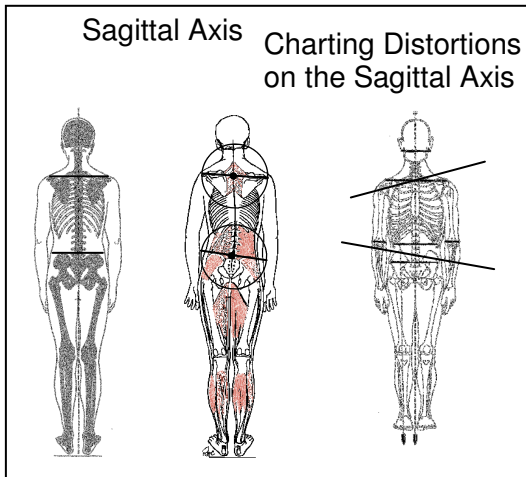
TX # ② Date Fee IVC R.M.T. TX # ② Date Fee IVC R.M.T.

Postural Distortion: Charting Made Simple

Without sufficient practice, massage therapists may lose postural assessment skills, even though these findings can be significant to the case. I think one of the reasons we drop postural assessment in everyday practice is that we may have been taught a method that is too time and labour intensive. Do we really need to take 24 postural landmarks? Will the scapula vary if we measure both the inferior and superior aspects?

I propose three basic measurements that will tell us 90% of the information we need to know about postural distortions. By measuring the shoulder and pelvic girdles for superior / inferior position (sagittal axis), tilt position (coronal axis) or torsion (vertical axis) we can, by association, discern whether the muscles are functionally balanced or dysfunctional i.e. shortened-tight or lengthened-strained.

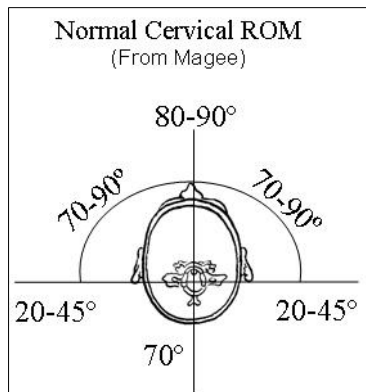
Examine the following diagrams⁹. To the left is the distortion and to the right, how to notate the distortion. (Note: all assessments are completed on a forward-facing image)



⁹ MediClip: Manual Medicine 1 and 2. Williams and Wilkins. 1997. 1 800 527 5597

Charting Range of Motion (ROM) Findings

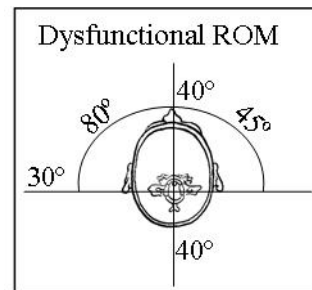
Measuring change in range of motion pre- and post- treatment can be one of the most effective ways to measure your results in massage therapy effectiveness. Whether you measure degrees of motion by sight, by device — i.e. goniometer — or by a three point scale (mild, moderate or severe limitation in movement), your assessment technique must be standardized to produce reliable results. It's a skill worth developing!



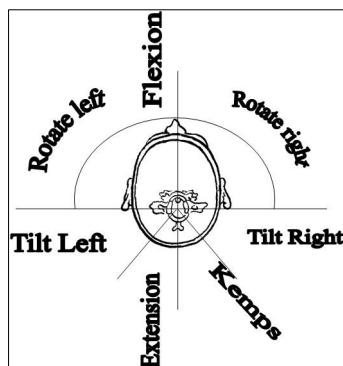
In the following diagrams, we illustrate standard ROM for the cervical spine. Examine the various ranges that can be initiated actively, passively and against resistance.

Included are examples of functional range¹⁰ and dysfunctional range. To be more specific, you may record beside the degree measurement if the movement was passive (P ROM), active (A ROM) or resisted (R ROM).

If you do not work with auto insurance or Worker's Compensation (WSIB) claims, or you are not competent using degree measurements, you may consider a three-point scale to measure mild, moderate or severe restriction in range of motion.



Be aware that, in case of an injury where there is a legal claim, your records could be audited and used in a legal proceeding. Therefore, the degrees method of measurement, commonly applied in orthopedics, physiotherapy and chiropractic, may be worth learning.

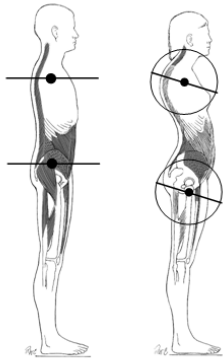


A worksheet is provided on the next page. Give your hand a try by assessing three individuals (could be colleagues, friends or family members) for postural distortion and cervical or lumbar range of motion. The left side of the worksheet illustrates common postural distortions, and the right provides an opportunity for you to record your findings. Give it a try!

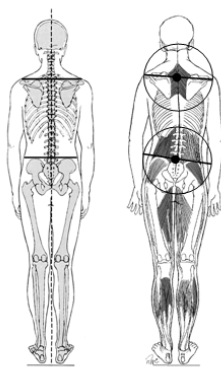
After a few practice sessions, you'll be incorporating postural assessment and range of motion again in every treatment. These findings are invaluable to increasing your success for discovering the true cause of complex pain patterns.

¹⁰ Magee, D.J: Orthopedic Physical Assessment, 2nd edition. W.B. Saunders 1992, pg 40

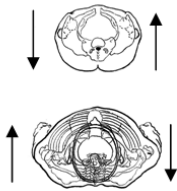
Coronal Axis—Functional and Distorted



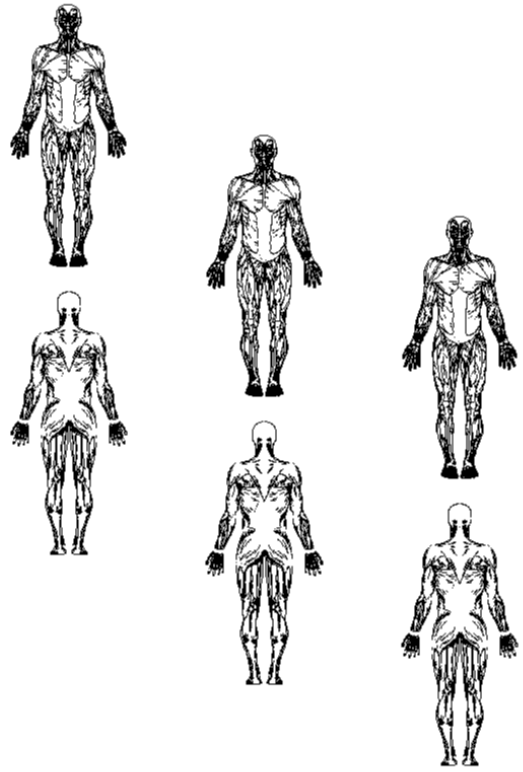
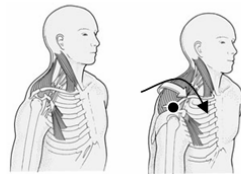
Sagittal Axis—Functional and Distorted



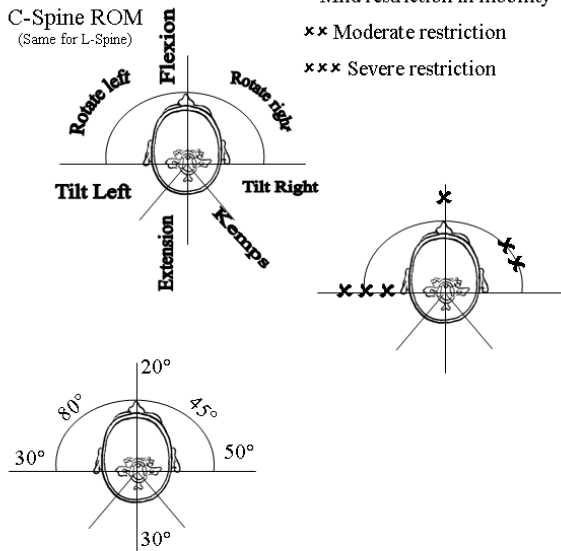
Vertical Axis



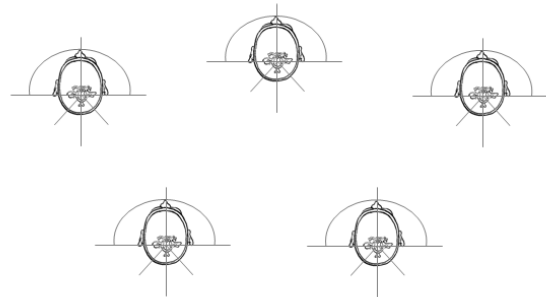
Charting distortion on the vertical and coronal axis simultaneously



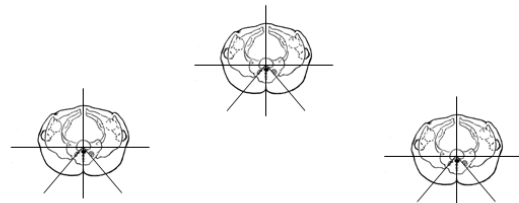
C-Spine ROM
(Same for L-Spine)



Neck ROM



Lumbar Spine ROM



The Short on Short Hand

An essential tool in reducing your notation time is to learn how to short-hand your notes. Some prefer long-hand, or the use of symbols and visuals. This system is adaptable to whatever style you prefer.

There are many nursing texts, and even some massage therapy references for learning how to short-hand notation. I was influenced early on by Diana Thompson's book, "Hands Heal: Documentation for Massage Therapy"¹¹, which cites at least four pages of short-hand notation. A summary of short-hand notations are available on the next page.

The area where I observe that notation lacks most is in the description of palpation findings – fortuitously we will be covering this in the next chapter! Ideally, our profession would do well to standardize notation to improve quality assurance and contribute to research application.

You will require a notation key – an index page of your notations - should your records ever be audited or required for medical-legal reports in court. The notation key helps others reading your notes to discern their meaning. You may wish to combine your current notations with some I've listed to create your own key.

Following are examples of short hand notation in real application. For a complete example, see the Assessment / Treatment completed example at this end of this chapter.

On palpation, we note the right Levator Scapula muscle has tension: ^R Lev Scap m Tens.

We may wish to qualify the tension (+), texture (x), tenderness (!) and temperature (^) of the muscle. Qualifying these attributes specifically allows us to measure changes from our interventions.

Using a three-point grade of mild, moderate and severe to qualify our palpation findings, we find the muscle is moderately tight, moderately fibrous texturally, severely tender and mildly temperate (warm). We may notate it this way: ^R Lev Scap m Tens ++ xx !!! ^

Let's look at a Rhomboidus muscle in spasm/strain (S/S), with secondary findings of a posturally shortened Pectoralis Major that is at probable cause:

^L Rhomb Maj m S/S +++ x !!! ^^ ^

^L Pec Maj/Min mm M Def ⇔ ⇐ + xxx ! ^

You may not need this degree of qualification for your purposes, especially if you're not working in a rehabilitation/medical environment. However, you can see the potential of becoming very specific with qualifying your findings.

You will find short-hand notation of common applications on the next page.


¹¹ Thompson, D.L: Hands Heal: Documentation for Massage Therapy - A Guide to S.O.A.P. Charting
Charting Skills for Massage Therapists: A Self-Study Workbook
© 2007. Donald Quinn Dillon. All Rights Reserved

<p><u>Palpatory findings</u></p> <p>Tens muscle tension S/S muscle spasm / strain MTP myofascial trigger point M Def muscle deficiency / weak jt. fix'n joint fixation +++ tension: mild + mod ++ severe +++ xxx texture: min x mod xx very fibrous xxx ☆ tender: mild ☆ mod ☆☆ severe ☆☆☆ ▲ temperature: warm ▲▲ inflamed ▲▲▲ ▼ temperature: cool ▼▼ ischemic ▼▼▼ ** edema / swelling ↺ referred pain</p>	<p><u>Active Movement & Treatment Positioning</u></p> <p>Flx'n flexion Ext'n extension tilt tilt / lateral flexion ↻ rotation Abd'n abduction Add'n adduction sup'n supination pron'n pronation evers'n eversion invers'n inversion A ROM active (independent) ROM P ROM passive (assisted) ROM R ROM resisted ROM / muscle testing WNL within normal limits sup supine prn prone SL sidelying ↓ seated</p>
<p><u>Static Posture and Body Planes</u></p> <p>↻ ↻ torsion ↑ elevation ↓ depression ⇒ protraction ⇐ retraction ⇔ shortened muscle (posturally) ⇔ lengthened muscle (posturally) med'l medial lat'l lateral ant'r anterior post'r posterior / dorsal sup'r superior inf'r inferior prox proximal dist distal int'l internal ext'l external ceph cephalad caud caudad</p>	<p><u>Subjective Responses</u></p> <p>mild mild mod moderate sev severe cnstnt constant freq frequent intrmt intermittent sldm seldom or never ↑ increase ↓ decrease Δ / ∅ change / no change in condition A: aggravates symptoms R: relieves symptoms AFX affects, has an affect on</p>
<p><u>Body Areas</u></p> <p>cran cranium face face mand mandible C-spine cervical spine T-spine thoracic spine L-spine lumbar spine sacrum sacrum ribcage ribcage or torso abdom abdomen lmbscr lumbosacral plvc pelvic shdr grd shoulder girdle UE upper extremity digit (#) fingers / toes plvc grd pelvic girdle LE lower extremity thigh thigh leg / ft leg/foot</p>	<p><u>Conditions, Therapeutic Intervention and other</u></p> <p>HA headache WAD whiplash associated disorder TMJ xx temporomandibular joint dysfunction ! tdn tendonitis DDD degenerative disc disease CTS carpal tunnel syndrome MT massage therapy MFR myofascial release NMT neuromuscular therapy CST craniosacral therapy MET muscle energy technique / positional release MLD manual lymph drainage ART active release technique ACUP acupuncture REM-EX remedial exercise MEDs medications IVC informed verbal consent ⌚ time treatment began and ended</p>

Assessment / Treatment Template: Completed Example

Below is a completed assessment/treatment example. Note the check-boxes used to ensure key information is collected. Short-hand is used to notate a great deal of important information quickly and concisely. Postural and ROM images are notated. In this example, the therapist has darkened areas of moderate and severe tension (see shaded areas on posterior posture image) to make her charting more meaningful to her.

In the next few chapters, we'll discuss how to finish the remaining sections of this template, including palpation findings, treatment, outcomes and recommendations/treatment plans.

<p>Identifier: John Smith</p> <p>Symptom Picture</p> <p><input checked="" type="checkbox"/> Location <input checked="" type="checkbox"/> Onset <input checked="" type="checkbox"/> 24 hr pattern</p> <p><input checked="" type="checkbox"/> Intensity <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Radiation</p> <p><input checked="" type="checkbox"/> Aggravates <input checked="" type="checkbox"/> Relieves <input checked="" type="checkbox"/> Other symptoms</p> <p><input checked="" type="checkbox"/> Other treatment <input checked="" type="checkbox"/> Related History <input checked="" type="checkbox"/> Social, Occupational and Recreational</p> <p>Yellow Flags</p> <p><input checked="" type="checkbox"/> General health <input checked="" type="checkbox"/> Weight loss <input checked="" type="checkbox"/> Rheumatoid Arthritis</p> <p>Drug Therapy: <input checked="" type="checkbox"/> Meds R <input checked="" type="checkbox"/> Long-term Steroids or Anti-coagulants</p> <p><input checked="" type="checkbox"/> X-Ray / Med imaging <input checked="" type="checkbox"/> Neurological symptoms <input checked="" type="checkbox"/> Dizziness</p>	<p>1° LB pain (L SI), freq (3x/wk) O: 5 wks ago, lifting heavy box...felt strain 24hr: morn stiff—eases w/ activity, s/t disrupts sleep I: 6-8/10, "grabs me...weak" ⇐ Left butt/ham A: stand/sit > 30 min., lift/bend, stomach sleep R: ice, stretch, mod activity pain med (Tylenol #2—2x/day) Afx: sleep, sit/stand, work, not bowel/blad 2° (L) ham/leg tight w/ intermit. Knee pain (MD dx: OA) Tx: chiro—4 visits, min Δ Hlth hx: MVA age 18, neck tx Age 29, weight-lift—LB injury No wgt-loss, RA or steroids/anti-coag., x-rays Knees 2002 Meds: tyl #2, Viox (knee), Lipitor (cholest.) No neuro sympt. Or dizz.</p>		<p>Findings, Treatment and Recommendations</p> <p>Observations</p> <p><input checked="" type="checkbox"/> Postural Distortion <input checked="" type="checkbox"/> Pallor and respiration <input checked="" type="checkbox"/> Guarded movement</p> <p>Tests</p> <p><input checked="" type="checkbox"/> Range of Motion <input checked="" type="checkbox"/> Joint Physiological and Accessory mobility <input checked="" type="checkbox"/> Orthopedic and Neurological Tests</p> <p>Palpation: <i>Identify</i> (cause of symptoms) Classify: <input checked="" type="checkbox"/> Muscle Spasm/Strain <input type="checkbox"/> Muscle Tension <input type="checkbox"/> Myofascial Pain / Dysfunction <input type="checkbox"/> Postural/Mechanical Chain <input checked="" type="checkbox"/> Joint Fixation <input type="checkbox"/> Neuro-Vascular Entrapment <input type="checkbox"/> Outside Scope (refer out)</p> <p>Quality:</p> <ul style="list-style-type: none"> • Tenderness ☆ • Texture * • Tension + • Temperature ▲ <p>Treatment:</p> <ul style="list-style-type: none"> • Method • Region • Focus • Position • Modality <p>Outcomes/Notes:</p> <p>↓ LB pain/spasm 75% ↑ mobil. (L) PF/SI jts ↓ tension AO <u>mm</u></p>	<p>Posture and lumbar ROM as noted Gait—torsion pelvis, (L) UE 0 swing Pallor OK, breath slight laboured +++*** (L) Q.L., glute group, (R) T/L E. Spinae <u>mm</u> ▲(R) SI, ++** (R) AO <u>mm</u> SLR (R) 45° w/pain, (L) 45° stiff Fix'n (L) PF / SI jts, Weak (L) Quad/Ham—other motor/reflex WNL</p> <p>Opinion: chronic lumbar spasm/strain, w/ fixation (L) PF/SI jts</p> <p>Tx: MET (L) PF/SI jts MFR AO & (L) QL/E. Spin. NMT spine [T/L E. Spinae] (L) hip and flank <u>mm</u> Prone w/ heat to low-spine/hips</p> <p>R - Rem-Ex / Referral & Treatment Plan</p> <p>Lumbar and psoas stretch Home: hot/cold contr. 4 TXs @ 2x/week</p>
<p>Date: October 25, 2005 TX # 1 Ⓞ 18:00—19:00 Fee: \$75 IVC ✓ R.M.T. DQD © Donald Quinn Dillon, M.T. 2005</p>				

Quick Tip: Need a Booster in Orthopaedic Assessment?

We can all use a little review when it comes to measuring range of motion, orthopaedic and neurological testing. Here are some great ideas that will take little time, and in most cases little money:

1. Review textbooks – MaGee, Hoppenfeld – or take an assessment workshop
2. Meet with a few colleagues once/month to review assessment for a body region
3. Stage “Assessment night” in your local chapter. Let three people research and prepare a presentation for the group. Then, let everyone practice!

Chapter 6: Case Studies / Labs

Assignment:

Record your case history and assessment findings of these two cases on the Assessment / Treatment templates available for download (we'll tell you how in a minute). Feel free to add more orthopedic tests and other examinations for practice!

Determine your clinical opinion and, using your imagination, write out the treatment you would expect to provide, the outcomes you might achieve during the initial assessment and treatment, and your treatment plan. The plan should include remedial exercise you would prescribe or referral to other practitioners you would make. Complete a second treatment for Elio Costalis.

When you're ready to begin, contact MTCOach via email for the link. When both cases are complete, scan your worksheets and email to coach@mtcoach.com. We'll send you confirmation for completing the self-study course!

Case Study: Elio Costalis, age 54

Location: Lower back (right SI region)

Onset: Fell off a ladder while cleaning his eaves-trough three weeks ago. He now experiences lower back pain

24 hour pattern: Worse on awakening, eases up within a ½ hour of “moving around” and some stretching

Intensity: 8-9/10

Quality: Achy pain in low back and right buttock, sharp with abrupt movement

Radiation: Achy pain in his right buttock, which travels down the back of the lateral thigh to just above the knee.

Aggravates: Worsens when lifting moderate weight or arising from sitting position

Relieves: He has tried heat but prefers ice to ease his lower back pain. Little seems to relieve the buttock and posterior thigh ache.

Other symptoms: The only other injury Elio remembers is a right shoulder injury, he believes at age 42, in which he received several “injections” to address his pain. For the most part the treatment worked and his shoulder has not bothered him until recently with falling off the ladder.

Elio experiences mood swings and a short temper, which he believes is caused by the pain and his frustration of limited activities.

Other treatment: Elio saw his physician within a week of the recent injury. The x-ray results showed “arthritis” in the lower spine. Elio has gone to his chiropractor for the last two weeks, with little benefit.

Related History: Elio had several lower back injuries — in high school football at age 17, and at work twice - ages 38 and 45. The latter injury required him to miss six weeks of work. He had x-rays for the latter two injuries and the diagnosis was “muscle spasm and strain”, with no boney pathologies noted.

Social/Occupational/Recreational: Elio normally attends the fitness club 2 times/week and participates in 20 minutes of cardiovascular training with 40 minutes of resistance-training and stretching. He has been unable to participate since the injury to his back

General health: Good

Rapid weight loss: No

RA: No

Meds: One aspirin a day as recommended by his physician for his heart. He also takes 10 mg Amitriptyline as needed for mild, intermittent depression and as a sleep aid. He also takes Vitamins B and C, Ginseng and Ginko Biloba on a daily basis to raise his energy levels and sharpen his concentration

Use of steroids/anti-coagulants: Aspirin

X-Ray/med imaging: For shoulder, 12 years ago

Neurological symptoms: No radicular symptoms, no loss of bladder control or urgency to urinate since the injury.

Dizziness: No

Elio consents to an examination and treatment to resolve this problem. On standing posture, Elio presents with a right torsioned iliac bone, which makes the right iliac crest lower than the left on standing postural assessment. The right shoulder girdle also torsions forward, and presents lower (caudad) than the left. Elio’s breathing seems laboured.

Lumbar ROM is limited moderately in tilt left, and severely limited in extension. Straight-leg raise is limited on the right to 45 degrees and 60 degrees on the left. Hip ROM is normal with pain in all ranges bilaterally. There is pain on joint challenge to the right sacroiliac joint.

On palpation, there is severe muscle tension in the left lumbo-sacral erector spinae myofasciae, abdominal obliques and gluteus maximus (as well as the hip abductors). The

right mid-thoracic muscles are equally tensioned, with moderate fibrosis in texture. The right quadriceps/hip flexor muscles and shin muscles also display moderate tonus and fibrosis. There is fixation in the left pelvi-femoral and sacro-iliac joints on joint play.

2nd Treatment for Elio. (Three days later)

Elio returns and reports his symptoms were 50% better the day following treatment, but some of the pain and stiffness has returned. He remembers that several days before the eavestrough incident, he was playing basketball with his son and felt “a twinge” in his lower back. He was prompted to remember this based on your excellent case history taking last session.

His postural distortions have improved, with minimal torsion in the shoulder or pelvic girdle now. Pain and restricted ROM is minimal in left tilt and mild on extension. There is no pain on joint challenge to the SI joints.

Palpation yields moderate tension in the left L/S E. Spinae, and right hip flexors, as well as the mid-thoracic E. Spinae myofasciae. Fibrosis in these areas is still moderate.

Following your treatment, Elio feels 80% improved, with minimal stiffness on lumbar range-of motion and no pain. He’s very happy!

You prescribe some low back stretches and you refer Elio to a physiotherapist for core strengthening. You ask to see him two more visits.

Note:

The following chapters are included in the full workbook version

Chapter 3: Palpation Findings and Forming a Clinical Opinion

Chapter 4: Treatment Plans / Completing the Treatment Record

A Framework for Treatment Plans

Treatments, Outcomes and Recommendations

Chapter 5: Pain Questionnaires and Special Templates for Insurance

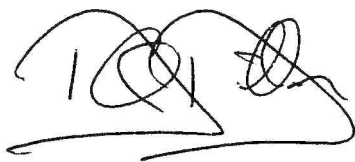
Plus the second case study

Contact us to [order your copy](#)

Appendix

Congratulations on completing *Charting Skills for Massage Therapists: The Self-Study Workbook*. I began this workbook by describing why I believe charting is more than meeting one's regulatory requirements as a therapist. Now that you've gained practical knowledge and experience in applying this system, I think it's appropriate to end the workbook with a theoretical background for taking this material to the next level — acknowledging palpation as an objective finding.

Thank you for working with me to evolve our profession.



p.s. Make sure to register this workbook to receive the templates, plus bonus material! Email coach@mtcoach.com ...for registered purchasers only!

Palpation as an Objective, Measurable Finding

There is something fantastic about the kinaesthetic sensation of palpating soft-tissues. Even after fifteen years of providing manual therapy, I am still awed when I feel myofasciae release. There's that point of resistance, a welling of heat in my fingertips, a last ditch effort to maintain the repressed tension...and then it releases. Like a wave washing against the shore and then quietly, easily retreating — the soma has transformed.

The body after a bodywork session is not the same one that entered the clinic room earlier. The neurological pathways have changed, the tonus system has been rebalanced, particles of life exchange in unhampered ways amongst the interstitial fluids where just before there was constriction. There is something lost trying to convey in words what I feel as a powerful interchange between the therapist's hands and the tissues-in-need. I use metaphors to explain this sensation to patients that have never experienced the sensation of constricted tissue release in their cradling fingers.

Yet it has become of major importance to describe our palpatory findings in terms easy for non-manual therapists to understand. In my opinion, one of the most significant obstacles of our profession is our inability to clearly convey the physiological changes that occur with our intervention. We talk about decreasing muscle tension, lessening sympathetic nerve firing, and increased circulation...but somehow these do not appropriately describe the capacity of what we do.

This topic has been of importance to me for sometime. As I teach manual therapists how to keep accurate and detailed charting records, there has always been the obstacle of describing soft-tissue change. We can perform orthopaedic assessments, range of motion

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

testing, reflex tests...but these are somehow incomplete in describing the findings we need to articulate. I asked the coordinator of a Designated Assessment Centre (part of the Auto Insurance system in Ontario) why she didn't employ a massage therapist when assessing patients of motor vehicle accidents. She renounced that the physiotherapist, chiropractor and orthopaedic specialist could do the assessment, and a massage therapist wasn't needed.

In my role on the Ontario Massage Therapist Association (OMTA) board, I reviewed the injury classification codes that were under consideration by the insurance companies to document conditions and interventions for auto insurance cases. Most codes were related to fractures, nerve injuries and other severe pathologies. I believe headaches and strain were the only conditions identified that manual therapists may regularly treat. There was no mention of muscle weakness, postural distortion, nerve entrapment, muscle tension, or even well-documented phenomena like myo-fascial pain and dysfunction. Hence, a universal soft-tissue language identifying the body's dysfunctional musculoskeletal manifestations is yearning for development.

When did manual therapy fall out of fashion? Hippocrates, well known as the "father of modern medicine", is often quoted for his holistic views in therapy and his use of bodywork and natural remedies in treatment. Apparently medicine relied heavily on tinctures from the ecosystems around us until the discovery of penicillin. Following this discovery, a fervent wave of enthusiasm broke on the shores of health care with the promise that all ills of humankind could be treated bio-chemically with good science and innovation.

It appears to me that not only our naturally-derived remedies have fallen into disfavour, but the use of manual therapy to mobilize, irrigate, manipulate, stimulate or sedate physiological processes and encourage tissue repair also appears old-fashioned. When I go to my family physician, his diagnosis comes primarily from the case history he extracts. Gone are the days of thorax percussion, manually taking a pulse, and other methods of palpation as a means of creating a clinical picture. My purpose is not to criticize physiatry, but to question why manual assessment and palpation has mostly disappeared from mainstream medicine.

I project an evolution is upon us—a cyclical rebirth of treating the person as whole. I imagine combined therapeutic approaches to assess and treat the whole individual. Pharmaceutically / bio-chemically, yes...but also bio-mechanically and psycho-emotionally.

So how do we articulate in a manner conducive to the understanding of laypersons the intricacies of what we do? How do we keep the form and shape and context of our work as we fumble with the description of the kinaesthetic?

We can start with the perspectives of leaders in the bodywork and movement re-education field to build a framework of terms easily applied and easily understood by even those outside our field. Terms that can be measured and identified, and used to educate the people we treat as to how this somatic "interruption" happened in the first place. Some terms and concepts are already familiar and documented — myofascial trigger points, the facilitated segment, the reflex arc, muscle spasm/strain, the process of inflammation and

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCOach—Cultivate Your Massage Therapy Practice www.MTCOach.com

tissue repair — are terms familiar to most health care professionals. Perhaps it won't be long before concepts such as “still-point” in Craniosacral therapy, or “unwinding” in myofascial release, or “hook-up” in Trager become documented, easily definable and identifiable terms.

John Upledger, DO of the Upledger Institute describes the phenomena of the “Energy Cyst” as a localized disturbance in the body's physiology, caused by a disruptive physical force and complicated by negative emotional intent. He uses physics nomenclature to explain entropy — a measure of the degree or disorder or randomness in the (mechanical) system. Connective tissue is portrayed as a highly conductive system, channeling micro-current to the various organ systems of the body. The organ systems rely on this micro-current to maintain health and function.

When a mechanical force disrupts this connective tissue system, its ability to channel this micro-current is impaired. Upledger uses the analogy of copper wire being struck by a hammer: the impact distorts and flattens the wire, impairing the conductivity of the wire. The wire must be stretched and reoriented so it can resume its normal capacity again.

The body accommodates traumatic force through its tissue density. In many cases, the injury is resolved through natural physiologic repair processes. In other cases, and especially Upledger notes, when there is negative emotional charge around the mechanism of injury, the body cannot resolve the problem and instead forms a barrier around it. Over time, this walled-in Energy Cyst can disrupt a variety of physiological processes.

This may explain why people respond to trauma differently, and recover at different rates and capacities. In my experience as an assessor in a Designated Assessment, I have noticed that some people that do not recover at expected rates are marginalized and labeled as “malingerers”. We may benefit from a new model that considers the biomechanical/biochemical and psycho-emotional manifestations of trauma to address residual pain more effectively.

Don Hanlon Johnson, in his book *Bone, Breath and Gesture*, presents the principles of pioneers in the bodywork/body awareness field such as Elsa Gindler, Marion Rosen, F.M. Alexander, Moshe Feldenkrais, Bonnie Bainbridge-Cohen, Ida Rolf, Deanne Juhan and Judith Aston. Johnson states in the introduction “the unique contribution of the people in this volume is to have developed practical strategies for affecting a return to the healing intelligence of the body...these somatics innovators have challenged the dominant models of exercise, manipulation, and self-awareness as alienating people from their bodies. They have developed alternative ways of moving, touching, and being aware that bring us closer to the wisdom inherent in the ancient structures of collagen, nerve fibre, and cerebrospinal fluid.”¹²

Leon Chaitow, DO, ND, in his text *Modern Neuromuscular Techniques*¹³ writes of a “stress response sequence” well documented in osteopathic and medical literature. We can observe a predictable downward spiral (see the 24 points in chapter three of this

¹² Johnson, D.H.: *Bone, Breath & Gesture - Practices of Embodiment*. North Atlantic Books. 1995. xvi

¹³ Chaitow, L.: *Modern Neuromuscular Techniques*. Churchill Livingstone 1996: 6-7

workbook) if intervention is inappropriate, inadequate or not applied when necessary. Given that these are already well-known physiological processes, could we not use them to explain how these processes are at work in manual therapy?

There may be potential for the grading of soft tissue dysfunction, using Chaitow's sequence (see chapter three) as a guide. For example, a recent injury showing signs of acute inflammation may be a stage one soft-tissue lesion, with more fibrous changes, postural distortion and referred pain syndromes indicating a level two. Level three may include diffuse and global central nervous system (CNS) changes like facilitated segments, advanced myo-fascial pain syndromes, and reports of fatigue and inability to relax by the patient. The level of change would certainly have ramifications for the treatment plan designed, and would indicate the application of manual therapy early in the injury process.

Further in his book, Chaitow describes palpatory diagnosis that the therapist can use to determine the state of health of the skin, connective tissue, muscles, and bony structures. Some may be familiar with Hilton's neurological law, which states: "a nerve trunk which supplies a joint, also supplies the muscles that insert over that joint, and the skin over those insertions."¹⁴ So, the therapist that can properly evaluate the overlying skin for edema, tension, or fibrous changes can gather a great deal of clinical information about the painful area.

Given the cost of soft-tissue injury to both workplace safety programs and auto insurance benefits for rehabilitation, perhaps manual therapy can be considered a valid intervention and attract more research dollars by all stakeholders in rehabilitation.

Deane Juhan describes the transition of fascia's ground substance from solid to gelatinous, and back again to solid. This is why we see postural changes occur after just one treatment, why energy and vitality increase while fatigue dissipates, why chronic pain dissipates and strength and stamina renew. This process called "thixotropy" is induced "...by means of pressure and stretching, and the friction they generate, the temperature and therefore the energy level of the tissue has merely been raised slightly. This added energy in turn promotes a more fluid ground substance which is more sol and ductile, and in which nutrients and cellular wastes can conduct their exchanges more efficiently. In addition to this mechanical stimulation of pressure and stretching, a powerful thermodynamic effect can be produced upon the bio-energetic field of the patient by the stronger and healthier bio-energetic field of the therapist. This comes partly in the form of literal body heat transferred by the therapist's penetrating touch, and partly from subtle forms of energy such as galvanic skin responses or vibratory rhythms."¹⁵ Thomas Myers, writer and practitioner of Structural Integration (Ida Rolf's movement), presents a system that examines the structural relationships of the spine and extremities to each other. His system of "anatomy trains" uses the continuous connective tissue system with its contractile-capacity muscle units to illustrate how to examine and treat the body from a global perspective. In his model, the student can determine how pain and dysfunction can be quite remote from the causative structure.

¹⁴ Material from St. John Neuromuscular Therapy seminars

¹⁵ Juhan, D.: *Job's Body: A Handbook for Bodywork*. Barrytown, NY: Station Hill, 1987: 69-70

In the April / May 1995 issue of *Journal of Soft Tissue Manipulation*, Rob MacDonald outlines a classification system entitled “muscle dysfunction syndromes”. MacDonald writes about the work of Dr. Hans Kraus, creator of the YMCA’s “the Y’s way to a healthier back”. Kraus identified four categories of muscle dysfunction: trigger points, muscle tension, muscle spasm/strain, and muscle deficiency (or weakness).¹⁶ I believe this is a significant classification for manual therapists because it allows the profession to put names to the conditions therapists kinaesthetically are identifying.

Paul St. John, LMT of the St. John Neuromuscular Pain Relief Centre describes his method of neuromuscular therapy as “a comprehensive program of soft tissue manipulation techniques that balance the central nervous system with the structure and form of the musculoskeletal system.” He identifies five mechanisms as initiating pain responses in these organ systems: ischemia, trigger points, nerve compression or entrapment, postural distortion and biomechanical dysfunction. My personal experience in applying the concepts behind St. John’s neuromuscular therapy have yielded tremendous results in my practice simply because it works and people and their referring health care providers can understand my description of the process.

I hope this appendix has provoked your thinking process in identifying, classifying and qualifying the sensations you feel in your work. It is my hope further that we can discuss these words and develop them into a working language complete with gradients of soft-tissue dysfunction, that can be used when addressing colleagues as well as those outside the profession. By then, we may all be speaking the same language.

* This article has been modified, and originally appeared in *Journal of Soft Tissue Manipulation*, Winter 1998/1999

¹⁶ MacDonald, R.: Muscle dysfunction syndromes. *JSTM* April/May 1995: 5-7

About the Author



Donald Quinn Dillon, R.M.T. has contributed over 50 articles to various massage therapy periodicals in both Canada and the U.S, including *Massage Therapy Canada* the OMTA's *Body Politic* and *Massage Therapy Today*, and the *American Massage Therapy Journal*.

Don has assisted the Investigations and Complaints committee of the College of Massage Therapists of Ontario (CMTO) in cases involving record-keeping. He has also served as a case assessor for auto-insurance cases for the Designated Assessment Centre (DAC) in Niagara for three years.

Within the last year, Don has presented to the Massage Therapist Association of Alberta (MTAA), the Association of Massage Therapists and Wholistic Practitioners (AMTWP) and the Massage Therapist Association of Saskatchewan (MTAS). Don has been a three-time presenter at the Ontario Massage Therapist Association's (OMTA) Hands Together conference.

Don received the OMTA's President's Award of Merit in 2000, and the Hand of Thanks Award in 2002. He served on the OMTA board from 1993 to 1997. During this time, he represented the OMTA in the auto insurance fee negotiations, and drafted the original OMTA brochures targeted to auto insurance adjusters and health care professionals.

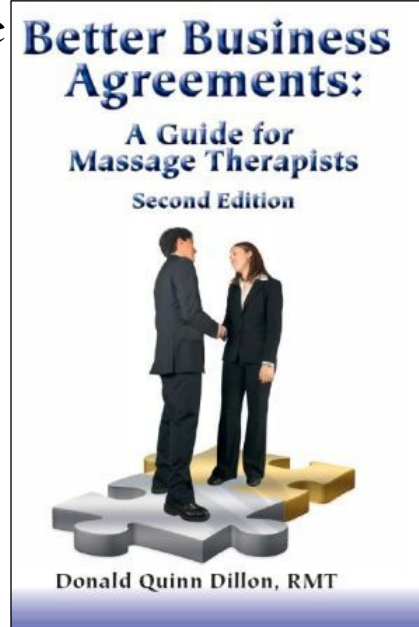
Don began his practice in 1991. He has worked in chiropractic, spa, and medical clinic environments before opening his own clinic in St. Catharines, Ontario. His primary focus is treating chronic biomechanical problems, and employs three associates with diverse skills to round out the clinic's service offerings.

Don lives in the Niagara region of Ontario with his wife Cheryl and their children Gabriel and Noah.

Also by MTCoach

Better Business Agreements: A Guide for Therapists

To sign up for the FREE MTCoach E-Newsletter learn about MTCoach seminars or find out about MTCoach scheduled appearances, visit www.MTCoach.com.



Special Offer

- Are you a director of a massage therapy teaching college, and would like to make the curriculum in Charting Skills available to your students?
- Are you a clinic manager and want to ensure uniform charting practices in your clinic by all your associates?
- Are you a professional association seeking to raise the standards in your association?
- Do you sell products and services to massage therapists, and are looking for another source of income?

Charting Skills for Massage Therapists can be purchased at special volume rates for orders of 6-49, and 50-plus copies. Contact coach@mtcoach.com for details!

Charting Skills for Massage Therapists: A Self-Study Workbook

© 2007. Donald Quinn Dillon. All Rights Reserved

Brought to you by MTCoach—Cultivate Your Massage Therapy Practice www.MTCoach.com