MATRIX REPATTERNING FOUNDATION: ASSESSMENT, TREATMENT FORM **Name:** ____________________ **Date:** ____________

Primary Restriction: ⬭ **Size:** ↔ ↕ **Shape:** ⌒ **Tone:** ↑↓ **Treated:** ◎

INTAKE

SIZE (CM)

	LT:	RT:
TBS:	____	____
TBP:	____	____
FMD:	____	____
PAT:	____	____

HIP

LT:	RT:
FL:	FL:
ER:	ER:
IR:	IR:
EX:	EX:

SHOULDER

LT:	RT:
AB:	AB:
ER:	ER:
IR:	IR:

STABLE (X, ✓):

KNL ❑A ❑P

KNR ❑A ❑P

❑ SHL ❑ SHR

❑ HIP L ❑ HIP R

❑ L4,5

OUTCOME

SIZE (CM)

	LT:	RT:
TBS:	____	____
TBP:	____	____
FMD:	____	____
PAT:	____	____

HIP

LT:	RT:
FL:	FL:
ER:	ER:
IR:	IR:
EX:	EX

SHOULDER

LT:	RT:
AB:	AB:
ER:	ER:
IR:	IR:

STABLE (X, ✓):

KNL ❑A ❑P

KNR ❑A ❑P

❑ SHL ❑ SHR

❑ HIP L ❑ HIP R

❑ L4,5

Intake Subjective:

Outcome Subjective:

Legend:
TBS Tibial Shaft; **TBP** Tibia, proximal epiphysis; **FMD** Femur, distal epiphysis; **PAT** Patella
FL Flexion, **ER** External rotation, **IR** internal rotation;
AB Abduction
KNL Knee, left; **KNR** Knee; right,
SHL Shoulder, left;
SHR Shoulder, right

Assessment and Treatment Checklist:

- ☐ Shape and Size
- ☐ ROM, Stability, Tone
- ☐ Bio-electric Scan
- ☐ Demonstrate Influence of PR's to Client
- ☐ Vector Primary
- ☐ Treatment
- ☐ Demonstrate objective improvements

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