

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, ✓):

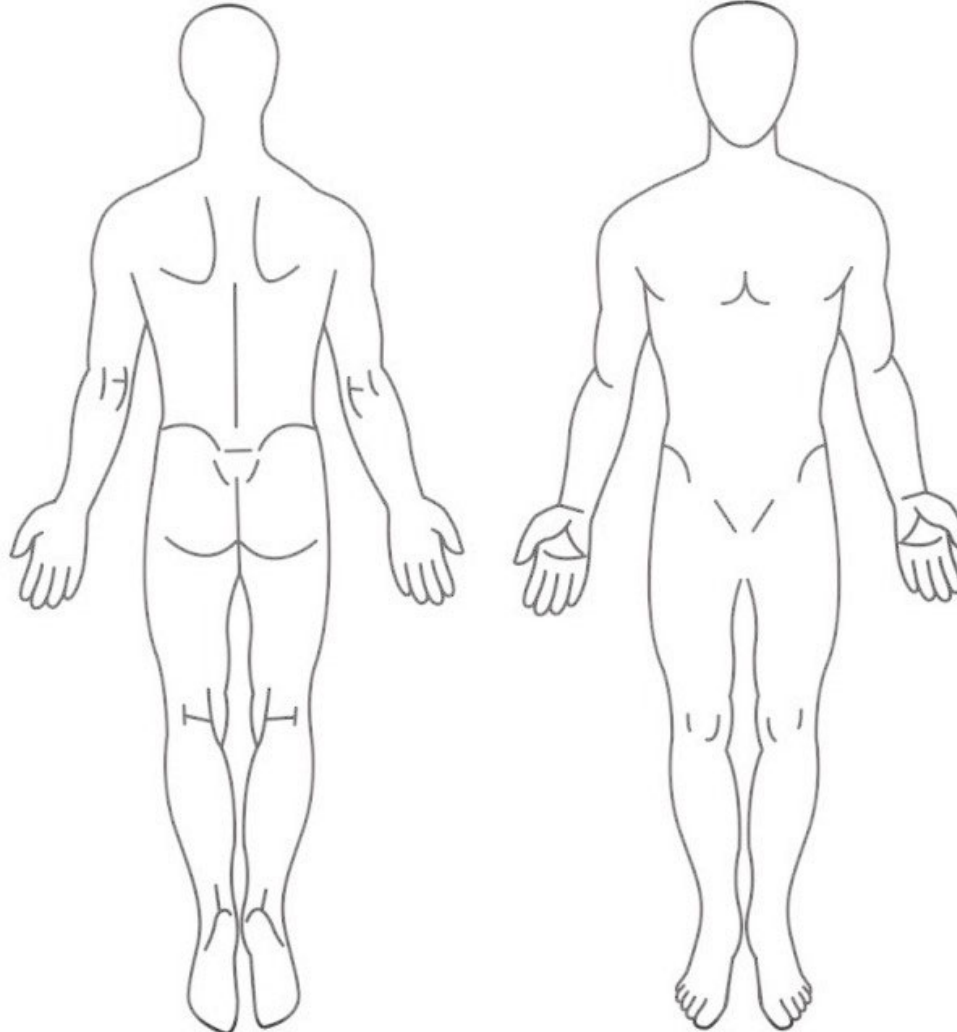
KNL A P

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