Practices 808

1. an l5 s1 disc lesion does not cause-------heel walking and weak dorsiflexion of the great toe
2. a prominent right transverse process of l1 in a right sectional convexity is most effectively corrected by a dbl thenar adj with the_____ hand contact on the prominence while the doctor stands to the_____of the prone pt. ----------right/right
3. to adjust a spinous left body right sblx of c5 with the pt. supine, the pt 's head is rotated to the_____and the lower cs is place to the_____----------left/extension
4. pt. presents with marked loss of head rotation to the rt. static palpation reveals spasm and tenderness of the left obliquus capitus sup. and inferior muscles. a_____adj. with a ____segmental contact pt. is indicated----------rotary occiput; left mastoid
5. most consistent with non-structural scoliosis----compensatory
6. appropriate measurement for listing a vertebra with ☒ interspinous space below and ☒ above----------flexion
7. occiput listing, head tilt to left, w/o rotation by the poste rior plumb line----------right lateral
8. pt. presents with pain over the psis and referred pain over the greater trocanter into the groin and occasionally down the back of the thigh. there is sciatic notch tenderness ?------side posture of the sacroiliac articulation
9. pt. presents with arthralgia, paresthesia and mild weakness cold intolerance------- hypothyroid
10. sacral apex left refers to sacral rotation within which body plane-----coronal
11. rational for always using a superior to inferior lod for adjusting atlas -------when c1 misaligns laterally it also rides sup. on the condyles 12. muscle palpable near its origin near the pubic bone-----adductor group
12. vb listing appropriate for a vertebra right with a right superior spinous listing---------left rotation with a left lateral flexion
13. 57 yof, smoker, bilateral calf cramp with activity relieved by rest------cardiovascular
14. segmental contact point in lumbar vb not safe for adj-----tp's
15. static postural analysis of a pt. reveals that the left shoulder is higher than the right and the neck is flexed to the left and rotated to the right--------left scm and left latissimus dorsi
16. atlas rotation and posteriority of the left tp. motion palpation reveals that the right tp does not move posteriorly. lod?----- right side a-p
17. prominent rt. tp of t12 in a left sectional convexity is best corrrected with a sgl hand pisiform contact on the ____side of the sp---------of the prone pt.----------left/left
18. lateral neck flexion and rotation with the face oriented away from the side of lateral flexion results from_____scm/same side
19. pt. lower ts back pain, precipitated by bending backwards and into the right and relieved by lying down. pain is sharp superficial radiating pain------dermatomal
20. ☒ difference between the psis and the s2 tubercle on the right and the right psis is lower on the left indicates------posterior to inferior and externally rotated
21. ls displays smooth arc during lateral bending and stacking or restriction during left lat. bending. spinal distortion------right concavity and left convexity
22. base post. sacrum and a concurrent l5 spondylolisthesis-----superior to inferior lod
23. lumbar motion mvmts has the least lateral flexion------l5,s1
24. to normalize l.s. mvmts at the c5, c6 motion segment while the pt. is seated and the doctor stands on the opposite side of the pt.----segmental contact (pull move)
25. prominent right tp at t7 in a rt. sectional convexity is most effectively corrected by a sgl hand pisiform contact on the___process while the doctor stands to the___of the prone pt------right/right
26. palpation of cs reveal the articular pillar at c5-----right tp
27. dc's left inferior hand to contact a side lying pt. to correct an anterior pelvic listing-----anterior superior ilium on the right
28. ipsilateral heel lift is contraindicated for tx of-----posterior superior sacrum
29. 26 yom 3 day hx of generalized lbp, = right bowstring sign, right gluteal muscles----piriformis syndrome
30. vb is right posterior and superior, the right tp process is-----posterior and superior
31. atlas sblx anterior superior restricts ------forward flexion
32. contact point o pt. is used to correct an ant. sup. occiput sblx with a cervical chair adj. procedure-----superior portion of the glabella
33. posterior observable finding characteristic of a right or left lateral occiput--------- ipsilateral high ear and mastoid
34. prominent left tp of l2, left convexity, most effectively corrected by------a right hand contact on the left mammilary

35. ileac sblx indicated by and [illegible] vertical and horizontal measurements of the obturator foramen on an a-p lumbo-pelvic x-ray------posterior inferior external
36. prominent rt. tp of l5, left convexity, sgl hand pisiform----left, left
37. 34 yof, 3 month hx weakness and numbness, index finger and thumb----wrist adjustment (cs not present)
38. dc hand contact point used for seated rotary break cs move----middle finger
39. motion segment in lumbar spine has greatest range of segmental lat. flexion------l1,l2\ (transitional area)
40. primary consideration to determine rotary cervical manipulation-----angle of the facets
41. pt. lower back, hip, posterior-lat. thigh and anterior leg to the great toe, weak quads, paresthesia in the anteromedial thigh and knee--------piriformis syndrome
42. rt. piis with wide flat right buttock and rt. foot flare. the best pt. placement and segmental contact point for a side posture-----right side up, medial aspect of psis
43. sblx with let. foot pain referred to posterior calf muscle-----cuboid
44. the first barrier to joint mvmts in motion palpation is------physiologic
45. 34 yo pt. with marked ts kyphosis. xray indicate roughened ts end plates with slight ant. compression of the vb------scheuermanns dz
46. 35 yom with sever lbp, radiates into the right buttock after heavy lifting------do not use rotation
47. [illegible] interspinous space below and [illegible] interspinous space above---extension
48. contact point of pli-l---------right lamina
49. lig. fixation cz-------an abrupt block with no give at the end rom
50. grade 4 deltoid muscle strength and a +1 biceps reflex-----c5 adjustment
51. t12 – negative theta y and a neg. theta z is most effectively corrected by a dbl thenar adjustive procedure with a _____hand contact while the doctor stands to the_____ of the prone pt.-------(pli-t)-----right/right
52. elderly female with diffuse osteoporosis, hyperkyphotic------sacral apex and auxiliary thoracic contact
53. most significant distortion in a lateral scoliotic curvature------coronal plane
54. to correct posteriorly rotated right laterally flexed occiput with pt, seated----left, right
55. supine rotary break to adjust c6 right lateral flexion with left vertebral body rotation---left lamina pedicle jx
56. pain and inability to perform speed's test, yerguson's, abbot saunders and ludington's---------biceps tendon
57. weakness of abdominals and hamstrings results in-----anterior tilt [illegible] lumbar lordosis
58. quantifies spinal sblx-----goniometer
59. left ts convexity, prominent tp on left, which hand------- right hand contact on the left side of pt.
60. prominent left t12 tp, left convexity-----left tp on left side of prone pt.
61. atlas rotation in the transverse plane is corrected by what elements of a side posture adjustment-------doctor position
62. ts left laterally flexed -------[illegible] vertical dimensions on the right side of the ts disc spaces
63. low shoulder 2[illegible] to si ligamentous instability often involves hypertonic muscles----- latissimus dorsi
64. cs sblx adjusted with pt. supine and the head level and rotated 45[illegible] to the right--------- left posterior sblx
65. applied to remove coronal plane rotation of the sacrum if sacral apex has done left-------counter clockwise torque
66. paresthesia. finger flexion------c8
67. deflection to nerve scope-----sharp
68. arthritic in 2[illegible] to trauma of cs------c5-c6
69. contact point of c7 in right lat. flexion------pls—
70. not risk factor for vvao-------adolescent pt.
71. contraindicated for adjustment of high velocity low amplitude thrust---------- transverse ligament instability
72. indicates an acj separation-------step deformity
73. chair adjustment dc contact point-----tip of the index finger
74. passive mobilization of si joint-----dejarnette blocking technique
75. palpation of lesser tuberosity of the humorous is enhanced by------externally rotating
76. joint of foot w/o a-p motion-------subtalar
77. posterior plumb line reveals------eop---s2 tubercle
78. left lateral fixation of body, contact-------left posterior inferior
79. pelvic malalignment cz ipsilateral long leg----as ilium

80. closed wedge toward the posterior of a disc space on a lateral lumbosacral x ray--- --segment above is posterior to segment below
81. representative of lumbar vb posteriority, right spinous rotation, with right convexity and an open wedge on the left------pri-sp
82. a short stabbing non-radiating pain which occurs during passive rom-------facet capsulitis
83. in the gonstead analysis which spinous listing applies to the 5th lumbar vertebra------pri-m
84. gonstead x-ray analysis, spinous listing applies to 5th lumbar vertebra-----pls-m
85. describes vb rotation in diagram------right rotation left lateral flexion
86. injury to shoulder what type of exercise initially-passive pendular
87. acute back injury-ice
88. which muscles should be strengthened for hyperlordosis in the ls-----abdominals
89. as ilium-------psoas muscle
90. contact and line of drive for a asin-------ischial contact, medial to lateral lod
91. presence of_____absolute contraindication-------osteomyolitis
92. median nerve may be entrapped where------pronator teres
93. a right l4, l5 medial disc protrusion will effect-----right lean, l5 nerve
94. ortho test for spastic scalene ms.------ adson's test
95. muscles responsible for lateral flexion to the right-----right scm
96. invert the foot it also-----plantar flexes
97. right sided hip pain following a fall. which orthopedic test would be most helpful in
98. pinpointing the problem----patrick's test
99. best exercise in the tx of spondylolisthesis-------flexion of the knee's and hips while supine
100. segmental contact point on the patient is used to correct an as occiput----sup. glabella
101. asr atlas listing contact point on segment-----right tp
102. appropriate way to evaluate pelvic and shoulder unleveling----scoliometry
103. side posture adjustment, superior hand left shoulder and soft pisiform of inf. hand on 3rd lumbar mammilary process---l3 mammilary push move
104. advise pt. not to_____ an ulnar bursitis--------splint
105. side posture pt. pain on side down-----trochanteric bursitis
106. how will body compensate for unilateral fixed si joint------shorter stride on same side
107. correct lod for a piin when contacting the psis-----p-a, i-s, medial to lateral
108. medial rotation of the radial head inhibits which motion of the radius and ulna----- supination
109. an anterior pelvic tilt is best corrected by-------sole lifts
110. extension exercises should be prescribed to correct-----weak gluteus (mackenzie)
111. relative contraindication to adjusting------aneurysm
112. best describes dbl transverse adjustment------dbl crossed arm bilateral pisiform
113. contraindication for adjusting acute facet syndrome-----prone
114. which vb body positio listing describes a cervical vertebra which is misaligned with right superior deviation of the spinous process----left rotation, left lateral flexion
115. ganglion impar----care in coccus adjustment
116. correct lod for an anterior thoracic------a-p, s-i
117. which bones make up the knee-----femur, tibia, patella
118. during left lateral bending, a normal upper lumbar thoracic spine forms a _____convexity with the rotation of the spinous to the_____ --------sp's to the left,body to the right
119. left posterior superior iliac spine is posterior compared to the right. pain is localized to the right si joint. the most appropriate case management is-----right ilium
120. a toed out foot flare with pronation of the foot may indicate which pelvis listing-------in ilium
121. on x-ray listing for in. innominant to be as. what is the shape of the obturator foramen---------decreased vertically
122. fixed vertebra in a left lateral flexed position with left spinous rotation. which tp position describes the static position of the vertebral sblx----------right posterior superior
123. correct contact point for a thoracic vertebra in left lateral flexion and right spinous rotation-----left side of the spinous

124. wrist extension from the neutral occurs mainly at the-----proximal carpometacarpal
125. the ankle adj. that is least traumatic for an acute inversion sprain----------dorsiflexion with eversion
126. occiput listing best corrrected with pt. lying supine and the pt's head rotated 90⍰toward the right---------left posterior superior
127. standing pt. observation: left psis is higher then the right psis. which malposition is present if the psis is fixed----------as
128. chronic patellar dislocation-------vastus medialis
129. listing of spinous pls-m indicates a body fixed in_____ rotation and ____lateral flexion----------right, right
130. spinous listing corresponds to an lpi transverse process listing----prs body
131. vb right posterior and superior, the left tp is-----anterior and inferior
132. left post. rotated occiput, flexed to the right----left, left
133. doctor stands and contacts right lamina pedicle jx of c2-----rt-lt, i-s
134. prone pt. extended legs one is shorter then other, flex knee's, sort leg becomes longer then opposite leg--------positive derifeild
135. most appropriate procedure to adjust a post. rotated scrum and ipsilateral anterior superior ilium is to-----sacrum to ilium
136. weak ab's and hamstrings result in what pelvic tilt-----anterior, ⍰ lordosis
137. dc exam reveals, post. inf. right ilium sblx accompanied by an apparently wide flat buttock and????
138. narrowed buttock on right psis anterior and superior-----asex
139. pr-m at l1 indicates------a right scoliosis
140. ⍰ lateral to medial glide of the tibia may indicates weakness-----mcl
141. prominent rt tp of t12 in a left convexity is best corrected with a single hand pisiform on the _____sp while dc stands on the _____side of pt.-------left sp, left side of pt.
142. l3 lumbar vb has rotated to the left and superior and the left tp is posterior, lod is ------p-a, counter clockwise, i-s
143. palpation reveals the space between the 2nd sacral tubercle and the left psis is greater than the distance between the 2nd sacral tubercle and the right psis indicates--------external ilium on the left
144. side lying push procedure to correct a right l3 tp on the right convexity------left hand contact on the right mammilary process
145. diagram-----prs
146. dysfunction of the dorsal spine will have an effect upon which of the following joints------scapulocostal
147. contact point of a pli-m at l5 is the ____process of l5----right mammilary
148. ipsilateral widening ans internally rotated ilium will produce which position of the ilium on an x-ray-------in widened
149. adj of right post. innominant ans a right short leg, the inf. support is placed on the - ------right acetabulum
150. meralgia paresthetica-----lateral femoral cutaneous
151. radicular pain but not referred pain----------a sensory deficit in dermatomal patterns
152. pain an inability to perform speed's and yergason's test---biceps tendon
153. pars defect due to lytic and stress fracture------isthmic (type ii a)
154. disc lesion of l3, l4, will effect------rectus femoris
155. ⍰ left lateral flexion of l4, 5 segment, pt should be---(right) side lying and dc contact—(l4 spinous)
156. lumbar sigl hand pisiform thrust should be delivered with a (slight) and a—(high) and a (slow) release
157. general side posture adj-----utilizes a body drop adjustment
158. most common cause of spinal stenosis----djd
159. least likely to require a referral to another doc------cluster ha
160. tx of a hyper mobile joint--------stabilize
161. result of bilateral hypertonicity of psoas---lumbar hyper lordosis
162. + nerve conduction test--------ivd herniation
163. disc injuries is most resistant to manipulative therapy-------sequestered fragment
164. an l3 lesion with only one pedicle seen on x-ray-----hemivertebra
165. not an accurate recording for the use of a brace-------not to correct a curve of less then 20⍰
166. ⍰ left lateral flexion, ⍰ left rotation, ⍰ flexion and extension ?---------pri
167. c5-c6 nerve root involvement-------deltoid muscle and biceps reflex
168. traction can be used fore----------facet syndrome

169. motr, sensory and reflex deficits due to ivf encroachment of c5-c6------wrist extension,
170. prs specific adjustment for c5--------spinous, seated
171. avoid flexion----------carpal tunnel syndrome
172. testing extensor pollicis brevis----------finkelsteins
173. drive used to correct lower ts (always)----------i-s
174. sharp hadley's s curve to the right cz'd by----------tight erector spinae muscles
175. purpose of indifferent hand in ts thumb move is---------stabilize the head
176. sever extension of vb no other finding----------double thumb transverse
177. internal coccygeal adj. one must be careful not touch------ganglion impar
178. synonymous with slr----------lasegue
179. tx most appropriate for pain, swelling and inflammation in a 2[illegible] knee strain------ice (cryotherapy)
180. 14 yof pain with extension-------osgood schlatters dz
181. chronic lbp is mc assoc. ----------disc syndrome
182. p-a blow to knee----------acl damage
183. l4 muscle check----------tibialis anterior
184. least specific cs adjustment----------supine master cervical
185. best exercise for scheuermanns----------extension
186. exercise places the spine in extension to correct disc problems------mckenzie
187. flexion exercises used to correct a pelvic misalignment ------williams
188. home exercise for tos pt-------stretch pec minor
189. true if adj pt with reiter's syndrome----------it gets worse and progressive
190. not home care for tos---------holding there hand over there head for sleeping
191. decrases gastric motiltiy------cervical adj.
192. break in pars with no ant. mvmt-------spondylolysis
193. to adjust base post. sacrum----------except side posture, sup, hand contact
194. hypotonia, nystagmus, ataxia, dysdiadochonesia----------cb
195. recently injured joint-------passive exercise first
196. exercises for carpal tunnel syndrome------isotonic extension
197. isometric-----for joint injury= no mvmt
198. isotonic------strength
199. isokinetic--------rehab-----same speed
200. no heel lifts for----------long leg, long leg rotation
201. williams exercises are used for--------weak hamstrings, weak abdominals
202. not used for upper cervical adjustment-------thumb move
203. restricted flexion and restricted internal rotation--------asin
204. associated with anterior atlas sblx----------lateral
205. best to treat recurrent chronic or an acute lbp---------cryotherapy

- ATLAS SBLX ANTERIOR SUPERIOR RESTRICTS FORWARD FLEXION

- CONTACT POINT 0 PT. IS USED TO CORRECT AN ANT. SUP. OCCIPUT SBLX WITH A CERVICAL CHAIR ADJ. PROCEDURE SUPERIOR PORTION OF THE GLABELLA

- POSTERIOR OBSERVABLE FINDING CHARACTERISTIC OF A RIGHT OR LEFT LATERAL OCCIPUT IPSILATERAL HIGH EAR AND MASTOID

- PROMINENT LEFT TP OF L2, LEFT CONVEXITY, MOST EFFECTIVELY CORRECTED BY A RIGHT HAND CONTACT ON THE LEFT MAMMILARY

•ILEAC SBLX INDICATED BY AND 1' VERTICAL AND HORIZONTAL MEASUREMENTS OF THE OBTURATOR FORAMEN ON AN AP LUMBOPELVIC XRAY POSTERIOR INFERIOR EXTERNAL

•PROMINENT RT. TP OF L5, LEFT CONVEXITY, SGL HAND PISIFORM LEFT, LEFT

•34 YOF, 3 MONTH HX WEAKNESS AND NUMBNESS, INDEX FINGER AND THUMBWRIST ADJUSTMENT (CS NOT PRESENT)

• DC HAND CONTACT POINT USED FOR SEATED ROTARY BREAK CS MOVE MIDDLE FINGER

40. MOTION SEGMENT IN LUMBAR SPINE HAS GREATEST RANGE OF SEGMENTAL LAT. FLEXION LI,L2 (TRANSITIONAL AREA)

41. PRIMARY CONSIDERATION TO DETERMINE ROTARY CERVICAL MANIPULATION ANGLE OF THE FACETS

42. PT. LOWER BACK, HIP, POSTERIORLAT. THIGH AND ANTERIOR LEG TO THE GREAT TOE, WEAK QUADS, PARESTHESIA IN THE ANTEROMEDIAL THIGH AND KNEE PIRIFORMIS SYNDROME

43. RT. PIIS WITH WIDE FLAT RIGHT BUTTOCK AND RT. FOOT FLARE. THE BEST PT. PLACEMENT AND SEGMENTAL CONTACT POINT FOR A SIDE POSTURE RIGHT SIDE UP, MEDIAL ASPECT OF PSIS

44. SBLX WITH LET. FOOT PAIN REFERRED TO POSTERIOR CALF MUSCLE CUBOID

45. THE FIRST BARRIER TO JOINT MVMTS IN MOTION PALPATION IS PHYSIOLOGIC

46. 34 YO PT. WITH MARKED TS KYPHOSIS. XRAY INDICATE ROUGHENED TS END PLATES WITH SLIGHT ANT. COMPRESSION OF THE VB SCHEUERMANNS DZ

47. 35 YOM WITH SEVER LBP, RADIATES INTO THE RIGHT BUTTOCK AFTER HEAVY LIFTING DO NOT USE ROTATION

48. L INTERSPINOUS SPACE BELOW AND 1' INTERSPINOUS SPACE ABOVE EXTENSION

49. CONTACT POINT OF PLIL RIGHT LAMINA

50. LIG. FIXATION CZ AN ABRUPT BLOCK WITH NO GIVE AT THE END ROM

51. GRADE 4 DELTOID MUSCLE STRENGTH AND A +1 BICEPS REFLEX CS ADJUSTMENT

52. T12 NEGATIVE THETA Y AND A NEG. THETA Z IS MOST EFFECTIVELY CORRECTED BY A DBL THENAR ADJUSTIVE PROCEDURE WITH A HAND CONTACT WHILE THE DOCTOR STANDS TO
THE ___OF THE PRONE PT. (PLIT) RIGHT/RIGHT

53. ELDERLY FEMALE WITH DIFFUSE OSTEOPOROSIS, HYPERKYPHOTIC SACRAL APEX AND AUXILIARY THORACIC CONTACT

54. MOST SIGNIFICANT DISTORTION IN A LATERAL SCOLIOTIC CURVATURE CORONAL PLANE

55. TO CORRECT POSTERIORLY ROTATED RIGHT LATERALLY FLEXED OCCIPUT WITH PT, SEATED LEFT, RIGHT

56. SUPINE ROTARY BREAK TO ADJUST C6 RIGHT LATERAL FLEXION WITH LEFT VERTEBRAL BODY ROTATIONLEFT LAMINA PEDICLE JX

57. PAIN AND INABILITY TO PERFORM SPEED'S TEST, YERGUSON'S, ABBOT SAUNDERS AND LUDINGTON'S BICEPS TENDON

58. WEAKNESS OF ABDOMINALS AND HAMSTRINGS RESULTS IN ANTERIOR TILT 1' LUMBAR LORDOSIS

59. QUANTIFIES SPINAL SBLX GONIOMETER

60. LEFT TS CONVEXITY, PROMINENT TP ON LEFT, WHICH HAND RIGHT HAND CONTACT ON THE LEFT SIDE OF PT.

61. PROMINENT LEFT T12 TP, LEFT CONVEXITY LEFT TP ON LEFT SIDE OF PRONE PT.

62. ATLAS ROTATION IN THE TRANSVERSE PLANE IS CORRECTED BY WHAT ELEMENTS OF A SIDE POSTURE ADJUSTMENT DOCTOR POSITION

63. TS LEFT LATERALLY FLEXED 1' VERTICAL DIMENSIONS ON THE RIGHT SIDE OF THE TS DISC SPACES

64. LOW SHOULDER 2° TO SI LIGAMENTOUS INSTABILITY OFTEN INVOLVES HYPERTONIC MUSCLES LATISSIMUS DORSI

65. CS SBLX ADJUSTED WITH PT. SUPINE AND THE HEAD LEVEL AND ROTATED 45° TO THE RIGHT LEFT POSTERIOR SBLX

66. APPLIED TO REMOVE CORONAL PLANE ROTATION OF THE SACRUM IF SACRAL APEX HAS DONE LEFT COUNTER CLOCKWISE TORQUE

67. PARESTHESIA. FINGER FLEXION C8

68. DEFLECTION TO NERVE SCOPE SHARP

69. ARTHRITIC IN 2° TO TRAUMA OF CS C5C6

70. CONTACT POINT OF C7 IN RIGHT LAT. FLEXION NOT RISK FACTOR FOR WAO ADOLESCENT PT.

72. CONTRAINDICATED FOR ADJUSTMENT OF HIGH VELOCITY LOW AMPLITUDE THRUST
TRANSVERSE LIGAMENT INSTABILITY

73. INDICATES AN ACJ SEPARATION STEP DEFORMITY

74. CHAIR ADJUSTMENT DC CONTACT POINT TIP OF THE INDEX FINGER

75. PASSIVE MOBILIZATION OF SI JOINT DEJARNETTE BLOCKING TECHNIQUE

76. PALPATION OF LESSER TUBEROSITY OF THE HUMOROUS IS ENHANCED BY EXTERNALLY ROTATING

77. JOINT OF FOOT W/O AP MOTION SUBTALAR

78. POSTERIOR PLUMB LINE REVEALS EOPS2 TUBERCLE

79. LEFT LATERAL FIXATION OF BODY, CONTACT LEFT POSTERIOR INFERIOR

80. PELVIC MALALIGNMENT CZ IPSILATERAL LONG LEGAS ILIUM

81. CLOSED WEDGE TOWARD THE POSTERIOR OF A DISC SPACE ON A LATERAL LUMBOSACRAL X RAYSEGMENT ABOVE IS POSTERIOR TO SEGMENT BELOW

82. REPRESENTATIVE OF LUMBAR VB POSTERIORITY, RIGHT SPINOUS ROTATION, WITH RIGHT CONVEXITY AND AN OPEN WEDGE ON THE LEFT PRISP

83. A SHORT STABBING NONRADIATING PAIN WHICH OCCURS DURING PASSIVE ROM FACET CAPSULITIS

84. IN THE GONSTEAD ANALYSIS WHICH SPINOUS LISTING APPLIES TO THE 5TH LUMBAR VERTEBRA PRIM

85. GONSTEAD XRAY ANALYSIS, SPINOUS LISTING APPLIES TO 5TH LUMBAR VERTEBRA PLSM

86. DESCRIBES VB ROTATION IN DIAGRAM RIGHT ROTATION LEFT LATERAL FLEXION

1. INJURY TO SHOULDER WHAT TYPE OF EXERCISE INITIALLYPASSIVE PENDULAR

2. ACUTE BACK INJURYICE

3. WHICH MUSCLES SHOULD BE STRENGTHENED FOR HYPERLORDOSIS IN THE LS ABDOMINALS

4. AS ILIUM PSOAS MUSCLE

5. CONTACT AND LINE OF DRIVE FOR A ASIN ISCHIAL CONTACT, MEDIAL TO LATERAL LOD

6. PRESENCE OF ABSOLUTE CONTRAINDICATION OSTEOMYOLITIS

7. MEDIAN NERVE MAY BE ENTRAPPED WHERE PRONATOR TERES

8. A RIGHT L4, L5 MEDIAL DISC PROTRUSION WILL EFFECT RIGHT LEAN, L5 NERVE

9. ORTHO TEST FOR SPASTIC SCALENE MS. ADSON'S TEST

10. MUSCLES RESPONSIBLE FOR LATERAL FLEXION TO THE RIGHT RIGHT SCM

11. INVERT THE FOOT IT ALSO PLANTAR FLEXES

12. RIGHT SIDED HIP PAIN FOLLOWING A FALL. WHICH ORTHOPEDIC TEST WOULD BE MOST HELPFUL IN PINPOINTING THE PROBLEMPATRICK'S TEST

13. BEST EXERCISE IN THE TX OF SPONDYLOLISTHESIS FLEXION OF THE KNEE'S AND HIPS WHILE SUPINE
14. SEGMENTAL CONTACT POINT ON THE PATIENT IS USED TO CORRECT AN AS OCOIPUT SUP. GLABELLA

15. ASR ATLAS LISTING CONTACT POINT ON SEGMENT RIGHT TP

16. APPROPRIATE WAY TO EVALUATE PELVIC AND SHOULDER UNLEVELING SCOLIOMETRY

17. SIDE POSTURE ADJUSTMENT, SUPERIOR HAND LEFT SHOULDER AND SOFT PISIFORM OF INF. HAND ON 3RD LUMBAR MAMMILARY PROCESSL3 MAMMILARY PUSH MOVE

18. ADVISE PT. NOT TOAN ULNAR BURSITIS SPLINT

19. SIDE POSTURE PT. PAIN ON SIDE DOWN TROCHANTERIC BURSITIS

20. HOW WILL BODY COMPENSATE FOR UNILATERAL FIXED SI JOINT SHORTER STRIDE ON SAME SIDE

21. CORRECT LOD FOR A PIIN WHEN CONTACTING THE PSIS PA, IS, MEDIAL TO LATERAL

22. MEDIAL ROTATION OF THE RADIAL HEAD INHIBITS WHICH MOTION OF THE RADIUS AND ULNA SU P1 NATION

23. AN ANTERIOR PELVIC TILT IS BEST CORRECTED BY SOLE LIFTS

24. EXTENSION EXERCISES SHOULD BE PRESCRIBED TO CORRECT WEAK GLUTEUS (MACKENZIE)

25. RELATIVE CONTRAINDICATION TO ADJUSTING ANEURYSM

26. BEST DESCRIBES DBL TRANSVERSE ADJUSTMENT DBL CROSSED ARM BILATERAL PISIFORM

27. CONTRAINDICATION FOR ADJUSTING ACUTE FACET SYNDROME PRONE

28. WHICH VB BODY POSITIO LISTING DESCRIBES A CERVICAL VERTEBRA WHICH IS MISALIGNED WITH

RIGHT SUPERIOR DEVIATION OF THE SPINOUS PROCESSLEFT ROTATION, LEFT LATERAL FLEXION

29. GANGLION IMPAR CARE IN COCCUS ADJUSTMENT

30. CORRECT LOD FOR AN ANTERIOR THORACIC AP, S1

31. WHICH BONES MAKE UP THE KNEE FEMUR, TIBIA, PATELLA

32. DURING LEFT LATERAL BENDING, A NORMAL UPPER LUMBAR THORACIC SPINE FORMS A _____CONVEXITY WITH THE ROTATION OF THE SPINOUS TO THE SP'S TO THE LEFT,

BODY TO THE RIGHT

33. LEFT POSTERIOR SUPERIOR ILIAC SPINE IS POSTERIOR COMPARED TO THE RIGHT. PAIN IS LOCALIZED TO THE RIGHT SI JOINT. THE MOST APPROPRIATE CASE MANAGEMENT IS RIGHT ILIUM

34. A TOED OUT FOOT FLARE WITH PRONATION OF THE FOOT MAY INDICATE WHICH PELVIS LISTING IN ILIUM

35. ON XRAY LISTING FOR IN. INNOMINANT TO BE AS. WHAT IS THE SHAPE OF THE OBTURATOR FORAMEN DECREASED VERTICALLY

36. FIXED VERTEBRA IN A LEFT LATERAL FLEXED POSITION WITH LEFT SPINOUS ROTATION. WHICH IP POSITION DESCRIBES THE STATIC POSITION OF THE VERTEBRAL SBLX RIGHT POSTERIOR SUPERIOR

37. CORRECT CONTACT POINT FOR A THORACIC VERTEBRA IN LEFT LATERAL FLEXION AND RIGHT SPINOUS ROTATION LEFT SIDE OF THE SPINOUS

38. WRIST EXTENSION FROM THE NEUTRAL OCCURS MAINLY AT THE PROXIMAL CARPOMETACARPAL

39. THE ANKLE ADJ. THAT IS LEAST TRAUMATIC FOR AN ACUTE INVERSION SPRAIN DORSIFLEXION WITH EVERSION

40. OCCIPUT LISTING BEST CORRRECTED WITH PT. LYING SUPINE AND THE PT'S HEAD ROTATED 90° TOWARD THE RIGHT LEFT POSTERIOR SUPERIOR

41. STANDING PT. OBSERVATION: LEFT PSIS IS HIGHER THEN THE RIGHT PSIS. WHICH MALPOSITION IS PRESENT IF THE PSIS IS FIXED AS

42. CHRONIC PATELLAR DISLOCATION VASTUS MEDIALIS

43. LISTING OF SPINOUS PLSM INDICATES A BODY FIXED INROTATION AND
LATERAL
FLEXION RIGHT, RIGHT

44. SPINOUS LISTING CORRESPONDS TO AN LPI TRANSVERSE PROCESS LISTING PRS BODY

45. VB RIGHT POSTERIOR AND SUPERIOR, THE LEFT TP IS ANTERIOR AND INFERIOR

46. LEFT POST. ROTATED OCCIPUT, FLEXED TO THE RIGHTLEFT, LEFT

47. DOCTOR STANDS AND CONTACTS RIGHT LAMINA PEDICLE JX OF C2 RTLT, IS

48. PRONE PT. EXTENDED LEGS ONE IS SHORTER THEN OTHER, FLEX KNEE'S, SORT LEG BECOMES LONGER THEN OPPOSITE LEG POSITIVE DERIFEILD

49. MOST APPROPRIATE PROCEDURE TO ADJUST A POST. ROTATED SCRUM AND IPSILATERAL ANTERIOR SUPERIOR ILIUM IS TO SACRUM TO ILIUM

50. WEAK AB'S AND HAMSTRINGS RESULT IN WHAT PELVIC TILT ANTERIOR, t LORDOSIS

51. DC EXAM REVEALS, POST. INF. RIGHT ILIUM SBLX ACCOMPANIED BY AN APPARENTLY WIDE FLAT BUTTOCK AND????

52. NARROWED BUTTOCK ON RIGHT PSIS ANTERIOR AND SUPERIOR ASEX

53. PRM AT LI INDICATES A RIGHT SCOLIOSIS

54. t LATERAL TO MEDIAL GLIDE OF THE TIBIA MAY INDICATES WEAKNESS MCL

55. PROMINENT RT TP OF T12 IN A LEFT CONVEXITY IS BEST CORRECTED WITH A SINGLE HAND
PISIFORM ON THE SP WHILE DC STANDS ON THE SIDE OF PT. LEFT SP, LEFT SIDE
OF PT.

56. L3 LUMBAR VB HAS ROTATED TO THE LEFT AND SUPERIOR AND THE LEFT TP IS POSTERIOR, LOD IS PA, COUNTER CLOCKWISE, IS

57. PALPATION REVEALS THE SPACE BETWEEN THE 2 SACRAL TUBERCLE AND THE LEFT PSIS IS GREATER THAN THE DISTANCE BETWEEN THE 2ND SACRAL TUBERCLE AND THE RIGHT PSIS INDICATES EXTERNAL ILIUM ON THE LEFT

58. SIDE LYING PUSH PROCEDURE TO CORRECT A RIGHT L3 TP ON THE RIGHT CONVEXITY LEFT HAND CONTACT ON THE RIGHT MAMMILAR)' PROCESS

59. DIAGRAM PRS

I. DYSFUNCTION OF THE DORSAL SPINE WILL HAVE AN EFFECT UPON WHICH OF THE FOLLOWING JOINTS SCAPULOCOSTAL

2. CONTACT POINT OF A PLIM AT L5 IS THE PROCESS OF L5RIGHT MAMMILARY

3. IPSILATERAL WIDENING ANS INTERNALLY ROTATED ILIUM WILL PRODUCE WHICH POSITION OF THE ILIUM ON AN XRAY IN WIDENED

4. ADJ OF RIGHT POST. INNOMINANT ANS A RIGHT SHORT LEG, THE INF. SUPPORT IS PLACED ON THE RIGHT ACETABULUM

5. MERALGIA PARESTHETICA LATERAL FEMORAL CUTANEOUS

6. RADICULAR PAIN BUT NOT REFERRED PAIN A SENSORY DEFICIT IN DERMATOMAL PATTERNS

7. PAIN AN INABILITY TO PERFORM SPEED'S AND YERGASON'S TESTBICEPS TENDON

8. PARS DEFECT DUE TO LYTIC AND STRESS FRACTURE ISTHMIC (TYPE II A)

9. DISC LESION OF L3, L4, WILL EFFECT RECTUS FEMORIS

10. LEFT LATERAL FLEXION OF L4, 5 SEGMENT, PT SHOULD BE(RIGHT) SIDE LYING AND DC CONTACT(L4 SPINOUS)

11. LUMBAR SIGL HAND PISIFORM THRUST SHOULD BE DELIVERED WITH A (SLIGHT) AND A(HIGH) AND A (SLOW) RELEASE

12. GENERAL SIDE POSTURE ADJ UTILIZES A BODY DROP ADJUSTMENT

13. MOST COMMON CAUSE OF SPINAL STENOSIS DJD

14. LEAST LIKELY TO REQUIRE A REFERRAL TO ANOTHER DOC CLUSTER HA

15. TX OF A HYPER MOBILE JOINT STABILIZE

16. RESULT OF BILATERAL HYPERTONICITY OF PSOASLUMBAR HYPER LORDOSIS

17. + NERVE CONDUCTION TEST IVD HERNIATION

18. DISC INJURIES IS MOST RESISTANT TO MANIPULATIVE THERAPY SEQUESTERED FRAGMENT

19. AN L3 LESION WITH ONLY ONE PEDICLE SEEN ON XRAY HEMIVERTEBRA

20. NOT AN ACCURATE RECORDING FOR THE USE OF A BRACE NOT TO CORRECT A CURVE OF LESS THEN 20°

21. LEFT LATERAL FLEXION, 1 LEFT ROTATION, FLEXION AND EXTENSION ? PRI

22. C5C6 NERVE ROOT INVOLVEMENT DELTOID MUSCLE AND BICEPS REFLEX

23. TRACTION CAN BE USED FORE FACET SYNDROME

24. MOTR, SENSORY AND REFLEX DEFICITS DUE TO IVF ENCROACHMENT OF C5C6 WRIST EXTENSION,

25. PRS SPECIFIC ADJUSTMENT FOR C5 SPINOUS, SEATED

26. AVOID FLEXION CARPAL TUNNEL SYNDROME

27. TESTING EXTENSOR POLLICIS BREVIS FINKELSTEINS

28. DRIVE USED TO CORRECT LOWER IS (ALWAYS) IS

29. SHARP HADLEY'S S CURVE TO THE RIGHT CZ'D BY TIGHT ERECTOR SPINAE MUSCLES

30. PURPOSE OF INDIFFERENT HAND IN IS THUMB MOVE S STABILIZE THE HEAD

31. SEVER EXTENSION OF VB NO OTHER FINDING DOUBLE THUMB TRANSVERSE

32. INTERNAL COCCYGEAL ADJ. ONE MUST BE CAREFUL NOT TOUCH GANGLION IMPAR

33. SYNONYMOUS WITH SLR LASEGUE

34. TX MOST APPROPRIATE FOR PAIN, SWELLING AND INFLAMMATION IN A 2° KNEE STRAIN ICE (CRyo THERAPY)

35. 14 YOF PAIN WITH EXTENSION OSGOOD SCHLATTERS DZ

36. CHRONIC LBP IS MC ASSOC. DISC SYNDROME

37. PA BLOW TO KNEE ACL DAMAGE

38. L4 MUSCLE CHECK TIBIALIS ANTERIOR

39. LEAST SPECIFIC CS ADJUSTMENT SUPINE MASTER CERVICAL

40. BEST EXERCISE FOR SCHEUERMANNS EXTENSION

41. EXERCISE PLACES THE SPINE IN EXTENSION TO CORRECT DISC PROBLEMS MCKENZIE

42. FLEXION EXERCISES USED TO CORRECT A PELVIC MISALIGNMENT WILLIAMS

43. HOME EXERCISE FOR TOS PT STRETCH PEC MINOR

44. TRUE IF ADJ PT WITH REITER'S SYNDROME IT GETS WORSE AND PROGRESSIVE

45. NOT HOME CARE FOR IOS HOLDING THERE HAND OVER THERE HEAD FOR SLEEPING

46. DECRASES GASTRIC MOTILTIY CERVICAL ADJ.

47. BREAK IN PARS WITH NO ANT. MVMT SPONDYLOLYSIS

48. TO ADJUST BASE POST. SACRUM EXCEPT SIDE POSTURE, SUP, HAND CONTACT

49. HY,'OTONIA, NYSTAGMUS, ATAXIA, DYSDIADOCHONESIA CB

50. RECENTLY INJURED JOINT PASSIVE EXERCISE FIRST

51. EXERCISES FOR CARPAL TUNNEL SYNDROME ISOTONIC EXTENSION
    a. ISOMETRIC FOR JOINT INJURY= NO MVMT
    b. ISOTONIC STRENGTH
    c. ISOKINETIC REHAB SAME SPEED

52. NO HEEL LIFTS FOR LONG LEG, LONG LEG ROTATION

53. WILLIAMS EXERCISES ARE USED FOR WEAK HAMSTRINGS, WEAK ABDOMINALS

54. NOT USED FOR UPPER CERVICAL ADJUSTMENT THUMB MOVE

55. RESTRICTED FLEXION AND RESTRICTED INTERNAL ROTATION ASIN

56. ASSOCIATED WITH ANTERIOR ATLAS SBLX LATERAL

57. BEST TO TREAT RECURRENT CHRONIC OR AN ACUTE LBP
CRYOTHERAPY

Progression of adult onset scoliosis: due to asymetrical disc compression and degeneration

Least likely to aggrevate SI: A. leg pain B. Low Back C. Sitting SLR D. Supine SLR

Best contact for Rt. Lat flexion with Lt. Body rotation: CCW torque / Lt. body

Internal coccyx torque: Traction pull

Pt. on rt. side, Dr. Pisiform on Lt. sacrum thrust is anterior:
Correcting Lt. rotated/ fixed Lt. sacrum/ a P1 sacrum

Deflect needle during analysis: Capillary dilation

Rt. mastoid higher than Lt., more of Rt. cheek visible when viewed from the posterior:
Rt. post./superior 0cc.

Lovett negative: Body rotation toward high side of sacrum

Lt. flexion of cervical spine, pt. seated, Dr. stands where as they use a reinforced digital contact:
On the side of the fixation

Lateral break cervical adjustment: angle of facets

22y.o. female, acute neck pain, better on Rt. lat. flexion, inability to rotate or laterally flex the neck to the right. 2 days ago while driving she was hit from the rear w/ head turned to the it. What was injured?
A. Rt. zygapophyseal jt. B. Lt. trap C. Rt. trap D. Rt. levator scapular mm

Pain down post. lat thigh, antalgic posture and weak toe extension, treatment:
Distract IA DISC to treat (L5 NR)

Exercise to correct hyperlordosis and +Thornas: Psoas stretch

Extension malposition of thoracic spine: Compare spinous processes

Thoracic spine transverse: 2 interspinous spaces above and 1" lateral.

Articular movement in the paraphysiological zone: Joint Play

0cc to C1Rt. mastoid is lower: Lt. lat 0CC

PSIS has point tenderness medial to it: Anterior sacrum

Segmental lateral fixation in Lumbars: Intertransverse muscle

Bilateral mm spasm L5 and IA diped in: Spondylolisthesis

Figure 8 motion while walking: SI joints

ant. pelvic tilt (hyperlordosis): weak hamstrings and lower abdominal mm weak

Wedges to correct Rt. PI, put inferior support under:	Rt. acetabulum (SOT)
Anterior sacral base:	Contact lateral sacral base.
M.C. cause of low back injury:	faulty lifting
Bilat. spasm of rectus capitus posticus muscle:	Extention 0CC
Thrust most injurous to lumbar disc:	Long lever rotation
Bilat. cervical break used for:	Cervical hyperlordosis
M.C. cause of meralgia paresthetica:	long distant running (Lat. Fern. Cut. nerve)
25y.o. male, boring unilateral headache, runny eyes and nose:	Cluster
Knife edge:	To correct extension
L3 Spinous Lt. wl Rt. Body rotation contact:	Rt. mamillary of L3
C.P. for L4 in Lt. lat. flexion, Rt. spinous Rotation:	Rt. side of spinous
Strengthen vastus rnedialis:	with any knee injury
Least specific adjustment:	Master Cervical
Static palpation, there is svere tenderness over the spinous, and with percussion extreme pain:	FRACTURE
6Oy.o. Headache assoc. w/ polymyalgia meretica:	Temporal Arteritis
25 y.o. female, scoliotic deviation toward low side of sacrum, no vertebral body rotation, normal disc spacing and IVD space:	Adjust SI joint
To decrease heart disease, in addition to diet therapy,:	Increase serum triglycerides
To manage joint play:	full ROM performed passively
Upper SI fixaton, pt. prone, hand superior to PSIS;	LOC= Lat. and caudal while other hand contacts the sacrum on the same side.
Talus least likely to niisalign:	Posterior
Rotation subluxation of proximal redial/ulnar joint. Your SCP=	Post. lat. aspect of radial head
Ant. lunate:	M.C. in carpal tunnel
Rt. lateral flexion of lumbar spine causes quadratus lumborum to contract:	Essentrically on Lt. and spinous to rotate toward the concavity
Lumbar hyperlordosis:	Short hip flexors
Lovett +:	most likely to be assymptomatic
Motion palpation	can't be used to determine phases of degeneration.
SCP to correct Occiput in Lateral flexion:	Mastoid process
Lt. posterior rotated occiput while seated, patients head is laterally flexed to the left and rotated to the right,	
Seated cervical rotary C.P.:	Middle finger

Crossed thumb transverse technique used to compensate for: Small skeletal structure of children

Nutrition for treatment of intermittant claudication: Vit. E

Regular pillow while supine: flexion in cervical spine

Chronic cervical pain: use most conservative care

Dr. on Lt./ Pt. prone/ thenar contact on Rt. side w/ the head rotated what are you correcting: Occiput

Bilateral multifidy contraction: Don't rotate

ADI: F/E Lat.

Advanced PA: C1C2 rotary break contraindicated

Bilateral thenar contact of occiput: Posterior atlanto occipital jamming

Degenerative skin changes near site of lesion: Disturbed trophic function.

SI not characteristic: Nerve root compresionl absent achilles reflex. THERE ARE NO NERVE ROOTS AT THE SI

Central spinal stenosis of lumbar spine presents with: flexion

T.P. of atlas: inferior and anterior to occiput

Complete blockage w/ no springy end feel: Articular

Best position for disc: supine w/ pillow below knees (knees flexed)

Cauda equina syndrome is a surgical emergency

Medial disc lesion: Lean toward side of lesion to get out of pain. Irritated by well leg raiser and Firesteins

Lidners: aggrivates a lateral disc lesion antalgia lean away from the side of lesion

Scoliosis visceral compromise: 5Odegrees or more

Traction: don't use with protective spasm

Lovett +: Rt. rotaory scoiosis

Thomas test: if +, do psoas stretch

Patellofemoral: M.C. joint to mess up in the knee

M.C. cause of pain while going down stairs

M.C. jt to degenerate

Rt. Spinous rotation, rt. lat. flexion: Contact Lt. mainillaiy and CCW torque

Adjust pt. w/ lumbar disc prolapse could result in: Cauda equina syndrome

Occiput contact mastoid for lateral flexion contact rim of occiput (mastoid groove) for rotation fixation

Lumbar: a compensatory or secondary curve

T.I.A.: regression of symptoms Win 12-24 hours

Motor ataxia: cerebellum: tandem walk, heel to shin, finger to nose

Sensory ataxia:		Posterior columns
Lhermittes sign:		if +Multiple Sclerosis
Cafeaulait spots:		Neurofibromatosis
m.c. directon for coccyx to subluxate:		Anterior
To palpate the medial side of foot (talus):		Eversion (pronation)
Sacral apex to left= Right inferior (sacral base) draw it out to understand		
Dermatome's:	Ingunial ligament:	T12
	Dorsum of big toe:	L5
	Medial big toe:	L4
	Lateral big toe:	L5
	Plantar big toe:	Si
Nutrient utilized by cigarette smoking:		Vit. C
SI pain in inferior aspect:		AS
	Hyoid bone=	C3
	Thyroid	C4/5
	Cricoid=	C6
Unable to nod:		adjust 0cc/Cl
Abberant motion:		one vertebra
Meralgia paresthetica		(AKA ant. sciatic): Lateral femoral cutaneous nerve
Double thumb contact:		Thoracics in children
AP Thrust w/ inf. LOC:		flexion extension disrelationship (Anterior thoracics)
Hyperextended and ratated:		most havic for cervical spine
Knife edge ulnar contact corrects:		Extension
Lt. torsion injury hurts when turn(rotate):		Don't do a lumbar roll
Adjust your amplitude(depth) w/ elderly patients.		
Tech to aggrivate acute L4/L5 Posterior/lateral disc protrusion:		
Side posture w/ protruded side down		
Chronic lumbar facet problem. Most likely movement to hurt it further:		Extension
Spinous to convexity on it.:		contact the spinous on the lt.
Chronic subluxation of T59:		effects digestion
Myositis Ossifican's:		ossification of mm following injury
Lat. epicondylitis:	M.C. mm effected:	extensor carpi radialis brevis
Side posture specific=		Toggle recoil
Pottinger saucer deformity:		dip in spinouses AKA ant. thoracics

Practices 808

Patient wl diverticulitis: don't eat rasbemes

Most accurate indicator of chronic nerve root injury: Hyporeflexia

Loss ofjt. play: mobilize
Loss of ft. stability: stabilize

10mm short leg on Lt: P1 on Lt.; have LEFT scoliosis and LEFT lumbar body rotation.

AKA Lovett + 1 Rotatory scoliosis

Most specific LOC for subluxation at T3/ pt. prone: PA/SI

With anterior movement of the occiput, the distance between Cl transverse and the mandible on the same side: increases

Lateral plumb line normally passes 1"2" anterior to lat. malleolus

Hyperfiexion / hyperextension injury: Whiplash

Supraspinatus nun atrophy: nerve lesion midcervicals

Segmental contact point w/ diversified listings: Laminapedical junction

Supine lumbar traction: low back pain caused by jamming of facets.

Flexion-extension 50 % and 0cc/Cl, than C5/6 otherwise all other cervical are equal.

DJD of hip: strengthen extensors

Plantar flexion helps palpate: Talus

Thoracic kyphosis: due to vertebral body shape

Acute facet syndrome: Ice and bed rest

Covered thumb tech. used to adjust: Hyperflexibility of the rib cage

Myofacial leg pain: characterized by superficial and lancinating.
Spinous has increased distance from the one above and is closer to the one below: Extension

Extended ilium: Post in!'. and medial

Dynamic adjustment to lower lumbars w/ disc prolapse may result in: Cauda Equina Syndrome

Restricted neck flexion indicated fixaton at which segment:
A. Cl2 B. C23 C. C45 D. ClTi 0cc/Cl not a choice. C5/6 not a choice. Than pick multiple levels!

Motion at Occ/Cl/C2: 0cc. and Cl rotate as a unit for the first 45 degrees, that C2.

What measures detrimental effects of scoliosis: Spirometer (visceral compromise)

Wallenburg syndrome (post. inf. Cerebellar Art.):

Most likely to develop after a hyperextension adjustment.

Adductor magnus origin palpable at: Syphysis pubis

Least mobile segment on lat. bending in erect posture: L5S1

Muscle that rotates the atlas and turns the face toward the same side: Splemous capitus and inf. oblique

Practices 808

Palpate for FIE of SI joints: best done standing

Don't adjust a joint w/ infection.

Unlevel pelvic dimples: Pelvic obliquity

M.C. patellar disllocation creating quad. tension:

Lateral (stretches rec. medialis.)

Glut. med= abductors Trendelenburg

Lt. lat flexion/ Rt. body rotation Rt. post. superior transverse process

Sacral base anterior: SCP=Apex (look at diagram)

Gonstead uses spinouses as reference point.

Bilat. heel lifts or sole lifts are contraindicated for: Lumbar sprain

Sole lifts given for: Ant. pelvic tilt/ Hyperlordisisi and Bastrop's Dz.

Rt. spinous rot. and lt. lat. flexion: SCP= rt. side of spinous, on right

Cl move lateral and superior on same side.

Spinous pt of reference listing wilt. lat flexion and lt. body rotatoin= Rt. posterior superior spinous

IVD:is at the lower aspect of the 1W in the lumbar spine.

Rt. scapula: refered pain from T4.

Absence of disc at 0cc/Cl:
predisposes it to subluxation

Hilton Law: supply's everything

Dynamic intersegmental: Kinetic

T4 by itself= Gall Bladder

Peptic ulcer: T5lO

Deformed IVD compression: CREEP

Permanent nerve damage: Axoplasmic abberation

Lushka jt's. primary fxn: lat. flexion of cervical spine

Bradycardia from upper cervical: +ofvagal sympathetic??????

General adaptation syndrome: Alarm, Resistance, Exhaustion

Hypolordosis puts more stress on: C5/6

SI pubic sym. fixation puts more biomechanical stress on L5.

LOC= IS and Facets

L5 rt. body rotation and Rt. lat. flexion, with a rt. scoliosis: Contact RI. mamillary wl CCW torque

ASIS & PSIS all line up in same coronal plane from lateral.

Practices 808

Ribs:	Bucket handle
Body listing:	Rt. rotation and Rt. lat. flexion
Bastrop's Dz:	Kissing spinouses
Gluteus medius:	Provides lateral stability to posture
Hypertension taking diuretics:	Need to take K+ also.
TF fibers w/ spongy end feel:	muscluar
"hard end feel in all directions:	Articular
of of one direction:	Ligamentous
Thermography	should be a qualitative not a quantitative measure for clinical evaluation.
Rt. head tilt, have Left 0cc listing	
Mill's test:	used to treat adhesions of the common extensor tendons (Lat. epicondylitis)
Splenius capitus:	from 0cc to thoracics
Terminal Point talble=	Thompson table
Lumbar spine has	triangular shaped canal.
Hairy patch over lumbar spinous before you afdjust,	consider bony malformations.
MASTER CERVICAL:	Hyperlordotic move for cervicals.
M.c. cause of spondylolisthesis:	1. trauma 2. Bilateral?