Assessable Warm-ups ©2024

Key Movement Concepts & Goals:

- Create a safe and effective training session and environment.
- The 1st few moments in a training session should provide #irreplaceable value.
- Remove client fear of evaluation. Hide the assessable movements into the warm-up.
    - Cover assessable movements associated with major societal postural distortion.
    - If you completed an intake, attempt to individualize the movements based on goals or perceived restrictions.
- Prepare the client for the workout ahead, while individualizing based on the assessable exercises.
- All movements are a combination of tissue extensibility and joint stability (i.e. mobility). Some skew one way or the other.

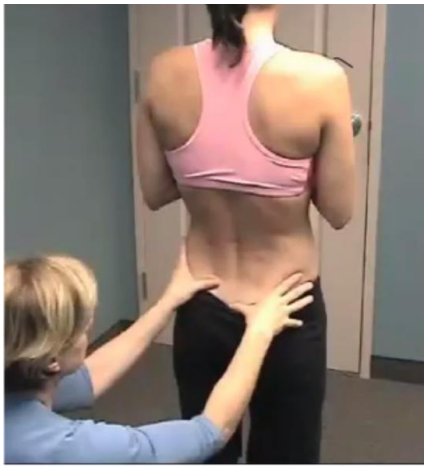
Rx:

- Most 1st sessions should be fullbody
    - Block 1 (Mobility). Focus on ROM & include 2-3 upper and lower dominant movements; 2-3 Check Points, which can double as movements or stand alone.
        - After completing the mobility section, Check In[in] for improvements.
        - **C[Ins] identify if the NS likes or dislikes the previous movements**
    - Block 2 (Specific Stability). Moderate load movements designed to stabilize main movement patterns. Use multivector foundation movements???
    - Perform remaining Check Pts during day 2 training session.

Mobility Check Points & Warm-up Sequence (choose 2 or 3 assessments)	
Upper (1-2 sec pause at end ROM) 1. Check Pt: Tall Kneel Back Scratch 2. Check Pt: Prone Y Arm Lift - Opposite Arm & Leg Lifts (x6/si) 3. Check Pt: Side Lying Active Spinal Rotation (x6/si) - Bretzel 1 – Shoulder Rolls (x8/si) - Tall Kneel Back Scratch (x6/si: no pain only) - All Fours Wrist Pull Apart (x6/si) C[in]: Tall Kneel Back Scratch (improved?) ++++ Day 2++++ 4. Check Pt: Tall Kneel Side Bend (x6/si) 5 Check Pt: Kneeling Side Plank - Side Bending Child's Pose 10 & 2 (x4/si) - Kneeling Side Plank w Clam (x6/si) C[in]: Side Bend (improved?)	**Lower (1-2 sec pause at end ROM)** 1. Check Pt: Active Knee to Chest (K2C) 2. Check Pt: Straight Leg Raise (SLR) - Alternating Knee to Chest Grabs (x6/si) - Supine Core Pullover Straight Leg Raise or Dead Bug (x6/si) - Side Lying Reach & Rotate (x6/si) C[in]: K2C or SLR (improved?) ++++ Day 2++++ 3. Check Pt: Ankle Mobility (x8/si) 4. Check Pt: Hands on Hip Squat (x4/angle) - Rear Foot Banded Staggered Squat (x8/si) C[in]: Squat or Ankle (improved?)

Fullbody Screen & Correctives

Hands on Hips Squat (Fullbody Stability & Mobility



Viewpoints: Posterior & Lateral
Camera ideally at hip height such that ankles – hands can be viewed

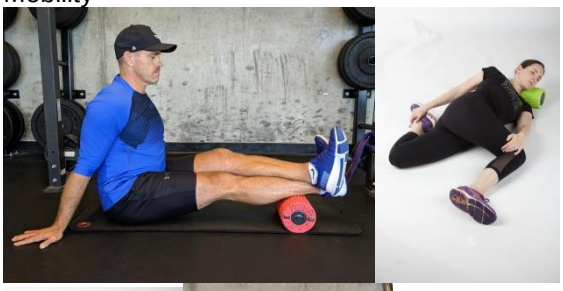
Key Execution Points:
1. Slide hands down side of torso, placing flat hands on the iliac crest
2. Fingers facing fwd, w thumbs warpped around the back of sitting on the ilium (posterior view), flat (lateral view), index finger on ASIS anterior view.
3. 2 to 3 squats per view
4. Ask client to look down at hands & report if they are rotated fwd L or R

Ideal Outcome: torso & tibia angle parallel; thighs parallel to floor without major indications

Posterior Indications:
1. Ankles / Ft: turning out, medial malleolus rotating inwards
2. LPHC / hips: shifting R or L, Hands tilting up R or L, Hands rotating forward L or R

Lateral Indications:
1. LPHC / hips: Excessive forward lean, spinal postures flexed or extended

Corrective Mobility:
Calves (See Ankle Mobility)
Bretzel (See
Rear Ft Banded Squat or Kickstand Ankle Mobility



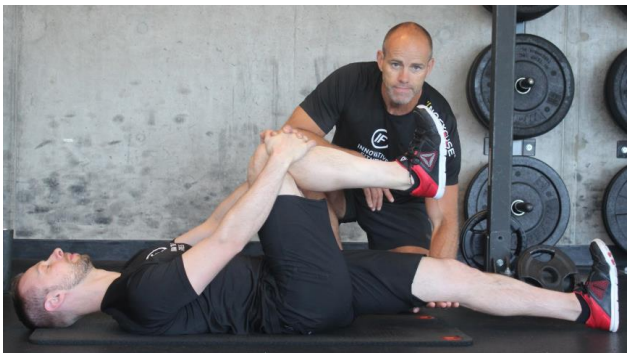


Lower Dominant Screens

&

Correctives

Active Knee to Chest (Hip Flexor Complex)



Viewpoints:

1. Lateral

Execution Key Points:

1. Elevation of the straight leg thigh / bent knee
2. Straight leg externally rotates
3. NB* if 1 leg elevates more than other – that hip flexor complex is the priority

(Part 2: TFL vs Psoas) Sit upright w legs straight and toes pointing towards sky (ad block under hips when this position can't be obtained (see demo)…
- ask client maintain a neutral spine while lifting the straight leg as high as possible.
- ask client if the movement was felt in the thigh or top of hip (i.e. TFL)
- If client flexes upper back to create movement and back of thigh was elevated during part 1, assume an overactive psoas

Indications:

a. Asymmetry in R L ROM
b. Leg/ft externally rotates (view 2)

Level 0 – Pain
Level 1 – Thigh less than perpendicular to torso
Level 2 – Thigh / front of knee btwn navel and sternal notch below xiphoid process
Level 3 – Thigh / front or knee above your xiphoid process

Corrective Mobility:

- MFC TFL Scrub
- MFC High Thigh & Psoas Pin & Move
- Knee to Chest Pulls w Assistance (band)
- Cook Hip Lift
- Standing Wall March or Mountain Climbers

Active Straight Leg Raise - SLR (Pelvic Stability & Lower Mobility)



Viewpoints:

1. Lateral
2. Head to Camera

Execution Key Points:
(Part 1):Client is back lying w legs straight
-Instruct to keep down leg straight (neutral) w toes pointing towards ceiling
-Client lifts other leg straight towards same side shoulder without lifting head or twisting foot

(Part 2)Tighten abs (see demo and reassess)…if difference (see corrective mobility: Pelvic Stability)

Indications:

- Pain in low back or buttock
- ROM > client heel below knee
- Asymmetry in R L ROM
- Pelvic stability (change in lumbar arch)
- Leg/ft externally rotates (view 2)

Corrective Mobility: 2x more on indicated side
Asymmetry

1. MFC: bottom of ft, Short Head of Hamstring & or Glute External Rotators, Biceps Femoris, TFL, TLF
1. Mobility: Band Pullover Straight Leg Lower
2. Strengthen: Dead Bug, McGill “the Curl Up”, 2ft Wide or Cook Hip Lift Bridge, L-sit Straight Leg Raise

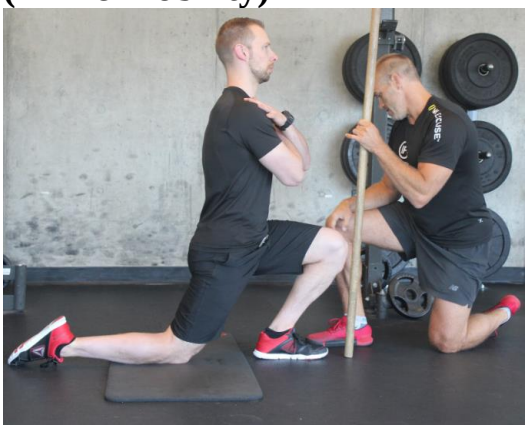






Ankle Checks & Notes

Split Kneel / Kickstand (Ankle Mobility)





Viewpoints: Lateral

Key Execution Points:
Begin in the tall kneeling in a hip width kickstand position (i.e. Back knee in line w front ankle / medial malleolus)

Ideal Outcome: knee 6 inches or 15 cm beyond the 2nd and 3rd toe

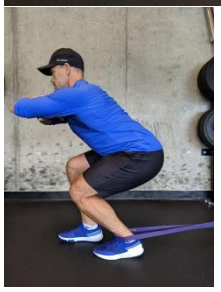
Indications:

- Patellar or heel pain
- ROM from 2nd & 3rd toe to dowel or knee cap not beyond medial ankle bone
- Asymmetric ROM to dowel (>1 inch)

Corrective Mobility:

1. MFC: calves, achilles, opposite hip flexor (as shown). Move knee inside or outside dowel.
2. Mobility: band tall kneel posterior glide w TFL stretch & or staggered squat
2. Strengthen: activate tib. anterior via dorsiflexion





Upper Dominant Screens

&

Correctives

Prone Y Straight Arm Lift



Viewpoints: Head to Toe (as shown). Camera hip height or above

Ideal Outcome: without major compensation, both wrist 12” off the floor, biceps equidistant from ears & straights

Key Execution & Set-up Points:

- Can use a dowel (90° on top of head) or arms only (approx. same width)
- Feet pointed and remain on floor
- Place & keep forehead on rolled up towel (goal a neutral head posture)
- Lift arms as high possible & hold for measurement or screenshot

Indications:

- Pinky or Dowel < 6 inches off floor
- Dowel shifts to 1 side (1 bicep closer to ear)
- Dowel Rotates or 1 hand higher than other)
- Elbow(s) bent (pec minor or lats)
- Shoulders elevated (upper traps)

Corrective Mobility: P2P

- MFC Scrub: Traps
- MFC Pin & Move: Lats
- Wide Armed Child’s Pose OR
- Suspension Trainer Hinge Hang
- Test Dowel Lifts & Dislocations
- Ft Elevated Overhead Pressing

Active Spinal Rotation (ASR)




Viewpoints: head or feet to camera

Camera ideally at hip height or lower

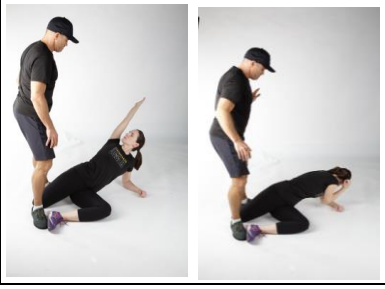
Key Execution Points:
1. Ideally head supported base of skull w a rolled up towel or foam roller
Knees bent to 90' and bottom of ft in line w glutes
2. Palm on palm w straight arms at chest level
3. keep bottom arm on and knees on floor while rotating top arm and head to opposite side.

Ideal Outcome: without major compensation, the rotating arm & both shoulders on the floor for both sides.

Indications:
- Pinching / pain in low back
- Wrist >9" off floor
- Asymmetrical test result
- Humeral head anterior
- Hand below shoulder level
- Non neurtral thorax (shifted)
- Low back arched
- Excessive rotation of pelvis

Corrective Mobility:

1. MFC **– Scrub** pec major / minor, biceps, TLF
2. Assisted Mobility Doorway Chest Stretch; FR Angel Sweeps,
3. Resisted Mobility: Banded Si2Si Knee Drops; Rib Grab Bretzel; Prone Angels
4. Integrated: Straight Arm Horizontal Pulls

Kneeling Back Scratch (Shoulder Mobility)



Viewpoints:
Side & Posterior

Key Execution Points:
1. Tall (if knees are an issue) or Seated Kneeling
2. Place Arms in T position with clinched fist
3. Using 1 clean movement, neutral spine & head, reach & bend 1 arm under and other over, attempting to touch them behind the back

Ideal Outcomes:
TOP HAND: below or in line with spine of scapula
BOTTOM HAND: above or in line with Inf. border of scap

Posterior Indications:
- Relative distance from anatomical areas indicated above
Top Hand: Pec major/ minor, Subscapularis, Lats, Teres Major, Triceps, Serratus anterior
Bottom Hand: Pec minor, Infraspinatus, Teres minor, Supraspinatus

Lateral Indications:
Top Hand: Upper arm not vertical, forward of ear
Bottom Hand: Upper arm not vertical (infraspinatus), shoulder forward (Pec major/ minor)

Corrective Mobility:
1. MFC Top: triceps, lats
2. MFC Bottom: pecs, post shoulder
3. Mobility: Bretzel, Split Kneel Bow & Arrow, Up Dog
4. Strengthen: Rhomboids, low trap



Tall Kneeling Side Bend (Lateral Line Mobility)

2. Chin Flex & Extend
3. Half Kneeling Side Bend



Viewpoints: Front

Key Execution Points:

1. Create fist, extended hips, no rotation
2. NB* direction of rotation, degree of hip shift, distance of knuckles from floor

Ideal Outcome: Symmetrical & approx. 2 inches from floor

Indications:

- Fist > 6” from floor
- Asymmetrical ROM from floor
- Asymmetrical lateral curve
- Torso rotation vs lateral flexion

Corrective Mobility:

1. MFC: opposite side to restriction (low lats and QL)
2. Mobility: Child’s Pose to 10 or 2, Band half kneel assisted side bend, Boomerang
3. Strengthen: strengthen same side QL and lats (Ipsi lat pulldown & side bend, SB wall side sit-up







Active Spinal Rotation (ASR)



Viewpoints: head or feet to camera

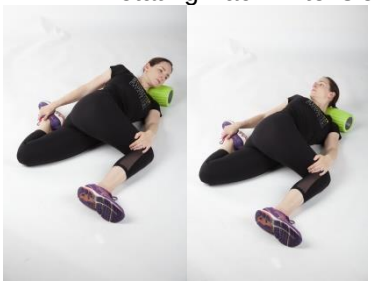
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Key Execution Points:
1. Ideally head supported base of skull w a rolled up towel or foam roller
Knees bent to 90' and bottom of ft in line w glutes
2. Palm on palm w straight arms at chest level
3. keep bottom arm on and knees on floor while rotating top arm and head to opposite side.

Ideal Outcome: without major compensation, the rotating arm & both shoulders on the floor for both sides.

Indications:
- Asymmetrical test result
- Non neurtral thorax or shoulder
- Plane change in test arm (pecs)
- Low back arched
- Excessive rotation of pelvis

Corrective Mobility:
1. MFC – pec major / minor, biceps, traps, opposite side TFL
2. Mobiltiy: Rib Grab Bretzel
3. Reach & Rotate
4. Strengthen: Side to Side Knee Drops, Rotating Back Extension





Side Plank (R): Shoulder & Scapulothoracic Stability

- Low function: knee bent 90°



- High function: legs straight



Viewpoints: rear to camera or assessor (side lying). Camera ideally at hip height or lower

Key Execution & Set-up Points:

- Feet & hips stacked
- Elbow directly below shoulder
- Top hand on top hip
- Hips fully extended
- Ask client to side lie with feet stacked and in a straight line with elbow
- Ask client to lift hips as high as possible & until straight

Ideal Outcome: straight line from earlobe to knee or ankle; scapula flat on thorax.

Indications:

- Glute med weak on myoneural test
- Prisoner weak on myoneural test
- Scapula winging
- Lateral neck muscles overactive
- Hip drop / shift
- Hip rotation
- Fatigues quickly

Corrective Mobility: P2P

- Boomerang or Banded Half Kneel Side Bend Reach
- SB Side Sit-ups
- Kneeling Side Plank
- Suspension Trainer or Floor Hip Drops