Spinal Reflex Analysis: Reach for the pivotal point in physical medicine...
A Letter from the Founder and President of Spinal Reflex Institute, International

I experienced recurrent low back stiffness and pain from the age of sixteen. As a cross country runner, sciatic pain would plague me repeatedly with the worst episode lasting well over a year and a half. Massage, chiropractic, and medical treatment were unsuccessful for years and the threat of spinal fusion loomed as a final option to manage the chronic pain.

After twenty-five years of various therapies, it was the use of Spinal Reflex Analysis procedures that eliminated the pain... completely!

The use of SRA in Massage, Chiropractic, and Exercise Therapy has profoundly changed my personal health and allowed me to run once again. I am more flexible, and I can run farther and faster than at any point in my life, regardless of underlying lumbar asymmetrical facet tropism, degenerative osteoarthritis, severe disc narrowing, herniation, and spinal stenosis without the pain and restrictions imposed by those conditions.

Today, the demand for effective soft tissue protocols in Medical Massage and Physical Therapy is growing rapidly, enhanced effectiveness of Chiropractic and Osteopathic manipulative procedures is expected, improved muscle balance, performance, and recovery in Physical Therapy and Sports Medicine is sought after. Accurate physical diagnostics and non-pharmaceutical options in Medicine is publicly supported. Faster and more effective post surgical recovery and improved joint function in Orthopedics and viable “soft wiring” differential diagnostics in Neurology are needed. These are all benefits derived from SRA protocols.

Based on extensive European and American research, the discovery and development of Spinal Reflex Analysis through eleven years of intensive clinical application, evolved into the material available to you today. Material that offers solutions to all fields in physical medicine.

I utilize SRA protocols in my practice 100% of the time. My case outcomes are significantly more successful, and my practice has grown because of it.

Dr. Frank Jarrell
Professional Benefits
Consistent and reproducible inter professional protocols are necessary for evaluation, management, and predictable outcome in physical medicine. Palpation, range of motion, muscle strength, physical and orthopedic testing, X-rays, MRI’s, and CT scans are often site specific and rarely encompass the dynamic relationship between neurology, joint physiology, soft tissue function, and biomechanics. SRA based evaluation and management procedures are concise, reproducible, and highly effective in the evaluation and integration of complex neuro-musculo-skeletal treatment programs. Spinal Reflex Analysis protocols are as predictable as the knee-jerk reflex and the clinical and performance benefits are live tested and substantial. SRA is a “must do” for any form of health care and performance enhancement based in physical medicine.

Public Benefits
SRA is readily explained both in theory and in clinical practicality. SRA subjective and objective information inherently matches the symptom profile and is readily supported by the physical findings. SRA based ergonomics, strengthening and stabilization of intrinsic/core muscles supplement the therapeutic portion of an SRA program of treatment, recovery, and performance enhancement. Net outcome includes consistent reduction in pain, improved mobility, balanced musculature, and structural decompression.

Preliminary Sports Enhancement data is encouraging
Baseline ROM’s for hip flexion, hip extension, knee flexion and vertical jump was established for 14 healthy athletes through the Fort Lewis Athletic Department. SRA based AP Therapy was administered over 3 sessions with pre and post markers recorded for each session. Average ROM increases are between 25% and 41% for hip flexion, 7% for knee flexion and 4% for vertical jump. Ranges are from 7% to 105% net increase in ROM. Although preliminary data on this study is early, the trend and overall improvement is consistent with clinical observation in symptomatic patients. The study is being performed by Dr. Frank Jarrell, Robert Culver, MES, NCMT and Dana Osorno, NCMT.

C3 ASR implicated in knee dysfunction
C3 axial spinal reflex activity is implicated in aberrant soft tissue function and biomechanics of the knee. Reflexive psoas contracture reduces net hip extension and compromises L4 neurology resulting in knee extensor hypertonicity (medial aspect), patellar tracking errors, and restricted overall knee flexion.

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Spinal Reflex Analysis is:

Spinal reflexes exercise influence over primary (axial) and secondary (peripheral) soft tissue tone, contraction and function. Prolonged axial spinal reflexes (ASR) lead to soft tissue myofascial syndromes, fibrosis, joint compression, and osteoarthritis (Fassbinder). “The primary functionally abnormal position of a vertebral unit followed by myotendinotic changes represents the primary spondylogenic reflex syndrome.” (Dvorak and Dvorak)

Early works by Sutter, Wyke, Maigne, Travell, Rinzler, Schmerl, Jurghanns and others illustrate the neuro-physiology of the spinal reflex. Sutter’s original work is based on EMG studies of axial soft tissue contractions in response to vertebral facet joint injection of a noxious compound. His, and other original studies, albeit informative of this mechanism, did not evolve into functional clinical application. The spinal reflex syndrome has largely gone unnoticed some 25 years later. Until now, identifying the predominant spinal reflex in a clinical setting and utilizing effective treatment protocols were absent in their entirety.

Dr. Loyd F. Jarrell researched, designed and developed clinical protocols for the rapid and specific identification of the involved spinal segment and further developed soft tissue and hard tissue treatment procedures to arrest the spinal reflex syndrome and enhance physical health and sports performance.

SRA is a Powerful System for the Medical Massage Therapist

SRA is an effective means of evaluation and management of axial spinal reflex syndromes and their reactions. Spinal Reflex Analysis addresses the most prevalent source of neuro-musculo-skeletal pain and dysfunction encountered in current clinical settings.

You can learn to apply basic and advanced SRA skills through Spinal Reflex Institute International continuing professional education courses.

SRA identifies the driver behind most soft tissue dysfunction in the human body.

Case Study:

Patient: 63 year old female, highly active in skiing, biking, tennis, and other outdoor activities. Client suffered a meniscus tear in the right knee as a result of a collision with another skier two years prior. Client had subsequent arthroscopic repair of medial meniscus and partial removal and repair of the lateral meniscus.

Initially, she was in therapy with some success focusing on exercises to rebuild hip and leg musculature. Her current therapist is addressing long-term muscular imbalances in the lower extremities.

Presentation: Prior to skiing: slight limp with a hesitation to weight the leg and continuous low-grade pain while climbing stairs. Post-skiing: stiffness and decreased ROM leading to increased pain with activity and climbing steps. ROM in flexion was fifteen degrees less than the left knee. Knee pain was sufficient enough to affect sleep.

CC’s post skiing lasted for 3-5 days.

SRA Evaluation: Spinal reflex at C3 Rt. with psoas compression of L4

Treatment: Client was treated after skiing. Treatment consisted of approximately twenty minutes of AP therapy for a C3 Rt. soft tissue pattern. Emphasis was placed on the ipsilateral side of reflex sartorius and tibialis anterior muscles. ROM post-treatment was equal to left knee without pain and restriction. Stair climbing and general motion was pain-free and the prior favoring of the right knee in ambulation was resolved. Prior sleep disruption from the knee condition for the two nights following treatment was resolved.

Recommendations: Continue to develop leg strength and right/left balance of musculature. Begin AP therapy 1-2 times weekly for 6 weeks to reduce underlying spinal reflex syndrome. Apply SRA Spinal Rehab. program.

Massage Therapy

Assessment, identification, and treatment of soft tissue contractures originating from the spinal reflex are emphasized. A working understanding of SRA as the primary cause of myofascial pain and dysfunction, prolonged muscle and ligament contractions, and muscle hypertonicity is provided through NCBTMB Certified seminar’s on SRA Attachment Point (AP) Therapy. SRA-AP Therapy can be complimented by other soft tissue techniques without compromising the effectiveness of SRA procedures.
Critical differential assessment will help the therapist avoid the common trap found in physical medicine of fixating on the point of pain and direct the therapist instead, toward recognition of the cascading soft tissue reactions originating from the axial spinal reflex syndrome.

Physical therapy directed by, and applied according to, the SRA spinal segment is an extremely accurate and highly effective strategy for reducing and managing the pathophysiology underlying many common and obscure biomechanical conditions.

SRA based assessment protocols allow for efficient management of traumatic and non-traumatic rotator cuff and knee conditions, knee and shoulder post surgical recovery and management, various factors in restricted joint range of motion, post sports and trauma recovery, impairment reduction for enhanced athletic performance, life style enhancement, and core strengthening.

Case Study:

Patient: 56 year old male with a 5 year history of bilateral rotator cuff syndrome diagnosed as frozen shoulder. Initial 12 weeks of PT and Cortisone injections with mild improvement followed by complete relapse within 4 weeks. CC was aggravated by driving trucks and lifting activities.

Presentation: Rt.>Lt. restricted shoulder ROM in all directions with persistent low-grade ache and pain. Elevation was restricted to 85’ Rt. and 110’ Lt. with full recruitment of ascending traps. Active and passive ROM were equal.

SRA Evaluation: Compound C4 and C1 bilateral reflexes inducing a secondary L5 spinal reflex with a net soft tissue contracture pattern of bilateral latissimus dorsi, levator scapula, and descending trapezius fibers. Combined contractures resulted in a full “lock down” of the scapulas bilaterally.

Treatment: SRA based Attachment Point therapy per involved reflexes netted an elevation increase of 45+ degrees in the Rt. and a 60+ degree increase in left ROM on the first treatment. Two follow-up treatments netted shoulder ROM function to within 5% of normal Rt. and full ROM Lt. Spinal intrinsic exercises, home stretches, and ergonomic education was prescribed.

Recommendations: Maintain intrinsic muscle strength through home therapeutic exercise and pursue AP Therapy on a PRN basis (currently 1x per 6-12 weeks).

SRA is the only evaluation and management system available to you to effectively treat the spinal reflex mechanism!
Chiropractic

Spinal Reflex Analysis is core to the Chiropractic profession; whereas a working knowledge of clinical neurology, clinical presentation, and any one of numerous spinal manipulation / adjusting techniques places chiropractic in a favorable position to effectively treat the spinal reflex syndrome. The procedural benefit is found in rapid identification and efficient treatment. Direct and indirect neurological assist is noted with often profound reduction in symptoms and improved biomechanical function. Further case management is achieved through SRA training in ergonomics and postural re-education, nutrition and dietary strategies, and stress reduction. SRA based medical massage and physical therapy now become effective adjuncts to the spinal adjustment.

Case Study:

**Patient:** 20 year old female complains of LBP from dance and theater related activities. Onset 3 months, no prior or current history of spinal trauma, familiar conditions or pathology. Related orthopedics were essentially negative.

**SRA Evaluation:** T7 Lt. with 1/2 inch FLLD. Lumbar plain film studies were unremarkable with no evidence of pathology or biomechanical alterations.

**Treatment:** CMT for T7 Lt. SRA pattern with prescribed postural education and therapeutic exercise. CC was resolved within 6 weeks. *Patient returned 3 months later post MVA* as a passenger in a motor vehicle that sustained a same side impact at 35 m.p.h.. Presenting symptoms included relapse of LBP in addition to acute mid-cervical spine pain and spasms. Whiplash induced SRA findings included C3/C4 per plain film studies revealing excessive segmental translation in flexion and extension. Acute post MVA scoliosis per cervical spinal reflex pattern was noted per reflexive soft tissue contraction. Noted resolution within 90 days utilizing SRA based CMT and rehabilitative exercises.

**Recommendations:** CMT prn to prevent aberrant spinal biomechanics and home exercises to maintain ligamentous integrity.

Chiropractic CMT is Directly Supported by SRA Procedures

SRA and chiropractic are naturally linked in that the primary spinal reflex is synonymous with the unstable spinal segment and constitutes the traditional definition of a “subluxated vertebra”. The subluxated vertebra is less than “luxated” in that it does not require immediate surgical intervention to stabilize. It does however, affect local and radicular neurology originating at the nerve root and sclerotomal based pain originating at the facet articulation.

Aberrant neurology secondary to spinal biomechanics precedes the majority of soft tissue reactions ranging from hypertonicity to myofascial pain and dysfunction. Soft tissue is pain fiber, or nocioceptively rich and constitutes the greater portion of a pain complex. Chiropractic care is at the heart of a neurologically based diagnostic protocol and SRA further clarifies the science behind the clinical application of chiropractic care. SRA protocols for the application of CMT (chiropractic manipulative therapy) is a powerful tool that significantly ramps up accuracy and efficacy in virtually all chiropractic cases. Cross professional utilization of complimentary SRA procedures in Massage and Physical Therapy are proven effective adjuncts to the strong neurological base that constitutes the profession. Further complementation through SRA Nutritional protocols provide a health oriented long term benefit to the chiropractic patient.
Medical Diagnostics and OMT Procedures

SRA procedures for medicine allows for enhanced accuracy in assessing neuro-musculo-skeletal status and its’ relationship to presenting symptoms. Differential diagnostics take on new meaning when the spinal reflex mechanism is identified and appropriate therapies are emphasized as adjuncts to, or alternates for, pharmacological options with safe and effective long term benefit. Anti-inflammatory diets and physical fitness procedures for spinal strength and stability are included. Effective referral pathways are emphasized for maximum improvement.

SRA based early detection and intervention of progressive osteoarthritis, neuralgia, neuritis, motor weakness, and visceral compromise allows for increased prevention of progression to surgical status. Viable OMT protocols are presented with clear relations to sympathetic/parasympathetic tonal affects and reduced visceral and hormonal impairment.

Case Study:

Patient: 47 year old male with chronic progressive cough and episodic esophageal spasms, difficulty swallowing, and respiratory constriction when supine at night leading to acute hypoxia.

History: Mild GERD, extensive recurrent muscle and joint pain and spasms in the extremeties and cervical spine, chronic fatigue, multiple lumbar herniated disc and recent snowboarding related cervical spine whiplash.

Findings: Vitals WNL with noted sub-optimal temp. (97.4 oral). Thyroid, blood count, and endoscopic eval. of esophagus WNL less suspected incomplete closure of the cardiac sphinchter and possible secondary esophageal spasms.

Diagnosis: Possible acalasia and mild GERD. SRA Findings: C3/C4 ASR secondary to cervical hyperflexion sprain. T3 secondary ASR noted.

Discussion: GERD and acalasia would explain the esophageal spasms and difficulty swallowing. However, the coupling of lower base temp. and extensive musculoskeletal history may imply sub-clinical hypothyroidism aggrevated by cervical trauma, leading to global soft tissue hypertonicity.

Treatment: 6 mo. Armour thyroid, dietary changes, and SRA based cervical stabilization w/ CMT resulted in complete remission to three years follow-up evaluation.

Osteopathic

Spinal Reflex Analysis for Osteopathic Medicine provides a system of rapid assessment and identification of the primary involved spinal segment. Further emphasis on axial spinal reflex induced somato-somato and somato-visceral reflexes is provided as a bases for systems management. SRA strategies in spinal manipulation and soft tissue techniques are emphasized and correlated to the cranial-sacral model and integrated with sympathetic-parasympathetic management.
Neurology

SRA Neurological protocols effectively separate ‘hard-wired’ impinging syndromes from the more prevalent ‘soft-wired’ symptomology associated with myofascial, sclerotomal and myotomal sources. The spinal reflex is noted to be at the core of most ‘soft-wired,’ or referred and ill-defined pain syndromes and neatly fills in this void in pain management. SRA reduces the ambiguity associated with multiple concurrent sensory and motor compression syndromes and allows for improved differential diagnostics.

Case Study

Patient: 43 year old female with prior history of chronic fatigue moderately resolved and no significant trauma.

Presentation: Four months of visual blurring of unknown etiology. Prior diagnostics and treatment included evaluation by neurologist, neuro-opthamologist, ophthalmologist, internist, chiropractor, naturopath, acupuncturist, herbalist, massage therapist, and physical therapist. Tests include (unremarkable) brain MRI and blood workup. The response to treatment was marginal. Additional symptomology included bilateral elbow pain and ache, right wrist pain and binding, bilateral anterior thigh ache, bilateral knee pain, and frontal headaches.

SRA Evaluation: Revealed a C2 spinal reflex mechanism with secondary C5, T2, T5, L3, and S1 reactive segmental dysfunction. All muscle, ligament, and joint reactions noted per SRA patterns with direct correlation of sternal-clido-mastoid and trapezius myofascial referred headaches and visual blurring.

Treatment: CMT (chiropractic manipulative therapy) specific to SRA protocols was administered over two consecutive days with a complete remission in elbow, knee, and thigh symptoms, 85% reduction in headaches and visual blurring, third treatment after two day interlude 95% successful.

Recommendations: Continue SRA based CMT, heat myofascial muscle condition 1x/day for two plus weeks, increase anti-stress and anti-inflammatory dietary factors, actively modify posture and computer ergonomics. Implementation of SRA Therapeutic exercise program.

Spinal Reflexes: The Orthopedic Connection

Case Study

Patient: 45 year old female with history of 4 surgical procedures on the right knee dating from high school to 1996. Separate orthopedic evaluations in 2000 confirmed final option as total knee replacement. Patient declined and tolerated pain, locking, edema, and restricted ROM for three additional years.

Evaluation: Review prior records and recommendations. Noted right knee flexion at 81 degrees passive and 74 degrees active, Extension noted at -9 degrees.

SRA Findings: Sac/T6 SRA patterns were treated utilizing CMT and Attachment Point Therapy. Right knee ROM increased to 134 degrees passive and 131 degrees active before discomfort was noted and post activity edema was negligible after 5 treatments. Patient has resumed snowboarding and hiking and is retaining functional gains between treatments. Prolonged sitting triggers sacral ASR activity.

Recommendations: Continue SRA based protocols until MMI is achieved. Emphasize SRA based exercise therapy for self management.

The Post Surgical Benefits of SRA can be Profound

Orthopedic

Spinal Reflex Analysis protocols have shown clinically significant improvement in post surgical recoveries in ROM, pain and edema for elbow, shoulder, ankle, foot and spinal procedures. SRA protocols are presented to allow for pre and post surgical options in management and rapid recovery. Suggested therapeutic pathways are provided with clear and effective outcome based monitoring emphasized.
The SRA Sports Performance Specialist has an in depth commitment to mastering the SRA assessment and procedural standards used specifically in professional sports. The SRA - SPS portion is a highly sought certification standard reserved for select professionals who wish to work with professional athletes and performing arts programs through SRI International.

**Case Study**

**Client:** 28 year old male professional cyclist with persistant left medial and inferior subpatellar knee pain for two years. Prior impact injury to lower extremity with a diagnosis of tibia bone bruise. History of physical therapy and massage resulting in marginal improvement. Current procedures included taping the patella to modify tracking. No evidence of improvement noted.

**SRA Findings:** Sacral and C3/4 alternating compound spinal reflex pattern was noted. Hypertonicity and attachment tendonosis noted in the distal aspect of the sartorius and adductors. Secondary iliotibial band and psoas contractures evident on the left more than the right. Noted Lt.>Rt. hip extension no greater than 14 degrees passive on the Lt.

**Treatment:** AP Therapy coupled with CMT per SRA protocol resulted in immediate doubling of hip extension and negative knee pain under loading with intensive training on the same day.

**Recommendations:** Spinal stabilization to reduce spinal reflex induction of soft tissue impairment leading to aberrant tibial and patellar tracking. Evaluate and modify cycling ergonomics.

SRA is the only evaluation and management system available to effectively treat the axial spinal reflex mechanism.

**Sports Medicine and Performance**

Spinal Reflex Analysis for Sports Medicine places emphasis on the neurological aspect of strength and coordination. Research indicates that thirty-five plus percent of muscle strength, coordination and output is non-mass related. SRA training and strengthening programs reduce neurological impairment of maximum performance and enhance balance, coordination, and core motion. Combined increases in accuracy, strength, endurance, and net recovery are realized. Rapid recovery allows for greater intensity and frequency in training.
Spinal Reflex Analysis

SRA is a system of evaluation and treatment strategies designed to identify the most prevalent causative mechanism of physical pain and dysfunction: the spinal reflex (ASR).

SRA is the only clinically proven system for the identification and treatment of the spinal reflex syndrome. Whether caused by trauma, disease, or lifestyle, SRA procedures have proven invaluable in reducing acute and chronic pain, stiffness, discomfort, and poor performance.

Improvement is seen in a variety of conditions ranging from traditional aches and pain, unresponsive post surgical procedures, injury recovery, to notable gains in athletic performance.

SRA is the pivotal point in physical medicine. Ask your therapist or doctor today if they are using SRA procedures.

The Language of SRA

Patterns are formed in our tissues that reflect the current and historical status of our functional health... and we can read these patterns as a language. SRA is the language between the nervous system, the spine, and the soft tissue of the body.”

The Diagnosis and Treatment of Spinal Reflex Syndromes, Dr. Frank Jarrell

SRA is the tool to “turn off” spinal reflexes!

Each vertebra produces reflexive contractions in not just one muscle, but in many muscles and ligaments throughout the body. These spinal reflexes can be strong or weak, and will cause persistent spasms that lead to long term fatigue, ache, pain, stiffness, joint compression and subsequent wear (arthritis).

Spinal reflexes can be “turned on” and can “get stuck” when we are injured, stressed or affected by the many physical, chemical, and emotional challenges of modern life.

General aches and pain, acute and chronic muscle spasms, compensatory posture, scoliosis, myofascial pain, sclerotomal pain, chronic joint pain, rotator cuff and knee pain, poor recovery from knee and shoulder surgery, elbow and wrist pain, headaches, neck and back pain, stiffness and more... can be caused by or influenced by spinal reflex syndromes.

Reach for SRA... an ageless approach to a modern world!

“The SRA analysis and adjustment were by far the most thorough and comprehensive that I have experienced.” A. King

“The method you used in your Chiropractic workshop with regard to my “frozen shoulder” issue has had continued success thus far. I have retained what I would guess to be at least 97% of the virtually full range of motion you got me to during the session. Additionally, throughout Sunday and Monday following I did not experience any of the range of motion pain I had been experiencing on a regular daily basis for weeks in my work and leisure movements. It’s funny how it takes a while to dawn on you that “hey, I reached for that item and it didn’t hurt like it always does.” K. Burgess
SRA Certification and Training

There are three levels of SRA certification, each qualifying the practitioner for a distinct proficiency to deliver care within the scope of their profession through SRA therapeutic protocols.

Level I Basic certification qualifies a practitioner to perform fundamental identification for specific treatment of simple spinal reflex patterns, SRA case management basics, and essential inter-professional referral protocols.

Client/Patient conditions best served by this level are general musculo-skeletal pain and discomfort, low grade chronic conditions, and clients or patients referred for general SRA care. Material is scope of practice specific for your field of physical medicine.

Level II Advanced certification qualifies the practitioner to evaluate and treat compound spinal reflex patterns, identify ergonomic, repetitive motion, and trauma induced causes, establish advanced case management and inter-professional relations.

Client/Patient conditions best served by this level are acute and chronic neuro-musculo-skeletal conditions, compound reflex patterns, patients and clients utilizing multiple practitioners. Material is scope of practice specific for your field of physical medicine.

Level III Specialist certification contains two divisions: SRA Health Care Specialist and SRA Sports Performance Specialist. Each qualifies the practitioner to assess and acquire a clinical standard of evaluation and treatment including differential assessment, complex and goal specific case management and performance.

Client/Patient/Athlete conditions best served by this level are acute, chronic, or trauma based conditions, complicated health history, post orthopedic surgical recovery, unresponsive or abandoned cases, collegiate or professional athletic performance enhancement and injury recovery, and performing arts. Material is scope of practice specific for your field of physical medicine.

Prerequisite and Training:
Level I Basic Certification is 16 hours and requires current certification or licensure in your field according to your state requirements.

Level II Advanced certification is 16 hours and requires Level I Basic certification and proficiency.

Level III Specialist Certification Program – All Level II graduates may apply for enrollment in Level III Specialist Certificate Program. This is an advanced professional curriculum and enrollment is limited. Call for details.

Visit SpinalReflex.com or call 1-877-259-5520 for a list of SRA Level I, Level II, or Level III practitioners near you.

SRA based exercises for strengthening and performance

Bob Culver, NCMT, MES is expanding upon our current program of accelerated MVA and sports injury recovery protocols. This material is progressing into the development of spinal strengthening and sports enhancement exercises based on current SRA research. Continued expansion of spine centered ergonomic education is under development.

SRA curriculum in place for use in NVCC Myotherapy Program

SRA based material has been accepted for inclusion in the continuing education curriculum of the Northern Virginia Community College system.

Ms. Tricia Grafelman, NCTMB, former science teacher and current instructor in Anatomy, Physiology, and Massage, attended the December 2003 SRA course held in Manassas, VA. She is instrumental in developing potential integration of SRA materials in the NVCC system, and is working toward SRA Instructor Certification. She is author of Graf’s Anatomy and Graf’s Physiology: two preliminary review and reference texts recommended for the Level I and Level II courses in Medical Massage. She can be contacted at GrafsAnatomy.com or linked via SpinalReflex.com

SRA shows tremendous potential

SRA AP and CMT procedures show tremendous potential in preliminary application to athletic recovery and performance. Fort Lewis College women’s basketball player returns to conference playoffs with complete resolution of pain and spasms after three treatments over two days. Condition was marginally responsive to ER care prior to SRA.

Also: Effective elimination of knee pain noted with two world class cyclists in 1-2 treatments. Ultramarathonist experiences doubling of hip flexor and quadracept ROM in one treatment and continued hip stabilization over 6 weeks @ 1x / wk.
Medical Massage
Physical Therapy
Chiropractic
Osteopathic
Medical
Neurology
Orthopedic
Sports Performance