

Name and title: _____ Date: _____

**Evidence Based Treatment for the Sacroiliac Joint: Integrating Function in the Pelvis, Sacroiliac, Symphysis Pubis, Hip & Lumbar Spine
Basic, Intermediate & Advanced Material**

Post Test Block 1

Please read all answers as there is only one correct answer.

This covers the Quotations, Anatomy and Motion Section of the workbook

1. According to Alvin Stoddard, the differential diagnosis between SIJD and _____ is difficult.
 - a) Sciatica
 - b) Low back pain
 - c) PID, visceral disease
 - d) Hip pain

2. Of all authors quoted, (please see QUOTATIONS at the front of the workbook) a wonderful philosophical writing was presented by:
 - a) Gregory Grieve, PT
 - b) John Barnes, PT
 - c) Robert S. Hershey, DO
 - d) John Upledger, DO

3. According to Hesch, a very common site for transverse plane compensation in response to transverse plane asymmetry of the hip and/or pelvis is the
 - a) Hip
 - b) L5 segment
 - c) Upper cervical spine
 - d) Cervicothoracic junction

4. The average sacrum/sacroiliac joint tapers in the frontal plane
 - a) Top to bottom
 - b) Side to side
 - c) Like an s-curve
 - d) Like a pyramid

5. With the client in prone, the dorsal surface of the sacrum is tapered at about 45 degrees in the transverse plane. The angle parallels the slope of the ilia/gluteals laterally, with the posterior surface of the sacrum _____ than the ventral (anterior) surfaces of the sacrum.
 - a) Narrower
 - b) Wider
 - c) Trapezoid shaped
 - d) Same as the lumbar facets

6. A side view of person, with “x-ray vision” would reveal that the general shape of the SI joint (both sacral and iliac surfaces) is somewhat like
- The TMJ
 - Like a boomerang tapering anteriorly
 - The femoroacetabular joint
 - The TMJ
7. The PSIS’ are located just lateral to _____ segment which is also the apex of the joint surface (where upper and lower portions of the joint meet) and is a theoretical transverse axis of rotation.
- Coccygeal
 - Lumbosacral
 - Pubic crest
 - S-2
8. The biceps femoris portion of the hamstring muscle sometimes evades the insertion on the ischial tuberosity and directly inserts onto the _____. Other times, it can be conjoined (attaches to both).
- Ischial spine
 - Sacrotuberous ligament
 - Piriformis and gemelli
 - Obturator membrane
9. Radiographs can give a false sense of intra-articular bony arthrosis (fusion), whereas _____ allow for accurate interpretation within the entire joint space.
- CT or MRI
 - X-rays
 - Ultrasound
 - Palpation
10. The Hesch Method emphasizes that for normal pelvic/SIJ function
- Motion must occur in the SIJ
 - Motion must occur in, but especially *through* the SIJ
 - Motion is irrelevant because it is so minor
 - Motion must be measured with a goniometer
11. In a physiological motion dysfunction, the joint/structure is
- Stuck at end range
 - Probably with normal mobility present in all directions
 - Able to move further in the direction
 - In loose-pack position
12. In physiological motion dysfunction, the joint/bony structure cannot move out of it without
- A gentle prolonged passive force
 - A grade V thrust manipulation
 - MET (Muscle Energy Technique)
 - First treating inflammation with NSAIDS

13. In non-physiological movement dysfunction, the joint/structure might be stuck in all directions it is:
- a) Stuck at end-range
 - b) Gliding and rotating normally
 - c) Lacking synovial fluid
 - d) An inflammatory condition such as rheumatoid arthritis or ankylosing spondylitis
14. The Hesch model is probably best described as a
- a) Pain model
 - b) Pathology model
 - c) Osteopathic model
 - d) Biomechanical model
15. Normal SIJ motion is about 2 degrees rotation or
- a) 2mm of glide
 - b) Measured in centimeters
 - c) Objectively measured with palpation and visual observation
 - d) 2 angstroms of helical motion
16. Normal pubic symphyseal width is
- a) 1 cm
 - b) 2-4mm
 - c) 10mm male, 15-25 in the post-partum female
 - d) Measured via palpation
17. If the left pubic bone glides posteriorly motion must also occur
- a) In the right SIJ
 - b) In the left SIJ
 - c) In the upper lumbar spine
 - d) 12th rib
18. The sacroiliac and the hip joint are very similar in terms of
- a) Nerve roots levels
 - b) Shape
 - c) Degrees of rotation available
 - d) Having a labrum for added stability

BLOCK 2 POST TEST

Please read all answers as there is only one correct answer.

This covers the Radiology, Function and Dysfunction, through Principles of Manual Therapy sections of the workbook.

1. The Hesch model of treatment is:
 - a) A direct treatment-approach
 - b) An indirect treatment-approach
 - c) A myofascial method
 - d) Based on craniosacral rhythm

2. In upright posture the base (top) of the sacrum moves anterior and inferior and the apex (bottom) moves posterior and superior. This forward bending of the sacrum causes:
 - a) Pubic joint instability
 - c) Pelvic loosening
 - d) Enhanced joint compression and stability
 - e) Chronic pain

3. Motion in and through the SIJ is due to:
 - a) Active and passive extrinsic forces
 - b) Muscles pulling inside the SI joint
 - c) Craniosacral rhythm
 - d) Labor and delivery only

4. Treatment to restore normal passive accessory motion in and through the pelvis and SIJ:
 - a) Is ideally performed with active movement
 - b) Typically requires a sustained passive force
 - c) Always requires grade V HVLA manipulation
 - d) Only achieved with strain/counter strain

5. Left to right side-glide of the pelvis is a complex movement involving
 - a) Lumbar spine, hip, pelvis and sacroiliac
 - b) Balanced craniosacral rhythm
 - c) Very large forces
 - d) Strapping patient on a traction table

6. Asymmetry of the pelvis with standing hip flexion indicates that
 - a) The ilium moved on the sacrum
 - b) The SIJ is unstable
 - c) The SIJ should have a MIS (Minimally Invasive Surgery)
 - d) The pelvis moved asymmetrically on the weight-bearing femoral head

7. The Hesch spring tests are designed to
 - a) Reproduce pain
 - b) Evaluate stages of disc disease
 - c) Treat a stuck SIJ
 - d) Evaluate mobility

8. When screening movement dysfunction of the SIJ one should also screen
 - a) Hip and lumbar motion dysfunction
 - b) Visceral motility of the thyroid
 - c) Acupuncture meridians
 - d) Fourth toe flexion

9. The signs and symptoms of SIJD are
 - a) Much like other pain syndromes such as LBP, piriformis syndrome, hip and groin pain, etc.
 - b) Very similar to sciatica from lumbar radiculopathy
 - c) Not necessary to evaluate as stabilization exercises are the appropriate intervention
 - d) Predictable such that hands-on screening is not necessary

10. When clients complain of “hip pain” one should
 - a) Suggest hip radiographs
 - a) Refer to an orthopedic hip preservation specialist
 - b) Check the piriformis
 - c) Start by clarifying what they mean by “hip” including location and suggest a common terminology as some refer to the ilium as the hip.

11. A positional dysfunction describes
 - a) If it is hypo
 - b) If it is hyper
 - c) If the joint is stable
 - d) Where it is in space in relation to another structure or in reference to an ideal

12. An example of True Hypomobility which most likely not improve with treatments would be:
 - a) 70-year old rancher and rodeo cowboy with multi-joint degeneration (osteoarthritis)
 - b) Cirque du Soleil gymnast
 - c) Multiparous female
 - d) A gymnast

13. Apparent hypomobility is
 - a) To be ignored in an evidence-based practice
 - b) Is easy to treat and restore normal motion
 - c) Measured with a goniometer only
 - d) Easily treated with restoration of normal movement a frequent accomplishment

14. Apparent hypermobility, as opposed to true hypermobility, is
- Only measured with CT scan
 - Often dramatically improves when the opposite directional hypomobility is treated
 - Is genetic and not responsive to manual therapy
 - Will not respond to brief intervention
15. True general hypermobility aka hypermobility syndrome or Erlos-Danlos Syndrome is consistent with
- Dark Sclera
 - Kyphosis
 - Scoliosis
 - Joint hyper-extension
16. Relaxin:
- Mediates pelvic joint loosening by itself
 - Appears to act in concert with other hormones, such as estrogen, causing pelvic loosening
 - Is a synthetic hormone found in birth control pills and tea
 - Has been discredited
17. An A-P film of the pelvis:
- Is ideal for measuring width of the symphysis pubis
 - Readily captures sagittal plane rotation of the pubic bones
 - Is used to diagnose mild SIJ hypermobility
 - Used to diagnose hypermobility syndrome
18. Hesch Method addresses muscle inhibition/weakness
- As a precursor to muscle energy treatment
 - By restoring mobility in order to reduce mechanoreceptor reflex inhibition on muscle function
 - Via acupressure points
 - Using strengthening as first intervention
19. Regarding leg length inequality
- Immediate correction with heel lift is advocated as it will enhance pelvic symmetry
 - Built up shoes are best
 - Leg length correction via lift is only done after maximizing biomechanical function of the extremities and lumbopelvic region
 - Only correct if greater than ½"
20. Hesch model of treatment is best referred to as
- The grade 5 oscillation viscoelastic manipulative thrust
 - The indirect muscle energy creep model
 - Viscoelastic creep model
 - The joint compression method

21. The Hesch model of treatment is unique in that

- a) It favors HVLA thrust
- b) It favors treatment of hypomobility initially, over treating any hypermobility
- c) It uses myofascial release first
- d) It balances craniosacral rhythm

BLOCK 3 POST TEST

Please read all answers as there is only one correct answer.

This covers the Evaluation, Spring Tests and Treatment Philosophy sections of the workbook.

1. Prior to performing a sacroiliac or pelvic mobility exam, one should do a thorough history and screen for pathology
 - a) In the lumbar spine, hips and lower extremities
 - b) In the cardiovascular system
 - c) In the CNS
 - d) In the lymphatic system

2. It is more difficult to palpate bony landmarks in
 - a) Standing
 - b) In prone or supine
 - c) In the early am when they are stiff
 - d) Eastern Europeans

3. Regarding standing posture and motion initiated in standing, one must consider that findings may reflect compensations and the body's response to gravity, and
 - a) Weight-bearing compensative response to proximal and distal biomechanical dysfunctions
 - b) Postural effect on craniosacral motion
 - c) Eyes open versus eyes closed
 - d) Skin temperature variations

4. Supports can be helpful in cases of mild to moderate pathology, and trial sometimes is the only way to discern if appropriate. Research shows 40% greater compression when worn
 - a) Over the trochanters
 - b) L5-S1
 - c) Vertical
 - d) Lumbar and pelvis

5. The correct amount of force to apply when first performing a pelvic spring test is 15 to 30#, however, in the clinic the best amount of force for any, and all clients is:
 - a) Essentially the same in all patients
 - b) Always variable regardless of client
 - c) Somewhat variable and should be the least amount of force that gives useful information.
 - d) More if hypermobile

6. This model suggests that the spring tests give us information about motion occurring
 - a) In the SIJ only
 - b) In and *through* the SIJ
 - c) In cranial sutures
 - d) As measured with goniometry

7. The spring tests are named for
 - a) The direction of force as applied by the clinician's hand
 - b) The direction the pelvis moves as a unit whether functional or dysfunctional
 - c) The direction of recoil on the same the same side
 - d) The direction of tri-plane motion that will occur in the joint

8. The Quick Screen of The Pelvis: Palpation and Basic Pelvic Spring Test Grading Form is a
 - a) Useful tool to Xerox for practicing the spring tests and palpation part of an evaluation
 - b) Unnecessary short cut
 - c) Part of the MET Muscle Energy Technique
 - d) Taught in PT school

9. The Indications and Contraindications are general guidelines only, the clinician must be ever mindful of
 - a) The unique presentation of each client, and paying attention to the presenting complaint, duration of symptoms, the impact on their lifestyle, and the client's own unique interpretation of the presenting complaint
 - b) He patient's insurance coverage
 - c) The patient's understanding of evidence-based practice
 - d) The norms for evaluation time in the region

10. Passive springs tests measure motion going *through* the pelvis as opposed to
 - a) Motion only occurring within the SIJ
 - b) Via HVLA thrusts
 - c) Six-degrees of freedom
 - d) Craniosacral motion

BLOCK 4 POST TEST

Please read all answers as there is only one correct answer.

This covers the, Three Singular Restrictions of Hip and Pelvis Dysfunction, and The Most Common Pattern sections of the workbook.

1. The most common pattern is defined by Hesch as having several consecutive, predictable movement dysfunctions of the lumbopelvic complex and includes but is not limited to:
 - a) Sacral torsion
 - b) Upslip ilium
 - c) Right anterior and left posterior ilium
 - d) Unilateral sacral flexion

2. The Most common pattern is unique in contrast with the Muscle Energy Treatment (MET) model in that the MET model predicts dysfunction
 - a) In an *a la carte* manner, instead of a predictable group sequence
 - b) That requires HVLA
 - c) Hypermobility
 - d) Instability

3. The workbook is helpful in that it is laid out with Positional Dysfunction, Movement Dysfunction, Other (when appropriate), the Mandatory Spring Test(s), and Optional Spring Tests. It also lists:
 - a) Treatment, patient position, self-treatment, retest and home program, with photos for each
 - b) The correct stabilization exercises
 - c) The compensatory area of the body and how to treat it
 - d) A list of the osteopathic patterns of SIJD

4. This method emphasizes:
 - a) HVLA
 - b) Patient education in self-treatment
 - c) Dry needling
 - d) Alignment

5. According to this model, some of the movement dysfunctions in the most common pattern:
 - a) Do not require repeat treatment and might not require a home program
 - b) Should not be all treated on day 1 to avoid soreness
 - c) Are un-physiologic
 - d) Require x-ray for diagnosis

6. The type 1 inflare/outflare, collectively called flare
 - a) Happens in the sagittal plane
 - b) Is evaluated in prone based primarily based on a blocked lateral spring test
 - c) Is the most painful type of SIJD
 - d) Does not reflexively inhibit muscle function
7. If the sacrum is rotated and side bent at end-range to the left, L5 will most likely:
 - a) Rotate and side bend in the same direction with a distal compensation to the opposite direction
 - b) Will not rotate
 - c) Cause a S-1 radiculopathy
 - d) Counter-rotate
8. After balancing the pelvis in a presentation of the most common pattern, L5 will then typically:
 - a) Be treated in flexion, right side bending, and right rotation
 - b) Rotate opposite the sacrum
 - c) Require extension exercises
 - d) Require flexion exercises
9. When the clients return, it is important to evaluate:
 - a) How they are performing their home program
 - b) Neural tension signs
 - c) Big toe extension for gait
 - d) Their understanding of pain science
10. The McKenzie approach would evaluate a Pelvic Side Glide, (which they call a Pelvic Shift) by observing it in standing. In contrast, this approach would evaluate it:
 - a) With a passive spring test in supine, based on mobility restriction which may be too subtle to be noted visually
 - b) With a photograph
 - c) With a posture grid
 - d) With an x-ray
11. The passive side-lying stretch for a pelvic side glide pattern appears to be more effective than a standing wall stretch, because:
 - a) The anti-gravity muscular response is eliminated with the side-lying treatment
 - b) The wall cannot yield
 - c) The craniosacral system is not constrained
 - d) Of the righting reflex
12. Internal rotation of the hip can be tested in supine with the legs straight and:
 - a) Is a more functional position than is prone with knees flexed 90-degrees
 - b) Is practiced by most therapists
 - c) Has extensive research
 - d) Is not as functional as rotation of the hip in sitting

BLOCK 5 POST TEST

Please read all answers as there is only one correct answer.

This covers the Sacral Torsion sections of the workbook.

1. When describing the *oblique axis* of rotation and side-bending of the sacrum, one should name the axis for
 - a) The top of the axis, such as left: \ or right: /
 - b) Named for the bottom of the axis, such as left: /, or right: \
 - c) Named for the direction the sacrum is rotated
 - d) Only the sagittal plane

2. According to the definition, when a sacral torsion is present, there is a combination of:
 - a) Rotation and side bending (and flexion/extension)
 - b) Pure glide about an A-P axis
 - c) A right posterior and left anterior ilium
 - d) Side-bent coccyx which requires direct mobilization before treating the sacrum

3. Sacral torsions can sometimes be found in prone neutral, in which case they will enhance in:
 - a) Sitting position
 - b) Prone press-up
 - c) The ideal posture
 - d) Happy baby yoga pose

4. When a sacral torsion is present:
 - a) There will be asymmetry at S2 bilaterally
 - b) One quadrant will be prominent and stuck
 - c) HVLA is indicated
 - d) The pelvic floor must be released first

5. An example of a simple, lucid way to name a sacral torsion is for example:
 - a) Left rotation on a left oblique axis
 - b) A left lower sacral quadrant which is prominent and stuck
 - c) Not important in this model
 - d) Triplane, multi-axis sacral rotation and side-bending fixational pattern

6. This approach prefers
 - a) Self-treatment as the primary approach to treating a sacral torsion
 - b) Strain-counter strain
 - c) Lumbar stabilization exercises
 - d) Craniosacral therapy

BLOCK 6 POST TEST

Please read all answers as there is only one correct answer.

This covers Upslip/Downslip of the Pubic Bones and Upslip/Downslip Ilium section of the workbook.

1. When treating a superior pubic bone:
 - a) A simple, direct method utilizes hip abduction with traction.
 - b) Use the MET shotgun method regardless of Superior or Inferior Pubic Bone.
 - c) First align the sacrum
 - d) Use strain-counter strain
 - e) Use HVLA

2. Upslip and downslip are non-physiologic patterns of movement because they
 - a) Occur during normal gait
 - b) Can be induced with muscular forces
 - c) Follow anterior or posterior ilium
 - d) Cannot move further in the direction of dysfunction

3. The Osteopathic belief that downslip is very common but self-corrects during gait can be challenged
 - a) By the fact that downslip patterns are found in the clinic via screening with spring tests and the ilium is found to be stuck
 - b) By palpatory findings
 - c) With force diagrams
 - d) By comparing and contrasting, all types of pelvic motion dysfunction

4. Upslip and downslip are subtle regarding palpation. Therefore,
 - a) Perform superior and inferior spring and check sacrotuberous ligament tone
 - b) Use standing hip flexion test
 - c) Treat for both patterns
 - d) Use MET

5. Regarding upslip, one can reasonably predict
 - a) Lumbar sagittal concavity on the same side
 - b) Lumbar sagittal convexity on the opposite side
 - c) Blocked inferior glide of ilium
 - d) All the above

6. Downslip can:
 - a) Slacken the sacrotuberous ligament
 - b) Present with a taut sacrotuberous ligament
 - c) Present with normal superior and inferior spring through the hemipelvis
 - d) Easily be observed

7. When there is a combination pattern in which there is an upslip or downslip, coupling with an anterior or posterior ilium, it is important to:
 - a) Treat the Upslip/Downslip first
 - b) Treat the rotation first
 - c) Correct the sacrum
 - d) Use MET

8. The dysfunctional side of the symphysis pubis is typically
 - a) More painful when palpated
 - b) The superior pubic bone
 - c) The side with a posterior ilium
 - d) The same side as the sciatica

BLOCK 7 POST TEST

Please read all answers as there is only one correct answer.

This section covers the posterior glide sacral fixation and 2nd most common pattern of SIJD from the workbook.

1. The 2nd Most Common Pattern consists of
 - a) Bilateral Anterior Ilium and Bilateral Inflare
 - b) Hyperflexed L5
 - c) Sacral torsion
 - d) Hip flexion contracture

2. Exercise prescription for a person with the 2nd most common pattern would emphasize a
 - a) Flexion approach as a general philosophy
 - b) Extension exercises
 - c) MET approach
 - d) Lumbar stabilization as first intervention

3. Regarding the 2nd most common pattern, one might also expect:
 - a) A stuck cuboid bilaterally
 - b) Hypermobility Syndrome
 - c) Upper cervical hyperextension
 - d) TMJD

4. A person with a posterior glide sacral fixation will have:
 - a) A rigid pelvis with compensatory hyperextension at the upper thoracic spine and rib cage and hyperextension at the occipitoatlantal joint
 - b) General hypermobility with a loose gait pattern
 - c) Postural-induced dizziness
 - d) Bilateral hip dysplasia if left untreated

5. Ideally, treating someone who has the 2nd most common pattern will achieve the following:
 - a) Gain vertical and AP dimension in the L5-S1 neuroforamen
 - b) Bilateral inflare
 - c) Subtalar neutral
 - d) Lumbar extension

6. A person who presents with the 2nd most common pattern probably is:
 - a) Hyper-lordotic
 - b) Posterior tilt of the pelvis
 - c) Tight labrum left hip
 - d) Neurotic

7. When evaluating bilateral inflare:
 - a) Both sides will be stuck when lateral spring testing is done in prone at ~45-degrees
 - b) There is no such thing as Bilateral Inflare.
 - c) Deep sulcus from ilium to sacrum
 - d) Treat bilateral sacral torsion

8. If the sacrum is forward bent, then L5 will:
 - a) Follow and can be described as being hyperextended
 - b) Be hyperflexed
 - c) Remain in neutral
 - d) Reflect the occiput

9. A sacrum stuck in posterior-glide will result in:
 - a) All pelvic spring tests being blocked
 - b) Blocked rotation in the sagittal plane only
 - c) Compensatory hypermobility throughout the rest of the body
 - d) Bilateral upslip of the pubic bones

BLOCK 8 POST TEST

Please read all answers as there is only one correct answer.

This covers the Evaluating and Treating Faulty Lumbar Motion section of the workbook.

1. Lumbar motion coupling dysfunction usually occurs in:
 - a) Flexion
 - b) All lumbar segments
 - c) Side bending alone
 - d) Hyperextension

2. L5-S1 can be variable in the manner in-which rotation and side-bending couple:
 - a) Due to asymmetry of facet orientation
 - b) In all persons
 - c) Only in trauma cases
 - d) If they have L5 sacralization

3. This method suggests that motion coupling of L5-S1 should be evaluated in:
 - a) Flexion and extension, side-bending and rotation will be self-evident
 - b) Flexion only
 - c) Passive glide
 - d) Addition to testing sacral myofascial mobility

BLOCK 9 POST TEST

Please read all answers as there is only one correct answer.

This covers the Lower Wind-Swept Pelvis section of the workbook.

1. In the presence of a left lower wind-swept pelvis the lower left pubic bone is
 - a) Anterior
 - b) Posterior
 - c) Superior
 - d) Rotated posteriorly

2. With a wind-swept pelvis to left pubic motion is blocked when doing
 - a) PA spring test on the left ischium
 - b) Inferior glide to the pubic bone
 - c) Superior glide to the ischium
 - d) Shotgun MET

3. A 2x4x8" ½ round foam is placed under the _____ for five minutes to correct the pubic rotation
 - a) Left ischium in supine
 - b) Right ischium
 - c) Pubic bone on the left
 - d) Left ilium in supine

4. If a patient has a left lower wind-swept pelvis, the left ischium is _____ in relation to the mid gluteal crease
 - a) Lateral
 - b) Medial
 - c) Superior
 - d) Inferior

5. The right hip is stretched into
 - a) Abduction for two minutes and (separately) in internal rotation
 - b) Extension
 - c) Adduction
 - d) FABER position

6. If the coccyx is side bent left it is treated with
 - a) Passive pressure applied to the right ligaments for 3-5 minutes and with direct contact on the left side of the coccyx pushing it to the right for 3-5 minutes
 - b) Internal contact on the midline
 - c) The right side of all coccyx segments pushing to left
 - d) Strain-Counter Strain

7. If the ischia appear to be wind-swept left but they have normal medial and lateral spring mobility (and no other pelvic motion dysfunction is identified), an appropriate conclusion would be:
 - a) Patient has a leg length inequality
 - b) The person has a bony developmental asymmetry
 - c) It is caused by muscle imbalance
 - d) They obviously have SIJD

8. Sometimes after correcting the lower pubic rotation and the lateral and rotational pattern of the lower pelvis it is then appropriate to:
 - a) Address a side-bent coccyx
 - b) Correct the compensatory rotation at C7-T1
 - c) Reflexively treat asymmetry of lateral gaze
 - d) Quiz the patient's understanding of modern pain science

9. A side-bent coccyx is:
 - a) Best evaluated externally with a deeper sulcus
 - b) Evaluated internally
 - c) Best addressed by treating trigger points in the pelvic floor
 - d) Easy to validate with a lateral x-ray

BLOCK 10 POST TEST

Please read all answers as there is only one correct answer.

This section draws from the chapter on sitting comfort and on the biography on the back cover of the workbook.

1. Sitting comfort can be enhanced by:
 - a) Raising the seat pan such as with a cushion to raise the hips slightly high than the knees
 - b) Wearing compression shorts
 - c) Taking aspirin whenever you sit more than 15-minutes
 - d) Distracting yourself with contemporary music

2. For a developmental asymmetry of the height of the pelvis you can try placing:
 - a) 5mm 4" x 6" piece of craft foam
 - b) A McKenzie roll on the seat back
 - c) A 2" coaster under the leg of the chair
 - d) A low sandal on one foot and a cowboy boot on the other

3. If you suspect asymmetrical development of the femoral neck you can:
 - a) Place a 1.5" x 4" soft foam under the trochanter
 - b) An ischial lift
 - c) A lift under the distal femur
 - d) A lift under one leg of the desk

4. Additional information on this approach regarding the lumbopelvic and whole-body material can be found:
 - a) At Vimeo searching "sacroiliac"
 - b) At You Tube searching "Hesch" and specific topics such as "hip"
 - c) With a paid subscription
 - d) The APTA orthopedic section website

5. Patients with scoliosis who experience sitting discomfort may present with significant asymmetry such that
 - a) An orthotist should design a sitting brace
 - b) Surgery may be indicated if sitting is uncomfortable
 - c) An ischial lift plus a support behind one ilium on the back of the chair can be very helpful
 - d) Surgical referral is mandatory