Upledger Institute Case Study
CranioSacral Therapy – Concussion/Pain
By Amy Sanders, O.T.R., LMT, CST-T

K.M. Case Study

10/26/17
Client is referred to CranioSacral Therapy s/p concussion symptoms after receiving a blow to her head with a soft ball in January of 2017.

Primary symptoms reported are a "continual concussion headache." She attempted the medication amitriptyline for four months which showed no positive results, and with medical consult decided to stop the medication. Her Head pain is reported constant and above level 7 consistently.

Her goal for therapy is to lower or eliminate her head pain, tolerate her school caseload, and re-enroll in her class that she postponed due to injury. PMH includes R wrist fracture as a child.

Medications include fish oil, magnesium, B-2 and Claritin.

Head pain reported at 7.25 today initially.
Treatment techniques:
C2 segmental release, noted R sided pull into thoracic inlet.
Treatment techniques:

OCB release with reported connection into cranium.
Temporal balancing to facilitate correction of R restriction and posterior rotation
Frontal lift, and noted L sphenoid shear.

Improved quality and Rhythm of CSF after treatment.
Client reported head pain decreased to level 5 after treatment.

Treatment note 11/29/17
60 min session

Client reports feeling less tension overall throughout head since last session.
6.75 rating today, but with decreased visual clarity.
Treatment included OCB release with noted greater tension R side with drag into upper T spine and R scapula.

C2 and C3 segmental releases with improved dural glide.
Intra oral Bilateral ptergyoid releases.
Temporal balancing and occipital traction with noted medial and inferior pull on R.

Post session pain reported at 5.75 with tension in cranium "barely there."
Headache is described as a brain ache that was deep and is more surface. The pain in forehead is gone however is still present in the back.

Treatment session 60 mins 11/5/17

Client reports that her pain changes a lot now, and moves throughout her head. She has been able to eliminate her nap to sleep in study hall at school, and is not as fatigued after school. Pain is reported at level 5 in occipital and temporal areas. Pain has decreased since last session to level 4 per report at times.

Treatment techniques:
Thoracic inlet with R mid scapular approach.
Gentle self-unwinding and deep sighs with cranial connection reported.
OCB sustained release with dural traction and occipital spreading.
Spheno-basilar balancing with noted decompression.
After treatment client reports pain is at level 4.5 (deep) and tension is at level 6.
Client explains that her pain and tension are different. Pain is the deep sensation and tension is more surface pain that runs throughout head.

Treatment session 60 min 11/17/17
Client reports that she is holding at level 4.5-4.75 with head pain, but verbalizing able to stay stable with heavy school load and minimal sleep due to homework requirements. She reports feeling less emotional and is pleased that with increased stress, her head pain as not increased. Pain is reported today in parietal area.

Treatment
Thoracic inlet release, with dialogue around tension and pressure of being a junior in high school.
Hyoid release, OCB release and sustained parietal lift.

After treatment client reports feeling more healthy overall, with pain at 4.75 with less tension and pain being more surface focused than deep pain.

Treatment session 60 min 11/22/17

Client reports improved ability to stay focused on studies.
Treatment includes C2 segmental release.
R psoas release
Bilateral intraoral ptergyoid release and zygoma releases.
OCB decompression
SBJ balancing
Tension less after treatment

Treatment note 11/29/17 60 mins
Client reports that her brother accidently hit her head and pain over break is constant tension at 4.5, with deep pain at 5.0-5.5.

Thoracic inlet releases, R suprascapular releases. Intra oral jaw and zygoma releases, temporal balancing with noted R posterior rotation. L sidebend sphenoid lesion with correction.

Post treatment head pain reported at 4.25 with tension being more surface.

Treatment note 12/6/17 60 mins

Client reports pain 4.75-5 with constant changing from deep to superficial. Pain reported at base of skull today.
Noted with protracted shoulders and forward head during postural assessment.
Thoracic inlet, cervical spine releases, chest opening with pectoral releases. Intraoral jaw releases.
OCB release, temporal balancing parietal lift. Reports pain 4.5 with deep tension but “not a lot”
Instructed on gentle chest opening exercises supine over blanket roll, with demonstrated understanding.

Treatment note 12/20/17

Pain reported at 5-5.5 with tension level moving.
High focus at school for exams before break
Pain is reported R parietal, R forehead, R jaw.

Intraoral releases, R supra scapular releases specifically R trapezius.

Bilateral arm traction with gentle unwinding.
OCB release with traction and spreading.
Pareital decompression with noted restriction posteriorly.

Client reports improved C spine ROM and tension moving to surface after treatment with pain at 5.25.

Treatment note 1/8/18

Client reports sleeping a lot over break and says “intuitively that she knows her head hurts but can’t localize where the pain is”

R scapular releases with lateral glide, Bilateral chest opening and pectoral releases.
Intra oral releases with ear pulls to balance temporal bones.
Sacral decompression with noted L inferior shear.
Pelvic diaphragm release with verbalized connection into parietal area.
Parietal decompression
Home program sustained chest opening over blanket roll with T spine slight extension.

Head pain 4.75 with movement to surface from deep.

Final Treatment Note and Discharge Assessment
60 minutes

Client reports that she has found significant relief in her cranial tension and deep pain after receiving CST for her post concussion symptoms. Her mother reports concern over continued need for long hours of sleep. Therapist suggests a visit with MD. to discuss nutrition and sleep, along with continued anti gravity chest opening and neck lengthening exercises.

She rates her overall pain at level 4.5 (as constantly aware of her pain but able to complete all activites.)
She reports still needing several hours of sleep per day when school is in session, due to workload.

Treatment today consists of
Thoracic inlet, cervical spine releases, OCB release with dural traction.
Pelvic diaphragm release with right anterior rotational correction
Lumbo/sacral decompression
Dural rock and glide
Occipital spreading, temporal release and balancing, parietal lift.

Instruction on upright posture and appropriate positioning for school and homework of spine.

After the session, client reports relief and pain is at level 4.5 subjectively.

Client is now able to complete all required activities and head pain is reported at level 4-5 consistently, compared to initial reports of 7.25 and inability to complete her daily living activates.

In this case, CST provided hope, pain relief, but most important the ability for her to tolerate and maintain her school schedule. She re-enrolled for a class that she was unable to complete last semester after her concussion.

K.M. plans to visit with M.D. regarding alternative options for therapy.