

# **Upledger Institute Case Study**

## **CranioSacral Therapy – Chronic Pain/Headaches**

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A.A. Assessment and Treatment note 11/1/17

Caucasian female, 46 yrs, 138 lbs. High energy-likes the outdoors. Positive attitude but becoming discouraged by the limitations presented in the last three years due to physical health issues.

PMH:

A. Traumatic birth per parents- I was born quickly (within one hour). A nurse held me in birth canal for approximately 10 minutes to wait for doctor-mother given a drug-I had to be taken with forceps causing bruised temples for several weeks and a “deformity” in neck for several months (lump on right side of neck) as per parents.

B. Tick or habit (grunting type noise). Earliest memory, six years old to present (due to myofunctional therapy- June 2017 to present; I have discovered it is related to incorrect breathing).

C. Chronic neck pain, headaches, stiff neck and shoulders since high school (possibly earlier) mainly right side.

D. Bruxing / clenching – became aware of it at age 26 (possibly began Bruxing at an earlier age).

E. Irregular breathing – shallow breaths and then a large breath to catch up with lots of yawning in an attempt to get more air. Became aware of it in my early 20’s.

F. June 1993 - natural child birth.

G. February 1998 – natural child birth.

H. Fibroid on uterine wall causing severe bleeding over a year period of time causing near cardiac arrest with a hemoglobin reading of 4.1 resulting in a four pint blood transfusion in 2015.

I. Ablation procedure in 2015 – unable to remove entire fibroid due to placement on uterus.

J. Heightened plus discomfort / pain physical and emotional since 2014 / 2015.

K. Poor sleep for the past five years. 3-5 hours of per night common – restless sleep.

L. Occasional indigestion for past two years becoming chronic within the last year (2017).

M. Occasional light snoring in the past year (2017).

N. Left foot discomfort (nerve pain on top of foot above big toe since 2016).

O. Bunionectomy with two screws placed in on left foot in September 2016.

P. Never pain not resolved with Bunionectomy – slowly returned with additional pain in a bone in big toe limiting function (unable to walk any distance at a time, run, jump, stand on tip toes, squat using toes, etc. . . ).

Q. lingual Frenectomy with myofunctional therapy June 2017.

\*\*Note (symptoms improved since treatment):

See: B. Tick / Habit

C. Chronic pain / Stiffness

D. Bruxing / Clenching

E. Irregular Breathing

I. Poor sleep

J. Indigestion

K. Snoring

R. Screws from Bunionectomy removed from left foot one year post bunionectomy surgery September 2017. Cortisone shot given for nerve pain. Screws were 2 mm too long into ball of foot limiting function.

S. Frenectomy revision September 2017. Above symptoms still improved.

T. Reinjured left foot by kicking an object. Increased swelling and pain in left foot with aching big toe November 2017 - cortisone shot.

Therapeutic Assessment:

At rest, pt. reports tongue is numb from ½ way to tip, sense of taste is dulled, and with protrusion feels like burning and pulling back in with nerve pain with tethers attached. Concentrated on L side.

Tongue is functionally unable to protrude without this tightness

Tongue on the spot 32 mm

Max open 46mm

Cervical pain R greater than Left

AROM

Sidebend R 28 L 36

Flexion 33 Extension 58

Rotation L72 R 70

Thoracic spine

Rotation difficult and painful bilaterally

Low back pain

Sitting office work, aches 2-3 constant Right greater than Left

L foot pain post surgery

Recent cortisone shot, Scar tissue post surgery and orthotics

Unable to run jump squat tip toe and normal heel to toe gait.

11/1/17 Treatment note

Treatment note 60 minute session

Pt is tearful and noted limping today as she reported hitting her recent surgical L foot on a heater at home.

Noted R anterior Pelvic rotation, inflamed L foot dorsum.

Arced to R pelvis. Pelvic diaphragm release with noted R iliacus restriction, she felt release into her posterior R SI joint. As release occurs client is tearful with expression of difficulty standing in surgery at work and body pain throughout. Released to plantar surface of L foot with client expression her vision of cord like guitar strings running to distal Metacarpal of big toe. She said her toe had a word of expression of "pain" with emotional releasing during session. Pt felt release all the way into her cheeks and overall exhaustion of emotionality after treatment. She was able to weight bear and ambulate functionally after treatment.

Treatment note 11/15/17

75 minute session today

Arced to R neck. Thoracic inlet release with focused release on R subclavicular area anteriorly and mid scapular pull posteriorly. Client reported this is an area that "seizes up" frequently. Pt reported awareness from this space into R spine and Lower back.

Hyoid release with noted tension R greater than L and tingling noted throughout neck and face during release.

Client remembered walking into a trophy chest corner in elementary school and being knocked out with blood coming out of her parietal area of her head.

As treatment progresses she reports feeling the sensation of falling today.

The body leads to Occipital Cranial base by reporting of tension at the base of the skull. OCB sustained release with maximal compression and noted rotation of C1 and C2 anteriorly on R.

Gentle dural traction with C2 C3 segmental releases focused on dural tube.

Dialoging around visualizing the spaces of tension and checking in with the inner physician. Temporal releases with instruction for home program self care.

Instructed on self thoracic inlet release, and hyoid release with gentle hand placement over site for opening and improved body connection/awareness.

Session ended with instruction for body listening and good self care for the next week. Client reported feeling lighter and relaxed with less cervical pain.

Treatment Note 11/22/17

60 minute session

Client reports that she slept the whole night after last treatment and that she cant remember the last time that occurred.

Pt reports L foot feels better, she tolerated a 20 minute walk last night for the first time in 6 months. Tongue on the left side of phrenum "zings" when performing self treatment to keep the tissue from scarring. She reports increased "rawness" under her tongue iwht continued numbness from tip to ½ way back on tongue.

Her neck is reported tighter as the caseload at work has increased this week.

Treatment began with arcing to the L shoulder/heart space. Released thoracic inlet with energetic drag to the cervical spine specifically R C3 segments.

OCB sustained released with facial and head connections and dural drag into R gluteal/piriformis area and R S I Joint. Therapist then released intraorally bilateral pterygoids ,with noted restriction greater on L than R. Clilent verbalized seeing violet blue spots that expanded and contracted within her visual field corresponding with the CSR. Balancing of the system was called out for with sphenobasilar decompression and temporal balancing.

Treatment Note 11/29/17

60 minute session

Client reports that her foot is feeling better with improved ability to walk. Received another steroid shot today. She noted that her jaw felt relaxed after last treatment and she did not clench for 2 days. Today is voicing significant neck and shoulder pain radiating up into the cranial base.

Also noting in R hip and low back. Emotionally feeling like she is improving with ability to awareness in response to stressful situations.

Thoracic inlet release, with noted bilateral hand warmness.

Bilateral intra oral lateral pterygoid releases. Sphenomaxillary balancing, cranial pumping with improved SQAR cranially, OCB decompression.

Client verbalized blue color shifting within her field of vision, clearing out the blackness and moving in clearer colors.

At the end of her treatment she reported feeling relaxed, pain free and that she was getting her life back

Treatment note 1/10/18

Client reports work caseload increased over the holiday with resultant R neck/scapular pain due to more clients per day.

Reports joining a exercise group to work out 2-3 times per week and now able to run and squat with minimal pain.

Today notes R lower back pain and mid back pain with inhalation along with neck stiffness.

Treatment respiratory diaphragm releases, with connection to lumbar spine, L jaw and neck.

Thoracic inlet releases with noted feeling of anxiety and emotional concerns reported over her husbands health. Intra oral releases specifically bilateral pterygoids.

Occipital Cranial Base release and sphenoid decompression.

Relaxed and voiced pain relief after treatment

Treatment Note 1/19/18

60 minute session

Client reports that her SI joint feels better since last visit. She reports improved cervical spine ROM. She is able to continue to attend her exercise class with some foot pain/knots after class which she is using the Sole Mender as a technique for her home exercise program.

Tongue restriction underneath is greater on the right than left.

Thoracic inlet releases with verbalized anxiety sensation and decreased sense of ability to take a full breath.

Sub lingual releases with inferior hyoid releases produce full body awareness of anxiety symptoms and sensation in bilateral feet.

Noted decreased SQAR cranially with moderate OCB restrictions

Visual colors and shapes noted per patient purple and blues in central visual field.

Treatment Note 1/31/18

60 minute session

Client reports less clenching after intra oral releases last visit. Expresses that her mouth feels more open and wider.

Ability to walk on foot without difficulty, self treating. Improved tongue strength noted.

Thoracic inlet release, Cervical spine releases, respiratory diaphragm releases. Improved SQR and decreased anxiety after treatment.

Treatment note 2/16/18

Thoracic inlet release, OCB release, intra oral releases bilateral lateral pterygoids, sublingual sustained releases.

Respiratory diaphragm releases

Temporal technique and bone rebalancing

Dural tube traction and glide

Final Assessment

Client reports that she feels that without CST she wouldn't be where she is right now with her pain and function.

She is tolerating exercise workouts 2-3 times per week and is now able to walk normally and perform light running and squatting.

Her Low back and R SI joint pain is significantly diminished and she performs self treatment to prevent increased pain.

All motions in her cervical spine have improved, and she reports the hard "knot" in the R sternocleidomastoid area that she has had since birth is gone.

Cervical ROM

Flex 40

Ext 65

Sidebend R 26 L 33

Rotation R 76 L 88

Overall this client has improved significantly with full body responses and improved function with decreased pain.