RUHANI COLLEGE
OF HEALTH BUSINESS AND TECHNOLOGY

RUHANI COLLEGE OF MASSAGE THERAPY

CLINIC 1 · RU-RMT-13

Clinical Assessment & Clinical Reasoning

From findings to a safe, defensible plan

MODULE	FOCUS	PROGRAM
03 of 07	**Reading the Body, Thinking Like a Clinician**	**49 hours · 7 days**

Aligned with the CMTO Standards of Practice & Code of Ethics, CMTCA accreditation standards, and the FOMTRAC Inter-Jurisdictional Practice Competencies (Entry-to-Practice).

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Recap & Bridge from Module 2

From the story to the structured examination

You can now gather an accurate history, screen for safety and earn consent. Today you examine.

You have the story. the presenting concern, history and the client's goal.

You have consent. to assess — and you'll reconfirm it as you go.

Now you gather findings. through observation, movement testing and palpation.

And you reason. turning findings into an impression that guides the plan.

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Learning Outcomes

By the end of Module 3 you will be able to…

1. **Assess systematically**
   Perform a structured postural, range-of-motion and palpation assessment within scope.

2. **Select safe tests**
   Choose and perform assessment techniques safely, respecting cautions and comfort.

3. **Reason clinically**
   Interpret findings, form a working impression and identify what needs referral.

4. **Stay client-centred**
   Keep the client informed and consenting throughout the examination.

5. **Document objectively**
   Record objective findings clearly for the clinical record.

Session Roadmap

How today unfolds

1. **Observation & posture**
   What the body shows before you touch it.

2. **Range of motion**
   Reading active, passive and resisted movement.

3. **Palpation**
   Skilled hands answering structured questions.

4. **Clinical reasoning**
   Turning findings into a working impression.

5. **Documentation & practice**
   Recording the objective picture and assessing peers.

Why We Assess

Findings, not guesses, drive safe care

Assessment is how you confirm what's safe, locate the problem, and measure whether care works.

Safety. Assessment re-screens for anything that should modify, delay or stop treatment.

Focus. It localises the tissues and movements involved so treatment is targeted.

Baseline. It establishes measures you can re-test to prove change.

Communication. It lets you explain your reasoning to the client in plain terms.

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The Assessment Sequence

Observe, move, then touch

1. **Observe**
   Posture, symmetry, skin, swelling and how the client moves and holds themselves.
2. **Active range of motion**
   The client moves first — it's the safest way to gauge willingness and limits.
3. **Passive & resisted**
   You move the joint, then test against resistance, watching for pain and weakness.
4. **Palpate**
   Compare temperature, texture, tone and tenderness against the other side.
5. **Special tests**
   Only those indicated, performed within cautions, to refine the picture.
6. **Reason & record**
   Integrate findings into an impression and document them objectively.

Assessment Within Scope

Describe findings — never diagnose

DO

Describe "reduced, painful right-shoulder abduction"

Compare sides note asymmetry objectively

Localise tissue muscle, tendon, joint involvement

Refer when findings suggest serious pathology

AVOID

Name a disease diagnosing is outside scope

Over-test only assess what's indicated

Push through pain provocation has limits

Assume confirm with the client and findings

You describe and reason; you do not diagnose. When findings exceed your scope, refer or escalate.

CMTO STANDARD OF PRACTICE

Client-Centred Care in Assessment

CMTO · Client-Centred Care

Principle. Assessment is done with the client, around their goals and comfort, and only within your competence and scope.

WHAT THE STANDARD REQUIRES

- ◯ Assess in a way that respects the client's goals
- ◯ Keep the client informed as you assess
- ◯ Work within your competence and the MT scope
- ◯ Adapt the assessment to the client's comfort
- ◯ Refer or collaborate when findings require it

WHAT IT MEANS FOR YOU AS A STUDENT

- ◯ Tell the client what each test is for
- ◯ Reconfirm consent as you move to new areas
- ◯ Stop a test the moment it's too painful
- ◯ Don't perform tests you're not trained in
- ◯ Escalate uncertain or serious findings

Observation & Posture

What the body shows before you touch

Observation begins the moment the client walks in — how they sit, stand, move and undress all inform you.

LOOK FOR

Symmetry shoulder, pelvis and head position

Alignment spinal curves and limb positioning

Skin colour, swelling, scars, bruising

Guarding protective posture or muscle holding

INTERPRET WITH CARE

Variation is normal asymmetry isn't always a problem

Correlate match observation to the client's story

Objective language record what you see, not a label

Comfort note antalgic (pain-avoiding) postures

Common Postural Observations

Describe patterns objectively

1. **Forward head**
   with rounded shoulders
2. **Elevated shoulder**
   on one side
3. **Increased thoracic curve**
   kyphotic pattern
4. **Pelvic tilt**
   anterior or lateral
5. **Limb asymmetry**
   in stance or loading
6. **Antalgic posture**
   pain-avoiding positioning

Record these as observations to correlate with movement and palpation — not as diagnoses.

Movement & Gait

How the client moves tells a story

1. **Willingness vs ability**
   Reluctance to move may reflect pain, fear or guarding, not just restriction.

2. **Quality of movement**
   Watch for compensation, hesitation or a painful arc through the range.

3. **Gait**
   Note limp, reduced weight-bearing, or altered rhythm where relevant.

4. **Bilateral comparison**
   Always compare the involved side to the uninvolved side.

Range of Motion — Principles

Move safely, read carefully

1. **Active first**
   The client moves under their own control — safest and shows functional limits.

2. **Then passive**
   You move the joint to assess the non-contractile structures and end-feel.

3. **Then resisted**
   Isometric resistance tests the contractile tissue — muscle and tendon.

4. **Compare and record**
   Note range, pain location within the range, and symmetry with the other side.

AROM · PROM · RROM

What each movement test reveals

Sequencing active before passive before resisted keeps assessment safe and interpretable.

TEST	CLIENT / THERAPIST	CHIEFLY ASSESSES
AROM (active)	Client moves alone	Willingness, function, gross range
PROM (passive)	Therapist moves joint	Joint, ligament & end-feel; non-contractile
RROM (resisted)	Client resists therapist	Contractile tissue: muscle & tendon
Overpressure	Gentle, at end range	End-feel — only if AROM is pain-free

Reading End-Feel

The quality at the end of passive range

1. **Normal end-feels**
   Soft (tissue approximation), firm (capsular/ligamentous), hard (bone-to-bone) — each normal in the right joint.

2. **Abnormal end-feels**
   Empty (pain stops movement), boggy (swelling), spasm — flag these for reasoning and possible referral.

3. **Go gently**
   End-feel is assessed with light overpressure only when active movement is pain-free.

4. **Record it**
   Note the end-feel and any pain, and compare with the opposite side.

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Anatomy Review for Assessment

Refresh joints & muscles before palpating

A quick refresh of joint types, movements and muscle structure sharpens your ROM and palpation assessment.

- #20 **Joints — axial/appendicular skeleton, joint types & movements**
  youtube.com/watch?v=DLxYDoN634c

- #21 **Muscles, Part 1 — muscle cells, actin & myosin, contraction**
  youtube.com/watch?v=Ktv-CaOt6UQ

- #22 **Muscles, Part 2 — how muscles work together to create movement**
  youtube.com/watch?v=I80Xx7pA9hQ

- #19 **The Skeletal System — bone types, structure & remodeling**
  youtube.com/watch?v=rDGqkMHPDqE

Review only. Your A&P, Arthrology and Palpation Lab materials remain the assessed references.

Palpation — A Structured Touch

Skilled hands, specific questions

1. **Palpate with purpose**
   Each contact answers a question: what tissue, what quality, is it tender?

2. **Layer by layer**
   Move from superficial to deep, comparing left to right as you go.

3. **Communicate**
   Tell the client what you're doing and check comfort continuously.

4. **Correlate**
   Fit palpation findings to observation, movement and the client's story.

What Palpation Assesses

The four T's and more

ASSESS

Temperature warmth may signal inflammation

Texture smooth vs fibrous, adhesions

Tone hypertonic, hypotonic, guarding

Tenderness grade and locate carefully

ALSO NOTE

Swelling boggy, firm, localised or diffuse

Trigger points taut bands and referral, per training

Symmetry always compare both sides

Response the client's reaction to pressure

Special & Orthopedic Tests

Use them wisely and safely

1. **Only when indicated**
   Select tests that answer a specific question raised by your findings.

2. **Within your training**
   Perform only tests you've been taught and assessed on; consult your supervisor.

3. **Interpret cautiously**
   A single test is rarely conclusive; combine with the overall picture.

4. **Respect cautions**
   Stop if a test provokes significant pain or the client withdraws consent.

Record test, side (R/L) and result, as on your Treatment Record Form's orthopedic-test section.

Pain Provocation & Safety

Assessment must not harm

The goal is information, not maximal pain — you can assess thoroughly without hurting the client.

Warn and check. Tell the client a test may reproduce symptoms and confirm they're willing.

Grade your force. Use the least force that answers the question.

Stop signals. Any sharp, radiating or unexpected pain means stop and reassess.

Re-screen. If assessment uncovers a red flag, treatment may wait for referral.

Baseline Vitals

Simple objective measures you can re-check

Your Treatment Record Form captures pre- and post-treatment vitals — take them consistently and record them.

RECORD PRE-TREATMENT

Heart rate beats per minute, at rest

Respiratory rate breaths per minute

Blood pressure where indicated / available

Relevant results any imaging the client reports

WHY & HOW

Baseline a reference to compare post-treatment

Safety flags values that warrant caution or referral

Consistency measure the same way each time

Record enter in the Pre-Tx vitals field of the form

Recording ROM on the Form

The postural & range-of-motion section

Enter each joint you assess with active, passive and resisted findings — specific enough to re-test next visit.

JOINT	AROM	PROM	ARROM
e.g. R shoulder	Painful abduction ~90°	Full, firm end-feel	Weak / painful
Compare L side	Full, pain-free	Full	Strong, pain-free
Note units	degrees or range	end-feel quality	strength / pain
Be specific	measurable	reproducible	re-testable

Neurological Screening — Basics

When symptoms suggest nerve involvement

1

When to screen

Numbness, tingling, radiating pain or weakness in a limb warrants a basic neurological screen.

2

What you note

Altered sensation, reduced strength, or changes in reflexes described objectively — within your training.

3

Interpret with caution

Neurological findings often mean referral, not treatment; never diagnose.

4

Escalate

Any new or progressive neurological sign goes to your supervisor for referral.

Draws on Neurology 1 (RU-RMT-11). Basic screening only; refer serious or unclear findings.

Special Tests by Region

Examples — performed only within your training

Choose tests to answer a specific question. A test is one piece of evidence — never the whole picture.

REGION	QUESTION THE TEST HELPS ANSWER	CAUTION
Shoulder	Rotator-cuff or impingement involvement	Stop on sharp pain
Cervical	Nerve-root vs muscular pain	Gentle; screen first
Lumbar / hip	Local vs referred / neural pain	Avoid if red flags
Wrist / elbow	Tendinous vs joint involvement	Compare both sides

Perform only assessed tests, within cautions, and record test · side · result on the form.

Posture — Using a Reference Line

Make observation objective

1. **A consistent reference**
   Assess against a vertical reference (e.g. a plumb line) from the front, side and back.

2. **Landmarks**
   Note ear, shoulder, hip, knee and ankle relationships to the line.

3. **Describe deviations**
   Record what deviates and in which direction — objectively, without labelling.

4. **Correlate**
   Link postural findings to the client's symptoms and movement, not in isolation.

Grade Findings Consistently

So change is measurable

1. **Pain 0–10**
   same scale, rest and movement
2. **Tenderness**
   grade lightly and consistently
3. **Tone**
   hypertonic / normal / hypotonic
4. **ROM**
   degrees or proportion of normal
5. **Strength**
   note pain vs true weakness
6. **Both sides**
   always record a comparison

Consistent grading lets you prove change at reassessment — the point of measuring at all.

CMTO STANDARD OF PRACTICE

Safety & Risk Management in Assessment

CMTO · Safety and Risk Management

Principle. The therapist identifies and manages risks to the client throughout care, preventing harm and responding to incidents.

WHAT THE STANDARD REQUIRES

- ◯ Identify hazards and client-specific risks
- ◯ Take reasonable steps to prevent harm
- ◯ Recognise when care should stop or change
- ◯ Respond to and document incidents
- ◯ Work within a safe environment and scope

WHAT IT MEANS FOR YOU AS A STUDENT

- ◯ Re-screen for red flags as you assess
- ◯ Use the least force needed to gather findings
- ◯ Stop and escalate uncertain or serious findings
- ◯ Report any incident or near-miss honestly
- ◯ Never let 'getting the finding' outweigh safety

Clinical Reasoning

Thinking like a clinician

1. **Gather**
   Combine history and all objective findings into one picture.

2. **Hypothesise**
   Form a working impression of which tissues and movements are involved.

3. **Test**
   Use assessment to support or rule out your hypothesis.

4. **Refine**
   Adjust your impression as evidence accumulates — and stay open to being wrong.

Differentiate & Avoid Bias

Reason carefully

1. **Differentiate structures**
   Ask which tissue best explains the pattern of findings — contractile, inert or referred.

2. **Beware anchoring**
   Don't lock onto the first impression; let later findings change your mind.

3. **Beware confirmation bias**
   Actively look for findings that would disprove your hypothesis.

4. **Know your limits**
   If the picture doesn't fit, or suggests serious pathology, refer.

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From Findings to Impression

A worked example

1. **History**
   Right-shoulder ache, worse reaching overhead, desk-based work, no red flags.

2. **Observation**
   Slightly elevated right shoulder, mild forward-head posture.

3. **Movement**
   Painful right abduction mid-range; resisted abduction reproduces ache.

4. **Palpation**
   Tender, hypertonic right upper trapezius and deltoid; warm, no swelling.

5. **Impression**
   Findings consistent with soft-tissue overuse of the shoulder girdle — within scope to treat, no red flags.

Documenting the Assessment

The objective record

1. **Record what you found**
   Posture, ROM values, palpation and test results — objective and specific.

2. **Separate fact from interpretation**
   Findings are objective; your impression is reasoned interpretation.

3. **Note side and measures**
   R/L, degrees, pain scale — anything you can re-test later.

4. **Keep it defensible**
   Clear, accurate, complete and timely, per the Record Keeping standard.

Communicating Findings

Client-centred assessment includes explanation

Clients understand and engage far better when you explain what you found in plain language.

Plain terms. “Your shoulder is stiff and tender here, and reaching up is uncomfortable.”

No alarming labels. Describe findings without diagnosing or catastrophising.

Link to the plan. Connect what you found to what you propose to do.

Invite input. Confirm this matches the client's experience and goals.

When Assessment Says ‘Don't Treat’

Stopping is a clinical decision

Sometimes the right, professional outcome of an assessment is not to treat today.

Red flags. Refer for medical assessment before any treatment.

Unclear picture. Consult your supervisor rather than guessing.

Contraindication found. Modify, defer or refer as appropriate.

Document and refer. Record your reasoning and the referral you made.

Reassessment — Measuring Change

Prove that care works

1. **Re-test your baselines**
   Recheck the specific ROM, pain or palpation findings you recorded.

2. **Compare objectively**
   Use the same measures so change is real, not remembered.

3. **Adjust the plan**
   Progress, maintain or refer based on the response.

4. **Record it**
   Post-treatment findings and client feedback go in the record.

Assessing Peers

Today's simulation

1. **Full assessment sequence**
   Observe, test ROM and palpate a classmate as if they were a client.

2. **Consent and comfort**
   Reconfirm consent through the exam and stop on any discomfort.

3. **Reason aloud**
   Practise forming and explaining a working impression.

4. **Chart the objective findings**
   Complete the assessment section of the Treatment Record Form.

Common Assessment Errors

And how to avoid them

1. **Skipping observation**
   watch before you touch
2. **Testing resisted before active**
   keep the safe order
3. **Provoking pain needlessly**
   least force that informs
4. **Diagnosing**
   describe, don't label
5. **Ignoring the other side**
   always compare
6. **Not reconfirming consent**
   check as you move
7. **Anchoring on one idea**
   stay open to findings
8. **Vague documentation**
   record specific measures

Assessment Checklist

A complete, safe examination

STEP	DONE?
Consent reconfirmed for assessment	☐
Observation and posture recorded	☐
AROM tested and measured	☐
PROM / end-feel assessed where safe	☐
Resisted testing where indicated	☐
Palpation: temperature, texture, tone, tenderness	☐
Indicated special tests, within training	☐
Working impression formed and documented	☐
Red flags re-screened; referral if needed	☐

Assessment Feeds the Plan

A bridge to Module 4

A clear, well-reasoned impression is the launch point for a safe, goal-oriented treatment plan.

Goals. Your findings and the client's goals together define the plan.

Technique. The tissues involved point to appropriate techniques.

Cautions. Screening and cautions shape what you will and won't do.

Measures. Your baselines become the outcomes you'll re-test.

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Accreditation Alignment

Mapping Module 3 to FOMTRAC competencies

1. **PC 3**
   Performs assessment within scope and competence

2. **PC 5**
   Uses clinical reasoning to interpret findings

3. **PC 1**
   Recognises limits; refers appropriately

4. **PC 4**
   Maintains consent throughout assessment

5. **PC 6**
   Documents objective findings accurately

6. **CMTCA**
   Assessment & reasoning standards met

CMTO Standards of Practice are published at cmto.com; students consult the current text directly. PC references follow the FOMTRAC Inter-Jurisdictional Practice Competencies.

Key Takeaways

What to carry onto the clinic floor

1. Assess in a safe order: observe, then active, passive and resisted movement, then palpate.
2. Describe and reason from findings — you do not diagnose.
3. Keep the client informed and consenting throughout the examination.
4. Reason carefully: hypothesise, test, refine — and refer when the picture exceeds your scope.
5. Document objective findings you can re-test to prove that care works.

MODULE 03 COMPLETE

You can now gather meaningful findings and reason toward what they mean.

Up next ·

Treatment Planning & Evidence-Informed Practice

Module 4 turns your assessment into a client-owned, evidence-informed treatment plan — the right techniques, chosen safely, for goals the client agrees to.