ASSISTED STRETCHING POSTURES FROM THAI MASSAGE ON THE FLOOR

Developed by
Cassius Camden Clay, D.C.

Cassius Camden Clay, Chiropractor
404-808-4280
Atlanta, GA, USA
www.QuickSelfFixes.com
Help@QuickSelfFixes.com

Credits
Chris Savas: Photographer
Logan Ferrelle: Editor
Kristy Winkler: Model

ABOUT CASSIUS CAMDEN CLAY AND THE DEVELOPMENT OF THIS COURSE

Camden Clay is a Chiropractor, Kinesiologist(muscle testing specialist) and an Assisted Stretching Practitioner. The primary emphasis of his practice is improving musculo-skeletal function by identifying weak muscles and making them instantly strong using bodywork or self help techniques.

A NEW PARADIGM

The standard belief that exercise is the only way to make weak muscles strong is false! We now know that we can make a significant number of weak muscles instantly strong and keep them strong using Assisted Stretching of Connective Tissue.

Dr. Clay has proven beyond doubt that Assisted Stretching, like Chiropractic and Osteopathy, makes most weak muscles instantly strong. Dr. Clay developed a system of self healing called "Quick Self Fixes" which makes and keeps chronically weak muscles strong. Assisted Stretching was integral to the development of "Quick Self Fixes". See the chart on pages 33-35 which pairs Assisted Stretching Postures with the weak muscles they make strong and related "Quick Self Fixes".

After graduating from Life Chiropractic College in 1983, Dr. Clay has also studied and practiced Assisted Stretching Postures from Thai Massage since 1989, including four month-long trips to Thailand (1997, 1998, 1999 and 2000), studying one-on-one with extraordinary Thai Massage Masters. As of 2018, he has taught 284 Assisted Stretching workshops primarily within the massage profession. Over the years, this coursework has evolved from a five day workshop covering 100 postures into the current streamlined format of a two day workshop covering 20 postures. By eliminating redundancies, these 20 postures do the same work as the previous 100, and since they are done on the table, they are both easier on the practitioner and convenient to incorporate into a bodywork session. In his 30's, 40's and early 50's, Dr. Clay practiced Assisted Stretching on the floor mat as he was taught in Thailand. After age 55 he began practicing Assisted Stretching exclusively on the massage table. Practicing Assisted Stretching on the Table is better ergonomically and less labor intensive for the practitioner.

Practicing Assisted Stretching on the Floor is more versatile, yet any outcome achievable on the floor is also achievable on the table. If you are young and in great shape, go ahead and practice on the floor. It is awesome!

Shawne Murray, Camden's wife, consulted timelessly on the development of this course since its inception. Thank You Shawne.

Barbara Sharp, LMT helped write the first edition of 100 postures which was the blue print for this book. Thank You Barbara.

Created by
Dr. Cassius Camden Clay
Chiropractor

Top Advisor
Dr. Shawne Amina Murray
Osteopath

Co-Author
Barbara Sharp
Licensed Massage Therapist

Special Thanks to:
My Thai Massage teachers: Pishet Boonthumb, Chaiyuth Priyasith and Nicolette Vajk
Top Advisor: Dr. Shawne Amina Murray, Osteopath P: 404-246-3132 , E: Opthealth@ME.com
Co-Author: Barbara Sharp, Licensed Massage Therapist P: 404-512-1096, E: sharp64@bellsouth.net

TABLE OF CONTENTS

TABLE OF CONTENTS

Introduction

Thai Massage is an ancient healing system. In Thailand, Thai Massage has been practiced and taught in Buddhist monasteries. It has also been a family tradition handed down from one generation to the next. Thailand is a crossroads for healing information, including yoga from India and acupressure from China. Traditional Thai Massage combines assisted stretching postures with a unique and specific system of acupressure.

Dr. Clay teaches both specific Assisted Stretching Postures from Thai Massage and two stretches he developed, which are the Hip Joint Capsule Stretch (pg.25) and the Upper Cervical Connective Tissue Stretch (pg.29). Although he has studied traditional Thai Massage acupressure in depth and found it to be useful, it is also very time consuming. He does not use the acupressure point therapy and he does not teach it.

When doing Assisted Stretching, a deep knowledge of anatomy is not necessary, although it is very beneficial. Most Thai Massage practitioners in Thailand have not studied human anatomy. In Thailand, Assisted Stretching is usually performed on a floor mat with the client fully clothed.

Since the 1980s, yoga's popularity in the west has grown exponentially. Many people understand the benefits of practicing yoga. Explaining "Assisted Stretching" to them is easy. It is like yoga with help. Practicing yoga makes you flexible and strong. In Assisted Stretching, the client is passive while the Assisted Stretching practitioner is active. The client gets flexible while the therapist gets strong. It is sometimes referred to as "Lazy Person's Yoga". Presently, Assisted Stretching is practiced most by massage therapists, yoga instructors, physical trainers, physical therapists, and a few chiropractors and osteopaths. Dr. Clay believes that one day lay people will also commonly practice Assisted Stretching to facilitate flexibility, health, and stress relief for family members, friends and co-workers.

Hallmarks of Assisted Stretching are energy balancing, and muscle, tendon, ligament, and fascial stretching at their best. Our blood vessels, lymphatic channels, cerebral spinal spaces and nerves all travel through and are supported by our connective tissue. Connective tissue stretching causes increased circulation of blood, lymph and cerebral spinal fluid, facilitating the removal of cellular waste products and enhancing delivery of oxygen and nutrients to body tissues. It also helps align the musculoskeletal system and facilitates nerve communication. Assisted Stretching improves a person's balance, posture and gait. Assisted Stretching naturally helps relieve tension and pain, and facilitates clarity, emotional fortitude, and a propensity towards happiness!

Our older generation first began learning about weight training in the 1950's. They did not learn about flexibility training. So like generations before them, they are now old and stiff. It is never too late to improve your flexibility unless you have rigor mortis. Dr. Clay has a segment of his clientele who are in their 70s, 80s and 90s who come in regularly and use Assisted Stretching in place of yoga.

A traditional chiropractic theory states that the chiropractic adjustment moves a hard bone off of a soft nerve, thereby improving nerve function. Improved nerve function helps our "Innate Intelligence" heal and maintain our good health. Through muscle testing, Dr. Clay has documented that almost any dormant, weak muscle that he could make strong with a chiropractic adjustment, he could also make strong with Assisted Stretching. He hypothesizes that the chiropractic adjustment is actually a connective tissue stretching procedure using bones as levers to stretch connective tissues connected to that bone. Remember, connective tissue stretching not only facilitates nerve communication, it also facilitates blood flow, lymphatic drainage and cerebral spinal fluid flow.

Many times, Dr. Clay has witnessed mild to moderate scoliosis significantly improve or resolve completely with Assisted stretching of spinal connective tissues. Chiropractic was his previous treatment protocol for scoliosis. See "Scoliosis Resolution" video/book at www.QuickSelfFixes.com.

Assisted Stretching explores many biomechanical ranges of motion and is a tool for evaluating hyper and hypo-mobility of joint motion which would have otherwise been overlooked.

Assisted Stretching challenges the resiliency of connective tissue, resulting in additional elastin deposited in connective tissue by cells called fibroblasts. Increased elastin in the connective tissue creates increased flexibility and range of motion. It also softens fibrotic scar tissue caused by injury.

Assisted stretching is sustained often near the edge between ecstasy and pain but staying on the side of ecstasy. Often, it elicits from the client positive response sounds such as moans or groans, or statements like "Where have you been all my life!" Each stretch posture should feel challenging and safe to the client. Avoidance of pain is the highest priority in Assisted Stretching. If you are stiff and apprehensive about yoga and think that yoga is too hard and out of your league, consider receiving Assisted Stretching as an effective avenue for loosening you up as a prelude to the rigors of a yoga practice. Receiving Assisted Stretching prior to participating in a demanding sporting event is also very advantageous.

To become masterful as a practitioner of Assisted Stretching takes a few years of dedicated practice.

Practitioners and clients differ in body shapes, sizes, levels of strength, levels of flexibility, presence or absence of pain, etc. Based upon these variables and others, Assisted Stretching postures often may need to be improvised using the creative process and good sense to assure ergonomic viability for the practitioner while maintaining comfort and safety for the client. It is important to note that in any given stretch, the area that the client feels is stretching may in fact be different than the therapist's intent. The client will feel the stretch where they most need it.

People who practice yoga are instantaneously talented at stretching other people. Also, Yogi's naturally have outstanding ergonomics when practicing Assisted Stretching. As a practitioner, if you love Assisted Stretching, Dr. Clay recommends that you study yoga to be the best Assisted Stretching practitioner you can be.

Contraindications

- Post-traumatic disc herniation
- Joint replacements
- Recent surgery
- Cancer

Spinal discs are cartilage pads between most spinal vertebrae. The disc has a center space filled with a liquid which becomes less vicious with age. This fluid center of the disc is called the nucleus pulposus. It is surrounded by many tiny connective tissue fibers arranged in concentric rings called annular fibers. Disc herniations are tears in the annular fibers close to the nucleus pulposus; these tears allow this fluid filled center to move off center, thereby causing the disc to bulge. This disc bulge sometimes impinges on nerves where they exit the spine or less frequently on the spinal cord itself.

In initial stages of healing, discs are vulnerable to re-injury and are commonly exacerbated by spinal twisting and/or backward-bending(extension). Postures which cause spinal twisting or spinal extension are contraindicated when working with a client who has a recent history of disc injury. To help rule out disc herniations, screen for recent past or present history of spinal, buttocks and/or leg pain which was or is exacerbated by coughing, grunting, straining and/or sneezing. Check for an antalgic lateral lean. Also, is the pain worsened by leaning to the left or right? Any of these are positive findings that indicate possible disc herniation.

Do not engage any artificial joints with Assisted Stretching or you may cause harm.

Do not do Assisted Stretching on people who have recently had surgery. Consult with their medical doctor to be sure that Assisted Stretching is now safe for them.

Do not do Assisted Stretching on people who have cancer in stage one, two or three as it may stimulate metastasis through lymphatic stimulation. There is not documented research validating this concept. Yet, it does make sense and Doctors of Osteopathy teach this concept to their students at the Philadelphia School of Osteopathic Medicine in Georgia.

NO PAIN, NO PAIN
(Safety Rules)

No Pain, No Pain means that at no time during a stretch should you feel pain, or your client feel pain. Pain means you are doing something wrong and may cause injury, either to yourself or to your client. Instruct the client to say "stop" or "lighten up" if there is any pain. Not every client will even tell you they have pain, so watch their faces for red flushes (1st sign), pupil dilation (if you can see them), wincing, etc. If you have caused any pain, ease out of the posture slowly.

Exercise 1: As a target point for eliciting pain, apply deep trigger point pressure into the head of a soleus muscle to stimulate a sympathetic body response. As pain occurs, the skin hue in the face will suddenly change to a darker hue. This is caused by vaso-dilation and is almost instantaneous. The skin hue change is more evident in lighter skin tones and can also be seen in darker skin tones with practice. Sudden pupil dilation also occurs and is observable. Choose a light skinned, beardless person who is not wearing make-up.

The following rules are the standard for achieving the goal of "No Pain, No Pain"
1. Be Prepared
2. Go Slowly
3. You're Number One
4. Look Pretty
5. Never Trust Anyone
6. Just Be Nice

1. Be Prepared means that you keep yourself in good shape to physically and mentally to be able to do Assisted Stretching safely. Stretching people of various sizes, especially those bigger than you, and working with multiple people per day is strenuous work similar to working on the "Chain Gang". Keep your own body strong, stretched, rested and with balanced blood sugar. To enter another person's energy field safely, you must be clear and definitely focused.

2. Go Slowly means that all stretches should be done at a leisurely pace so that a client can tell you if a position becomes uncomfortable before it becomes painful. This is a pin then stretch style. When you first pin, and then stretch, as opposed to pinning AND stretching simultaneously, you cut the speed of your movements in half. It is important to release a stretch as slowly as you entered it. Going slowly, even walking slowly as you approach your client, subconsciously builds trust in the client; trusting that you will not do something sudden which may be harmful.

3. You're Number One means that you don't convert a client's pain into your pain! At no time should you ever do a stretch that is uncomfortable for you or may cause you pain or injury. It is better to simply not do some stretches if the mechanics of working with that particular client prohibit their safe execution. Take care of yourself first or you will not be able to stay in this field.

4) Look Pretty means that the therapist practices proper ergonomics by paying attention to his or her own body mechanics. The instructor of this course will help you with this (See "Proper Ergonomics" on page 7).

5) Never Trust Anyone simply means that you, the therapist, are 100% responsible for safety.

6) Just Be Nice. Commonly, Assisted Stretching practitioners on their journey to competency have a phase of stretching clients with too much force, thinking that more force is better. It is quite the opposite. Too much force causes the client to be tense, which prevents deep stretching and too much force can cause pain and harm. Stay just below the client's threshold for discomfort. It takes some practice to become competant at this.

Our Connective Tissue Is Connected Tissue

Stretching connective tissue anywhere facilitates loosening connective tissue everywhere. For example, stretching the calves and hamstrings reduces tension in the dura mater surrounding the brain and spinal chord and regularly relieves chronic, dull headaches at the base of the occiput.

Exercise 2: Firmly palpate your or your client's cranial saggital suture before and after stretching the client's legs (postures 1-10). Note that clients who had a sore saggital suture (approximately one in five) prior to having their legs stretched usually notice that the soreness is gone after the session.

In theory, the connective tissue in the calves and hamstrings tug on the dura mater surrounding the spinal cord which in turn tugs on the dura mater covering the brain. Resulting in a cranial imploding pressure as the spinal dura attempts to pull the brain through the foramen magnum.

Exercise 3: Contact the right and left lateral aspects of your atlas(C1) with your middle fingers. Next, with eyes closed, look far to the right and then far to the left several times. Feel how your atlas moves as your eyes move. While maintaining finger contact on the atlas on the left and right, stick your tongue out and move it far to the right and far to the left several times. Notice how your atlas moves as your tongue moves. These two exercises educate us kinesthetically how our connective tissue is connected tissue!

Stretching the lumbar aponeurosis with "Lumbar Connective Tissue Stretch" (Posture 16) is a "Master Fix" and usually makes all weak muscles found through Targeted Muscle Testing instantly strong! The Thoraco-Lumbar-Sacral Aponeurosis is the hub of our connective tissue system. Relaxation here creates massive connective tissue relaxation throughout the body improving bloodflow, lymphatic flow, cerebral spinal fluid flow and nerve communication.

How Long to Hold a Stretch

Focus on learning how to feel when the connective tissue releases. When it releases, there is a definite, palpable softening of the connective tissue. The stretch will usually elongate along the line of the stretch just a little bit. The therapist's body will also sometimes move slightly and softly into the direction of stretch.

Exercise 4: With a client lying face up on a massage table, grip one of their wrists and have them grip your wrist. With the client's arm and your arm straight at the elbow and with your shoulder pulled in and locked, slowly lean away from the client pulling their arm and shoulder to full tension using your body weight. The Client's shoulder girdle must be relaxed during this procedure. Now, wait patiently and focus. Within a matter of seconds, core connective tissue relaxes and the practitioner moves slightly away from the client. The primary therapeutic benefit of the stretch has been accomplished.

Some connective tissues stretch immediately as they are being pulled upon. Another group of connective tissue relaxes and stretches after a period of sustained stretching tension. This is your core connective tissue. Most people have had multiple experiences like they are falling through their bed toward the floor just as they are going off to sleep. It is proported that this happens when the core connective tissue relaxes all at once.

How to Flow Chi Energy
(**Unliftable Body)**

Most Assisted Stretching postures are designed combining biomechanics and physics to utilize the practitioner's weight, strength and "chi energy" as the forces for stretching the client.

Unwilling small children and unwilling dogs have the innate capacity to perform the "Unliftable Body". By flowing their Chi energy downward, unwilling children and unwilling dogs seem to have significantly gained weight, and they are much more difficult to pick up!

Exercise 5: Have a trusted person or two, with an armpit grasp, lift a lighter weight person one or two inches up from the floor. Prior to lifting, instruct the person(s) lifting you that this is not a contest. They are merely evaluating their perception of changes in your weight. Note the ease of the lift. Stand again on the floor, and flow your chi downward into the earth through your fingertips. Make your body including your fingers tight and stiff. Your fingers are pointing down towards the ground. Imagine that you are four years old and at a friend's birthday party and the cake is coming out soon. Unfortunately, you and your mom must leave the party now. You don't want to leave! Bend both of your knees a little and extend your arms and fingers as if they are flowing energy straight down into the earth. Silently and with full intention, chant to yourself: "Hell no, I won't go!" As you hold this firm stance, have your same friend(s) attempt to lift you straight up again without bending you backward. Notice what happens. Ha ha ha! It appears as though you have suddenly become much heavier!

I do not understand how this works, however, I guarantee that this phenomenon of flowing your chi and thus increasing your physical power will make you more effective as an Assisted Stretching practitioner. As you stretch your client and feel you need more power, you can use your weight, strength, and chi energy all together to accomplish your goal.

Proper Ergonomics

Dr. Clay studied the "Alexander Technique" in 1985 and again in 2009. Alexander said that when our muscles are truly relaxed, they elongate, thereby tractioning the human spine upward while standing or sitting. When in the "truly relaxed state", our muscles hold our skeleton up. When not in the "truly relaxed state", our skeleton holds our muscles up. When walking on a resounding wooden floor in the non "truly relaxed state", there is the sound of heavy heel strikes. In the "truly relaxed state", there is no sound of heel strikes on the floor. The conscious Tai Chi like person is also walking softly on Mother Earth and makes no sound of heel strikes on a resounding wooden floor. Ballet dancers also focus on spinal elongation as if hanging from a string attached to the middle of the top of the head.

Exercise 6: Practice the "truly relaxed state", by elongating your spine upward. This is best accomplished by imagining that your head is a well inflated helium balloon floating upward. Now imagine that your spine is a loose string tied to the balloon and hanging vertically toward the ground. You should feel a somewhat loose connection between your atlas and your occiput. Confirm this by using your hands to gently traction your skull upward and away from your atlas and gently wiggle your head with your hands while you walk softly. Once you feel the loosening between occiput and atlas, put your hands to the side. Also practice this concept while running as if your next step is your last before taking flight diagonally up into the air, resembling a bird ascending diagonally from the ground. Apply "Proper Ergonomics" while practicing Assisted Stretching.

Positional Release and Assisted Stretching

Positional Release was developed by Lawrence Jones, D.O. in the 1950's. The concept was first named "Spontaneous Release by Positioning". It is also referred to as Strain Counterstrain. Positional Release demonstrates that tender or painful areas in muscles discovered through palpation, are significantly less tender when the involved muscle section has been shortened to it's maximum. When in this passive position of muscle shortening, the tender or painful area may be "massaged away" with much less discomfort for the client. Why would a practitioner treat the involved muscle trigger point in any other position!

Assisted Stretching can be used to stretch and elongate a muscle or shorten an opposing muscle as preparation for a Positional Release treatment in the shortened muscle's trigger point. Assisted Stretching postures are a tremendous tool for locating optimal passive positions for shortest muscle lengths prior to trigger point therapy. Therefore Assisted Stretching is a highly useful addition to Positional Release.

Exercise 7: Apply "Positional Release" concept to trigger points using the piriformis or other buttocks muscles using the "Hip Flexor Stretch" (Posture 15).

Proprioceptive Neuromuscular Facilitation (PNF) and Assisted Stretching

PNF is a "Muscle Energy" technique developed by Fred Mitchell, Sr., D.O. in 1948. Most Assisted Stretching postures can further release tight muscles by adding the principles of PNF. Once in the Assisted Stretching posture, have the client gently contract with about 20% of their strength against your resistance for 5 seconds. Then allow a relaxation phase of three seconds. Follow by repositioning the posture into a slightly further stretch. Repeat this two more times for optimal benefit. Increased flexibility of the area being stretched should be observable after each of the PNF stretching segments. Assisted Stretching with PNF is a more effective stretching modality than Assisted Stretching by itself. Yet, the client must also work and sometimes they do not want to work; they just want to relax.

Exercise 8: Perform a PNF stretch on hip flexors (Psoas, iliacus, ilio-psoas and rectus femoris) using the "Hip Flexor Stretch" (Posture 15).

Appropriate Boundaries

When Assisted Stretching postures may involve breast contact, improvise the posture to avoid breast contact, or the therapists may use a thin pillow as a buffer between their breasts and the client.

Palpate Sacral Rhythm Prior To and After the Adductor Stretch

Exercise 9: With the person laying face down, lightly touch their sacrum with one hand, with fingers pointing toward the persons head. Imagine that you are wearing a high-tech jet pack and you land on the back of a beautiful stallion galloping in an open field. You land so lightly that the horse does not notice your presence, even as you slowly turn the jet pack completely off. Your body has merged with the horses galloping rhythm(as described by Ann Wells, D.O.). A healthy rhythm is long and slow, cycling between 8-12 cycles/minute. A dysfunctional rhythm is rapid as though "panting" for air. Do the adductor stretch (Posture 6) and re-evaluate the sacral pump's rhythm. The adductor stretch, thus far, always corrects a sacral dysfunctional rhythm.

The spinal cord and brain are bathed in cerebral spinal fluid (CSF). CSF is the equivalent of blood for the central nervous system (CNS). Blood is pumped by the heart. CSF is "pumped" in part by sacral movement. Dysfunctional cranial sacral rhythm leads to CRS (can't remember...stuff). In our chair sitting culture, people have very tight adductors because we do not squat. Tight adductors pull the pelvic girdle tight and this inhibits sacral respiration.

NOTES

WHEN TO CHANGE SIDES IN A FULL ASSISTED YOGA ROUTINE

- *Right and left reference the side of the client's body to which the therapist is standing*

POSTURES	*RIGHT*	*LEFT*
1. Calf Stretch		•
2. Calf and Hamstring Stretch		•
3. Medial Hamstring Stretch		•
4. Lateral Hamstring Stretch	•	
5. Iliotibial Band Stretch		•
6. Adductor Stretch		•
7. Knee Stretch		•
8. Hip Stretch		•
1. Calf Stretch	•	
2. Calf and Hamstring Stretch	•	
3. Medial Hamstring Stretch	•	
4. Lateral Hamstring Stretch		•
5. Iliotibial Band Stretch	•	
6. Adductor Stretch	•	
7. Knee Stretch	•	
8. Hip Stretch	•	
9. First Strong Posterior Leg Stretch	•	
10. Second Strong Posterior Leg Stretch	•	
9. First Strong Posterior Leg Stretch		•
10. Second Strong Posterior Leg Stretch		•
11. Sacroiliac Joint Stretch		•
11. Sacroiliac Joint Stretch	•	
12. Costo-Vertebral Ligament Stretch	•	
12. Costo-Vertebral Ligament Stretch		•
13. Cervical Connective Tissue Stretch		•
13. Cervical Connective Tissue Stretch	•	

WHEN TO CHANGE SIDES IN A FULL ASSISTED YOGA ROUTINE

POSTURES	*RIGHT*	*LEFT*
14. Hip Joint Capsule Stretch	•	
15. Hip Flexor Stretch	•	
16. Lumbar Connective Tissue Stretch	•	
17. T12 - T1 Thoracic Connective Tissue Stretch	•	
14. Hip Joint Capsule Stretch		•
15. Hip Flexor Stretch		•
16. Lumbar Connective Tissue Stretch		•
17. T12 - T1 Thoracic Connective Tissue Stretch		•
18. Upper Cervical Connective Tissue Stretch	•	•
19. Cranial Alignment Phase	•	•
20. Sitting Thoracic Spine Stretch	•	
20. Sitting Thoracic Spine Stretch	•	
21. Seated Shoulder Stretch		•
21. Seated Shoulder Stretch	•	

Posture 1
Calf Stretch

FIRST PIN:
- Rest client's lower leg on therapist's raised anterior distal thigh.
- Therapist's knee which is on the floor touches the client's lateral hip for added stabilization.
- Therapist faces client's foot.
- Therapist holds client's heel with therapist's hand and braces client's foot with therapist's forearm, bracing on the big toe side of client's foot.

SECOND PIN:
- Therapist pins the belly of client's tibialis anterior muscle with thumb pushing firmly toward client's foot. (Therapist still faces toward client's foot). This action helps prevent knee hyper-extension.

THE STRETCH:
- Therapist firmly dorsiflexes the client's foot by leaning therapist's body weight toward client's head. During this lean, therapist faces toward client's head.

THERAPIST ERGONOMICS:
- Elongate spine.
- Pinning arm is straight.

CAUTION:
- Do not apply any pressure which might hyperextend the knee.
- Do not do this stretch on people with double jointed knees.
- Do not perform with knee prosthetics.

NOTE:
The higher up the leg is from the table, the more intense the stretch is.

Posture 2
Calf and Hamstring Stretch

FIRST PIN:
- Rest client's lower leg on therapist's raised anterior distal thigh.
- If Therapist is much larger than client, therapist may kneel with client's lower leg resting on therapist's middle thighs.
- Therapist's knee which is on the floor touches the client's lateral hip for additional stabilization.
- Therapist's head faces client's foot.
- Therapist holds client's heel with therapist's hand and braces client's foot with therapist's forearm, bracing on the big toe side of client's foot.

SECOND PIN:
- Therapist pins the bellies of quadriceps muscles by gripping the middle of the quadriceps and pushing firmly toward client's foot. (Therapist still faces toward client's feet.) This action helps prevent knee hyper-extension.

THE STRETCH:
- Therapist firmly dorsiflexes the client's foot.
  During this lean, therapist faces toward client's head.

THERAPIST ERGONOMICS:
- Elongate spine.
- Pinning arm is straight.

CAUTION:
- Do not apply any pressure which might hyper-extend the knee.
- Do not do this stretch on people with double jointed knees.
- Do not perform with knee prosthetics.

NOTE:
The higher up the leg is from the table, the more intense the stretch is.

Posture 3
Medial Hamstring Stretch
3 Variations

THE PIN:

- Therapist holds client's heel with one hand and keeps arm straight.
- Or Therapist holds client's heel with one hand and braces elbow on distal anterior thigh.
- Or Therapist braces client's heel with a shoulder (deltoid muscle) contact.
- Therapist contacts the client's non stretching leg with a hand on the belly of adductor longus.

THE STRETCH:

- Therapist lunges and firmly pushes client's lower leg toward the outside of the client's shoulder, bringing the stretch to full tension, yet without fully straightening the client's leg at the knee.

THERAPIST ERGONOMICS:

- Elongate spine.

CAUTION:
Do not push the client's heel forward by straightening your arm, push the client's heel forward by lunging.

NOTE:
This stretch is a hamstring warm-up stretch partially straightening the client's leg.

Posture 4
Lateral Hamstring Stretch

THE PIN:

- Therapist straddles client's non-stretching leg.
- Therapist holds client's heel with one hand and keeps arms straight (not pictured).
- Or Therapist holds client's heel with one hand and braces elbow on anterior distal thigh.
- Or Therapist braces client's heel with a shoulder (deltoid muscle) contact.
- Therapist's other hand or fist contacts the client's ischial tuberosity on the side of the leg being stretched and pushes client's ischial tuberosity toward the floor firmly.
- Or Therapist holds client's heel with two hands and braces clients ischial tuberosity with knee pushing toward the floor.

THE STRETCH:

- Therapist lunges and firmly pushes client's lower leg toward the outside of the client's shoulder, bringing the stretch to full tension, yet without fully straightening the client's leg at the knee.

THERAPIST ERGONOMICS:

- Elongate spine.

CAUTION:
Do not push the client's heel forward by straightening your arm, push the client's heel forward by lunging.

NOTE:
The stretch is a hamstring warm-up stretch partially straightening the client's leg.

Posture 5
Iliotibial Band Stretch

THE PIN:

- With thumb or knee contact, therapist bears a firm pressure directly on the anterior aspect of the middle of the iliotibial band.

THE STRETCH:

- With thumb(usually thumb) or knee, the therapist firmly drags client's IT Band anterior to posterior (analogous to an arrow pulling on a bow string). This is a cross connective tissue fiber stretch.
- Repeat this procedure twice more, just above and just below the center of the IT Band.

THERAPIST ERGONOMICS:

- Elongate spine.

CAUTION:
Discomfort is common. Do not cross client's pain threshold.

NOTE:

With smaller people, use a thumb contact, with much larger people use a knee contact.

Posture 6
First Adductor Stretch

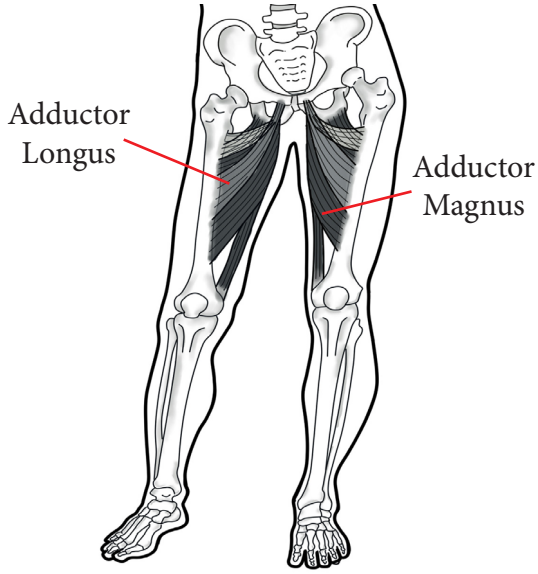
FIRST PIN:
- Brace client's foot of bent leg on therapist's knees which is on the mat.
- Therapist pushes client's leg inferior to superior (in relation to the client's body) to full tension by lunging forward.

SECOND PIN:
- Therapist crosses forearms and contacts the bellies of the client's adductor longus muscles.
- Therapist pushes deeply into the belly of both adductor longus, pinning the muscle between therapist's hands and the proximal femurs.

FIRST STRETCH:
- Therapist stretches the adductor longus fascia on the bent leg side by dragging the pinned connective tissue toward the client's knee on the same bent leg side.

SECOND STRETCH:
- Pin the belly of adductor magnus on the same side and repeat the above pin and stretch procedure.

THERAPIST ERGONOMICS:
- Elongate spine.



Alternate Stretch; hold knee of leg being stretched.

Posture 7
Knee Stretch

THE PIN:
- Client's leg is bent at the knee to a 90 degree angle.
- Therapist places foot on client's distal posterior thigh. (See photo to choose which foot)
- Therapist's hands grip client's ankle with thumb over thumb contact on anterior thalus.
- Therapist tractions thalus in a scooping motion anterior to posterior and superior to inferior in the thalo-calcaneus joint plane line. (This is a bonus stretch, stretching the ligaments which connect the thalus and calcaneus.)

THE STRETCH:
- Stretch is accomplished by therapist leaning backward.

THERAPIST ERGONOMICS
- Elongate spine.
- Shoulders drawn in and backward.
- Arms straight.

CAUTION:
This stretch is contraindicated for prosthetic knees, after recent knee surgery or with any knee pain whatsoever.

Posture 8
Hip Stretch

FIRST PIN:

- Therapist holds client's ankle, one hand contacts the talus/ tibia junction on top, the other hand holds the heel on bottom.
- The balls of the therapist's feet firmly contact the client's inferior ischial tuberosity, toes pointing straight up. Therapist's outer foot acts to stabilize this posture contacting the lateral ischial tuberosity.

SECOND PIN:

- Therapist leans backward pulling client's leg to the point that therapist's toes are dorsiflexed.
- Therapist's arms are straight or therapist's arms may be bent at the elbow; if so, hold elbows close to therapist's body for additional stabilization.

THE STRETCH:

- Therapist pushes the balls of feet toward the client's head, thereby tractioning the client's femur head away from the acetabular cup. This traction causes minor movement.

THERAPIST ERGONOMICS:

- Elongate spine.
- Shoulders drawn in and backward.
- Depending on size, therapist may end up lying down supine.
- For therapist's comfort, it is ok if the feet approach the ischial tuberosity diagonally in rather than perpendicular.

NOTE:

- Therapist's foot is acting as a pivotal fulcrum for the client's femur/ acetabular joint. Therapist's foot acts like a tent pole, with the client's hip like a tent draping over the tent pole.
- Make sure your grip on the foot remains comfortable for your client.

Posture 9
First Strong Posterior Leg Stretch

THE PIN:
- Client's leg is straight and locked at the knee.
- Therapist braces client's lower leg against therapist's shoulder farthest from the client.
- Therapist holds client's knee in extension by reaching medially around the inner thigh, grasping the anterior, lateral distal thigh.
- Therapist's hand contacts the big toe side of the client's foot.
- Therapist leans forward to bring the posterior leg connective tissue to full tension.
- Therapist hand drags the client's quadriceps fascia lateral to medial causing mild internal rotation of the leg.
- Both of Therapist's legs contact both of Client's legs for additional stabilization.

THE STRETCH:
- Therapist slowly dorsiflexes client's foot.

THERAPIST ERGONOMICS:
- Elongate spine

NOTE:
A female therapist should not allow the client's leg to contact her breast. Keep the leg on the shoulder/arm junction or use a thin pillow as a buffer on the therapist's chest.

Posture 10
Second Strong Posterior Leg Stretch

THE PIN:

- Therapist is on knees in an upright position.
- Client's leg is straight, locked at the knee.
- Therapist holds client's knee in extension by reaching medially around the inner thigh, grasping the anterior, lateral proximal thigh close to the client's torso.
- Therapist holds client's heel with one hand.
- Therapist rotates the client's foot medially into a slight "pigeon toe" position by dragging and rotating proximal thigh.
- The therapist sits back and in doing so, the therapist's arm holding the client's heel is straightened. Arm straightening is not by pushing arm forward using force.
- Bring the client's leg to full extension.

THE STRETCH:

- While holding this pin, therapist then raises own body up, inferior to superior up to one inch by moving therapist's buttocks away from heels. This lifts the client's pinned leg upward.

THERAPIST ERGONOMICS:

- Elongate spine
- Therapist's arms are straight; elbows locked.
- Shoulders draw in and backwards.
- Use positioning, not strength, to straighten arms.
- The final lift is accomplished by raising therapist's and client's body together. Use principles of "Proper Ergonomics".

CAUTION:

This move is contraindicated for any knee or hip replacements and on people who are double jointed at the knee. If client is much bigger than therapist, this move may be contraindicated.

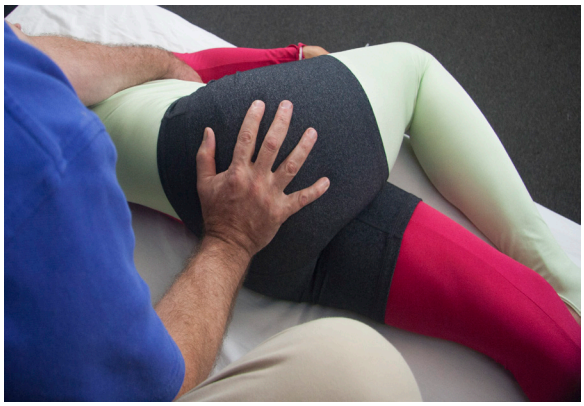
Posture 11
Sacroiliac Joint Stretch

THE PIN:

- Therapist's hand contacts client's lower rib cage closest to the floor.
- Therapist's other hand contacts client's buttocks in the belly of piriformis.
- Therapist braces elbow on his/ her proximal inner thigh on belly of adductor longus.
- Therapist firmly holds client's lower rib cage (which is closest to the floor) gently upward and toward therapist. This is not a pulling move, this is a brace for the stretch, which is a pushing move.

THE STRETCH:

- Therapist pushes client's ilium by lunging forward and a little toward client's feet to elongate client's spine.
- Apply pushing force during exhale only. This usually takes about three respiration cycles to reach full tension.



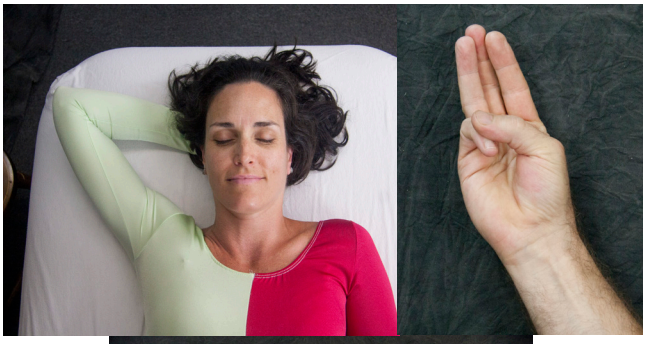
THERAPIST ERGONOMICS:

- Elongate spine

NOTES:

- Whenever we torque the spine, we elongate the spine.
- Therapist's arm which is holding the ribcage, moves to allow resistance free breathing.
- Ligaments that connect the pelvis together are quite thick, therefore, this posture takes longer to relax the connective tissue than any other posture. Be patient and wait for the release.
- Stretching the sacroiliac joint may elicit the sound of bones repositioning. If so, say "Good Stretch!"

Posture 12
Costo-Vertebral Ligament Stretch

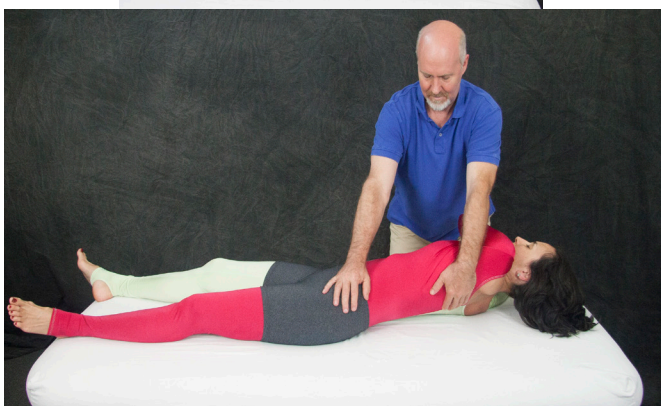


FIRST PIN:

- Therapist may straddle the client (not pictured).
- Client places hand closest to therapist under head.
- Therapist pulls other arm to roll the client up.
- Therapist switches hands, where the hand pulling the client up now contacts the rib(s).
- Therapist's hand contacts client's rib neck with middle, index, and ring finger working together as a gripping unit. (see photo) Contact fingers are in lamina groove medial to the ribhead. Grip is aided by contacting the rib near the junction of the rib neck and rib body as the rib travels posteriorly from spine.
- Therapist is positioned toward client's head so as to elongate client's spine during this stretch.

SECOND PIN:

- Therapist contacts client's anterior superior iliac spine (ASIS) with the other hand on the side that is being stretched and pins the pelvis to the floor mat by pushing downward gently.



THE STRETCH:

- Therapist leans backward and toward the client's head to stretch each rib head away from the spine one rib at a time.(T12 to T1)
- Each rib requires a new stretch, working your way from lower ribs to higher ribs.

THERAPIST ERGONOMICS:

- Elongate spine.
- Arms straight.
- Shoulder of stretching arm is drawn in.

NOTES:

- Therapist may contact segments of client's hemi-ribcage with therapist's whole hand to mobilize groups of ribs versus one rib at a time.
- Therapist may improvise by using both hands on ribs on larger clients who do not roll up and hence do not need to be pinned down.
- Always elongate the client's spine, when torquing the spine.

Posture 13
Cervical Connective Tissue Stretch

THE PIN:
- Therapist straddles the client.
- Therapist firmly pins the nonstretching side of client's shoulders in an anterior to posterior direction.
- Therapist cradles client's occiput with other hand.
- Client's nose is turned toward the pinned shoulder.

THE STRETCH:
Therapist gently and slowly stretches client's head and neck superior and then laterally away from the pinned shoulder in an arch.

THERAPIST ERGONOMICS:
- Elongate spine
- The pull of the client's occiput is achieved by the therapist simply leaning away from the client.
- Therapist focuses on tractioning the client's neck inferior to superior throughout this procedure.

NOTE:
- Pointing the client's nose toward the pinned shoulder prevents pinching in the upper cervical spine.
- This lateral cervical flexion stretches the synovial membranes between the cervical facet joints and stretches a thick aponeurosis over the cervical inter-vertebral foraminas as well as the cervical intervertebral ligaments.

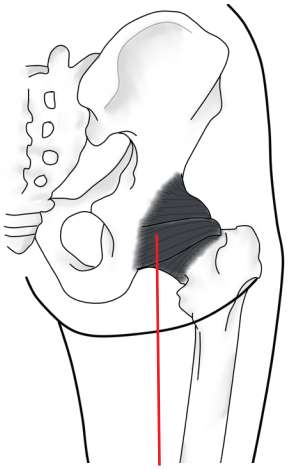
Posture 14
Hip Joint Capsule Stretch

THE PIN:
- Client lies on side with pillow under head and bolster under top leg.
- Using deep thumb pressure or T-Bar, contact inferior most aspect of the hip joint capsule between the greater trochanter and ischial tuberosity.

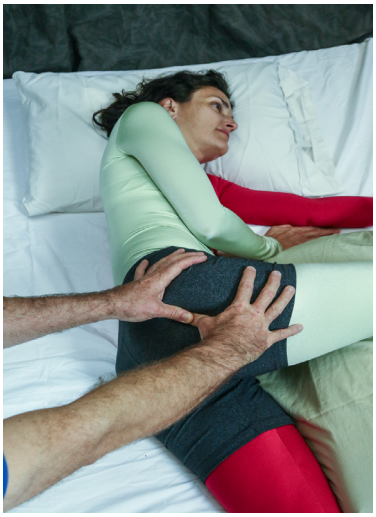
THE STRETCH:
- Slowly and in small multiple increments, pin and then stretch and hold the hip joint capsule tissue and associated ligaments inferior to superior between the greater trochanter and ischial tuberosity.
- Repeat the above pin and stretch procedure from this inferior aspect to the most superior aspect of the hip joint capsule beneath the anterior aspect of the tensor fascia latae muscle.

THERAPIST ERGONOMICS:
- Elongate spine

NOTE:
- Be sure to stay between the greater trochanter and ischial tuberosity. These are your two most important landmarks for staying on track at first.
- Study the anatomy of the hip joint capsule and associated ligaments, including the Y Ligament of Bigalow. This capsule is broad, thick and flat. It connects the femur neck to the acetabular cup rim from all angles (360 degrees). It is quite sturdy.
- Tension in the hip joint capsule is a major cause of decreased range of motion and discomfort in the hip joint particularly in older people. This is a relatively unknown fact and the hip joint capsule is rarely, sufficiently stretched by body workers.
- This stretch was developed by Camden Clay, D.C.
- This technique may cause bruising, so ask permission to possibly cause bruising in advance.



Right Hip
Joint Capsule
Posterior View



Posture 15
Hip Flexor Stretch

THE PIN:
- Client is on side lying with a pillow under head.
- Therapist is positioned behind client, close to client's spine, and facing toward client's feet.
- Therapist's knee, fist, or palm of hand is placed on client's top buttocks over the piriformis belly.
- Therapist holds client's knee by reaching under client's lower leg to support lower leg during this stretch. (If the knee is not supported, it may feel pinchy).
- Client's pelvis must be perpendicular to the floor throughout this stretch or rolled slightly anterior to perpendicular.
- Therapist pushes knee, fist or palm firmly into the belly of the piriformis muscle in the client's buttocks.

CAUTION:
- If client's hips do not remain perpendicular, this stretch may shift the apex of the stretch from the proper place in the anterior hip joint capsule to the improper place in the anterior junction of L5-S1 and cause a painful "pinching" at the L5-S1 level.
- Do not pull the leg into extension through the horizontal plane.
- Do not overextend the hip joint.

THE STRETCH:
- Therapist leans upper body backward to extend client's thigh diagonally up and backward.
- Include superior to inferior traction of thigh pulling the femur slightly away from the acetabular cup.
- Therapist assists the stretch with the other hand on the client's quadriceps.

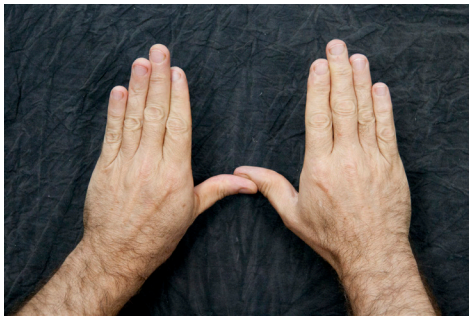
THERAPIST ERGONOMICS:
- Elongate spine.
- Arms drawn in and shoulders back.
- Arm closest to client's torso is straight.

NOTES:
- Proprioceptive Neuromuscular Facilitation(PNF) definitely enhances the effectiveness of this posture.
- This posture stretches the hip flexors and also the anterior aspect of the hip joint capsule.
- This stretch releases tight hip flexors and immediately helps elders who are stuck in flexion (leaning forward as they attempt to stand up straight).

Posture 16
Lumbar Connective Tissue Stretch

THE PIN:

- Client lies on side with pillow under head and bolster under top leg.
- Therapist is in a lunge position behind client at lumbar spine and faces toward lumbar spine.
- Therapist contacts high lamina groove of L3 with a thumb on thumb contact and pushes posterior to anterior in the high lamina groove to tension. (Lumbar facets align in the saggital plane. So, pushing posterior to anterior is in line with the lumbar facets.)



THE STRETCH:

Part A

- Therapist pushes posterior to anterior deep into the high lamina groove of L3 to full tension.
- Hold this stretch until you feel a connective tissue softening or release. This is a small movement. (This pin stretches lumbar inter-vertebral ligaments, synovial membranes and inter-vertebral discs.)

Part B

- Therapist stretches the lumbar aponeurosis, a thick leather-like covering over the low back.
- Therapist continues pushing posterior to anterior in the lamina groove of L3.
- Therapist pulls lumbar aponeurosis from a medial to lateral direction (which is toward the sky in this side lying position) to arch the aponeurosis over quadratus lumborum.
- Hold this stretch until you feel a connective tissue softening or release. This is a small movement.
- Repeat this procedure for L5 and L1, L2 and L4.

THERAPIST ERGONOMICS:

- Elongate spine.
- Arms are straight.
- The "push" is accomplished from therapist's hips lunging forward, not by using upper body strength.

NOTES:

- When fixated vertebrae are discovered through motion palpation, spend extra time stretching to resolve the fixation(s).
- This posture is a "Master Fix" and usually makes all weak muscles found through Targeted Muscle Testing instantly strong!

Posture 17
Thoracic Connective Tissue Stretch

THE PIN:
- Client lies on side with pillow under head and bolster under top leg.
- Therapist is in a lunge position behind client at lumbar spine and facing toward client's head.
- Therapist contacts high lamina groove of T12 with a thumb-on-thumb contact. This pin pushes the thumb contact posterior to anterior in the thoracic lamina grooves.

THE STRETCH:
- Therapist pushes thumb-on-thumb contact deep into client's high lamina groove of T12. Push firmly posterior to anterior and inferior to superior.
- Hold this stretch until you feel a connective tissue softening or release.
- Repeat this procedure at each level from T12 through T1.
- T3 to T1 pull client's top shoulder anterior to posterior to prevent compressing the heart and lungs.

THERAPIST ERGONOMICS:
- Elongate spine.
- The"push"is accomplished from therapist's hips lunging toward client's head, not by using upper body strength.
- Arms are straight.

NOTES:
- Thoracic facets are in the coronal plane. So, pushing from inferior to superior is in line with thoracic facets.
- Therapist hips face client inferior to superior.
- Therapist may use a pisiform contact between T12 and up to T7.
- This stretches the thoracic inter-vertebral ligaments, synovial membranes and inter-vertebral discs.
- When fixated vertebrae are located, spend extra time stretching to resolve fixations.

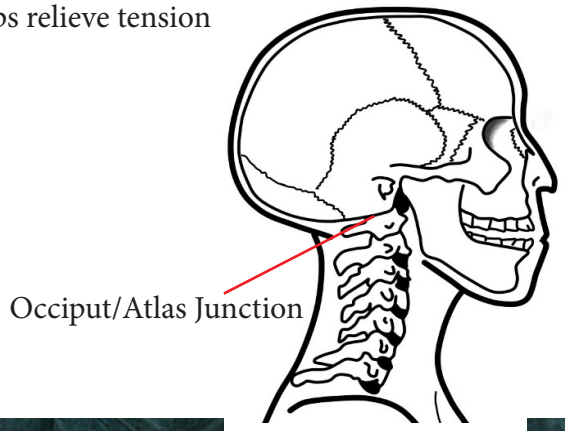
Posture 18
Upper Cervical Connective Tissue Stretch

THE PIN:
- Client lies supine.
- Therapist is seated superior to client.
- Therapist cradles the client's occiput with one hand.
- Therapist contacts between the inferior mastoid process and atlas with middle finger of that same hand.
- Client's head is turned toward the side of contact.
- Therapist's other hand gently stabilizes the top of the client's head.

THERAPIST ERGONOMICS:
- Elongate spine.

THE STRETCH:
- Therapist drags the middle finger between the occiput and atlas with deep pressure, slowly, lateral to medial from the mastoid process to below the external occiput protuberance(EOP). This stretches a thick aponeurosis between the occiput and the atlas.
- Therapists rocks from side to side to enhance the stretching effect of dragging the middle finger between the atlas and the occiput.
- Always traction the occiput away from the atlas during this procedure.

NOTE:
- This stretch may release atlas fixations causing massive overall body functional improvements.
- This stretch was developed by Dr. Camden Clay and is a "Master Fix" making all weak muscles found through Targeted Muscle Testing instantly strong!
- This posture also helps relieve tension headaches



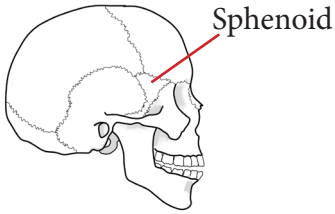
Posture 19
Cranial Alignment Phase

THE PIN: N/A

THE STRETCH: N/A

THERAPIST ERGONOMICS:
- Elongate spine.
- Pillow is in therapist's lap to support forearms.

Most yoga classes end with a relaxation phase called "Shavasana". This is the Thai Massage version of Shavasana. Sit quietly for several minutes or more, allowing structured time for the client's cranium to integrate with the body's newly created space.



CRANIAL ALIGNMENT PHASE:
- Client lies supine.
- Therapist sits superior to the client's head.
- Therapist rests forearms on a pillow in therapist's lap if needed.
- Therapist cradles the client's occiput with fingers of both hands.
- Therapists thumbs very, very lightly contact the right and left greater wings of sphenoid.
- Therapist hands lightly touch to cradle the temporal bones.
- Therapist's and client's eyes are closed.
- Therapist imagines that the client's head is a giant water balloon with slow, dynamic, intentional, specific hydrostatic pressure changes occurring. Cranial movement may move away from fingers or into fingers. It is a dance! Back and forth.
- Therapist quietly and gently follows these slow pressure changes giving very mild kinetic energy through the therapist's hands and fingers to follow and hence facilitate these subtle cranial movements.
- Therapist becomes aware that the erratic cranial unwinding movements have stopped and that the cranium is pulsating in an even tide as the cranium swells and then shrinks back and forth at a rate of 8 to 12 cycles per minute.
- Palpating the cranial rhythms prior to an Assisted Stretching session is unremarkable. Palpating the cranial rhythms just after an Assisted Stretching session is MIND BLOWING! The cranium is a microcosm for the body. The body has just been dramatically opened by making space with Assisted Stretching, now the cranium wants to assimilate this new found relaxation. The therapist is not putting cranial bones in place, the therapist is following cranial bones into place with gentle kinetic energy. In Osteopathy, this is called an "Indirect Technique" when the cranium moves into the fingers and is a "Direct Technique" when the cranium moves away from the fingers.
- Watch the short video "Cranial Alignment Phase" at QuickSelfFixes.com

EXERCISE:
- Contact your right sphenoid (see #2 on drawing) with your right middle finger, contact the left sphenoid with your left middle finger. Push left sphenoid to right in horizontal plane and feel the right sphenoid move. Push right sphenoid left and feel the left sphenoid move. Thus, proving cranial bones have motion! The cranium has 23 bones that are in motion.

Posture 20
Seated Thoracic Spine Stretch

THE PIN:

- Client sits with legs crossed. Client crosses arms over chest so that the hand of the top arm (furthest from chest) is pointing in the direction of the spinal twist.
- Therapist gets in close diagonally behind client on side of the top arm.
- Therapist braces elbow on inner thigh.
- From the direction that the client is going to be rotated toward, therapist reaches around client and grasps client's top elbow. This sets up the ability to rotate the client.
- Therapist's thumb contacts client's lamina groove of one vertebrae somewhere from T12 to T4.
- Therapist's thumb is vertically in line with client's lamina groove, pointing up the spine.
- Client must be sitting up right perpendicular to the floor throughout the procedure.

THE STRETCH:

- Therapist pushes thumb in lamina groove posterior to anterior and inferior to superior.
- Therapist torques client by rotating own body with the motion. The client's elbow hold will provide the main rotation. The thumb in lamina groove will provide the spinal ligament stretch by pushing the vertebral ligaments anterior to posterior and inferior to superior. The therapist must also raise own body upward 1/2 to 1 inch(use "Proper Ergonomics"), bringing the client's body upward as well into an elongated state. Remember, always elongate the spine when torquing the spine. Also, do not allow the client to lean forward, backward, or to either side during the torque. The client's body is rotating on a vertical axis.
- Always repeat this stretch on opposite side.
- This procedure may be performed anywhere between T12 and T4 depending upon the client's needs and allotment of time.

THERAPIST ERGONOMICS:

- Elongate Spine

NOTE:

- This posture causes the client to be proprioceptively responsible for maintaining the seated position. This facilitates their waking up and prepares them for driving a car.

Posture 21
Seated Shoulder Stretch

THE PIN:
- Therapist is behind client, with one knee stabilizing the client's side on the opposite side of the stretch.
- Client's target arm is positioned hand behind client's head.
- Therapist's fingers are interlaced around client's arm at the distal triceps.
- Therapist positions his/her closest ventral, proximal forearm at the costal-vertebral junctions of T2 and T3. Therapist pulls client's arm superior and posterior in an arching direction.

THE STRETCH:
- Therapist pushes his/her forearm on the costal-vertebral junctions from posterior to anterior and inferior to superior in an arching direction.
- At the same time, therapist pulls client's arm superior and posterior in an arching direction.
- Therapist lifts client slightly by lifting own body using "Proper Ergonomics".

THERAPIST ERGONOMICS:
- Elongate Spine

NOTE:
This posture causes the client to be proprioceptivally responsible for maintaining the seated position. This facilitates their waking up and prepares them for driving a car.

This chart references this Assisted Stretching book with Dr. Clay's Targeted Muscle Testing book and Quick Self Fixes book.

	POSTURE	MUSCLES MADE STRONG	QUICK SELF FIX
1	Calf Stretch	N/A	Soleus Stretch Fix
2	Calf and Hamstring Stretch	N/A	N/A
3	Medial Hamstring Stretch	N/A	Hamstring Warm-Up Stretch
4	Lateral Hamstring Stretch	N/A	Hamstring Warm-Up Stretch
5	Iliotibial Band Stretch	• Tensor Fascia Latae, Belly • Gluteus Medius, Belly of Posterior Division • Quadratus Lumborum, Belly of Spinal Division • Multifidus, Iliolumbar Division, Superficial Layer	Iliotibial Band Fix
6	Adductor Stretch	N/A	Adductor Stretch Fix
7	Knee Stretch	• Popliteus • Peroneus Tertius	Knee Fix Meniscus Fix
8	Hip Stretch	• Rectus Femoris, Belly of Straight Head Division • Psoas Major, Belly • Tensor Fascia Latae, Belly	Hip Fix
9	First Strong Posterior Leg Stretch	N/A	Hamstring Fix
10	Second Strong Posterior Leg Stretch	N/A	Hamstring Fix
11	Sacroiliac Ligament Stretch	Piriformis	Piriformis Fix Sacroiliac Ligament Fix Pelvic Fix
12	Costovertebral Ligament Stretch	• Middle Trapezius, Bellies of Middle, Superior and Inferior Divisions • Pectoralis Major, Bellies of Superior and Inferior Divisions • Lower Trapezius, Medial Divisions • Latissimus Dorsi, Bellies of Middle, Superior and Inferior Divisions	Connective Tissue Procedure B Clavicle Fix

	POSTURE	MUSCLES MADE STRONG	QUICK SELF FIXES
13	Cervical Connective Tissue Stretch	• Anterior Deltoid, Bellies of Medial and Lateral Divisions • Middle Deltoids, Bellies of Anterior and Posterior Divisions • Upper Trapezius, Medial Zone of Scapular Division	Connective Tissue Strap Procedure C Guided Neck Stretch Fixes
14	Hip Joint Capsule Stretch	N/A	N/A
15	Hip Flexor Stretch	• Rectus Femoris, Belly of Straight Head Division • Psoas Major, Belly • Tensor Fascia Latae, Belly	Hip Fix
16	Lumbar Connective Tissue Stretch	• Quadratus Lumborum, Belly of Spinal Division • Multifidus, Superficial Layer of Iliolumbar Division • Transverse Abdominus, Belly of Inferior Division • Psoas Major, Belly • Gluteus Medius, Bellies of Posterior Division • Latissimus Dorsi, Bellies of Middle, Superior and Inferior Divisions	Connective Tissue Strap Procedure A This procedure is also a "Master Fix" and usually makes all weak muscles found through Targeted Muscle Testing instantly strong.
17	T12-T2 Intervertebral Ligament Stretch	• Middle Trapezius, Bellies of Middle, Superior and Inferior Divisions • Pectoralis Major, Bellies of Superior and Inferior Divisions • Lower Trapezius, Medial Division • Latissimus Dorsi, Bellies of Middle, Superior and Inferior Divisions	Connective Tissue Strap Procedure B
18	Occiput/Atlas Connective Tissue Stretch	Master Fix makes many seemingly unrelated muscles instantly strong	Occiput Glide Fix
19	Cranial Alignment Phase	N/A	N/A

	POSTURE	MUSCLES MADE STRONG	QUICK SELF FIXES
20	Sitting Thoracic Spine Stretch	• Middle Trapezius, Bellies of Middle, Superior and Inferior Divisions • Pectoralis Major, Bellies of Superior and Inferior Divisions • Lower Trapezius, Medial Division • Latissimus Dorsi, Bellies of Middle, Superior and Inferior Divisions	Connective Tissue Strap Procedure B
21	Shoulder Stretch	• Infraspinatus • Teres Minor • Supraspinatus • Subscapularis • Pectoralis Minor, Belly • Pectoralis Major, Bellies of Superior & Inferior Divisions • Middle Trapezius, Bellies of Middle, Superior & Inferior Divisions	Shoulder Fix Clavicle Fix