The Functional Movement Screen

When I see a new patient, at the appropriate time, I perform a **Functional Movement Screen** which guides their treatment in PT. This intake screen makes more sense than every other evaluation process I have seen in over 25 years of clinical practice. Using this screen, I quickly determine one's mobility and stability dysfunction, which provides a perfect starting point for exercise and therapy.

As a Sports Physical Therapist, I operate on the basis that there are three considerations to athletic performance:

- **Foundational Movement** (the quality of flexibility, stability, ROM, and strength)
- **Functional Movement** (The ability to move through full ranges of motion in quantity with agility)
- **Skill** (the mastery of the specific movement demands of a particular sport)

I have had a lot of success treating athletes over the years, tackling their recovery by moving them from one set of activities to the next in this context. Working with non-athlete patients in this paradigm has proven to be both very effective and rewarding as well, seeing individuals resolve their injuries and return to their unrestricted sporting or working lives.

The **Functional Movement Screen** addresses the foundation necessary to build a good functional exercise program – that being normal mobility and stability. To complete the screen, I perform a series of up to 23 common and uncommon musculoskeletal and movement screening tests. For example, one such test is a "full squat with hands overhead". The Deep Squat is used to assess bilateral, symmetrical, mobility of the hips, knees, and ankles. This full squat test demonstrates the value of screening in the following example: A person with lower back pain can have multiple causes for this pain; back pain often being a symptom of another dysfunction. The patient in this example is able to curl up in a ball while lying on their back, but is unable to perform a full squat while weight bearing. In this case the cause, tight calves, would only be identified in the weight bearing posture. An additional quick screening test in the half kneeling position confirms the ankle as the source of the mobility restriction. This determines the first battery of exercise given to the patient; those that help restore the foundation of weight bearing movement at the ankle. As this mobility restriction is resolved, the patient then moves on to more aggressive functional exercises that require full ROM of the ankle, which they were unable to perform prior. These new exercises will challenge him or her in multiple planes of motion at higher intensity. The combination of restored mobility in the ankle and the introduction of the higher intensity functional exercise will often eliminate lower back pain in patients such as the example illustrated above. I have seen it happen literally hundreds of times.

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