



FIX BACK & NECK PAIN

WHEN CONVENTIONAL CARE HASN'T WORKED

THE PATIENTS I WORK WITH

These are the patients who have done the rounds. Imaging, injections, physical therapy, sometimes surgery. They've been told everything looks normal. They feel unheard. Their pain has become a fixture. My practice is built specifically for the complex, multi-system patient who hasn't responded to conventional care — and who needs more than any single modality alone can provide.

TWO MODALITIES, ONE INTEGRATED APPROACH

Most spine practices offer one or the other. I integrate both, in real time, session by session — adjusting based on what each patient's body needs that day.

MANUAL THERAPY & MOVEMENT RESTORATION

- Fascial release
- Psoas and deep core work
- Joint mobilization
- Somatic release of held patterns
- **Restores movement**

MEDX SPINAL STRENGTHENING

- Deep spinal extensor isolation
- Pelvic stabilization eliminates compensation
- Quantifiable strength and ROM data
- Progressive loading of the deep stabilizers
- **Builds capacity within that movement**

WHY BOTH, TOGETHER

Manual therapy without strengthening rarely holds — the body returns to its old patterns. Strengthening without manual therapy fails when fascial restriction and joint hypomobility limit the very movement we're trying to load. Treating both, together, is what produces durable change.



LEARN MORE:
FixBackNeckPain.com
(425) 758-4619
2447 152nd Ave NE,
Redmond, WA 98052

MANUAL THERAPY & MOVEMENT RESTORATION

Restoring movement is the first job. Restriction in the fascial system, the deep hip flexors, and the segmental joints of the spine prevents the body from moving through its full range — and no amount of strengthening will hold gains made on top of that restriction.

FASCIAL RELEASE

Targets the connective tissue that organizes movement. Effective for chronic patterns of guarded movement, post-injury restriction, and the patient whose pain wanders rather than localizes.

PSOAS AND DEEP CORE WORK

The psoas is often the unspoken driver in chronic low back pain. Releasing this muscle and the surrounding deep core structures changes how the spine loads — and is frequently what allows other interventions to finally work.

JOINT MOBILIZATION

Restores segmental motion at the spine, SI joints, and hips. Patients with hypomobile segments cannot recruit the deep stabilizers properly until joint motion is restored.

SOMATIC RELEASE OF HELD PATTERNS

Some pain is held — patterns of guarding, bracing, and protection that the nervous system has learned over years. Addressing the somatic component is often what produces durable change in patients with trauma history or autonomic dysregulation.

MEDX SPINAL STRENGTHENING

Once movement is restored, the deep spinal stabilizers must be strengthened. MedX equipment (developed at the University of Florida) is the only system that effectively isolates these muscles — conventional rehab equipment cannot, because the pelvis recruits and substitutes during loaded exercise. I trained and certified through the University of Florida MedX program and have been integrating this protocol for 35+ years.

See the enclosed MedX flyer for clinical detail.

CONDITIONS TREATED

LUMBAR / LOW BACK

1. Chronic low back pain
2. Post-surgical pain
3. SI joint dysfunction
4. Lumbar radiculopathy
5. Degenerative disc disease

CERVICAL

1. Chronic cervical pain
2. Post-concussive cervical syndrome
3. Cervicogenic headaches
4. Cervical spondylosis
5. Whiplash and post-MVA cervical pain
6. Forward head posture syndromes

COMPLEX / MULTI-SYSTEM

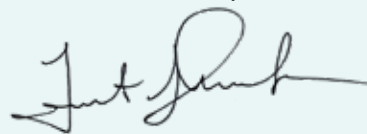
1. Postural pain syndrome
2. Patients with neurological symptoms complicated by fascial restriction
3. Chronic pain with autonomic component
4. Patients who have plateaued in PT or chiropractic care
5. Pre-surgical conditioning for elective spinal procedures

WHAT TO EXPECT

Most patients begin to feel meaningful change within the first 3 to 4 sessions. Discharge from active care is typically between 10 and 14 sessions, depending on the complexity of the presentation and the patient's history. Post-surgical and complex multi-system patients often require longer.

I do not promise outcomes I cannot deliver. When a patient is not a fit, I tell them — and I tell you — within the first few visits. When a patient does fit my approach, the goal is durable change: not symptom management, but functional restoration that holds over time.

I write back to referring providers with an initial assessment letter, a progress update at the appropriate clinical milestone, and a discharge summary at the close of care. You will not have to chase me for updates.



Trent Shuford, LMP
Cert. MedX Tech., University of Florida