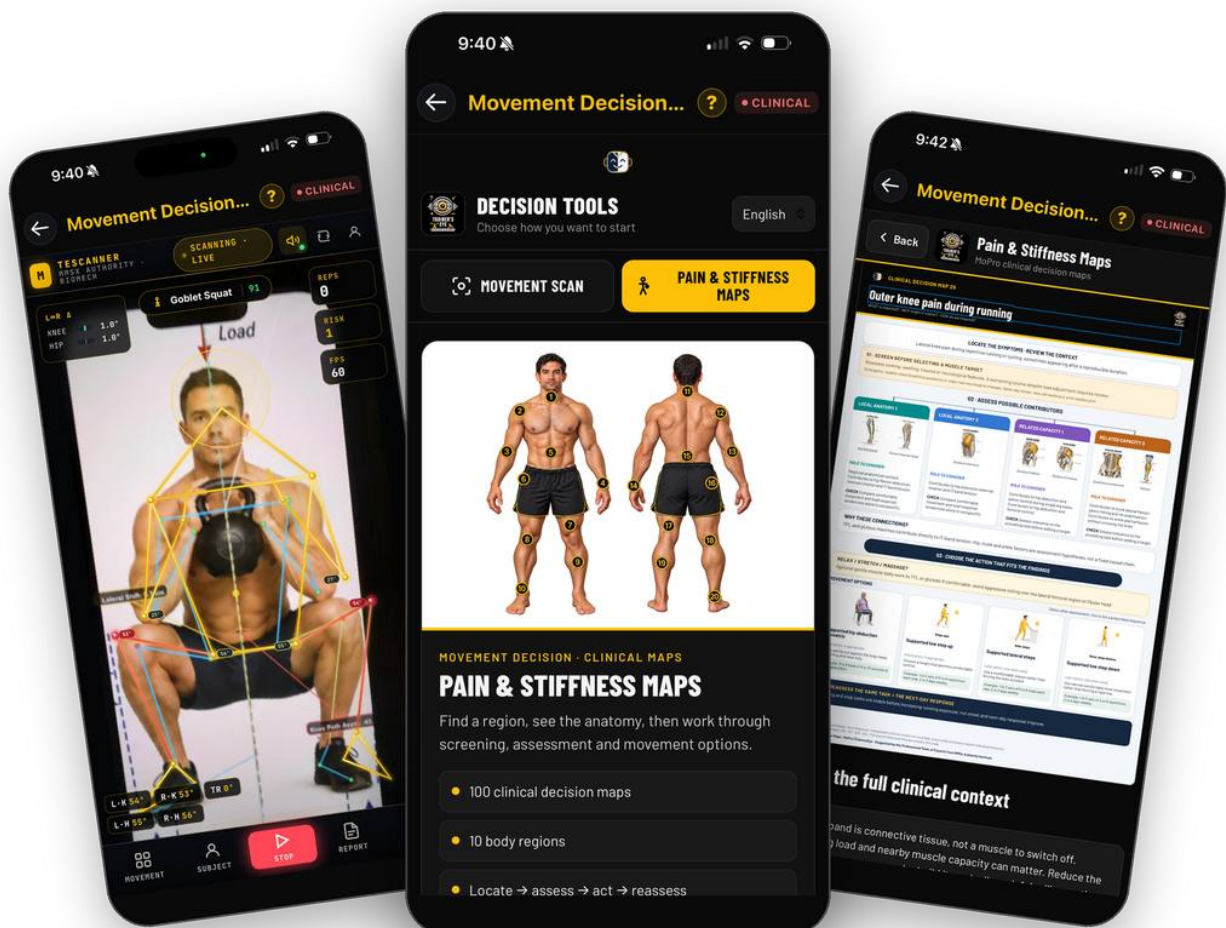


USER GUIDE

Movement Decision Tool

Two ways to a movement decision – a live camera scan of the lift, or a clinical map from where it hurts.

How to use the tool, step by step – in the TrainersEye app





What is the Movement Decision Tool?

The Movement Decision Tool is the TrainersEye clinical decision hub. Choose how you want to start. Movement Scan turns the phone camera into TESScaner: pick the target movement from the library, set the phone up as the card instructs, and the MMSx pose brain scores the lift live – joint angles, left-right deltas, reps, risk, form score – and issues a Movement Decision Document to print or save. Pain & Stiffness Maps starts from the client instead: tap where it hurts on the 20-point body map and open a clinical decision map that walks you through locate, screen, assess the contributors, choose the action and reassess – anatomy plates, movement options and evidence references included. Both are decision support suggested by the professional team of experts from MMSx Authority Institute; neither is a diagnosis.

Movement Scan

Pick the movement, set the phone as instructed, scan live: angles, left-right deltas, reps, risk and a form score, then a Movement Decision Document.

Pain & Stiffness Maps

Tap one of 20 body points – 1 to 10 on the front, 11 to 20 on the back – and open the clinical decision maps for that region.

Locate → assess → act → reassess

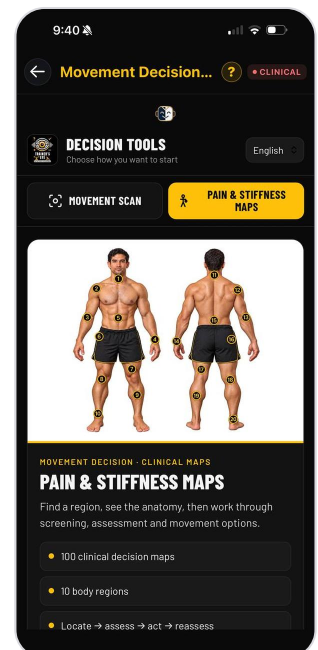
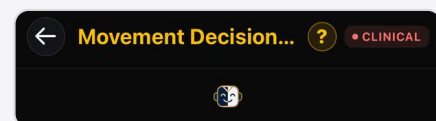
Every map runs the same four steps: locate and screen, assess the possible contributors, choose the action that fits, reassess the same task next day.

Clinical, not diagnostic

Assessment hypotheses with evidence references, from the professional team of experts at MMSx Authority Institute – independent clinical review stays with you.

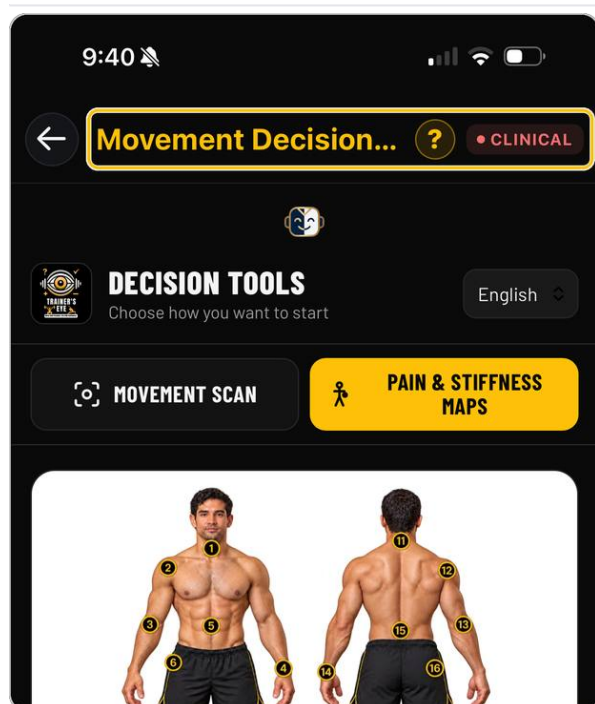
Where to find it

Open the TrainersEye app, go to the Dashboard and tap Movement Decision Tool. It is part of the Clinical plan. The question mark at the top opens help on every screen.



This guide in thirteen steps

- 1 Open the tool
- 2 Choose how you want to start
- 3 Select the target movement
- 4 The scanner controls
- 5 Scan live
- 6 Read the live angles, then stop
- 7 The Movement Decision Document
- 8 Where does it hurt
- 9 Pick the point
- 10 Open a map
- 11 Read the decision map
- 12 The full clinical context and the evidence
- 13 Language and help



PART 1 · GETTING STARTED

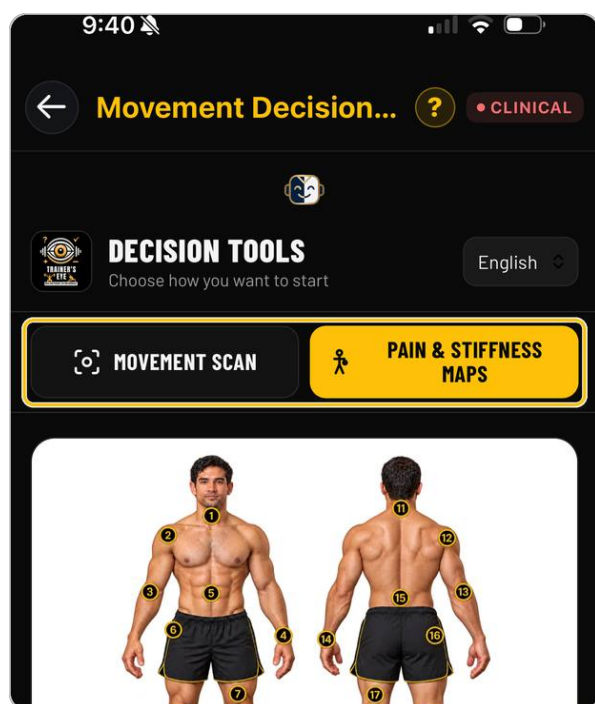
STEP 1

Open the tool

From the Dashboard, tap Movement Decision Tool. It is a Clinical-plan tool; the badge beside the title shows Clinical.

TIP

The question mark beside the badge opens help on every screen.



PART 1 · GETTING STARTED

STEP 2

Choose how you want to start

Two doors: Movement Scan – the camera scan of a lift – and Pain & Stiffness Maps – the clinical maps from where it hurts.

TIP

Scan when you have the client in front of you moving; Maps when the complaint comes first.



PART 2 · MOVEMENT SCAN

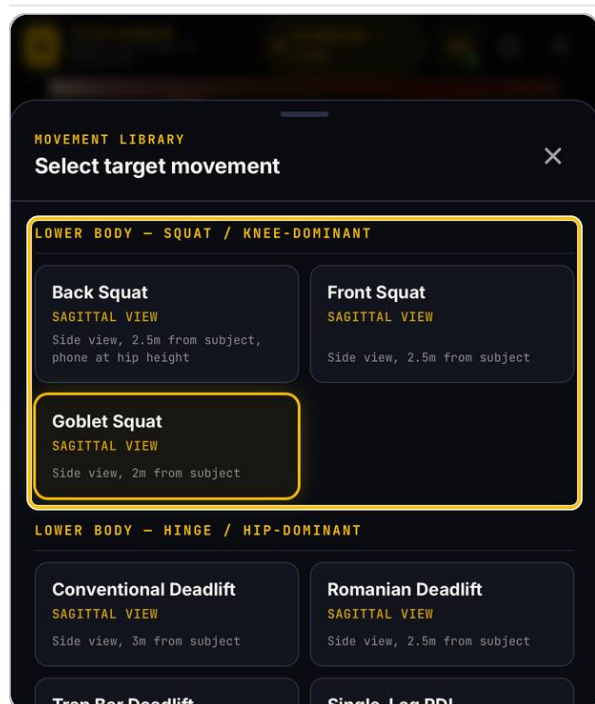
STEP 3

Select the target movement

The Movement Library groups lifts by pattern – squat and knee-dominant, hinge and hip-dominant, single-leg and split-stance. Each card names the view and the camera distance: side view, 2 to 3 metres from the subject, phone at hip height.

TIP

Set the phone exactly as the card says – the angles are only as true as the view.



PART 2 · MOVEMENT SCAN

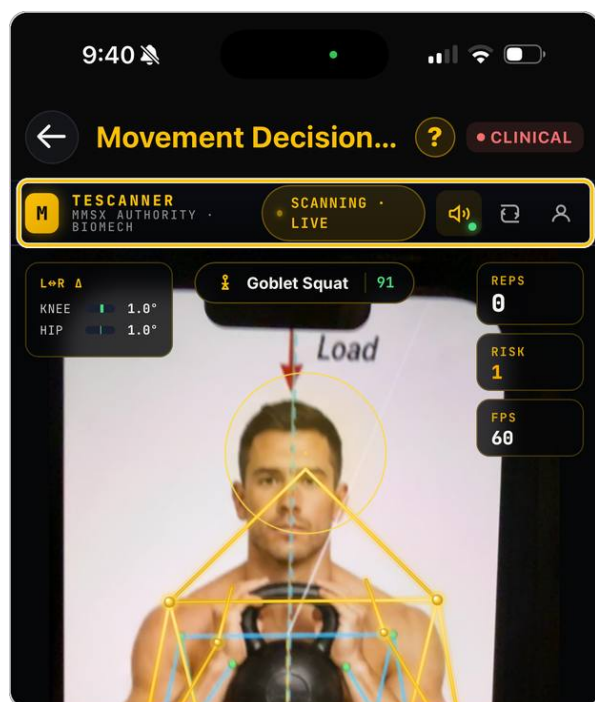
STEP 4

The scanner controls

The TEScanner header shows the status – Scanning · Live – the voice cue toggle, the camera flip and the subject profile. The bar at the bottom has Movement, Subject, Stop, Report and Flip.

TIP

Turn the voice cue on when you coach from the floor; the scanner speaks the cue so you need not read the screen.





PART 2 · MOVEMENT SCAN

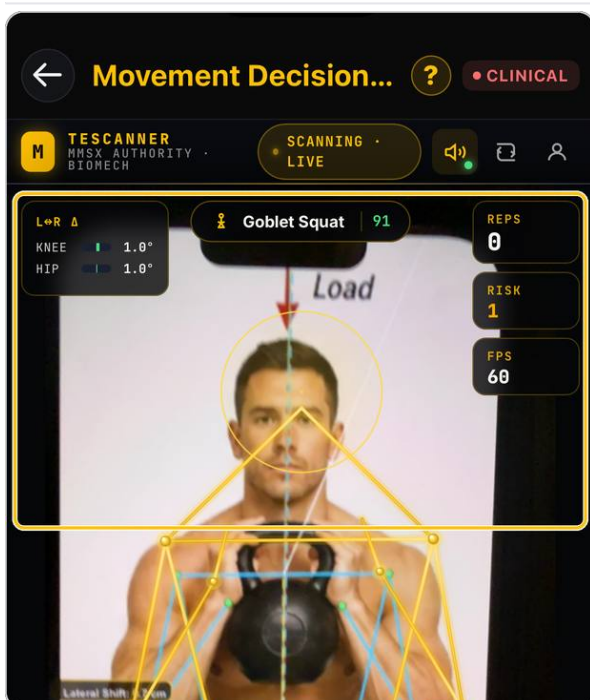
STEP 5

Scan live

The skeleton draws over the client. The HUD shows left-right deltas for knee and hip, the movement with its live form score, reps counted, risk flags and frames per second.

TIP

Wait for the rep counter to move before you judge a score — the first frames are calibration.



PART 2 · MOVEMENT SCAN

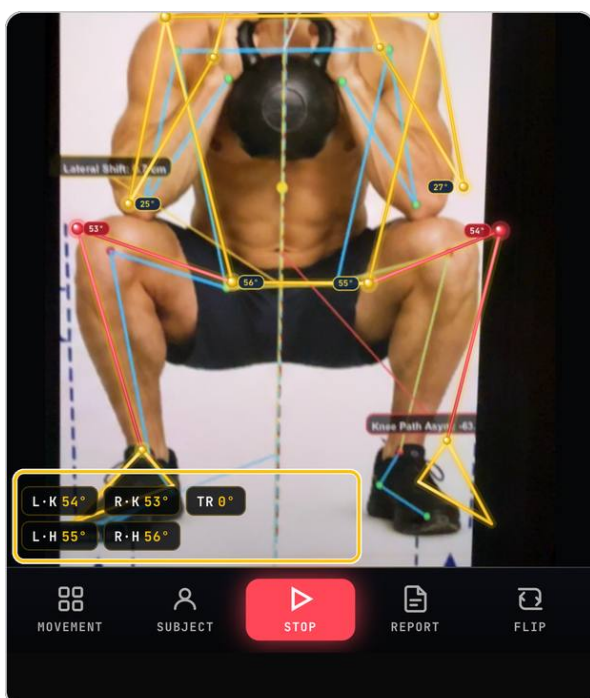
STEP 6

Read the live angles, then stop

The chips along the bottom give left and right knee, left and right hip and trunk angle, live. Tap Stop when the set is done.

TIP

A left-right delta above a degree or two on the same rep is the thing to look at first.





Subject
age —

— kg · — cm
Per subject profile

MOVEMENT
Goblet Squat
Lower Body — Squat / Knee-Dominant

SESSION
102s
0 reps · 60 fps capture

Performance Indices

91
/ 100
FORM SCORE · PEAK

91
/ 100
FORM SCORE · MEAN

TOTAL REPS
0
Detected

RISK FLAGS
1
Warnings

Print / PDF

Save Scan

PART 2 · MOVEMENT SCAN

STEP 7

The Movement Decision Document

Report opens the scan report: subject and session — anthropometry, movement, duration, reps, capture rate — then the performance indices: form score peak and mean out of 100, total reps and risk flags. Print / PDF or Save Scan.

TIP

Save Scan keeps the session; Print / PDF is the copy for the client's file.

on the front of the body, 11-20 on the back.

Body map
100 maps · 20 points

Front
1-10

Back
11-20

Both
1-20

Tap a numbered point to see its maps.

PART 3 · PAIN & STIFFNESS MAPS

STEP 8

Where does it hurt

The body map has 20 numbered points: 1 to 10 on the front, 11 to 20 on the back — Front, Back or Both. Tap the point where the client feels it.

TIP

Both shows front and back together for a client who cannot decide which side it is.



PART 3 · PAIN & STIFFNESS MAPS

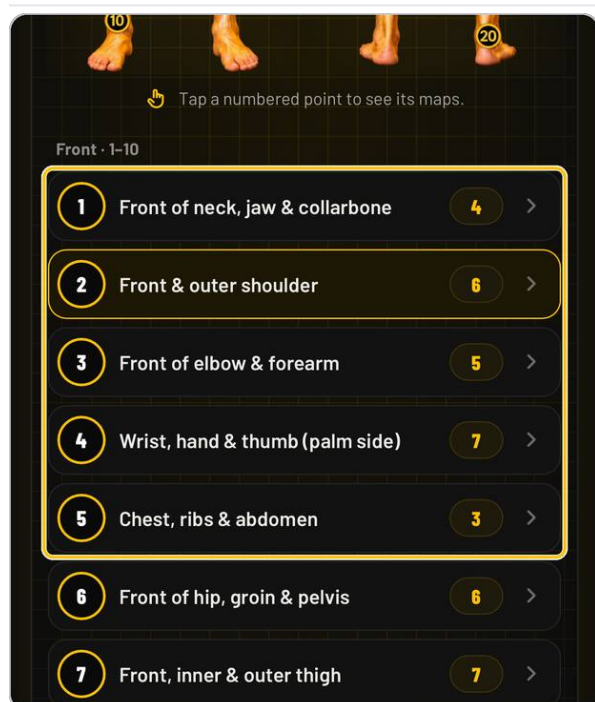
STEP 9

Pick the point

Under the map, every point is listed by name with the number of clinical maps behind it — front of neck, jaw and collarbone; front and outer shoulder; knee and kneecap; ankle, foot and toes.

TIP

The count is how many distinct complaints that region carries — the knee has the most.



PART 3 · PAIN & STIFFNESS MAPS

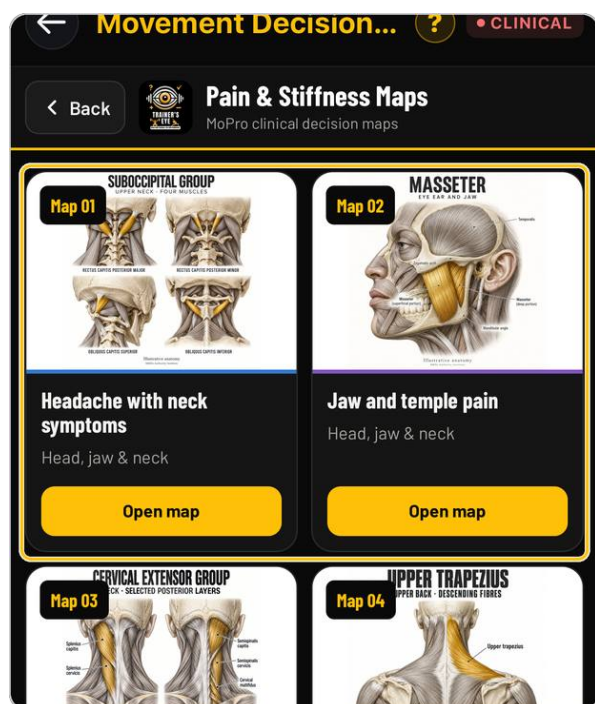
STEP 10

Open a map

Each map card shows the anatomy plate, the complaint it covers and its region. Tap Open Map.

TIP

Read the card's anatomy plate first — it names the muscle group the map is about.





PART 3 · PAIN & STIFFNESS MAPS

STEP 11

Read the decision map

Every map runs the same way: locate the symptoms and review the context; 01 screen before selecting a muscle target; 02 assess the possible contributors — local anatomy and related capacity, each with a role to consider and a check; 03 choose the action that fits, with movement options and example doses; 04 reassess the same task and the next-day response.

TIP

The movement options are chosen after assessment — the map says so itself: not a prescribed sequence.

Pain & Stiffness Maps
MoPro clinical decision maps

CLINICAL DECISION MAP 25
Outer knee pain during running
What is required? What might I expect? How do we expect?

LOCATE THE SYMPTOMS · REVIEW THE CONTEXT
Lateral knee pain during repetitive running or cycling, sometimes appearing after a reproducible duration.

01 · SCREEN BEFORE SELECTING A MUSCLE TARGET
Reassess locking, swelling, trauma or neurological features. A worsening course despite load adjustment requires review.
Emergency: sudden chest/hearting symptoms or major new neurological changes. Same-day review: new calf swelling or shot swollen joint.

02 · ASSESS POSSIBLE CONTRIBUTORS

LOCAL ANATOMY 1	LOCAL ANATOMY 2	RELATED CAPACITY 1	RELATED CAPACITY 2
IT BAND Tibial band Tensor fasciae latae	GLUTEUS Gluteus maximus	HIP ABDUCTOR Gluteus medius Gluteus minimus	TRUNK Quadratus lumborum Soleus
ROLE TO CONSIDER Regional anatomical context. Contributes to hip flexion/abduction/extension and IT band tension. CHECK Compare comfortable movement and load response; tenderness alone is nonspecific.	ROLE TO CONSIDER Contributes to hip extension/external rotation and IT band tension. CHECK Compare comfortable movement and load response; tenderness alone is nonspecific.	ROLE TO CONSIDER Contributes to hip abduction and pelvic control during single leg tasks; contributes to hip abduction and femoral control. CHECK Assess relevance to the provoking task before adding a target.	ROLE TO CONSIDER Contributes to trunk lateral flexion/pelvic hiking and rib stabilization; contributes to ankle plantarflexion without crossing the knee. CHECK Assess relevance to the provoking task before adding a target.

WHY THESE CONNECTIONS?
ITB and gluteus maximus contribute directly to IT-band tension. Hip, trunk and ankle factors are assessment hypotheses, not a fixed causal chain.

03 · CHOOSE THE ACTION THAT FITS THE FINDINGS

RELAX / STRETCH / MASSAGE?
Optional gentle muscle-belly work to TFL or gluteals if comfortable; avoid aggressive rolling over the lateral femoral region or fibular head.

MOVEMENT OPTIONS
Select after assessment; this is not a prescribed sequence.

Supported hip abduction isometric	Supported low step up	Supported lateral steps	Supported low step down
Initial action, if appropriate Press gently out against the loop; keep breathing and relax fully. Example: 3 to 5 holds of 1 to 10 seconds at tolerable effort.	Initial action, if appropriate Choose a height that permits comfortable control. Example: 1 to 2 sets of 8 to 10 repetitions each side, 2 to 3 days weekly.	Later option, only when ready Use a comfortable stance rather than forcing the toes outward. Example: 1 to 2 sets of 8 to 10 steps each way, 2 to 3 days weekly.	Later option, only when ready Use natural comfortable knee movement rather than forcing a rigid line. Example: 1 to 2 sets of 8 to 10 repetitions, 2 to 3 days weekly.

04 · REASSESS THE SAME TASK · THE NEXT-DAY RESPONSE
Walking and step tasks are stable before increasing running exposure; run onset and next-day response improve.

Assessment hypotheses, not a diagnosis. Independent clinical review not recorded. Exact doses and doses require individual selection.
Evidence references: SSR, SSR, SSR, SSR. Full source files and links accompany this map.
Clinical Decision Maps: MoPro Trainerseye. Supported by the Professional Team of Experts from WHO's Authority Institute.

PART 3 · PAIN & STIFFNESS MAPS

STEP 12

The full clinical context and the evidence

Below the map, Read the Full Clinical Context explains the reasoning in plain language, and the footer lists the evidence references and states that these are assessment hypotheses, not a diagnosis.

TIP

The emergency and same-day review lines in step 01 are the ones to read aloud with the client.

Read the full clinical context

The IT band is connective tissue, not a muscle to switch off.
Running load and nearby muscle capacity can matter. Reduce the



PART 4 · LANGUAGE AND HELP

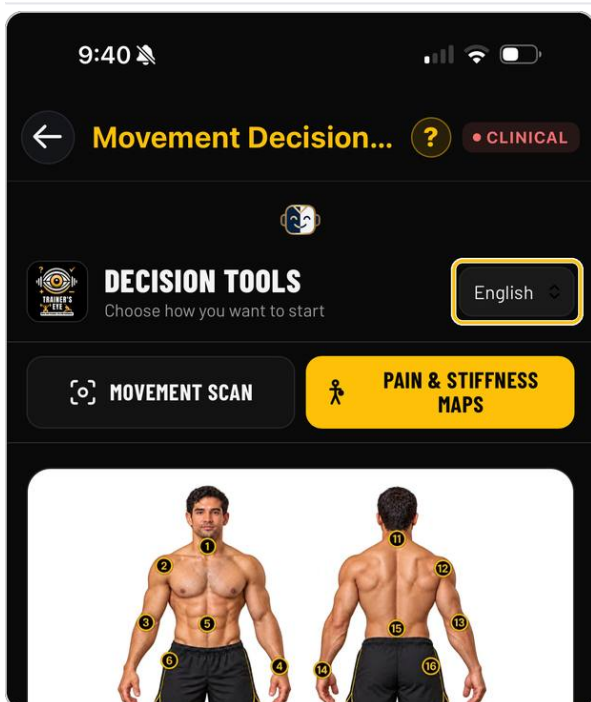
STEP **13**

Language and help

The language selector on the hub sets English, Hindi, Spanish or Arabic; the question mark at the top opens help on every screen.

TIP

Maps and the scan report follow the language you set.



You're ready

That's it. Open the Movement Decision Tool, choose how you want to start, and make the decision on evidence.



Reading a clinical decision map

Every map is built the same way. Here is what each part means.



- 1 Map number and title**
The complaint the map covers, and the three questions it answers: what is reported, why it might matter, how we respond.
- 2 Locate the symptoms**
Where it is felt and in what context.
- 3 Screen first**
Red flags to reassess before any muscle target – with the emergency and same-day review lines.
- 4 Assess possible contributors**
Local anatomy and related capacity, with their anatomy plates.
- 5 Role to consider and check**
What each contributor might do, and how to test it before adding a target.
- 6 Why these connections**
The reasoning – hypotheses, not a fixed causal chain.
- 7 Choose the action**
Relax, stretch or massage where appropriate, and the movement options with example doses.
- 8 Reassess**
The same task and the next-day response before progressing.



Move with **Precision.** Live with **Confidence.**

THE MOVEMENT DECISION TOOL IS PART OF TRAINERSEYE

Support: support@trainerseye.com · trainerseye.com

Movement Scan by TEScanner · Pain & Stiffness Maps by MoPro · Suggested by the professional team of experts from MMSx Authority Institute

Clinical decision support for qualified practitioners. Scan scores and clinical maps are assessment hypotheses, not a diagnosis; independent clinical review is not recorded. Exact drills and doses require individual selection.