FOR CLINICAL CONDITIONS SUCH AS

AC JOINT
ACHILLES TENDONITIS
ACL
ADDUCTOR STRAIN
ANKLE LATERAL SPRAIN
ANKLE MEDIAL SPRAIN
BICEPS TENDONITIS
BRACHIAL PLEXUS
BURSITIS OF THE ELBOW
BURSITIS OF THE KNEE
BURSITIS OF THE SHOULDER
CARPAL TUNNEL
CERVICAL SPONDYLITIS
CHONDROMALACIA
COSTOCHONDRAL
DEQUERVAINS
DISLOCATIONS
ELBOW HYPEREXT
ELBOW VALGUS LAXITY
EPICONDYLITIS
ERECTOR SPINAE
FASCIA CORRECTION
FINGER SPRAIN
FROZEN SHOULDER
FUNCTIONAL TAping
GAMEKEEPERS THUMB
HALLUX VALGUS
HAMMER TOE
HAMSTRING STRAIN
HEADACHE
HIP POINTER
ILIOTIBIAL BAND

CLINICAL THERAPEUTIC APPLICATIONS OF THE KINESIO TAping

Method

2nd Edition
CLINICAL THERAPEUTIC APPLICATIONS OF THE KINESIO TAPING® METHOD

KENZO KASE  JIM WALLIS  TSUYOSHI KASE
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Dedication from Jim Wallis:
Simply, to my mother
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Properties of Kinesio Tex® Tape

*Kinesio Tex®* Tape has been modified, since its creation, to mimic the qualities of the skin. In understanding the overlying concepts of the Kinesio Taping® Method, it is best to think of the basic and corrective techniques as the application/placement of your hands onto the patient. Keeping the concept of the tape replicating the placement of your hand on the patient, in combination with the tape mimicking the qualities of the skin, will assist you as you try to learn the Kinesio Taping® Method.

Kinesio Tex® Tape has been designed to allow for a longitudinal stretch of 55-60% of its resting length. This degree of stretch approximates the elastic qualities of the human skin. The tape is not designed to stretch horizontally. The Kinesio Tex® Tape is applied to the paper substrate with approximately 25% of available tension. The average roll of Kinesio Tex® Tape can stretch 35% from its resting length. The elastic qualities of the Kinesio Tex® Tape are effective for 3-5 days before the elastic polymer diminishes.

The thickness of the Kinesio Tex® Tape is approximately the same as the epidermis of the skin. This was intended to limit the body’s perception of weight and avoid sensory stimuli when properly applied. After approximately 10 minutes, the patient will generally not perceive there is tape on their skin.

The Kinesio Tex® Tape is comprised of a polymer elastic strand wrapped by 100% cotton fibers. The cotton fibers allow for evaporation of body moisture and allow for quick drying.

There is no latex in the tape. The adhesive is 100% acrylic and is heat activated. The skin must be free of oils and moisture prior to application. The acrylic adhesive becomes more adherent the longer the Kinesio Tex® Tape is worn. The acrylic adhesive is applied in a wave-like pattern to mimic the qualities of the fingerprint on the fingertip. This not only assists in the lifting of the skin, but also allows for zones in which moisture can escape.

Upon removal of the Kinesio Tex® Tape, there will be no glue residue remaining. This normally allows for multiple taping technique applications without skin irritation. If the patient has sensitive skin, it is recommended that the practitioner apply a small strip of tape and evaluate the patient’s reaction prior to full use.

The combination of the stretch capabilities, thickness, and adhesion allow the Kinesio Tex® Tape to approximate the qualities of the skin. The design of the Kinesio Tex® Tape, in combination with the unique application technique, create the Kinesio Taping® Method.

Basic Application Essentials

The success of the Kinesio Taping® Method is dependent upon two factors. One, proper evaluation of the patient’s condition to allow for application of Kinesio Tex® Tape on the proper tissue. Two, proper application of the Kinesio Taping® Technique. When the two are combined, an effective treatment modality is available to the practitioner. Early in the learning process, many practitioners believe they can utilize the method with little practice. Generally, this is true. However, success is limited by the practitioner’s ability to evaluate the patient’s condition and the possibility of mistakes in tape application. As stated previously, it is recommended that for the Kinesio Taping® Method a tape with elasticity from 35-40% be used. Using a tape which has a different adhesive, is thicker, does not breath, and has different elastic qualities will not produce the same results.

Primarily, the practitioner needs to “unlearn” tape application methods which have been previously learned. During conventional athletic taping, proper application requires using all of the available stretch. The concept is that by taking all of the stretch out of the tape, it will limit or assist a motion and provide for protection from injury/re-injury.

With the Kinesio Taping® Method, the practitioner needs to begin to conceptualize that the Kinesio Tex® Tape will assist the body’s return to normal function through the application of the tape onto the skin. The primary effect of tape application is generally superficial and by applying the Kinesio Tex® Tape with excess tension it’s effectiveness will be limited.
Skin Preparation

The skin should be free of oils and lotions and should be cleaned prior to tape application. Anything that limits the acrylic adhesive’s ability to adhere to the skin will limit both effectiveness and length of application.

For a limited number of patients, body hair may limit adhesion. If the degree of body hair limits adhesion then the practitioner may need to shave or clip the area to be treated. If applying tape in an area of moisture, the water resistant product may be preferable.

Removal of Tape from Paper Backing

To smoothly remove the paper backing, hold the tape vertically, place your index finger on the top edge of the tape. Then by pulling back or flexing your index finger towards your body, the tape will peel from its backing.

Any contact with the acrylic adhesive will diminish its adhesive abilities. Try to touch the adhesive as little as possible.

When removing the KinesioTex® Tape from the paper backing, only remove the amount required to begin the base application. Once base application is completed, the practitioner may want to peel the remaining paper backing away. When doing this, be careful to remove the backing while remembering that 25% of available tension is applied to the tape during manufacturing.

Two other common methods are used to remove the tape from the paper backing. One, tear paper backing just below the base of a Y cut, leaving the paper backing on the tails. As each tail is applied, the KinesioTex® Tape can be removed from the paper substrate using the paper off tension (25%). Two, remove the paper backing from the tails and lightly have the KinesioTex® Tape come into contact with the skin. Do not rub the KinesioTex® Tape as this will initiate glue adhesion. As the KinesioTex® Tape contacts the skin, it will grab the skin and be held in place.

If care is not taken in removing the paper backing from the KinesioTex® Tape, it may roll back and adhere to itself, making application difficult.

Selection of Kinesio Strip Type

Kinesio strip can be applied in the shape of a “Y”, “I”, “X”, “Fan”, “Web”, and “Donut”. The shape selected depends upon the size of the affected muscle and desired treatment effect.

The “Y” technique is the most common method of application. It is used for surrounding a muscle to either facilitate or inhibit muscle stimuli. The basic principle of therapeutic taping for weakened muscles is to wrap the tape around the affected muscle. This is accomplished by using the “Y” strip. The “Y” strip should be approximately two inches longer than the muscle, measured from Origin to Insertion.

The “I” strip can be used in place of the “Y” strip for an acutely injured muscle. The primary purpose of tape application following acute injury is to limit edema and pain.

The “X” strip is used when a muscle's Origin and Insertion may change depending upon the movement pattern of the joint (e.g.: Rhomboid).

The “Fan” strip is used for lymphatic drainage which is an advanced concept.

The “Web” is a modified fan cut. Both base ends are left intact, with the strips being cut in the mid section of the Kinesio strip.

The “Donut” cut is primarily used for edema in a focal or sport-specific area. A series of two or three overlapping strips are applied with the center removed from the KinesioTex® Tape. The center cut out, or “donut hole” is placed directly over the area to be treated.

With any of the five strip types, it is helpful to round the ends of the tape prior to application. The rounding helps prevent the square edges from catching and may increase the length of tape application.

Base Application

Following proper evaluation of the tissues involved, the practitioner determines to which basic muscles the Kinesio Taping® Method should be applied. Begin by placing the base of the Kinesio strip approximately 2 inches below the origin or two inches above the insertion of the muscle. (To determine origin or insertion of desired muscle, the practitioner may use manual muscle testing to determine application start and/or ending point).
Place the base in as close to an anatomical position as possible. Make sure to rub the base prior to any further movement. The base of the Kinesio strip is always started and ended with no tension in order to minimize discomfort from tape application.

**Tissue Stretch**

For all basic application techniques, the muscle/tissue to be treated should be put in a stretched position in combination with the stretch capabilities of the Kinesio Tex® Tape, will create convolutions as the skin is lifted. Skin convolutions may be present following the basic application or may appear during normal joint motion. It is believed that even if convolutions are not present, they are occurring. The convolutions aid in the normal flow of blood and lymphatic fluids.

**Tape Stretch/Tension**

The elastic qualities of the Kinesio Tex® Tape are designed for 55-60% stretch. When applying the Kinesio Taping® Method, it is important to apply the Kinesio strip with the correct degree of tension. If too much tension is applied, the effects are diminished. It is better not to have enough tension than too much. The proper tension application is one of the most critical factors in the application’s success. The terms "stretch" or "tension" are used interchangeably.

In each taping method, including basic, corrective techniques, and clinical conditions, the tension during tape application is critical.

Tape stretch tensions are listed as a percentage and descriptively. Percentages are listed as the percentage of stretch to be applied based upon 100% of the available tension. For example, 15-25%. The meaning of this is 15-25% of the available stretch, with 100% being the maximum stretch.

If you start with a 10-inch strip of KinesioTex® Tape, and you stretch it to its maximum available tension (40% of overall length), it would be 14 inches long. During application, if the technique requires 25% of the available tension, this would actually be 25% of the total available or 1 inch for a total length of 11 inches.

Tensions are also listed descriptively by terms which should convey the amount of tension desired.

Descriptions used are:
- full – (100%)
- severe – (75%)
- moderate – (50%)
- light or paper off – (15-25%)
- very light – (0-15%)
- none – (no tension)

**Tape Direction**

There are two basic application directions for treatment of muscles. For acutely over-used or stretched muscles, the tape is applied from INSERTION to ORIGIN to inhibit muscle function. For chronically weak muscles or where increased contraction is desired, the tape is applied from ORIGIN to INSERTION to facilitate muscle function.

INSERTION to ORIGIN application tape stretch/tension is very light or light, 15-25% of available tension. Using the preferred Kinesio Tex® Tape, this would simply require applying the tape by placing it on the muscle as it comes off of the paper backing (paper off tension). Remember that the Kinesio Tex® Tape is applied to the paper backing with approximately 25% of available stretch/tension. With taping from insertion to origin, it is important to
A 3-stripe Y technique may also be selected. The third tail is applied directly over the muscle belly. Once the basic application is complete, it is important to instruct the patient about a few areas of concern. The tape needs approximately 20 minutes to gain full adhesive strength. Exercise or activities which may initiate perspiration should not occur during this period. The tape can be worn for 3-4 days, and bathing or swimming is allowed. It is important to pat the tape dry and not use any type of heat device to dry the tape. The patient also needs to be comfortable with wearing the tape in a public setting.

"I" Strip Application

The application of the I technique follows the same basic principles as the Y technique. Instead of surrounding the muscle belly, the Kinesio strip is applied directly over the area of injury or pain. This technique has been found to be most effective following acute injuries to the muscle. Immediately following a muscle injury, the I technique should be applied. Then, after the acute injury phase, the practitioner may find increased results by switching to the Y technique.

"X" Strip Application

The X application follows the same principles as the Y and I techniques. The length of the X strip is measured with the muscle on a stretch. This is important, since an X technique is generally used for a muscle which crosses two joints and when it is maximally stretched it may greatly increase in length. The stretch is added to the middle 1/3 of the X strip, placed over the muscle belly, and the tails are laid down with no tension.

"Fan" Strip Application

The Fan Strip is applied with the muscle in a stretched position. For lymphatic correction, none to very light, 0-15%, of available tension is added to the Kinesio Fan Strip tails (4-8). The Fan Strip tails are laid over the area of edema or swelling, with the base located in the area of a lymphatic duct. For a more complete description, see Lymphatic Corrective Technique.
“Web” Strip Application

cut the middle of the Kinesio Tape into 4-8 strips. The KinesioTex® Tape is cut allowing for each end to remain uncut. Place patient in as much range of motion as the joint will allow. Apply one base, remove the web strips, add very light 0-15% of available tension and apply the second base. For a more complete description, see Space Corrective Technique.

“Donut” Strip Application

Begin by cutting a hole in the center of an approximately 6-inch Kinesio I strip. Cut approximately 2 inches of each end into 2 or 3 tails. Place patient in as much range of motion as the joint will allow. Apply light to moderate, 25-50%, of available tension to the Kinesio strip, and place the hole directly over the area of desired space. If more than one strip is applied, use light tension. For a more complete description, see Space Corrective Technique.

Tape Removal

After several days, the acrylic adhesive will have become quite strong. During the first few days, if an edge of the tape has begun to lift, it can be trimmed. To remove the tape from the patient it is generally much easier to do when they have bathed or the tape is moist. It is best to remove from the top down. This will be in the direction of the body hair and should limit discomfort. Lift the tape from the skin, applying tension between the skin and the tape, then pull the skin away from the tape rather than pulling the tape away from the skin.

If the “grip and rip” method is used, an irritation, pain and erythema may result. The application of mineral oil or milk of magnesia to the KinesioTex® Tape has assisted in tape removal.

Possible Limitations of the Kinesio Taping® Method

A limited number of patients may have excessive body hair and may require shaving or clipping. A limited number of patients may not allow the application of the Kinesio Taping® Method due to their resistance to shaving.

Approximately 20-30 minutes is required for the glue to become fully activated before the patient can become physically active. If activity occurs prior to this time, the tape may come off.

If KinesioTex® Tape is applied during physical activity, an extra adhesive may be needed to prepare the skin. Several commercially produced spray adherents are available. Once a spray adherent is used, the removal of the KinesioTex® Tape will be difficult. Commonly available tape adherent glue removers will not affect the adhesive glue since it is not rubber based as most athletic tapes.

The patient may be unwilling or may misunderstand the three to four day application of the technique. The patient must be aware that the tape is to remain on for several days and can be worn while bathing or swimming. The tape does not have to be removed if it has become wet, only towel off excessive moisture and allow to air dry.

Initial Difficulties in Application

The practitioner will need to “unlearn” previous training for use of athletic tapes. Pulling and using full stretch will diminish the effectiveness of this technique. One must begin to think differently about the possible therapeutic use of tape beyond simply assisting or limiting a movement.

A proper muscle evaluation is required to ensure the correct muscle is selected for treatment. If, following the initial Kinesio Taping® Technique application, the patient’s results were not as effective as hoped, the practitioner may want to reevaluate the patient. If the involved muscle was not properly taped, or an inappropriate corrective technique was applied, patient success may be limited.

If a patient has not worn Kinesio Tex® Tape before, they may not be willing to wear the tape in public. The patient needs to be informed of the 3-5 days of application and that even after the Kinesio Tex® Tape has become wet it will remain effective.
Sizes and Types of Kinesio Tex® Tape

There are several sizes of the Kinesio Tex® Tape available. Primarily a practitioner will use the 2 inches (5 cm) by 5.4 yards (5 meters) size. This is available in natural untreated, and natural, red, blue, and black that are treated for water resistance. If the water resistant product is selected, the roll will be one meter less in length to account for the cost of the water resistant treatment. The water resistant product works well in areas of high moisture or for patients working in moist environments. The 2-inch natural treated and natural untreated size can also be purchased in a 34.5 yard (31m) clinic roll for easier usage.

Also available is a 3-inch (7.5 cm) by 5.4-yard (5 meters) roll. This may be required on larger individuals or athletes. The 1-inch (2.5 cm) by 5.4 yard (5 meters) roll may be used for finger or neurological taping. 1 1/2 inch (3.75 cm) by 5.4 yard (5 meters) roll may be used on ankles or smaller patients.

The Kinesio Tex® Tape is also available in red, blue, and black in addition to the beige or natural color. The red is a darker color on the light spectrum and will absorb more light, slightly increasing the temperature under the Kinesio Tex® Tape strip. The blue is a lighter color on the light spectrum and will reflect more light, slightly decreasing the temperature under the Kinesio Tex® Tape Strip. There are no differences in the manufacture of the tape except the change in the dye color required for a color difference.

If the practitioner determines an increase in temperature is appropriate in the injury site, the red Kinesio Tex® Tape could be selected. If the practitioner believes that a reduction in tissue temperature is required, such as in tendinitis, the blue Kinesio Tex® Tape could be selected. Patients may have a preference for a color, and this may affect their perception of the effectiveness of the treatment.

Advanced Application Essentials

When applying the corrective techniques, there are a few essentials to a successful treatment for the patient. The practitioner must always follow the basic essentials of tape application when using a basic Kinesio Taping® Technique.

muscle application. Without properly applying the basic muscle application technique, the success of the corrective technique application may be limited. Proper skin preparation, removal of tape from paper backing, selection of tape width, tissue stretch, tape tension, direction of tape application, glue activation, and tape removal are all important in the overall successful treatment of the patient.

When applying more than one layer of the Kinesio Tex® Tape, the practitioner should first apply the Kinesio strip which will provide the primary therapeutic effect desired. As successive layers of Kinesio Tex® Tape are applied, their effect on the sensory receptors may create interference instead of clear, specific stimuli.

If the primary therapeutic goal is pain reduction, the practitioner may use a basic muscle technique from insertion to origin, along with a space correction or lymphatic correction. The practitioner may determine that the application of the lymphatic correction should be applied for the first 24-72 hours, then apply a space correction technique. After 72 hours, application of the basic muscle technique with a mechanical correction may be appropriate.

The best outcomes generally come from a "less is better" approach. Fewer layers of tape, less tension, and moderate inward pressure are examples of subtle changes transmitted from the Kinesio Tex® Tape to the superficial layers of the tissue.

During initial applications of the Kinesio Taping® Method, the patient should tell the practitioner if he or she is feeling the effects. In this instance the tape application can be modified for possible improvement in results. If the patient returns and believes the tape application exacerbated the symptoms, the ability of the practitioner to successfully treat the patient is limited.

The descriptions provided for the clinical conditions are not intended to be the only method of tape application for any condition. They are intended to be guides. The techniques described have been found in clinical practice to show results after repeated applications with many patients. Every patient presents his own specific symptoms, and the practitioner, through knowledge and experience, will determine the most appropriate course of treatment.
Section 1

Introduction to Corrective Techniques
INTRODUCTION TO CORRECTIVE TECHNIQUES

The Corrective Application Techniques are a continuation in the development of the Kinesio Taping® Method. Since 1973, when the original concept of the Kinesio Taping® Technique was begun, the technique has continued to evolve. This continuing development has added not only to the theoretical application, but also to the practical application, of the technique. Kinesio Taping Practitioners have developed their skills both by learning during seminars and via practical application. The Corrective Techniques have been formalized to help the Kinesio Taping Practitioner gain application and theoretical knowledge in a more systematic fashion.

During Kinesio Taping seminars, practitioners desiring to learn the Kinesio Taping® Technique have traditionally followed a similar pattern: first, basic concepts of the technique; second, basic application techniques are taught; third, practice and practical application on patients; fourth, additional seminar on advanced concepts; and fifth, sometimes general frustration with application of the advanced concepts without really understanding the theoretical background of the concepts.

Difficulties have arisen when a practitioner has completed a course and been introduced to clinical applications without receiving advanced training (Corrective Techniques). Many practitioners have thought that each clinical application was unique. This required the practitioner, in their mind, to learn each clinical application separately with little or no interconnection. In reality, this is not true.

The clinical application of the Kinesio Taping® Method is the systematic application of several elements of the Kinesio Taping® Technique with each element having a specific function. The practitioner initially evaluates the patient’s condition, determines which muscles are involved and initiates treatment to those muscles involved (basic concepts and application). Once the involved muscles are taped, the practitioner then needs to apply a clinical corrective technique to assist the body in correcting the condition.

There are 6 current Corrective Techniques: mechanical, fascia, space, ligament/tendon, functional, and lymphatic. The application methods of several of the Corrective Techniques overlap. The Kinesio Taping Practitioner determines the proper application following his/her evaluation.
Corrective Application Techniques

Mechanical Correction "Recoiling" - utilizes the stretching qualities of the Kinesio® Tex® Tape with inward pressure to provide for positional stimuli through the skin. The degree of stimulation is determined by the percentage of stretch applied to the tape during application, combined with the degree of inward pressure. Three techniques used are: 1) using the base of the Y to provide tension, 2) using the tails of the Y to provide tension, and 3) using the tension in the center of an I strip.

Mechanical correction generally uses moderate to severe 50-75% of available tension. The practitioner may select to use full tension, if appropriate.

Fascia Correction 'Holding' - to create and/or gather fascia in order to align the tissue in the desired position. The tension in the Kinesio® Tex® Tape is used to either hold or assist the fascia in the desired position. Two techniques are used: 1) manually positioning fascia then using tape to hold in place, 2) creating tension by ‘oscillating’ the tape and creating movement of the fascia.

Fascia correction, generally, uses light to moderate 25-50% of available tension.

Space Correction "Lifting" - to create more space directly above the area of pain, inflammation, swelling, or edema. The increased space is believed to reduce pressure by lifting the skin. Three techniques are used: 1) manually gather tissue into desired position and use tension of Kinesio® Tex® Tape to hold the position of the tissue, 2) utilize fascia technique of "oscillation", 3) use elastic qualities of Kinesio® Tex® Tape to pull and hold connective tissue in desired area.

Space correction generally uses light to moderate, or 25-50% of available tension.

Ligament/Tendon Correction "Pressure" - to create increased stimulation over the area of the ligament and/or tendon, resulting in increased stimulation of the mechanoreceptors. The stimulus is believed to be perceived as proprioceptive, simulating more normal tissue. Ligament technique: Kinesio® Tex® Tape is placed over the ligament with moderate to severe, or 50-75% of available tension. Tendon technique: tape over tendon is applied with moderate to severe, or 50-75% of available tension.

For both techniques the practitioner may apply full, or 100% of available tension.

Functional Correction "Spring" - used when the practitioner desires a sensory stimulation to either assist or limit a motion. The Kinesio® Tex® Tape is applied to the skin with moderate to full, or 50-100% of available tension during active movement. The increased mechanoreceptor stimuli are believed to act as a pre-load during end of motion positions.

Lymphatic Correction "Channeling" - used to create areas of decreased pressure under the Kinesio® Tex® Tape that act as channels to direct the exudate to the nearest lymph duct. Tape is applied with the base near the lymph node to which the exudate is to be directed, and the remaining tape is applied in a fan-like pattern with none to very light, or 0-15% of available tension.

The desired outcome is that, following a course in the Corrective Techniques, the practitioner will be able to select the technique appropriate for their patient’s condition, and not be limited to only those specific applications they have seen in a photo or demonstrated in a seminar.

The practitioner should recognize that for each clinical condition they may use a series of Corrective Techniques depending on the patient's condition and the therapeutic goal of the practitioner. Pain reduction may be the first therapeutic goal, and application of a space or lymphatic correction may be selected. After pain has decreased, a mechanical correction or fascia correction might be selected. The Corrective Technique allows the practitioner the opportunity to design a course of treatment for each patient based upon the patient’s needs and not a predetermined formula.
Mechanical Correction

The Mechanical Correction should be thought of as positional in nature and not as an attempt to keep the tissue or joint in a fixed position. This technique uses the properties of the Kinesio Tex® Tape, through the application of moderate to severe tension, to provide a stimulus perceived by the mechanoreceptors. The degree of stimulation is determined by the combination of appropriate tension and inward pressure that provides stimulus to deeper tissue. You, as a practitioner, will need to adjust your application technique to the needs of the patient.

This technique can be used to assist in the positioning of muscle, fascia tissue, or joint to stimulate a sensation which results in the body’s adaptation to the stimulus. Functional support can be maintained without losing active range of motion or inhibiting circulation. The Mechanical Correction can be used to either position the tissue in the desired position, provide stimulus in which the body will adjust position to minimize the created tension, or provide a “blocking” action of joint or tissue movement.

There are two methods used to place the tissue in the desired position: one, use of a manual technique, and, two, use of the elastic qualities of the Kinesio Tex® Tape. If using a manual therapy to provide positioning, first place the tissue in the correct or desired position, using techniques such as joint positioning or myofascial release, before applying the taping technique. When using the elastic qualities of the Kinesio Tex® Tape to provide correct positioning, tension can either be applied using the base of the Y (with the tails being used to dissipate the tension) or the tails (base of the Y is applied with no tension and the tails are stretched maximally with no tension on the ends).

A third method uses tension in the middle of the Kinesio strip with inward pressure to create a “blocking” action. The approximately 6-8-inch long Kinesio I strip is applied with moderate to full tension applied to the middle of the strip. The Kinesio strip is then applied directly over the joint, or tissue with inward pressure. The desired effect is limited movement of the joint or tissue.

When selecting either method, manual or elastic qualities of the Kinesio Tex® Tape, the intent of the tape is to use the “recoil” effect of the elastic polymer. The tape application is completed so that when the tape “recoils” back to its original position it creates tension upon the skin which creates sensory stimuli. The practitioner can either use the stimulus effect of the elastic qualities of the tape to create a corrective reaction or position the tissue without movement.

The recoil effect of the Kinesio Tex® Tape is in effect up to approximately 50% of available tension. After applying more than 50% of available tension, the recoil effect is minimized due to the inability of the elastic polymer to recoil.

The application of inward pressure provides for a deeper stimulus to mechanoreceptors affecting deeper layers of tissue. The combination of high tension and inward pressure is the primary component of the mechanical corrective technique.
Application of Y Technique, tension on tails

Application of Y Technique with tension on tails of Y: This technique uses the "recoil" effect of the elastic qualities of the tape to position the tissue in the direction of the base of the Kinesio strip. The amount of stretch applied to the Kinesio strip and degree of inward pressure determine the depth and perception of skin movement. By using tension in the tails, the practitioner is applying a subtle stimulus.

Start tape with no tension at the beginning. Hold base of Y to beginning of tails to not create any tension.

Apply moderate to severe tension, 50-75% of available. More tension can be applied over tendon or ligament. Tension is applied both in the longitudinal direction and with inward pressure.

When the desired tension has been applied, slide the hand which is holding the base of the Y tails up to the point of end tension. Leave approximately a 1-inch length of tape at end.

Lay down the final approximately 1 inch of remaining tape tails with no tension. Where appropriate, take joint through full range of motion prior to laying down ends.
Mechanical Correction Application Techniques

Application of Y Technique, with tension on base

Applying the Y Technique with tension on base: This technique uses the base of the Y cut to apply tension to the skin. The amount of stretch applied to the Kinesio strip and the degree of inward pressure determine the depth and perception of skin movement.

Start tape with no tension at the beginning. Hold base of tape to not create any tension.

Apply moderate to severe tension, 50-75% of available. More tension can be applied over tendon or ligament. Tension is applied both in the longitudinal direction and with inward pressure. Prior to tape application, the practitioner may want to place the patient's joint in a position which may either stimulate or limit motion.

When the desired tension has been applied, slide the hand which is holding the base of the Y up to the point of end tension.

Lay down the tails of the Y with no tension as the patient moves through a full range of motion. The tails should be splayed out to dissipate the tension created over as large an area as possible.
Mechanical Correction Application Techniques
Application of I Technique, with tension in tape

Application of I Technique with tension in the middle of Kinesio strip: This technique uses the application of tension in the middle of the Kinesio I strip and inward pressure to provide a "blocking" of movement. The amount of tension and inward pressure determine the degree of "blocking."

Begin by placing the center of a Kinesio I strip, of approximately 6-8 inches in length, directly over the tissue to be treated. Apply moderate to full tension, 50-100% of available, to the middle of the strip. Place the Kinesio strip over the treatment area with tension and inward pressure.

Use the Kinesio strip to create a "block" to limit movement of a joint or tissue.

Have the patient move into a position which places the joint or tissue being treated in a stretched position. Lay down the ends of the Kinesio I strip with no tension to dissipate the force added.

The application shown has approximately 1/2 of the Kinesio I strip over the lateral border of the patella to limit lateral tracking.
Fascia Correction

The fascia correction is applied to create and gather fascial tissue in order to position it in a desired alignment. Tape is applied to hold or assist fascia from unwinding to the unwanted position. This technique is intended to gently break down limitations of fascia movement via skin movement and elastic qualities of the Kinesio Tex® Tape.

Fascia is an interconnecting matrix that connects tissues from one layer to the next and within the same layer. It is like a 3-dimensional spiderweb which lies between each layer of tissue, and any acute or chronic inflammation there impairs the ability of the tissue to move.

The fascia technique is applied in two different application methods. First, one may use the elastic qualities of the Kinesio Tex® Tape to reposition the fascia or to limit its movement. Second, one may use the Kinesio Tex® Tape to hold the fascia in a desired position or limit its movement following application of a myofascial manual therapy technique.

The proper application technique for using the Kinesio Tex® Tape to hold a manual therapy technique is similar to the mechanical technique previously described. Following the manual therapy technique, the fascia is held in the desired position with one hand. The Kinesio strip cut in a Y pattern is then applied to hold the tissue in the desired position. The specific difference between a fascia correction and a mechanical correction is the use of inward pressure. Inward pressure is only applied when the practitioner desires a deeper effect. Generally the fascia correction is applied with little or no inward pressure.

The proper application technique for using the elastic qualities of the Kinesio Tex® Tape involves the “oscillation” of the Kinesio strip. Apply the base of the Y strip 1/2 to 1 inch below the area to be treated. The base is held to limit tension, and the practitioner “oscillates” or vibrates the tape in a longitudinal direction during application. The “oscillation” or vibration is gentle and may include a slight inward pressure if the effects are felt to be required in deeper tissues. This is felt to limit the “recoil” effect of the tape returning to its original position towards the base.
Fascia Correction Application Technique

Use of fascia correction technique to reposition fascia, tension on the base

Use of fascia Correction Technique to reposition fascia, with tension on the base: In this technique, the practitioner uses the elastic qualities of the Kinesio Tex® Tape to simulate a manual therapy technique. The elastic qualities of the Kinesio Tex® Tape will be applied using an “oscillating” motion in an attempt to reduce tension and adhesions between and within layers of the fascia. This technique may not be as effective as using a manual technique; however, if the practitioner is not skilled in a manual technique this may still allow an option for treatment.

Begin by placing the base of the Kinesio Y strip approximately 1/2 to 1 inch below the area of fascia to be treated, with no tension.

Apply light to moderate tension, (25-50% of available) to the tape in the direction fascia correction is desired. Hold the base with one hand to minimize excess tension on the base. The tape should be “oscillated” in the longitudinal direction. Minimal inward pressure should also be applied as the tape is being laid down. The inward pressure is not specifically intended to deepen the effect of the tape, but is only used to apply the Kinesio Tex® Tape during application; its function is to reduce the “recoil” effect of the Kinesio Tex® Tape.

Lay down the tails of the Kinesio Y strip with no tension.

This technique can also be used to pull the fascia in the opposite direction. If the practitioner desires to move the fascia “away from” an area, the elastic qualities of the Kinesio Tex® Tape can be used to accomplish this goal.
Fascia Correction Application Technique

Manual fascia winding or myofascial release, tension on base.

Use of manual fascia winding or myofascial release technique: Following the application of a manual therapy technique, position the fascia in the desired position prior to tape application. This technique can be used to either hold fascia in desired position or limit the movement of fascia into an unwanted position. Use the Kinesio strip to hold the corrective positioning of the fascia.

Use a manual technique to collect or correct fascia and soft tissue as appropriate.

Place base of tape slightly above or below soft tissue which has been gathered. Placing base of Kinesio strip with no tension at start, hold base to ensure no tension is added to the base.

Apply tension to the tape in the direction/opposite direction fascia correction is desired. Moderate to severe tension, (50-75% of available) is applied with minimal inward pressure. The desired effect is to “hold” the myofascial release technique in the desired position. This can also be accomplished by using the tails to hold the myofascial release as described in mechanical correction.

Lay the tails of the tape down with no tension. The tails should be splayed out to dissipate the created tension over as large an area as possible.
Space Correction

The space correction is applied to create more space directly above an area of pain, inflammation, swelling, or edema. The increased space that is created decreases pressure by lifting the skin directly over the treatment area.

The resulting decreased pressure assists in reducing the amount of irritation on the chemical receptors, thus decreasing pain. An increased level of circulation is also felt to occur in the area, allowing for increased removal of exudate. Stimulation of the mehnoreceptors may also aid in decreasing pain. By increasing sensory stimulation, the gate control theory of pain may be initiated.

Space is created by using the elastic qualities of the Kinesio® Tex Tape to lift fascia and soft tissue over the area of pain or inflammation. Tape application needs to be performed slowly, and the practitioner should not allow the skin to bunch (can cause a blister) under the Kinesio Tex® Tape or allow the technique to be applied with too much tension (causing irritation to the skin).

The space correction technique may be selected by the practitioner as a primary therapeutic technique following initial evaluation of the patient's condition. The patient may initially receive the greatest benefit from reduction of inflammation and pain. Following initial reduction in inflammation and pain, the practitioner may select another therapeutic technique such as fascial correction or mechanical correction.

There are four main techniques used with space correction. One, the elastic qualities of the Kinesio I-Strip can be used to pull the connective tissue toward the desired area by applying the Kinesio strip with tension out of the middle of the strip with no tension on the ends (modification of ligament and tendon correction). Multiple layers can be used depending upon the size of the area. Two, practitioners can utilize a manual therapy technique to gently gather the skin and fascia and use the Kinesio Tex® Tape to maintain the tissue over the desired area (fascial manual winding technique, see fascial correction technique). Three, practitioners can use fascial correction technique to create and hold tissue over the desired area (see fascial correction technique). Four, practitioners can use the “donut hole” or web cut.
Space Correction Application Techniques: I-Strip

Application of Kinesio I strip for space correction: This technique uses the elastic qualities of the KinesioTex® Tape to lift the skin and create space. This is accomplished by applying tension to the middle 1/3 section of the Kinesio strip and laying down both ends with no tension. A single strip or a series of overlapping strips can be applied. With this method, a "pocket" is formed under the tape, decreasing pressure and pain.

Generally an I strip is used for this technique. Cut the Kinesio strip to desired length, generally 6-8 inches. Tear the KinesioTex® Tape paper backing in the middle of the strip. Fold back the paper and apply tension to the middle 1/3 of the Kinesio strip.

Apply light to moderate tension, (25-50 % of available) to the Kinesio I strip in the middle 1/3 of the strip. Place the center of the Kinesio strip over the region of the desired space correction. A series of strips can be applied, with the intersection of each strip located over the desired space correction location (area of desired "pocket"). If multiple strips are used, decrease tension applied to each strip to limit accumulation of excess tension.

Move the patient through as full a range of motion as possible to minimize tension at ends of application. Lay down each end of the Kinesio strip with no tension.

Convolutions of the skin should be evident during joint range of motion. If convolutions are not present, the tape was applied with too much tension.
Space Correction Application Techniques:  
Facia Corrections used for Space Correction

Additional methods of space correction application: These are fascia correction techniques with the desired therapeutic goal of pain and inflammation reduction. The basic fascia correction application technique does not change, only the therapeutic goal changes. For complete explanation of each technique refer to Fascia Correction.

Use of manual fascia winding or myofascial release technique: Following the application of a manual therapy technique, position the fascia/skin in the desired position prior to tape application. With this application, the desired therapeutic goal is space correction. Effects on fascia may be a secondary therapeutic result. For review, see fascia correction. The region of space correction should be at the base of the tails.

Use of fascia correction technique to reposition fascia: In this technique, the practitioner is going to use the elastic qualities of the Kinesio-Tex® Tape to simulate a manual therapy technique. With this application, the desired therapeutic goal is space correction. Effects on fascia may be a secondary therapeutic result. For review, see fascia correction.

Use of a Kinesio I strip of approximately 6-8 inches with light tension, (15-25% of available, or paper off tension). The tension is added to the middle 1/3 region of the Kinesio I strip.

Begin the strip with no tension, and have the patient move the joint or tissue to be treated into a stretched position. As the patient moves into an active motion, lay down the Kinesio I strip with light tension.

If the application is applied correctly, convolutions in the skin will be present.
Space Correction: Hole and Web Technique

This technique uses a hole cut in the center of the Kinesio I strip slightly larger than the area to be treated. The two ends are cut into three tails of approximately 1/3 of the length of the Kinesio strip. The hole is placed directly over the area in which space is to be created. Light to moderate tension, (25-50% of available) is applied to the Kinesio strip prior to placement on the patient while they are in the stretched position. The tails are laid down with no tension to dissipate any force created during tape application.

Hole Technique

Begin by cutting a hole in the center of an approximately 6-inch Kinesio I strip. Be careful to not cut more than 1/2 of the available width of the KinesioTex® Tape. This will maximize its ability to adhere to the patient’s skin.

Cut approximately 2 inches of each end into 2 or 3 strips.

Place the joint into a maximally stretched position as pain and swelling allow. Initially this may be a limited ROM, however as pain and swelling are reduced ROM will improve.

In the center of the Kinesio strip tear the paper backing and peel back to allow for tension to be applied to the KinesioTex® Tape. Apply light to moderate tension, (25-50% of available) to the Kinesio strip and place the hole directly over the area of desired space. If more than one strip is applied, use light tension.

Lay down the tails on both ends with no tension. Splay the ends to dissipate tension which was created in the area of the donut.

Initiate glue activation prior to any patient movement.

Web Cut

Cut the appropriate length of tape, and fold the tape in half. Cut the Kinesio strip into 4-8 strips, leaving 1 inch at each end uncut. Begin by placing the joint into a maximally stretched position as pain and swelling allow. Two methods can be used. 1) begin by applying one end of the web cut with no tension below the area to be treated. Remove the web strips using paper off tension and apply the second base. 2) tear the paper backing at the center of the fan cut and peel back the paper backing. Apply very light to light tension, (15-25% of available) in the center area of the web cut. As best as you can, separate the web fan strips, so there is approximately 1/4 inch separation. Place the web fan strips over the desired treatment area. Lay down the ends with no tension.

Initiate glue activation prior to any patient movement.
Ligament/Tendon Correction

The ligament/tendon correction is applied to create increased stimulation over the area of a ligament or tendon resulting in increased stimulation to the mechanoreceptors. This stimulus is believed to be perceived as proprioceptive stimulation that is interpreted by the brain as more similar to normal tissue tension.

Kinesio Tex® Tape is applied for ligaments with moderate to severe tension (50-75% of available) with the tape directly over the area of the ligament. Maximum or full tension, (100% of available) may also be used if the practitioner determines it appropriate. The ends of the tails, as always, have no tension at the start or end of the tape application. It can either be applied from origin to insertion or insertion to origin, as determined by the practitioner. Generally, the tape should be applied from insertion to origin; in this manner the tension of the tape will be limiting the allowable movement of the ligament. (It may be desirable to have the patient move the area being taped through a limited or full range of motion if appropriate for function.)

Two methods of application for the ligament/tendon can be used. 1) begin by applying the Kinesio I strip with no tension at the beginning; apply desired tension over the length of the ligament; and then lay down the end of the strip with no tension. 2) begin by tearing the paper backing in the middle of the I strip. Apply desired tension to the middle 1/3 of the strip, then with tension held in the Kinesio strip apply the strip over the length of the ligament. End the application by having the patient move the body part through as much range of motion as possible and apply ends of strip with no tension.

Tape application for the tendon is similar, except that less tension, (50% of available) is applied directly over the area of the tendon. In the extreme case, severe (75%) tension may be applied. The ends of the tails, as always, have no tension at the start or end of the tape application. Tension can be increased directly over the area of the tendon. When the tape crosses over the muscle belly, the tension should be adjusted for either an origin to insertion (very light tension, 15% of available), or insertion to origin (light to moderate tension, 25-50% of available) application.
Ligament Correction Application Technique

Use of ligament correction technique application to create increased stimulation over the area of a ligament resulting in increased stimulation to the mechanoreceptors. Generally, the base of the corrective strip should be started at the insertion of the ligament. This should ensure the tension being created by the Kinesio strip has a shortening effect on the skin and joint.

Apply base of tape with no tension. Hold the tape base to ensure that no tension is added. Practitioner may want to practice the placement of the Kinesio strip prior to base placement to limit error on initial application.

Apply moderate to severe tension, (50-75% of available) along the approximate position of the ligament, with patient in a functional position (e.g. knee 20-30 degrees of flexion). The practitioner may use up to 100% of available tension, if appropriate.

Slide the hand that was holding tension at the base up to the end of tension position at approximately the origin of the ligament. Lay down the tail of the tape with no tension. Prior to completion of the Kinesio strip application, the joint may need to be moved through a full range of motion. Example: for the wrist corrective strip applied in neutral position, tails may be applied during flexion or extension.
**Tendon Correction Application Technique**

Use of tendon correction technique application to create increased stimulation over the area of a tendon that results in increased stimulation to the mechanoreceptors:
The proper application of the tendon correction technique will have an increased tension, moderate to severe (50-75% of available tension) over the length of the tendon. Tape applied beyond the tendon should be appropriate for an O to I or I to O application.

Apply end of tape with no tension. Hold the tape end to ensure that no tension will be placed on the base of the tape.

Apply moderate to severe tension, (50-75% of available) along the length of the tendon, with patient in a stretched position. Remember to reduce tension over belly of muscle for either origin to insertion or insertion to origin application.

Slide the hand that was holding the base up to the end of tension position. Lay down the base or tails of the tape with appropriate tension for I to O or O to I application.
Functional Correction

The functional correction is used when the practitioner desires sensory stimulation to either assist or limit a motion. The Kinesio Tex® Tape is applied to the skin with no tension during active movement. The tension created by the increased stimulation during active movement is believed to provide stimulation to the mechanoreceptors. The perceived stimuli are believed to be interpreted as proprioceptive stimuli, which act as a pre-load during end-of-motion positions.

The Kinesio Tex® Tape is applied by cutting the appropriate length of an "T" strip. Length should be approximately 4 inches above and below the joint or a length appropriate for the joint chosen. Place the joint or muscle to be taped in the appropriate position. Example: if assisting flexion and resisting extension, place the joint in flexion. Begin tape application at the distal end of selected joint with a minimum of 2 inches of tape with no tension. Apply appropriate tension (light, moderate, severe or full) then adhere the second base of the tape at the proximal end of the selected joint.

When first using the functional correction, the most difficult part is determining the proper tension during this phase of application. The first time a practitioner applies this technique, do not be surprised if either too much or too little tension is applied. The base should also be a minimum of 2 inches in length with no tension.

With one hand placed on each base, both proximal and distal, have the patient actively move the joint into the opposite range of motion position. Example: if assisting flexion and resisting extension, have the patient now actively move into extension. To finish the tape application, move both hands towards the middle of the joint and apply the remaining tape. Making sure to activate the acrylic glue by rubbing the Kinesio strip prior to releasing tension on the joint.

Following the functional tape application as described above, the patient will perceive stimuli, which will assist with flexion and resist the end position of extension (in example given). This is accomplished because the mechanoreceptors interpret the stimuli as normal joint position. During extension, the increased tension on the skin will provide a stimulus perceived as reaching the end of normal joint position. This perception is created through increased skin tension which would normally occur at end of motion. Flexion will be assisted as the perception of increased tension in positions of extension causes the repositioning of the joint to normalize perceived skin tension.
Functional Correction Application Technique

Use of functional correction technique to assist or restrict a motion (e.g. flexion or extension). It is believed this is accomplished by changing the perception of joint position through increased tension in the skin. The body will adjust joint position to normalize the increased tension on the skin.

The Kinesio Tex® Tape is applied by cutting the appropriate length of an 1 Strip. Length should be approximately 4 inches above and below the joint (or a length appropriate for the joint chosen).

Place the joint or muscle to be taped in the appropriate position. Example: if assisting dorsiflexion and resisting plantar flexion, place the joint in dorsiflexion. Begin tape application at the distal end of selected joint with a minimum of 2 inches of tape with no tension.

Apply an appropriate degree of tension from light to full and adhere the second base of the tape at the proximal end of the selected joint. Initially it may be difficult to determine the appropriate amount of tension; several applications may be needed prior to establishing proper tension. This base should also be a minimum of 2 inches of tape with no tension.
With one hand placed on each base, both proximal and distal, have the patient actively move the joint into the opposite range of motion position. Example: if assisting dorsiflexion and resisting plantar flexion, have the patient now actively move into plantar flexion.

To finish the tape application, move both hands towards the middle of the joint and apply remaining tape. Make sure to activate the acrylic adhesive prior to releasing tension, otherwise the Kinesio strip will have limited adherence.
**Lymphatic Correction**

The lymphatic correction is used to assist in the removal of edema by directing fluid towards a less congested lymphatic pathway and lymph node. This is accomplished by the lifting effect and elasticity of Kinesio Taping. The lifting of superficial skin decreases pressure and opens initial lymphatics, while the tape also creates a massaging action during active motion. The effect of Kinesio Taping on muscle also improves the efficiency of the deeper lymphatics by allowing maximum contraction and relaxation of a muscle.

The lymphatic system is a one-way system that relies on tissue pressure to assist in movement. During a 24-hour period, between 50 to 100% of plasma proteins leave the blood stream and are taken up by the lymph system. Approximately 2 liters of lymph are processed per day by the body.

Beginning in the superficial dermis at the level of the venous capillaries, the lymphatic system is responsible for the removal of waste products and larger cell proteins that are unable to be transported by the venous system. Interstitial fluid moves into the initial lymph collectors at which time it becomes lymphatic fluid. These initial collectors are extremely small, with flaps or openings that are attached to the skin by small filaments. Movement of skin and pressure changes open and close these vessel openings to allow filling and emptying. Deeper vessels called "lymph angions" lie between muscles and parallel to the venous system. Resembling a "string of pearls", they have one-way valves and utilize a stretch reflex to empty and fill the next angion, creating a type of peristalsis movement of the fluid. Muscle contraction and respiration also assists in propelling lymph throughout the body by creating deep pressure changes.

As lymph moves through the body, it needs to be processed prior to rejoicing the venous system and entering the heart. Lymph nodes concentrate and clean the lymph fluid of toxins, dyes, and 'unknown' cells. There are approximately 600 lymph "nodes" in the body, and most are located near organs or major joints of the body. The highest concentration of lymph nodes (160) is found in the neck region. Nodes have an arterial and venous supply that is responsible for increasing the viscosity of the lymph, taking up to 40% of lymphatic fluid content via the capillary circulation. Immune components such as "B" and "T" cells are also located in the lymph nodes, and foreign cells may be destroyed by macrophages or lymphocytes or stored here to be isolated from the body. The concentrated, node-processed lymph then moves into larger deeper lymphatic ducts that are located in the trunk. All ducts join in the upper chest and empty into the left jugular vein prior to returning to the heart.

Edema and inflammation occur when there is an increase in blood circulation and the lymphatic system is unable to keep up. This may be due to trauma, infection, autoimmune reaction (rheumatoid arthritis), or heat. Inflammation puts pressure on touch receptors. This increased pressure in the superficial layers and lack of skin movement inhibit lymphatic collectors, increasing edema.

* Special thanks to Ruth Coopee OTR-CHT, Vodder MLD-CDT, CKTI for her assistance with this correction technique.
Lymphatic Correction Application Technique

Use of lymphatic correction to create space and provide a channel for fluid to move towards lymph node. The Kinesio strip is applied using a fan cut. Initially it may be easier for the practitioner to use KinesioTex® Tape cut into 4 strips. Lymphatic drainage may improve using a fan cut into 5 and even 6 strips.

For lymphatic correction the Kinesio Tex® Tape is cut into approximately 1/4 to 1/2 inch strips, leaving approximately one inch uncut at the base.

The first Kinesio Fan Strip applied is a 5-strip cut. Apply the tails of the fan with none to very little tension, (0-15% of available) over area of edema. Place base of fan cut slightly above the lymph node to which lymph drainage is being directed. Have the patient move into a stretch position. In the example shown, the knee is in extension and the ankle in dorsi flexion.

The placement of the lymphatic strips is directed at the appropriate lymphatic duct; photo shows drainage to posterior medial aspect of knee. The second Kinesio Fan Strip is a 5-cut strip and has been applied in a crisscross pattern.

Photo shows drainage to region of Achilles tendon.

Precautions:
KINESIO TAping AND DEEP VEIN THROMBOSIS (DVT)
A thrombosis is "the formation, development or existence of a blood clot within the vascular system" (Tabers)
DVT are most often formed in the lower extremities secondary to venous stasis. Post operative, obese and sedentary individuals are in highest danger of developing DVT. They become life threatening if they dislodge move through the heart-resulting in a pulmonary embolism. They may also be found in the upper extremities as well. Therefore muscle taping is contraindicated if there is any suspicion of DVT.
Superficial Fan Cut taping for edema reduction according to some vascular surgeons is acceptable as it will not affect the tonus of the muscle to dislodge a clot.
Kinesio Taping for Scar Tissue

- Do not apply Kinesio Tex® Tape directly to a scar until it is well healed.
- Applying tape too early could cause excessive stress to collagen fiber cross-link formation.
- Be extremely cautious with patients with disease processes such as diabetes, venous insufficiency, and peripheral neuropathy.
- Scar correction assists in the softening of scar tissue and reducing adhesions and pitting. It helps to make the scar soft, flat, and pliable.
  - Position patient in maximal muscular and fascia/skin elongation of the scarred area. Lay down an I application to adhere the tape.
  - Pitting: Position patient in maximal muscular and fascia/skin elongation of the scarred area. Lay down an I tape with 75% stretch. Rub the tape after application to adhere the tape.
  - Apply cross strip with 75% tension on tape to lift pitted area.

- Space Correction:
  - Increase space by lifting fascia and soft tissue using the elastic quality of the Kinesio Tex® Tape. This will decrease the pressure, reduce irritation on the chemical receptors and decrease pain.
  - A space correction will assist in decompressing the involved area by utilizing the tape on stretch. The stretched tape will facilitate tissue mobilization over tissue adhesions. Effective over multidirectional adhesions.
  - Stretch the scar and surrounding tissue
  - Apply tape stretched in the middle with 30-40% stretch.

- Fascia Correction:
  - Used to gather and hold fascia tissue in the desired position.
  - Assists in breaking down adhesions and improving tissue movement.
  - Use inward pressure for a deeper effect.
  - Fascia correction generally accepted as the most effective in the treatment of scar tissue. Apply tape anchor in the direction of wanted tissue glide, as the natural elastic recoil in the tape will move toward the anchor, directing the fascia. Apply tape with 20-30% stretch. A “Y” application is recommended to dissipate the tension force on the skin. Use more tension when targeting deeper tissue and less tension when targeting superficial tissue.
  - Begin application in direction of desired tissue movement.
  - With tissue/muscle on stretch, gather tissue and apply tape with 20-30% stretch.
Muscle-Contraction Headache

A muscle-contraction headache may develop from forward flexion of the head during work, or from excess stress during activities of daily life. The example provided has been shown in clinical practice to have a high rate of success.

The Kinesio Taping® Method will assist with reduction in muscle tension. Clean the forehead to remove oils prior to application.

Two strips are applied, one above each eyebrow at approximately 45 degrees.

Apply first strip slightly lateral to the medial aspect of the eyebrow. Place one hand directly over the eye in the region of the hair line. Apply tension to the skin above the eyebrow in the direction of the hair line.

Lay down the Kinesio I strip with very light tension, (0-15% of available). Initiate glue activation prior to any further patient movement.

Begin strip two slightly lateral to the medial aspect of the eyebrow. Place one hand directly over the eye in the region of the hair line. Apply tension to the skin above the eyebrow in the direction of the hair line.

Lay down the Kinesio I strip with very light tension, (0-15% of available). Initiate glue activation prior to any further patient movement.

Basic Kinesio Taping® Method application of splenius capitis and semispinalis capitis:

Begin by measuring the Kinesio Y Strip from T3-T5 vertebræ to the base of skull.

Place the base of the Kinesio Y Strip over the spinous process of the T3-5 with the neck in neutral position and no tension on the base.

Be careful not to add tension to the tape. The nape region of the neck is very sensitive to tension; less is better in this region of the body.
Have the patient move into neck flexion. Apply the medial tail along the spinous process with very light tension, (0-15% of available) from T3-5 to C5-6. Then begin to angle the tail towards the mastoid process.

If the patient’s hair line is low, be careful not to apply the Kinesio Y strip tail on the hair; as this may cause an increase in symptoms. If possible, clip the hair in this region.

Initiate glue activation prior to any further patient movement.

Have the patient move into neck flexion with lateral rotation to the opposite side. Place the lateral tail to angle towards the mastoid process.

Initiate glue activation prior to any further patient movement.

This technique is repeated to provide relief on both sides of the neck.
Temporomandibular Joint (TMJ)

TMJ is a joint comprised of the condyle of the mandible and the mandibular fossa of the temporal bone. It may become injured from direct trauma, or degenerative changes may occur. Pain may be constant or be felt when movement of the jaw occurs.

The KinesioTaping® Method will assist in reducing pain and edema. Prior to tape application, the practitioner should have the patient open and close his/her jaw to locate the TMJ joint or location of pain. If this region is experiencing hypersensitivity, the tape should be applied with tension removed from skin prior to tape application.

The skin should be placed on a stretch prior to application to minimize pull of the tape on the sensitive skin. Place base of the Kinesio Y strip slightly posterior to the TMJ, with no tension.

Determine the path of the superior tail of the Kinesio Y strip prior to application: pull skin from the TMJ region in the direction of the nose. This will limit the addition of excess tension from the Kinesio Y strip.

Once tension has been removed from the skin, apply the Kinesio Y strip superior tail with very light tension, (0-15% of available).

Repeat the above step for application of the inferior tail of the Kinesio Y strip.
**Trigeminal Neuralgia**

*Trigeminal* Neuralgia is an inflammation of the 5th cranial nerve, or Trigeminus. The patient will experience a hypersensitivity in the lateral aspect of the face. This can be painful, and care must be taken to not exacerbate symptoms.

The KinesioTaping® Method will assist by decreasing the area of sensitivity and pain. The application should be left on as long as possible, so as not to cause an increase in nerve sensitivity. Each time the Kinesio Tex® Tape is removed, it will remove the superficial layer of dead skin cells, possibly increasing the skin sensitivity. Four strips of Kinesio Tex® Tape will be applied.

The first strip of Kinesio Tex® Tape is applied with the tension going from the TMJ to the nose region. For this application each of the three Kinesio Tex® Tape I strips should be cut so the stretch is applied in the horizontal, instead of the normal vertical direction. This is done by cutting the Kinesio Tape to the desired length, only doing so on the width. Before placing the tape on the patient, rotate the Kinesio Tex® Tape so the stretch is available laterally with none to very light tension, (0-15% available).

Place the base of second strip directly in front of the first strip, in the direction from the TMJ to the chin. Apply the base with no tension; hold the base with one hand to ensure no tension is added. Place the other hand in the region of the chin, and pull the skin towards the chin.

Apply the second Kinesio I strip with 15-25% paper off tension. Initiate glue activation prior to any further patient movement.

For the superior and medial Kinesio I strips, repeat the above process.

The superior Kinesio I strip should be angled superior to the eyebrow of the patient.

The medial Kinesio I strip should be angled towards the medial aspect of the nose.
Cervical Spondylitis

*Cervical* Spondylitis is an inflammation of one or more vertebrae in the cervical region. It is generally associated with degenerative joint disease and arthritis.

The Kinesio Taping® Method will assist in the reduction of edema and pain.

**Basic** Kinesio Taping® Method application of muscle taping for the Splenius Capitis and Semispinalis Capitis.

Begin by measuring the Kinesio Y strip from thoracic 3-5 to occiput of the skull.

Place the base of the Kinesio Y strip over the spinous process of T3-5 with the neck in neutral position and no tension on the base.

Have the patient move into neck flexion. Apply the medial tail along the spinous processes with very light to light tension, (15-25 % of available), or paper off tension, from T3-5 to C5-6. Then begin to angle the tail towards mastoid process of the skull along the hair line of the patient.

If the patient’s hair line is low, be careful to not apply Kinesio Y strip tail onto the hair, as this may cause an increase in symptoms. If possible, clip the hair in this region. Initiate glue activation prior to any further patient movement.

Have the patient move into neck flexion with lateral rotation to the opposite side. Aim the lateral tail towards the mastoid process with very light to light tension, (15-25 % of available), or paper-off tension. Initiate glue activation prior to any further patient movement.

This technique can be applied bilaterally, depending upon the patient’s symptoms.

**Example of Bilateral Application Splenius Capitis**
Application of the Kinesio Taping® Method for brachial plexus neuropathy. Measure a length of tape from just past the most distal point of paresthesia to the occiput of the skull. Cut a Y from the proximal end to approximately the insertion point of teres minor and major.

Tear the paper backing at the base of the Y cut and apply an approximately 2-inch area with no tension to the insertion point of the teres minor and major.

Have the patient move into shoulder flexion with horizontal flexion and neck rotation with lateral flexion to the opposite side of the symptoms.

Apply the superior tail along the upper trapezius to the occiput of the skull. The lower tail is placed either over any detectable trigger point or along the teres minor and major to approximately the axillary border of the scapula.

Have the patient flex his/her wrist and elbow while maintaining shoulder flexion. Apply the Kinesio Strip with very light to light tension, (15-25 % of available or paper off) along the paresthesia.

At the elbow adjust the Kinesio Strip to miss the olecranon process to avoid placing pressure over the olecranon bursa, or cut a hole in the center of the Kinesio Strip directly over the olecranon process.

Continue over the dorsum of the forearm to the dorsum of the hand.

The brachial plexus nerve strip only needs to be applied as far down the arm as the radiating pain is felt by the patient.

Completed application of the Kinesio Taping® Method for cervical spondylitis.
Neck Sprain or Whiplash

A sprain to the neck generally occurs as the result of a quick snapping of the head in forward flexion. It may be associated with a strained neck, since the same motion may cause an over stretching of the cervical paraspinal muscles.

The Kinesio Taping® Technique will assist with reduction in edema and muscle spasm, and, with the application of a ligament correction, limit painful neck movement.

Acute: First 24 - 72 Hours

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic correction techniques. For review, see lymphatic correction technique (pg. 39-40).

Begin by placing the base of the Kinesio fan strip at approximately the superior angle of the medial border of the scapula with the patient in a neutral spine position. Have the patient move into forward flexion with rotation to the opposite side. The tails of the fan strip should be angled upward at 45 degrees over the injured cervical segment with very light to light tension, (15-25% of available).

The second Kinesio fan strip is placed at approximately the superior angle of the medial border of the scapula opposite to the first Kinesio fan strip, with patient in neutral spine position. Have the patient move into forward flexion with rotation to the opposite side. The tails of the fan strip should be angled upward at 45 degrees over the injured cervical segment.

The two lymphatic correction strips should form a crisscross pattern over the injured cervical segment.
Post Acute: After 24-72 hours

Begin with the patient in a neutral neck position. Apply the base of the Kinesio Y strip with the cut of the Y at approximately the T1 or T2 spinous process, with no tension. Next, have the patient move into neck flexion. Apply the tails towards the occiput of the skull on each side. Tension should be very light (0-15% of available). Less tension is tolerable in the neck region as a result of the increased sensitivity of the region.

Prior to applying each tail, have the patient move into rotation to the opposite side. Lay the tips of the tails down with no tension.

Application of a ligament correction technique: For review, see ligament correction technique (pg 33-34).

Begin by tearing the middle of an approximately 4-6 inch Kinesio I strip through the center of paper backing. Apply moderate to severe tension, (50-75% of available) to the Kinesio strip. Place the center of the Kinesio strip over the region of the ligament requiring correction.

Inward tension may also be added as if applying a mechanical correction technique.

Have the patient move into neck flexion, and lay down the two base tails of the Kinesio strip with no tension. Initiate glue activation prior to any further movement.

Alternative method for patients in need of more support: Apply an I strip along each upper trapezius from insertion to origin. Apply an I strip along the cervical erector spinae muscles from inferior to superior. Apply a 3-inch Kinesio ligament correction strip directly over the area of pain.
**Rotator Cuff Impingement or Tendonitis**

*Rotator* Cuff Impingement is a term which refers to a compression of the supraspinatus, long head of the biceps tendon, or the subacromial bursae on the bony coracoacromial arch. When inflammation develops, the soft tissue is compressed against the bony arch causing an increase in edema and possibly, over time, a partial or full thickness injury. This condition may also be seen in combination with shoulder instability.

The KinesioTaping® Method will assist in reduction of edema and pain, with an increase in muscle activity to provide increased joint stability.

**Application** of the supraspinatus muscle taping from insertion to origin: This should be applied first as it is the primary tissue to be treated.

Begin by placing the base of the Kinesio Y strip 2 inches below the greater tuberosity of the humerus, with no tension.

Have the patient move into shoulder adduction behind the back, with lateral neck flexion to the opposite side.

Apply light tension, (15-25% of available) or paper off tension to the Kinesio Y strip. The superior tail should be applied superior to the spinous process of the scapula, between the upper and middle trapezius muscles and end at the supraspinous fossa on the superior medial border of the scapula.

The inferior tail should be applied along the spinous process of the scapula. Apply the distal 1-2 inches with no tension.

Initiate glue activation prior to any further patient movement.

Apply the deltid muscle taping from insertion to origin. In this illustration, all three portions are being taped as a group. The practitioner may elect to tape the muscles separately.

Begin by placing the base of the Kinesio Y strip 2 inches below the deltid tuberosity of the humerus with no tension.
Both anterior and posterior tails should be applied with light (15-25% of available) or paper off tension.

Place the shoulder in abduction to 90%, external rotation and horizontal extension. Apply the anterior tail along the outer border of the anterior deltid to approximately the AC joint. Apply the last 2 inches without tension.

Move the shoulder into horizontal flexion with internal rotation while maintaining abduction. Apply the posterior tail along the outer border of the posterior deltid to approximately the AC joint. Apply the last 2 inches without tension.

**Application** of mechanical correction technique with tension on base: For review, see mechanical correction technique.

Begin by placing the base of a 6-8-inch long Kinesio Y strip on the anterior aspect of the shoulder in the area of the coracoid process, with no tension. The base can be adjusted to place the cut of the Y directly below the region of pain.

One hand should hold the base to ensure no tension is added. Apply moderate to severe tension, (50-75% of available) with inward pressure surrounding the area of pain over approximately 1/2 of the Kinesio Y strip length.

When approximately 1/2 of the Kinesio Y strip has been applied, slide the hand which was holding the base up to the point of end tension on the Kinesio Tex® Tape.

Have the patient move into shoulder flexion with horizontal flexion. Apply the tails of the Kinesio Y strip in a splayed out pattern to dissipate the created force; no tension is applied to the tails.

Initiate glue activation prior to any further patient movement.

Completed Rotator Cuff Impingement or Tendonitis Kinesio Taping Application.
Scapulohumeral Dysfunction

Movement of the scapula in relation to the humerus during normal range of motion is referred to as scapulohumeral rhythm. For normal shoulder range of motion there must be a coordination of the humerus, scapula, and clavicle with the acromioclavicular and sternoclavicular joints. When there is excess joint motion of the glenohumeral joint, inadequate scapular movement, and/or decreased motion allowed at the acromioclavicular joint, a dysfunctional movement pattern occurs.

The Kinesio Taping® Method assists in decreasing pain, improving muscle function and can provide proprioceptive stimulus to facilitate a more normal movement pattern. The specific application technique cannot be described for the practitioner; this will need to be determined by the patient’s symptoms.

The following are examples of application techniques the practitioner may want to select; the correct application technique will be a combination that fits with the patient’s symptoms.

Glenohumeral Laxity - Anterior:

Application of the Kinesio Taping® Method for anterior glenohumeral laxity. For review, see Anterior Shoulder Instability (pg. 58-59).

Impingement of the Rotator Cuff:

Application of the Kinesio Taping® Method for impingement of the rotator cuff. For review, see impingement of the rotator cuff (pg 54).

Multi-axial Instability of Glenohumeral Joint:

Application of the Kinesio Taping® Method for multi-axial instability of the glenohumeral joint. For review see multi-axial instability of the glenohumeral joint (pg 58-59).
Taping for scapular abduction and upward rotation dysfunction:

*T*ape lower trapezius from origin to insertion to increase muscle contraction if the scapula is abducted and in upward rotation.

Begin by placing the base of the Kinesio Y strip at a 45-degree angle towards the inferior angle of the scapula, at approximately the level of the T10-12 spinous processes.

Have the patient move into shoulder abduction and horizontal flexion, apply light tension, (25 % of available), surrounding the lower trapezius muscle. Lay the tails down with no tension.

Taping for forward shoulder:

*Ap*ply an anterior glenohumeral laxity Kinesio technique.

Additionally, apply an upper trapezius muscle and a pectoralis minor muscle technique.

For the upper trapezius, begin by placing the base, of the Y strip lateral to the AC joint.

Have the patient move into adduction behind their back with lateral neck flexion. Apply light tension, (25% of available), surround the upper trapezius and lay the tails down onto the distal tip of the clavicle.

Application of pectoralis minor basic Kinesio technique:

*Ap*plication is for insertion to origin to reduce tension in the anterior aspect of the shoulder.

Begin by placing the base of a Kinesio Y strip at the coracoid process of the scapula, with no tension.

Have the patient move into abduction and external rotation of the shoulder. Apply very light to light tension, (15-25% of available or paper off). Place the upper tail along the superior aspect of the muscle to the junction of the third sternocostal joint. Place the lower tail along the inferior aspect of the muscle to the fifth sternocostal joint.
Shoulder Instability, Anterior or Multiaxial

Shoulder instabilities can develop after acute dislocations, chronic subluxation, or long term overuse activities which stretch the shoulder capsule (baseball pitching, playing tennis, javelin throwing). In most cases, the instability is the result of an acute injury to the anterior region of the shoulder capsule.

Kinesio Tex® Tape is not designed to mechanically stop a motion or movement of a body tissue. It does not have the tensile strength to stop the humeral head from dislocating.

The Kinesio Taping® Technique will assist in reducing edema and pain, and provide a proprioceptive stimulus through the skin that will cause the body’s tissues to adjust to the tension.

Acute Phase - First 24 to 72 hours

During the first 24 to 72 hours after an acute trauma to a subacromial bursa the primary goal is to limit inflammation.

Strip one: place the base of the Kinesio fan strip near the posterior inferior angle of the posterior deltoid, directing the tails of the fan over the AC joint and towards the clavicle region.

Strip two: place the base of the Kinesio fan strip near the anterior inferior angle of the anterior deltoid, directing the tails of the fan over the AC joint towards the lower trapezius insertion.

The two strips should form a crisscross pattern.

Application of the lymphatic corrective technique to reduce edema resulting from inflammation during acute phase; Two lymphatic correction strips will be applied. For review, see lymphatic corrective technique (pg 39-40).

Posterior: Begin by placing the base with no tension on the posterior part of the deltoid near the insertion of the teres minor and teres major. Direct the tails of the fan over the area of pain and/or swelling with very light to light tension, (15-25% of available).

Anterior: Begin by placing the base either on the medial or lateral part of the axillary region with no tension. Direct the tails of the fan over the area of pain or swelling with very light to light tension (15-25% of available).

The primary effect is to create a crisscross pattern over the area of pain and or swelling.

Depending upon the evaluation by the practitioner, a basic deltoid muscle taping technique may be applied. This may benefit overall shoulder support for shoulder instability.

The practitioner may also determine that additional muscles may require basic muscle application to assist with shoulder pain or weakness.

The insertion to origin technique, for early symptoms, is shown. For later applications, an origin-to-insertion technique can be used to provide stability.

Shoulder Instability - Anterior

Application of acromioclavicular mechanical correction technique: For review, see mechanical corrective technique (pg. 22-25).

Begin by tearing the Kinesio I strip in the middle of the paper backing and peeling the paper back. Apply the Kinesio I strip with 75-100% of available tension and inward pressure, with the center of the Kinesio strip between the AC joint and the humeral head.

More than one Kinesio strip may be appropriate depending upon the size of the patient.
Continuation of application of Mechanical Correction Strip.

Have the patient move into shoulder flexion and horizontal flexion, then apply the posterior tail with no tension. Initiate glue adherence prior to additional shoulder movement.

Have the patient move into shoulder abduction with horizontal extension then apply the anterior tail with no tension. Initiate glue adherence prior to additional shoulder movement.

In a glenohumeral mechanical correction, place the patient’s shoulder in slight external rotation. Apply the base of Kinesio I strip a minimum of 1-inch medially to the base of the AC mechanical correction, with no tension. With one hand, hold the base application to ensure no tension is added to the base.

Apply 50-75% available tension and inward pressure as the Kinesio I strip is pulled around the anterior and middle deltoid region, ending tension on the posterior border of the middle deltoid. The Kinesio strip is placed with the superior edge of the Kinesio Tex® Tape just inferior to the coracoacromial arch.

The practitioner may want to position the humerus in slight internal or external rotation depending upon the degree of shoulder instability.

Slide the hand which has been holding the anterior base of the Kinesio strip to the end point of tension.

Have the patient move into shoulder flexion and horizontal flexion, and apply the posterior base with no tension. It is preferable that the 2 Kinesio strips (AC and glenohumeral correction) do not end on each other. The Kinesio Tex® Tape adhesive is not as effective in adhering to itself as it is to the skin.
Shoulder Instability - Multiaxial:

A p p l i c a t i o n of functional correction technique for multiaxial instability. This concept may also be used for anterior instability. For review, see functional correction technique (pg 39).

Begin by placing the base of the Kinesio I strip approximately 3-4 inches superior to the acromioclavicular joint, with no tension.

The described technique can be modified by the practitioner for instability in more than one plane.

Have the patient move into shoulder abduction to minimum of 90 degrees. Apply the distal base of the Kinesio I strip 3-4 inches below the deltoid tuberosity of the humerus. Prior to base application, the practitioner will need to add tension to the Kinesio I strip. The degree of tension is determined by the amount of perceived limitation in range of motion desired. For initial application, 50-75% tension may be appropriate.

Place one hand on each of the base locations of the Kinesio I strip. Have the patient move into shoulder adduction. When the patient is in correct anatomical position, move the two hands together and initiate glue activation prior to any further movement.
Bursitis of the Shoulder

Bursitis of the shoulder most commonly occurs to the subacromial bursa, or subdeltoid bursae as it is also named. Inflammation of the bursae may result from chronic overuse, shoulder impingement, falling on the point of the shoulder, or direct trauma. Once the bursa becomes inflamed, it compresses surrounding soft tissues.

The Kinesio Taping® Method assists in reducing edema and pain. The practitioner may determine that following their evaluation of the bursitis, basic Kinesio Taping Applications of possible affected muscles may also be indicated. Suggested muscles are: Supraspinatus, deltoid, and biceps brachii.

Acute Phase - First 24 to 72 hours

During the first 24 to 72 hours of an acute trauma to a subacromial bursa, the primary goal is to limit inflammation.

Strip one: Begin by placing the base of the Kinesio fan strip near the anterior inferior angle of the anterior deltoit, directing the tails of the fan over the AC joint and towards the lower trapezius insertion.

Strip two: Begin by placing the base of the Kinesio fan strip near the posterior inferior angle of the posterior deltoit, directing the tails of the fan over the AC joint towards the clavicle region.

The two strips should form a crisscross pattern.

Post-Acute Phase - Past 72 hours

Application of space correction I strip: For complete review see patella tendinitis I strip technique (pg 157).

This strip is to act as a space correction technique to create space between the skin and bursae to allow for edema reduction. For complete review see space correction technique (pg 29).

The Kinesio I strip is started over the deltoid tuberosity with no tension. One hand holds the base to ensure no tension is added to the Kinesio strip.

Have the patient move into adduction behind the back, apply light tension (15-25% of available) to the Kinesio I strip until approximately 2 inches remain. Lay down the base with no tension.

Activate glue prior to any additional movement by the patient.

Convolutions may not be evident when patient is in anatomically neutral position. The convolutions will appear during shoulder movement.
Option 1: Basic Kinesio Taping® Method of application for supraspinatus muscle.
For complete description of supraspinatus muscle taping, see Rotator Cuff Impingement or Tendonitis (pg 54).

Option 2: Basic Kinesio Taping® Method application for deltoid muscle.
For complete description of deltoid muscle taping, see Rotator Cuff Impingement or Tendonitis (pg 54).

Option 3: Basic Kinesio Taping® Method application for biceps brachii muscle.
For complete description of biceps brachii muscle taping, see Bicipital Tenosynovitis (pg 68).
Acromioclavicular Joint Sprain

A sprain in the Acromioclavicular (AC) joint is a very common injury resulting from falling on an outstretched hand, landing on the point of the shoulder, or landing on the shoulder from the side. Pain and inflammation are generally felt on the “point” of the shoulder and can be felt during active shoulder movements. The Kinesio Taping® Technique uses the elastic qualities of the tape to hold down the clavicle near its formation of the AC joint with the acromion process of the scapula. The Kinesio strip will be applied using the mechanical correction, using significant stretch and inward pressure. A lymphatic correction technique may also be used to reduce edema as a result of the injury.

Option 1:

In the acute phase, 2 lymphatic correction strips will be applied. For complete review, see lymphatic corrective technique (pg 39).

Acute Phase - First 24 to 72 hours

During the first 24 to 72 hours of an acute trauma to a subacromial bursa, the primary goal is to limit inflammation.

Strip one: Begin by placing the base of the Kinesio fan strip near the anterior inferior angle of the anterior deltoid, directing the tails of the fan over the AC joint and towards the lower trapezius insertion.

Strip two: Begin by placing the base of the Kinesio fan strip near the posterior inferior angle of the posterior deltoid, directing the tails of the fan over the AC joint towards the clavicle region.

The two strips should form a crisscross pattern.

Option 2:

Application of the Donut Technique for reduction of inflammation.

Cut a hole in the center of a 6-8-inch Kinesio I strip. Tear the center of the paper backing and apply very light to light tension (15-25 % of available).

Apply the donut directly over the AC joint, laying the ends down without tension.

A series of two to three strips can be applied to maximize the lifting effect of the donut hole technique.
Depending upon the evaluation by the practitioner, a basic deltoid muscle taping technique may be applied. This may be found to benefit overall shoulder support following the AC joint injury.

The practitioner may also determine that additional muscles may require a basic muscle application to assist with shoulder pain or weakness.

Deltoid demonstrated is insertion to origin to reduce pain. Following initial stage, origin to insertion may be used to support AC region.

Option 3: Application of mechanical correction technique.

Begin by tearing the Kinesio I strip in the middle of the paper backing and peeling back the middle third of the paper backing. Apply the Kinesio I strip with 75-100% of available tension and inward pressure with the center of the Kinesio strip directly over the AC joint. Lay the ends down with no tension.

More than one Kinesio strip may be appropriate, depending upon the size of the patient.

Completed example of possible Kinesio Taping® Technique for Acromioclavicular sprain, with three mechanical correction strips applied.
Frozen Shoulder — Adhesive Capsulitis

Frozen shoulder is generally considered to be rare in a young healthy individual; it is much more common in an older person. The cause of frozen shoulder is not clear, but it does involve a thickening and contraction of the capsule which surrounds the joint. Adhesive capsulitis can occur in any joint. It is most common in the shoulder. The muscles which surround the shoulder become tightened and add to the difficulty of shoulder motion.

The Kinesio Taping® Technique will assist in reducing edema, pain, and increased muscle tension. The practitioner will need to determine the appropriate tissues to tape following their evaluation. The muscles used in the demonstrated application have been shown to be successful in clinical practice.

With frozen shoulder, remember the patient is limited in their shoulder movement pattern. During tape application, have the patient move through as much range of motion as possible. The practitioner may need to apply above-normal tension to accommodate for limited patient movement.

Basic Kinesio Taping® Method application for deltoid muscle, insertion to origin.

For review, see Kinesio Taping® Method of Rotator Cuff Impingement or Tendonitis (pg 54).

Basic Kinesio Taping® Method application for coracobrachialis muscle, insertion to origin.

Begin by placing the base of the Kinesio Y strip 2 inches below the medial middle border of the humerus, with no tension.

Have the patient move into shoulder abduction and extension.

Apply very light to light tension (15-25%) or paper-off tension to the tails of the Kinesio Y strip. The superior tail should follow the superior angle of the muscle belly, aiming for the coracoid process of the scapula.

The inferior tail should follow along the inferior angle of the muscle belly, aiming for the coracoid process of the scapula. Lay the distal 1-2 inches down with no tension.

Initiate glue activation prior to any further patient movement.
Basic Kinesio Taping® Method application for subscapularis muscle, insertion-to-origin.

Begin by placing the base of the Kinesio Y strip 2 inches lateral to the lesser tuberosity of the humerus, with no tension.

Have the patient move into shoulder abduction with horizontal flexion and internal rotation.

Apply light (15-25% of available tension) to the tails of the Kinesio Y strip. The superior tail should follow along the inferior border of the spinous process, aiming for the superior tip of the scapula. Lay the distal 1-2 inches down with no tension.

The inferior tail should follow along the inferior border of the scapula, aiming for the inferior tip. Lay the distal 1-2 inches down with no tension.

Initiate glue activation prior to any further patient movement.

Completed application for Frozen Shoulder technique.

An alternative subscapularis taping is to begin with the base of the Kinesio Y strip on the inferior lateral border in the axillary region (which more closely approximates the muscle’s origin). Have the patient abduct the shoulder, then internally rotate while applying the Kinesio tails along the muscles path.

Be careful not to irritate the sensitive skin in the axillary region using this application.

Optional: Basic Kinesio Taping® Method for Teres Minor, insertion to origin

Begin by placing the base of a Kinesio Y strip on the lower facet of the greater tuberosity of the humerus, with no tension. Have the patient move into abduction, horizontal flexion, with internal rotation.

Place the superior tail along the superior edge of the axillary border of the scapula. Place the inferior tail along the inferior edge of the axillary border of the scapula. Apply light (15-25% of available) tension.

Initiate glue activation prior to further patient movement.
Optional: Application of Kinesio Y strip as dermatome correction for assisting external rotation by releasing the tension of internal rotation.

Place the base of the Kinesio Y strip on the posterior lateral border of humerus.

Place the patient supine with their shoulder in as much abduction and external rotation as patient comfort allows. Provide support to limit patient pain.

Apply very light to light tension, (15-25% of available) to the tails of the Kinesio Y strip. The superior tail should be slightly inferior to the clavicle and end on the sternoclavicular joint. The inferior tail should follow the lower fibers of the pectoralis major to the costochondral joint.

The desired effect is to inhibit internal rotation, thus allowing for external rotation to occur in a passive movement.
Bicipital Tenosynovitis

Bicipital Tenosynovitis is an inflammation between the long head of the biceps tendon and the sheath which surrounds it. The inflammation most commonly occurs where the biceps tendon crosses under the transverse humeral ligament as it passes through the bicipital groove of the humerus. This condition is most commonly seen in overhead motion activities: Tennis, baseball, volleyball, and javelin.

The Kinesio Taping® Method will assist in reducing inflammation and pain. Bicipital Tenosynovitis is generally also associated with rotator cuff impingement or tendonitis.

Application of the biceps muscle taping from insertion-to-origin: This should be applied first, as it is the primary tissue to be treated.

Begin by placing the base of the Kinesio Y strip 2 inches below the biceps tuberosity on the radial head, or superior to the antecubital space on the humerus, with no tension.

Have the patient move into shoulder abduction, extension, and external rotation.

Apply very light tension, (15-25% of available) or paper-off tension to the tails of the Kinesio Y strip. The lateral tail should follow the outside edge of the long head of the biceps to the supraglenoid tuberosity of the scapula.

The medial tail should follow along the short head of the biceps to the coracoid process of the scapula.

Lay the distal 1-2 inches of both tails down with no tension.

Initiate glue activation prior to any further patient movement.

Application of mechanical correction technique with tension on base. For review, see mechanical correction (pg 22).

Begin by placing the base of a 6-8-inch long Kinesio Y strip on the anterior aspect of the shoulder inferior to the coracoid process, with no tension. The base can be adjusted to place the cut of the Y directly below the region of pain.

One hand should hold the base to ensure no tension is added. Apply moderate to severe tension (50-75% of available) with inward pressure surrounding the area of pain.
When approximately 1/2 of the Kinesio Y strip has been applied, slide the hand which was holding the base up to the point of end tension on the Kinesio Tape.

Have the patient move into shoulder flexion with horizontal flexion. Apply the tails of the Kinesio Y strip in a splayed out pattern to dissipate the created force. No tension is applied to the tails.

Initiate glue activation prior to any further patient movement.

Completed bicipital tenosynovitis Kinesio Taping® Method application.

Optional: Application of space correction technique with tension on tails in acute inflammation.

For review, see space correction (pg 29).

Begin by placing the base of a 6-8-inch long Kinesio Y strip on the anterior aspect of the shoulder inferior to the coracoid process, with no tension. The base should be adjusted to place the cut of the Y directly below the region of pain.

One hand should hold the base to ensure no tension is added. Apply light to moderate, tension (25-50% of available) onto the tails, having the tails surround the area of pain.

The tension is added to the tails to create a “recoil” effect with the Kinesio Tape. This will gather skin directly over the area of inflammation, resulting in decreased lymphatic edema.

Add tension to approximately 1/2 of the tail length on each strip. Slide the hand holding base tension to the point of end tension of the tails.

Have the patient move into shoulder flexion and horizontal flexion. Apply the tails of the Kinesio Y strip in a splayed-out pattern to dissipate the created force. No tension is applied to the remaining tape.

Initiate glue activation prior to any further patient movement.
Brachial Plexus Neurapraxia (Burner)

Brachial plexus neurapraxia, a condition characterized by a decrease in function of a peripheral nerve without degenerative changes occurring, is a common injury resulting from stretching or pinching of a cervical nerve root. General terms used commonly in reference to this condition are: Stinger, burner, or pinched nerve. If the neck is forced laterally and has a load placed upon it, the cervical nerve root can be affected.

The Kinesio Taping® Technique will assist by reducing effusion, inflammation, pain, and paresthesia. The length of the affected cervical nerve root involved will be taped along its dermatome.

The brachial plexus nerve strip can be initiated from either the neck or hand. It is important that each segmental application of the brachial plexus nerve strip be placed in a stretched position.

Measure a length of tape from just past the most distal point of paresthesia to the occiput of the skull. Cut a Y in the proximal end to approximately the origin insertion point of the teres minor and major.

Tear the paper backing at the base of the Y cut and apply approximately 2 inches to area with no tension to the insertion point of the teres minor and major.

Have the patient move into shoulder flexion with horizontal flexion and neck rotation with lateral flexion to the opposite side of the injury.

Using very light to light tension (15-25% of available), apply the upper tail along the upper trapezius to the occiput of the skull. The lower tail is placed either over any detectable trigger point or along the teres minor and major to approximately the axillary border of the scapula.

Have the patient flex their wrist and elbow and maintain shoulder flexion with horizontal flexion. Apply the Kinesio strip with very light to light (15-25 %) or paper-off tension along the paraesthesia.

At the elbow, either adjust the Kinesio strip to miss the olecranon process (to avoid putting pressure on the olecranon bursa) or cut a hole in the middle of the Kinesio strip directly over the olecranon process.

Continue along the forearm and to the dorsum of the hand.

The brachial plexus nerve strip only needs to be applied as far down the arm as the radiating pain is felt by the patient.
Application of pectoralis minor insertion-to-origin application technique: For complete description, see thoracic outlet syndrome (pg 74).

Begin by placing the base of the Kinesio Y strip superior to the coracoid process of the scapula with no tension. Have the patient move into shoulder abduction above 90 degrees and as much external rotation as possible.

Apply very light to light (15-25% of available) or paper-off, tension to the Kinesio I strip. The superior tail should aim for the 3rd costochondral joint. The inferior tail should aim for the 5th costochondral joint. Lay the distal 1-2 inches down with no tension.

Initiate glue activation prior to any further patient movement.

Basic muscle application of posterior scalenus insertion to origin technique:

Begin with the patient in a neutral position. Place the base of the 1 inch Kinesio strip at the first rib lateral to thoracic vertebrae 2-3. Have the patient move into neck flexion, rotation to the opposite side, and lateral flexion of the neck (chin on opposite shoulder).

Apply very light tension (10-15% of available) to the Kinesio strip. Direct the 1 inch strip towards the lateral aspect of the mastoid process.

Be careful not to apply too much tension, as this is a sensitive area. The patient may need to shave the hair in this region prior to tape application.
Section 4

Trunk and Back
Thoracic Outlet Syndrome

Thoracic outlet syndrome is a compression of the neurovascular bundle in the neck and shoulder. Structures which are commonly involved include: Subclavian artery, subclavian vein, and brachial plexus. Compression may occur in the areas of the pectoralis minor, first rib and clavicle, or the space between the anterior and middle scalene muscles.

The Kinesio Taping® Method will assist in reducing tension in the regions in which compression occurs. Following the practitioner’s evaluation, they will be able to determine the specific compression causing the thoracic outlet syndrome. The Kinesio Taping® Technique demonstrated includes the most clinically effective.

Basic Kinesio Taping® Method application of subclavius muscle, insertion to origin.

Begin by placing the base of the Kinesio I strip (1 inch width) inferior and slightly medially to the acromioclavicular joint, with no tension.

Have the patient move into shoulder abduction and external rotation.

Apply very light to light (15-25% of available) or paper off tension to the Kinesio I strip. Follow along the inferior aspect of the clavicle to the sternoclavicular joint. Lay the distal 1 to 2 inches down with no tension.

Initiate glue activation prior to any further patient movement.

Basic Kinesio Taping® Method application of pectoralis minor muscle, insertion to origin.

Begin by placing the base of the Kinesio Y strip superior to the coracoid process of the scapula with no tension.
Have the patient move into shoulder abduction above 90 degrees and as much external rotation as possible.

Apply very light to light tension (15-25% of available) to the Kinesio I strip. The superior tail should aim for the 3rd costo chondral joint.

The inferior tail should aim for the 5th costo chondral joint. Lay the distal 1-2 inches down with no tension.

Initiate glue activation prior to any further patient movement.

Basic Kinesio Taping® Method application of biceps brachii muscle, insertion to origin: For review, see bicipital tenosynovitis (pg 68).

Basic Kinesio Taping® Method application of scalenes anterior, insertion to origin.

With the patient’s neck in neutral position, begin by placing the base of the Kinesio Y strip along cervical 3-6 spinous processes, with no tension.

For anterior fibers, have the patient move into lateral flexion to the opposite side of pain with rotation to the same side (ear on opposite shoulder, and chin in the air on the same side of injury). Apply very light tension (10-15% of available) to the Kinesio Y strip. The medial tail should aim for the 1st costo chondral joint.

For lateral fibers, have the patient move into lateral flexion to the opposite side with rotation to the same side as the injury (ear on opposite shoulder, and chin in the air to opposite side of injury). Tail should follow for the junction of the proximal and medial 1/3 rd of the 1st rib. Lay the distal 1 inch down with no tension. The tail should end approximately 1 inch below the first rib.

Initiate glue activation prior to any further patient movement.
Sternoclavicular Joint Sprain

The sternoclavicular joint sprain is an uncommon injury, which is generally caused by a force transmitted through the shoulder to the clavicle. The joint is moveable and is the primary joint allowing for motion during the initiation of shoulder abduction to 90 degrees. It has a history of taking a long time to heal when injured.

The Kinesio Taping® Method assists by reducing edema and pain with the use of a space correction technique.

Application of the lymphatic corrective technique to reduce edema resulting from a sprain of the sternoclavicular (SC) joint: Two lymphatic correction strips will be applied. For complete review, see lymphatic corrective technique (pg 39).

Strip one begins inferior to the SC joint and fans out across the joint above the clavicle using very light to light tension (15-25% of available).

Strip two begins either medial or lateral to strip one and crosses over the SC joint.

The two strips should form a crisscross pattern.

Application of a space correction technique: For complete review, see space correction technique (pg 29).

Begin by tearing at the middle of an approximately 4-inch Kinesio I strip through the paper backing.

Apply very light to light tension (15-25% of available) to the Kinesio I strip. Place the Kinesio strip with the center of the strip directly over the SC joint and lay down the tails with no tension.

Repeat this strip application 2-3 times to create space directly over the SC joint.

Initiate glue activation prior to any further movement. An optional technique may utilize the mechanical correction technique with increased tension and inward tension to minimize SC joint movement.

For additional example, see AC joint (pg 172).

For stability use, a mechanical correction directly over the SC joint. See AC joint for example (pg 172).
Scoliosis

Scoliosis is a lateral curvature of the spine, most commonly in the thoracic region, with an associated rotation of the vertebral bodies. The condition can be functional or structural in cause. An unequal leg length and unequal muscle development are examples of a functional cause. Structural causes may include a bony defect in the spine.

The Scoliosis Technique demonstrated should only be used as an example. Following his/her evaluation, the practitioner will need to determine the location of the curvature and degree and direction of rotation to the spine.

The Kinesio Taping® Method will assist by either increasing or decreasing muscle tension and by creating tension through the skin to facilitate an “unwinding” of the spinal rotation.

Example shown is for right thoracic curvature with left lumbar curvature causing right shoulder to be forward and left shoulder to be back.

Application of a mechanical correction technique to provide a stimuli in which the body will adjust to increased tension in the skin, with tension on the tails. For review, see mechanical correction technique (pg 22).

For the anterior superior region, begin by placing the base of the Kinesio Y strip (approximately 6-8 inches) two inches below the area to be treated, with no tension. With one hand, hold the base to ensure no tension is added.

Have the patient move into back extension with rotation in the opposite direction of desired correction. Apply light to moderate tension (25-50% of available) to the tails of the Kinesio Y strip, the “recoil” action of the tails will provide the stimulus to the skin.

Apply the tip of the tail with no tension. Prior to any further patient movement, initiate glue activation.

Application of a fascia correction technique to provide a deeper stimuli to reduce tension within the layers of the tissue, with tension on the base. For review, see fascia correction technique (pg 27).

Begin with a Kinesio Y strip of approximately 6-8 inches. Place the base medial to the area to be treated, with no tension. With one hand, hold the base to ensure no tension is added.
Have the patient move into back extension with rotation in the opposite direction of desired correction. Apply light tension (25% of available) to the tails of the Kinesio Y strip with an oscillating motion. Move the hand on the base along the Kinesio Y strip and initiate adherence to the skin.

Apply the end of the tails with no tension in a splayed out pattern to dissipate created forces.

Initiate glue activation prior to any further patient movement.

For the anterior lower region, the technique applications will be repeated, except the motions will be reversed to provide stimulus in an opposite direction. The desired effect is to “unwind” the spine.

For the posterior superior aspect, tape should be applied on the opposite side from the anterior superior aspect.

The desired effect is to "unwind" the spine.

For the posterior inferior aspect, tape should be applied on the opposite side of the anterior inferior aspect. The desired effect is to "unwind" the spine.
Rib Fracture or Contusion

A fracture or contusion of a rib is usually associated with direct blunt trauma. They are common in collision sports, and it can be difficult to differentiate between a fracture and a contusion. Ribs 5-9 are the most commonly injured. Caution must be used in allowing a patient to participate with a fractured rib; if the fracture is pressed posteriorly, it may cause damage to a lung.

The Kinesio Taping® Method assists by reducing edema and pain and provides stabilization of the fracture site. This technique has been found to be preferred by patients, as it does not apply further pressure to a sensitive area and also allows for easier breathing.

In the acute phase of the injury, the practitioner may select to apply a lymphatic correction in a crisscross pattern over the site of the fracture or contusion.

Acute phase first 24-72 hours:

Application of lymphatic correction technique to reduce inflammation and pain. For complete review, see lymphatic correction technique (pg 39).

The first strip is applied inferior and posterior to the site of the rib fracture or contusion. The patient should be placed in as much shoulder abduction as possible. The fan strips are laid out over the injury site. The tails are applied with very light tension (10-15% of available).

The second strip is applied inferior and anterior to the site of the rib fracture or contusion. The patient should be placed in as much shoulder abduction as possible. The fan strips are laid out over the injury site. The tails are applied with very light tension (10-15% of available).

The two lymphatic correction strips should crisscross over the region of pain.

Post Acute:

The first strip applied is a mechanical correction technique. For complete review, see mechanical correction technique (pg 22).

Have the patient abduct their shoulder to approximately 90 degrees, if pain allows. Tear the middle of the paper backing of an approximately 6-8-inch Kinesio I strip and apply 75-100% of available tension.

Place the center of the Kinesio I strip over the fracture or contusion site with inward pressure. Make sure to not apply too much inward pressure as to increase pain.

Have the patient take in a full breath and lay down the two ends of the Kinesio I strip with no tension. A second corrective strip may be appropriate, depending upon the size of the patient.
With the arm still in an abducted position, tear the middle of the paper backing of an approximately 4-6-inch Kinesio I strip and apply 75-100% of available tension.

Apply one mechanical correction strip anterior to the suspected fracture or contusion site and perpendicular to the 1st strip with inward pressure.

Have the patient take in a full breath and lay down the two ends of the Kinesio I strip with no tension.

With the arm still in an abducted position, tear the middle of the paper backing of an approximately 4-6-inch Kinesio I strip and apply 75-100% of available tension.

Apply another mechanical correction strip posterior to the suspected fracture or contusion site and perpendicular to 1st strip with inward pressure.

Have the patient take in a full breath and lay down the two ends of the Kinesio I strip with no tension.
Intercostal Neuralgia

*Intercostal* neuralgia is seen as severe sharp pain along the course of the nerves located in the intercostal region. It may exhibit itself during cases of prolonged coughing.

The Kinesio Taping® Method will assist by reducing edema and pain along with the neural pathway.

*Treatment* for inflammation is provided by applying 2 Kinesio lymphatic corrective techniques.

For review, see lymphatic corrective technique (pg 39).

Have the patient move into shoulder abduction and lateral bending of the spine. Begin by placing the first lymphatic Kinesio fan base approximately 3-4 inches posterior and superior to the posterior superior iliac spine. Angle the fan tails at 45 degrees in a slightly superior and anterior direction. Kinesio fan strip is applied with 15-25% of available or paper-off tension.

The second lymphatic fan base is approximately 3-4 inches posterior and 6-8 inches superior to the anterior superior iliac spine. Have the patient move into abduction of the shoulder, lateral bending of the spine, and trunk rotation to the side opposite the inflammation. Angle the fan tails at 45 degrees in a slightly inferior and anterior direction.

The fan strips should form a crisscross pattern.

Completed application of the KinesioTaping® Method for Intercostal Neuralgia.
Costochondral Separation or Sprain

A separation or sprain to the junction of the costocartilage and rib is a common injury, even more common than rib fractures. It is generally caused by rotation of the rib cage or direct blunt trauma (such as landing on a ball). Pain and possible separation occurs on the junction of the costocartilage and the ribs. There will be difficulty with breathing and rotation movements of the thoracic spine.

The Kinesio Taping® Method will assist in reduction of edema or pain and provides stabilization of the injury site. This technique has been found to be preferred by patients, as it does not apply further pressure to a sensitive area and also allows for easier breathing.

In the acute phase of the injury, the practitioner may select to apply a lymphatic correction in a crisscross pattern over the site of the separation or sprain.

Acute Phase, first 24-72 hours:

In the acute phase, two lymphatic correction strips will be applied. For complete review, see lymphatic corrective technique (pg 39).

Begin by placing the base of the Kinesio fan strip inferior to the separated joint and medial to the sternum, directing the tails of the fan over the SC joint and towards the superior and posterior edges of the ribs.

A second strip begins by placing the base of the Kinesio fan strip inferior to the separated joint and lateral to the sternum. Direct the tails of the fan over the separated joint and towards the middle of the sternum manubrium.

The two strips should form a crisscross pattern.

The practitioner may also select to use the donut technique as described in AC joint sprain (pg 172).

The first Kinesio strip applied is a mechanical correction technique. For complete review, see mechanical correction technique (pg 22).

Have the patient abduct his/her shoulder to approximately 90 degrees, or as far as pain allows. Tear the middle of a 6-8-inch Kinesio I strip through the paper backing and apply moderate to severe tension (50-75% of available) to the tape.

Place the center of the Kinesio I strip directly over the separated joint with inward pressure. Make sure not to apply so much inward pressure as to increase patient’s pain.

With the arm in an abducted position, tear the middle of the paper backing of an approximately 4-6-inch Kinesio I strip and apply 75-100% of available tension.

Apply one mechanical correction strip, both anterior and posterior to the separated joint, with inward pressure.

Have the patient take in a full breath, and lay down the two ends of the Kinesio I strip with no tension.
Erector Spinae Muscle Strain, Lumbar Region

This muscle group provides vertebral stabilization and can become injured as the result of sudden overload in extension, weak muscles, or trunk rotation, and it may be associated with lumbar intervertebral disk herniation.

The Kinesio Taping® Technique will assist by reducing acute or chronic muscle spasm, edema, and pain. Several application techniques will be demonstrated: These are not the only options available to the practitioner. Following a complete evaluation, the practitioner may select variations of the described techniques.

An option which is not shown is the star technique, which is demonstrated in the lumbar disk herniation.

Application of basic Kinesio Taping® Method for the Erector Spinae Muscle group with a Y strip, bilateral treatment:

Begin by placing the patient in a neutral spine position. Apply the base of the Kinesio Y strip in the sacroiliac joint region, a minimum of 2 inches below the initiation of pain. If the pain is located in the thoracic or cervical region, apply the base approximately 2 inches below the area of pain.

For application of the tail of the Y strip on the right side, ask the patient to move into flexion with rotation to the opposite side. Apply the tail with very light to light tension (15-25% of available) or paper-off tension. For the last approximately 2 inches, lay down the tail with no tension. Initiate glue activation prior to any further patient movement.

Either have the patient return to neutral posture position, or have the patient move into forward flexion with rotation to the opposite side. This will allow the second Kinesio Y tail to be properly applied.

For the last approximately 2 inches, lay down the tail with no tension. Initiate glue activation prior to any further patient movement.

This technique can be applied using the Kinesio Y strip unilaterally or bilaterally.
H Technique application

Application of bilateral Kinesio I strip, with space correction for bilateral Erector Spinae muscle strain.

For each I strip application, have the patient move into flexion with rotation to the non-painful side. Apply very light to light tension, (15-25% of available).

The third strip is a space correction technique or, if desired, a corrective technique may be used in acute muscle spasm or strain.

Measure a Kinesio I strip long enough to extend approximately two inches on either side of the previously applied Kinesio strips.

Tear the paper backing on one end of the Kinesio I strip approximately 2 inches from one end. Apply light to moderate tension (25-50%) to an approximately 2-inch region of the Kinesio Tex® Tape.

Place this zone of tension directly over the region of greatest pain or spasm. If applying space correction, do not add any inward tension.

When the third strip has been applied over the area of pain, lay down the end of the Kinesio strip which is approximately 2 inches in length. Slide one hand towards the middle of the back and hold this no tension position.

Having the patient go into rotation will assist with minimizing tension on the ends.

Lay down the middle of the Kinesio I strip with no tension across the region of the transverse and spinous process, removing the paper backing from the next section of the Kinesio strip. With one hand, hold zone of no tension over the spine; with the other hand, apply another zone of light to moderate tension (25-50% of available) over the region of pain or spasm on the ipsilateral side.

When the zone of tension has been applied over the area of spasm or pain, apply the base of the Kinesio I strip with no tension.

Initiate glue activation prior to any further patient movement.
Optional: X Technique application

Application of bilateral Kinesio I strip, with space correction for bilateral Erector Spinae Muscle strain.

Begin by measuring a length of 2-inch-wide Kinesio Tex® Tape from approximately the greater trochanter, across lumbar region, and ending at the posterior inferior angle at the ribs.

Place the base of the Kinesio I strip inferior to the greater trochanter with no tension. Have the patient move into lateral flexion to the opposite side. Apply the Kinesio I strip, with light to moderate tension (25-50% of available) over the tensor fascia latae and over the PSIS.

Have the patient move into as much hip flexion as the patient tolerates. Apply the Kinesio I strip across the area of pain with light tension (25% available).

As the Kinesio strip reaches the lateral border of the erector spinae muscle group, end this section of tape application.

Have the patient move into lateral flexion to the side on which the tape was initially started. Angle the remaining Kinesio I strip towards the posterior inferior angle of the thoracic ribs using light tension (25% of available).

Initiate glue activation prior to any further patient movement.

For the opposite side, repeat the above steps.
Measure a strip of 3-inch-wide Kinesio Tex® Tape approximately the same length as used in the first layer. Begin by placing the base slightly medial and inferior to the first strip.

Have the patient move into as much hip flexion as allowed. Angle the strip over the ischial tuberosity and over the area of pain applying light tension (25% of available).

With the patient in hip flexion, have them also move into lateral bending to the painful side. Lay down the remaining length of Kinesio Tex® Tape.

Initiate glue activation prior to any further patient movement.

For the opposite side, repeat the above steps.

Measure a strip of 2-inch-wide Kinesio Tex® Tape approximately the same length as used in the first layer. Begin by placing the base slightly medial and superior to the second strip.

Have the patient move into as much hip flexion as allowed. Angle the strip over the ischial tuberosity and over the area of pain applying light tension (25% of available).

Initiate glue activation prior to any further patient movement.
For the opposite side, repeat the above steps.

Application of a space correction using a Kinesio I strip. For complete review, see space correction application modified I strip (pg 29).

Begin the base of 2-3 inches (depending upon the patient size) Kinesio I strip 10-12 inches in length in the coccyx region with no tension.

Have the patient move into as much hip flexion as possible. Apply light tension (25% of available) to the Kinesio I strip over the area of pain. Lay down the last 2-3 inches with no tension.

This strip may be modified by applying the 25% available tension to the center of the Kinesio I strip with application directly over the area of pain.

Initiate glue activation prior to any further patient movement.

The final strip is applied horizontally by repeating the above steps.

The practitioner may determine that one, two, three, or all four strips are appropriate. Size, activity, patient strength level, and clinical condition, along with practitioner experience, will determine the appropriate taping application.
Sacroiliac Sprain or Inflammation

The Sacroiliac Joint is formed by the sacrum and ilium and is held in place with strong ligaments that allow for a degree of movement. This joint can become hypermobile, sprained, inflamed, and hypomobile as the result of twisting, rotating, or motions that load forces to this joint.

For years, many believed this joint did not move and that, since it did not move, it could not become injured. When this joint becomes involved, it may lead to changes in posture, pelvic tilt, pelvic rotation, and lumbar spine mobility.

The Kinesio Taping® Method will assist in reduction of effusion and joint pain and assist in muscular balance associated with pelvic stabilization.

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic correction techniques. For review, see lymphatic correction technique (pg 39).

Begin by placing the base of the Kinesio fan strip approximately 2-3 inches superior to the sacroiliac (SI) joint along the spinous processes with the patient in a neutral spine position. Have the patient move into forward flexion with rotation to the opposite side from the injured joint. The tails of the fan strip should be angled inward at 45 degrees over the SI joint and end near the superior aspect of the gluteus maximus, using very light to light tension (15-25% of available).

The second Kinesio fan strip is placed approximately 2-3 inches inferior to the SI joint along the spinous processes with the patient in neutral spine position. Have the patient move into forward flexion with rotation to the opposite side of the injured joint. The tails of the fan strip should be angled upward at 45 degrees over the SI joint and end near the superior aspect of the posterior superior iliac spine.

Initiate glue activation prior to any further patient movement.

During evaluation, the practitioner may determine that several muscles are also involved. Possibly a tight iliopsoas, piriformis, gluteus maximus, or quadratus lumborum. In addition to the above described lymphatic correction, a basic muscle Kinesio Taping® Technique may also be appropriate.

For this example the quadratus lumborum has been taped. An insertion to origin technique was used with very light to light, (15-25% of available) or paper-off tension.
Spondylolysis and Spondylolisthesis

Spondylolysis is an acute or degenerative condition of the vertebrae in the lumbar 4-5 region that can be either bilateral or ipsilateral. The pars interarticularis region of the vertebrae may be fractured from repetitive trauma or a congenital weakness. Spondylolisthesis is a complication or result of spondylolysis that results in an anterior movement of the vertebral body. These conditions are generally exacerbated by repetitive hyperextension movements.

The Kinesio Taping® Method will assist by reducing effusion and pain and assist in muscular imbalance associated with pelvic stabilization.

Other options which are not shown: erector spinae strain and lumbar disk.

Acute: Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic correction strips.

For review, see lymphatic correction technique (pg 39).

Begin by placing the base of the Kinesio fan strip approximately 2-3 inches superior to the location of the edema along the lateral flank with the patient in a neutral spine position. Have the patient move into forward flexion with rotation to the opposite side as the edema. The tails of the fan strip should be angled inward at 45 degrees over the edema and end near the superior aspect of the sacroiliac joint using very light to light tension, (15-25% of available).

Strips may also be applied to direct the edema across the spinous process to the unaffected side.

The second Kinesio fan strip is placed approximately 2-3 inches inferior to the edema along the lateral flank in the region of the PSIS with the patient in neutral spine position. Have the patient move into forward flexion with rotation to the same side as the edema. The tails of the fan strip should be angled upward at 45 degrees over the edema and end near the spinous processes 2-3 vertebrae above the involved joint using very light to light tension, (15-25% of available).

Option 1: Star Technique Lumbar Back

Application of the star technique for lumbar intervertebral disk herniation.

A series of space correction 1 strips, 6-8 inches in length directly over the area of pain or inflammation.
Option 2: Application of psoas major basic Kinesio Taping® Method I strip.

B
egin base of Kinesio I strip, with no tension, on the abdomen at approximately thoracic vertebrae 12, slightly above the belly button and inferior to the inferior aspect of the rib cage. Have the patient move into hip extension to place psoas major in a stretch position.

Apply remaining I strip in direction of lesser tubercle of the femur on the medial aspect of upper 1/3rd of femur, with very light tension (10-15% of available). Apply the base with no tension.

A
pplication of erector spinae and gluteal combination Kinesio Taping® Method I strip:

Begin by placing the patient sidelying in maximum allowable hip flexion on the first side to be taped. Place the base of the I strip, with no tension, at approximately 2 lumbar vertebrae above the involved location.

Apply light to moderate tension, (25-50% of available) over the transverse process and angle towards the ischial tuberosity. The tape should end, with no tension, approximately 3-4 inches below the ischial tuberosity.

Repeat this process for the opposite side.

A
pplication of an anterior (abdominal) support I strip: The strip should reach approximately from the ASIS to ASIS plus 4-6 inches per side.

Begin by having the patient move into as much back extension as possible. Apply light to moderate tension (25-50% of available) to the area of the strip between the ASIS and ASIS. Place the tape in an upward, lifting motion approximately 2-3 inches below the level of the two ASIS.

To complete the anterior application, have the patient move into as much lateral flexion as possible to the opposite side.

With one hand, hold the tape at approximately the ASIS, apply very light to light tension (15-25 % of available) along a line toward the axillary space.

End the last 2-3 inches of the Kinesio strip with no tension. Initiate glue activation prior to any further patient movement.

Repeat process for opposite side.
Application of a posterior (lumbar) support 1 strip. The strip should reach approximately from the PSIS to PSIS plus 6 inches per side.

The Kinesio 1 strip between both PSIS is more clearly explained in erector spine muscle strain as the space correction technique (pg 29). The tape is applied to create space directly over the area of pain.

Apply 25 to 50% of available tension (light to moderate) directly over the area of pain. Between the areas of pain and past the areas of pain, no tension is added to the tape. The correction is applied with the patient in as much flexion as possible.

For each side, the application is completed by placing the patient in as much forward flexion and lateral bending to the opposite side as allowed.

One hand holds the Kinesio strip just lateral to the area of pain. The end of the Kinesio strip is angled over the greater trochanter toward the tensor fascia latae. The last 2-3 inches are laid down without tension.

Initiate glue activation prior to any further patient movement. Repeat process for opposite side.

Completed posterior application.
Myofascial Low Back Pain

Myofascial low back pain is a syndrome that refers pain when pressure is applied to a trigger point within a muscle. The trigger point is a sensitive area which refers pain in a generally predictable distribution. The pain syndrome has been associated with muscle involvement to the quadratus lumborum and piriformis. The Kinesio Taping® Technique also includes the external oblique abdominus with a fascial correction technique. If during the evaluation the practitioner is able to isolate a trigger point within a muscle, the trigger point should also be treated to reduce radiating pain.

The Kinesio Taping® Technique will assist in reducing edema, pain, muscle tension, and trigger point sensitivity.

Application of Quadratus Lumborum basic Kinesio Taping® Method Y strip (can also use I strip). This is an origin to insertion application.

Begin base of I or Y strip on PSIS with no tension. Place the patient in hip flexion with rotation to the opposite side.

If using an I strip, direct the Kinesio strip to approximately the spinous process of T10-T12.

If using a Y strip, direct the superior tail towards the transverse process of T12. Direct the inferior tailward to the transverse process of L-2-3. Both tails should be applied with appropriate tension for either the origin to insertion (25-50%), or insertion to origin (15-25%) technique.

Application of piriformis basic Kinesio Taping® Method Y strip (can also use I strip). This is an origin to insertion application.

Begin base of I or Y strip on the sacrum vertebrae with no tension, place the patient in hip flexion and adduction.

If using an I strip, direct the Kinesio strip toward the greater trochanter of the femur using very light to light tension (15-25% of available).

If using a Y strip, direct the tails to surround the piriformis muscle with both tails ending at the greater trochanter of the femur.

Application of External Oblique Abdominus basic Kinesio Taping® Method I strip (or can also use Y strip). This is an origin to insertion application.

Begin base of I or Y strip as close to the pubis symphysis as patient comfort and professional decorum allows, with no tension. Have the patient move into back extension with rotation to the opposite side.

If using an I strip, direct the Kinesio strip towards the inferior angle of the T10 - T12 ribs using light to moderate tension (25-50% of available).

If using a Y strip, direct the inferior tail toward the inferior angle of the T12 rib. Direct the superior tail toward the inferior angle of T10 rib.
Apply a fascia correction, tension on base, if no trigger point has been identified. For review, see Fascia Correction Technique (pg 27).

Begin by placing the base of the Kinesio Y strip with no tension. Apply tension to the tape in the direction fascia correction is desired. Stretch should be very light to light tension (15-25% of available). The tape should be "jiggled or oscillated." Minimal inward pressure should be applied as the tape is being laid down. The inward pressure is not specifically intended to deepen the effect of the tape, but is only used to apply the Kinesio Tex® Tape during application.

With this application, the practitioner would apply the fascia correction in the area they believe is limiting normal motion of the low back.

Apply a Space Correction if a trigger point has been identified. Apply a space correction technique directly over the trigger point. For review, see space correction technique (pg. 29).

Begin by placing the patient in a neutral or slightly stretched position. Tear the middle of the paper backing of a 4-6 inch Kinesio I strip. Apply light-to-moderate (25-50%) stretch to the center of Kinesio strip and apply directly over the area of pain as indicated by the evaluation.

Lay the two ends of the Kinesio I strip down without tension. Initiate glue activation prior to any further patient movement.

Completed application for Myofascial Low Back pain.
**Valgus Laxity of the Elbow**

A chronic valgus laxity of the elbow may develop from repetitive valgus forces being applied during overhead activities. During overhead motions, such as pitching in baseball, the shoulder is abducted with external rotation, elbow flexion, and a valgus force. This causes the ulnar collateral ligament of the elbow to become lax over time, allowing for excessive joint motion at the elbow.

The Kinesio Taping® Method will assist in reducing edema and pain and will, with the application of a ligament correction and functional correction, limit excessive valgus motion.

**Application** of a ligament correction technique. For complete review, see ligament correction technique (pg 33).

Begin base of ligament correction strip approximately 4 inches below the medial epicondyle of the humerus, with no tension on the base. Before application of the corrective strip, first estimate the line of the corrective strip to assist in application.

Place one hand on the base of the ligament correction strip prior to applying tension to the Kinesio strip. Apply ligament correction. Apply severe to full tension (75-100% of available) over the length of the ligament.

When the Kinesio strip has passed the end of the ligament, move the hand holding the base with no tension to the point of end tension above the elbow. Have the patient move into as much elbow flexion as possible. Lay the end of the Kinesio strip down with no tension.
Application of a functional correction technique. For complete review, see Functional Correction Technique (pg 37).

Measure a Kinesio I strip which will reach approximately 5-6 inches above and below the antecubital space. Begin by placing the patient's elbow in approximately 30 degrees of elbow flexion.

Apply the base inferior to the antecubital space with no tension.

Apply functional correction. Apply light to severe tension (25-75% of available) to the Kinesio I strip, and apply the superior base with no tension. The practitioner will need to adjust the amount of tension applied to the Kinesio Strip to adjust for appropriate movement limitation. Have the patient move into elbow extension.

While the patient is still in elbow extension, initiate glue activation prior to any further patient movement.

Optional: Application of basic biceps Kinesio Taping® Technique, from insertion to origin.

This should be placed prior to the functional correction technique. For complete review, see bicipital tenosynovitis (pg 68).
Bursitis of the Elbow

The Olecranon Bursa is the most commonly injured bursa of the elbow. It lies between the skin and the olecranon process of the humerus. A large effusion may be present on the posterior aspect of the elbow with limited range of motion in flexion.

The Kinesio Taping® Method will assist by reducing edema and pain.

Acute Phase - 24-72 Hours:

During the first 24 to 72 hours of an acute trauma to a bursa of the elbow, the primary goal is to limit inflammation. Two lymphatic correction strips will be applied. For complete review, see lymphatic correction technique (pg 39).

Photo on left: strip one begins at a 45 degree angle 3-4 inches below the lateral epicondyle of the humerus and ends on the medial aspect of the mid-triceps region. Apply very light to light tension (15-25% of available).

Photo on right: strip two begins at a 45 degree angle 3-4 inches below the medial epicondyle of the humerus and ends on the lateral aspect of the mid-triceps region. The two strips should create a crisscross pattern over the inflammation.

Option 1: Post-Acute Phase - past 72 Hours:

Application of a space correction technique using the modified ligament/tendon correction. For complete review, see space correction technique.

Begin by tearing the middle of an approximately 6 - 8-inch long Kinesio I Strip through the paper backing. Apply light to moderate 25-50 % of available tension to the Kinesio I strip in the middle 1/3 of the strip. Place the center of the 2-inch-wide Kinesio Strip over the region of the desired space correction. A series of strips can be applied, with the intersection of each strip located over the desired space correction location (area of desired “pocket”).

Move the patient through as full a range of motion as possible to minimize tension at ends of application. Lay down each end 1/3 of the Kinesio strip with no tension.

Convolutions of the skin should be evident during joint range of motion. If convolutions are not present, the tape was applied with too much tension.
Option 2 (Donut Hole Technique):

Begin by cutting a hole in the center of an approximately 6-8-inch Kinesio I strip. Be careful not to cut more than 2/3 of the available width of the Kinesio Tape®, as this may reduce its ability to adhere to the patient’s skin.

Cut the distal approximately 2 inches of each end into two to three tails.

Have the patient move into a mid-joint position for the area to be treated.

In the center of the Kinesio Strip, tear the paper backing and peel back to allow for tension to be applied to the Kinesio Tex® Tape. Apply light to moderate tension (25% of available), to the Kinesio Strip, and place the hole directly over the area of desired space.

Lay down the tails on both ends with no tension. Splay the ends to dissipate tension which was created in the area of the donut.

Activate glue prior to any patient movement.

Several layers may be used, depending upon the size of the patient and the degree of inflammation. If multiple strips are applied, tension level should be slightly decreased to accommodate the accumulative effects of multiple strips.

Option 3 (Web Cut Technique)

Cut the Kinesio Strip into a Web Cut with 4-8 strips. The Kinesio Tex® Tape is cut allowing for each end to remain uncut. Begin by placing the patient in a stretched position. The web is applied by applying one base, remove the web strips, and applying the second base.

Activate glue prior to any patient movement.

See knee bursitis for a complete description of web cut application for bursitis (pg 98).
Elbow Hyperextension

The elbow is a relatively stable joint which may become injured when it is forced past its normal end position of extension. The olecranon process in the olecranon fossa can act as a fulcrum when a force is applied causing a range of motion past normal 0 degrees of extension. Note: Females may normally have up to +3 degrees. Generally, the elbow will have marked edema and pain in the region of the ulnar collateral ligament.

The Kinesio Taping® Technique will include a lymphatic corrective taping to reduce acute edema, a ligament correction for the ulnar collateral ligament, a basic bicep muscle taping, and, if appropriate, a functional correction to limit elbow extension during the acute injury phase.

Acute Phase - 24-72 Hours:

Application of the lymphatic corrective technique to the antecubital fossa and region of the ulnar collateral ligament. For complete review, see Lymphatic Correction application (pg 39).

Strip one: begin by placing the base of the Kinesio fan strip inferior to the lateral epicondyle of the humerus. Direct the tails of the fan over the antecubital fossa toward the medial aspect of the mid-forearm using very light to light tension (15-25 of available).

Strip two: Begin by placing the base of the Kinesio fan strip inferior to the medial epicondyle of the humerus. Direct the tails of the fan over the antecubital fossa to the lateral aspect of the mid-forearm.

The two strips should form a crisscross pattern.

Ligament corrective technique application to the ulnar collateral ligament, if indicated as a result of the evaluation of the injury. For a mild hyperextension (no increased ligament laxity), this strip is optional. For moderate to severe (increased ligament laxity), this strip is recommended. For complete review of the ligament correction technique, see valgus laxity of the elbow (pg 96).

With patient’s elbow in much extension as possible, begin by placing the base of the Kinesio I strip ligament correction technique approximately 4 inches below the medial joint line of the elbow, with no tension.

With one hand, hold the base of the Kinesio I strip to avoid creating tension during application. Over the length of the ulnar collateral ligament, apply a ligament correction with 75-100% of available tension. When the tension reaches the end of the ligament, slide the hand holding tension on the base up to this point, and hold created tension.
Have the patient move the elbow into flexion and apply end of Kinesio strip with no tension.

**Post-Acute Phase: past 24-72 Hours:**

Application of the Biceps Brachii muscle basic Kinesio Taping® Technique. For complete review, see Biceps Tendonitis.

The desired result will be decreased muscle spasm in the biceps muscle from over extension during forced elbow hyperextension. The biceps should be taped using the insertion to origin method.

Application of the Functional Corrective Technique to limit elbow extension. For complete review, see functional correction technique (pg 37).

The degree of elbow extension to be limited is determined by the practitioner during evaluation. The desired result would be limitation of elbow extension just short of a painful position by the patient.

Place the inferior base 4-6 inches below the antecubital fossa with no tension. Hold this base with one hand. Apply moderate to full tension (50-100% of available) of the Kinesio I strip. The degree of tension is determined by the amount of elbow extension desired.

Apply the superior base approximately 4-6 inches above the antecubital fossa with no tension. Have the patient move into extension. Bring both hands towards the center of the I strip activating glue prior to any patient movement.

Completed application of the Kinesio Taping® Technique for Hyperextension of the Elbow.

Example shown is with biceps brachii from insertion to origin.
Lateral Epicondylitis of the Elbow

Lateral Epicondylitis results from repetitive extension of the forearm and wrist with excessive pronation. It is generally associated with overhead activities such as tennis, racquetball, baseball, and javelin. It is associated with pain on wrist extension and may be the result of poor mechanics by the patient.

The KinesioTaping® Technique will assist in reducing edema and pain. The techniques demonstrated are only basic examples of the possible choices available. The practitioner may also add space corrections during acute inflammation, fascia correction for chronic conditions, mechanical correction to apply pressure to an area, or a functional correction to limit a movement, or the practitioner may tape the supinator to assist or limit a motion.

An option which is not shown is a mechanical correction to "hold down" the common flexors of the wrist. An example is shown in Osgood-Schlatter syndrome (pg 170) and medial & lateral epicondylitis combination taping (pg 102).

Option 1: Kinesio I Strip with Space Correction

Apply the common extensor muscle taping from insertion to origin for acute inflammation. If the condition is chronic, origin-to-insertion taping may be appropriate.

Begin by placing the base of the Kinesio Y strip near the wrist in the region of the radial styloid process, with no tension. The elbow should be in slight flexion with wrist in neutral position.

This technique may also be applied using a Kinesio I strip in place of the Y strip. With this modification, lay the Kinesio I strip directly over the muscle belly.

Have the patient move into elbow and wrist extension with wrist ulnar deviation.

Apply very light to light (15-25% of available) or paper-off tension to the Kinesio Y strip. The inferior strip should follow the inferior aspect of the common muscle group. The superior strip should follow the superior aspect of the common muscle group. Both tails should end directed toward the lateral epicondyle of the humerus.

Lay down the distal 1-2 inches with no tension.

Initiate glue activation prior to any further patient movement.

Apply a space correction technique, tension on base, for the area of pain. For review, see space correction technique (pg 29).

Begin by placing the base of the Kinesio Y strip below the area of pain with the elbow in neutral position. Do not cross over the lateral border of the ulna - this may cause pain in this region.

Before applying the base of the Y strip, estimate the proper position so that when tension is removed from the tape the split in the Y will be placed inferior to the location of pain, but bisecting with the inferior tail of the previous Kinesio Y strip.

A mechanical or fascia correction may also be selected based upon the practitioner's evaluation.
With one hand, hold the base strip to ensure no tension is added. Apply light tension (25% of available) to the Kinesio strip. As tension is added, slide the hand holding the base up towards the area of pain. End tension when the split in the Y is bisecting the tail from the initial Y strip application.

Lay down the tails of the Kinesio Y strip with no tension. Initiate glue activation prior to any further patient movement.

If the technique is applied correctly, a "square" will be formed directly over the area of pain. This should create space and reduce pain and edema.

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**Option 2: Use of three tails of Kinesio strip with donut space correction.**

*Begin* by applying a Kinesio strip cut into three strips of equal width. The tape should be measured from the radial styloid process to the lateral epicondyle of the humerus.

Have the patient move into elbow and wrist flexion and ulnar deviation. Place the superior strip along the superior edge of the common extensor muscle group, the middle strip along the mid-belly of the muscle, and the inferior strip along the inferior edge. Apply very light to light tension (15-25% of available) during application.

*Application* of the donut space correction technique. For complete review, see space correction application technique (pg 29).

Begin by cutting a hole in the center of an approximately 4-6-inch Kinesio I strip. Be careful not to cut more than 1/3 to 1/2 of the available width of the Kinesio Tex® Tape. This may reduce its ability to adhere to the patient's skin.

Cut the distal approximately 2 inches of each end into 2 or 3 tails.
Have the patient move into a mid-joint position for the area to be treated.

In the center of the Kinesio strip, tear the paper backing and peel back to allow for tension to be applied to the KinesioTex® Tape. Apply light tension (25% of available) to the Kinesio strip and place the hole directly over the area of desired space.

Lay down the tails on both ends with no tension. Splay the ends to dissipate tension which was created in the area of the donut.

Activate glue prior to any patient movement.

A second and third donut space correction strip may be appropriate. Slightly change the angle, maybe as much as 45 degrees, to facilitate the gathering of more tissue. When the technique is applied correctly, skin should fill the donut hole and push above the level of the Kinesio Tex® Tape.
Medial Epicondylitis of the Elbow

Medial Epicondylitis results from repetitive forceful flexion of the wrist and valgus force on the elbow. It has also been called golfer's elbow, pitcher's elbow, and javelin elbow. It is associated with pain on wrist flexion and may be the result of poor mechanics by the patient.

The Kinesio Taping® Technique will assist in reducing edema and pain. The techniques demonstrated are only basic examples of the possible choices available. The practitioner may also add space corrections during acute inflammation, fascia correction for chronic conditions, mechanical correction to apply pressure to an area, or a functional correction to limit a movement.

An option which is not shown is a mechanical correction to “hold down” the common flexors of the wrist. An example is shown in Osgood-Schlatter syndrome (pg 170) and medial & lateral epicondylitis combination taping (pg 102).

Option 1: Kinesio I strip from Insertion to Origin

Apply the common flexor muscle taping from insertion to origin for acute inflammation. If the condition is chronic, origin-to-insertion may be appropriate.

Begin by placing the base of the Kinesio Y strip near the wrist in the region of the ulnar styloid process, with no tension. The elbow should be in slight flexion with wrist in neutral position.

This technique may also be applied using a Kinesio I strip in place of the Y strip. With this option, lay the Kinesio strip directly over the area of pain.

Have the patient move into elbow and wrist extension with wrist radial deviation.

Apply very light to light tension (15-25%) to the Kinesio I strip. Surround the muscle fibers with the tails of the Kinesio Y strip. The strips should be directed toward the medial epicondyle of the humerus.

Lay down the distal 1-2 inches with no tension.

Initiate glue activation prior to any further patient movement.

Option 2: Kinesio Y strip with space correction, therapeutic goal acute pain reduction.

The common flexor muscle taping from insertion to origin. The practitioner may also select the origin to insertion technique for a weak muscle.

Begin by placing the split of the Kinesio Y strip inferior to the region of pain with no tension, and keeping the elbow in neutral position.
Have the patient move into wrist and elbow extension with radial deviation.

Apply very light to light tension (15-25%) of available to the Kinesio Y strip tails. The lateral and medial strip should surround the area of pain.

Lay down the distal 1-2 inches with no tension.

Initiate glue activation prior to any further patient movement.

This technique can be modified using mechanical or fascia correction technique.

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### Option 3: Use of three tails of Kinesio strip with donut space correction.

**Begin** by applying a Kinesio strip cut into three strips of equal widths. The tape should be measured from the ulnar styloid process to the medial epicondyle of the humerus.

Have the patient move into elbow and wrist extension with radial deviation. Place the superior strip along the superior edge of the common flexor muscle group, the middle strip along the mid-belly of the muscle, and the inferior strip along the inferior edge. Apply light tension (15-25% of available) during application. Lay down the last 1-2 inches of each tail with no tension.

Application of the donut space correction technique:

**Begin** by cutting a hole in the center of an approximately 4-6 inch Kinesio I strip. Be careful not to cut more than 1/3-1/2 of the available width of the Kinesio Tex® Tape. This may reduce its ability to adhere to the patient's skin.

Cut the distal approximately 2 inches of each end into two or three strips.
Have the patient move into a mid-joint position for the area to be treated.

In the center of the Kinesio Strip, tear the paper backing and peel back to allow for tension to be applied to the Kinesio Tex® Tape. Apply light tension (25%) of available to the Kinesio Strip and place the hole directly over the area of desired space. If you use 2-3 strips, use a lower tension level (15-25%).

Lay down the tails on both ends with no tension. Splay the ends to dissipate tension which was created in the area of the donut.

Activate glue prior to any patient movement.

A second or even a third donut space correction strip may be appropriate. Slightly change the angle, maybe as much as 45 degrees to facilitate the gathering of more tissue. When the technique is applied correctly, skin should fill the donut hole and push above the level of the Kinesio Tex® Tape strips.
Little League Elbow

Little League Elbow is a common injury which occurs to the medial epicondyle of the humerus. The cause of this injury is an overuse of the common flexor muscle group during adolescence. It results from repetitive microtrauma of the bony attachment for the common elbow flexors which, during puberty, are stronger than the attachment.

The Kinesio Taping® Technique will assist in reducing edema and pain. There are several Kinesio Taping® Techniques which may provide reduced inflammation and pain; the practitioners will need to determine which techniques are best for their patients. If one technique does not provide significant results, another technique may.

Option 1: Application of a Mechanical Correction Technique

For acute pain relief, a mechanical correction strip may be applied in an attempt to “hold down” the apophysis of the medial epicondyle of the humerus. For complete review, see mechanical correction technique (pg 22).

Place the patient’s elbow in a slight flexion. Begin by tearing the paper backing of a 4-6-inch long Kinesio I strip in the middle. Holding both ends, apply moderate to severe tension (50-75%) of available, with inward pressure to the center of the Kinesio strip over the medial epicondyle of the humerus.

Prior to laying down the Kinesio strip ends, have the patient move the elbow into full extension and lay down the ends with no tension.

Option 2: Application of a Space Correction Technique

For review, see space correction technique (pg 29).

Apply light to medium tension (25-50% of available) to the center of a 4-6-inch I strip directly over the area space correction is desired.

Lay down the two bases of the Kinesio I strip with no tension.

Initiate glue activation prior to any further movement.

Several I strips may be used to form a star pattern.
Option 3: Kinesio I Strip with Functional Correction for Medial Epicondylitis of the Elbow

For a complete review, see Valgus Laxity of the Elbow (pg 96).

Option 4: Application of a 4-Tail Y Technique for Common Flexor Muscles of the Medial Epicondyle and the Supinator Muscle.

Begin by cutting 4 tails into an appropriate length of Kinesio Tex® Tape. Begin the base on the ulnar styloid process with the patient’s wrist and elbow in extension. Apply very light to light tension (15-25% of available) is applied.

The first two tails surround the common flexor muscle group. For a more complete explanation, see Medial Epicondylitis (pg 105).

The second two tails follow along the common extensor muscle group on the lower aspect of the forearm and then surround the supinator muscle in the upper forearm and elbow.

Application of the modified functional correction to the pronator teres muscle. For review, see functional correction technique (pg 37). Begin by placing the base of the Kinesio I strip slightly superior to the lateral epicondyle of the humerus with the elbow in 30 degrees of flexion and forearm in pronation position.
Have the patient move into elbow extension and forearm supination as the Kinesio I strip is being laid down. Apply mild to moderate tension (25-50% of available) to the Kinesio I strip. The strip should be directed toward the junction of the proximal and medial 1/3 of the radius on the lateral aspect.

Lay down the distal 1-2 inches with no tension. Initiate glue activation prior to any further patient movement.

This strip is intended to limit supination and assist in pronation, a functional correction.

Option 5: Kinesio Y Strip with Mechanical Correction (Space or Fascia Correction may also be applied)

For complete review of this technique, see medial epicondylitis of the elbow (pg 105).

The common flexor group is demonstrated by application using the 3-tails technique.

The mechanical correction shown has tension on the tails with moderate to severe tension (50-75% of available). The correction is applied to surround the area of pain and inflammation.
Carpal Tunnel Syndrome

Carpal tunnel syndrome is a compression between the carpal bones and the transverse carpal ligament. An inflammation may develop, or a decrease in ligament elasticity may develop, resulting in pressure placed upon the median nerve which lies within the tunnel. The most common cause is repetitive flexion of the wrist.

The Kinesio Taping® Method assists by reducing the edema and pain associated with the syndrome. The practitioner may also add space corrections during acute inflammation, fascia correction for chronic conditions, mechanical correction to apply pressure to an area, or a functional correction to limit a movement.

Option 1:

Measure a Kinesio I strip from the heads of the metacarpals to the epicondyles of the humerus. Make an X cut on the Kinesio Strip. For the distal portion, cut the X base at approximately the insertion of the palmaris longus tendon. For the proximal portion, cut the X base approximately four inches from the end of the strip.

Have the patient's wrist in a neutral position with the elbow in extension. Tear the Kinesio paper backing in the region between the two X tail cuts.

Apply a space correction technique in the center of the Kinesio X cut. For review, see space correction technique (pg 29).

Have the patient move into wrist and elbow extension. Apply light to moderate tension (15-25% of available) to the area in which the paper backing has been torn.

Place the area of tension over the carpal tunnel region of the lower forearm.

Have the patient remain in wrist extension. Place the distal tails of the X cut the 1st and 5th metacarpals with no tension.

Place the medial proximal tail off the X cut in the direction of the medial epicondyle of the humerus with very light to light (15-25% of available) or paper-off tension. No tension is added for the last 1-2 inches.

Place the lateral proximal tail of the X cut in the direction of the lateral epicondyle of the humerus with very light to light (15-25% of available) paper-off tension. No tension is added for the last 1-2 inches.
Apply a second space correction technique to the dorsum of the wrist.

Begin by tearing the center of the paper backing of a 6-8-inch Kinesio I strip. Apply very light to light tension, (15-25% of available) to the exposed Kinesio Tex® Tape with the wrist in a slightly flexed position.

Place the Kinesio strip with applied tension directly over the distal 2 inches of the ulna and radius on the dorsum of the hand.

With one hand hold the Kinesio I strip on both the radial styloid process and ulnar styloid process, and have the patient move into extension.

With the other hand, lay down the tails of the Kinesio I strip with no tension, or, if desired, cut the ends of the Kinesio I strip so there is a small space or opening between tape ends.

Option 2:
Apply of the basic Kinesio Taping® Method for the common flexor muscle group using a 3-stripe Y technique. For review, see lateral or medial epicondylitis (pg 102).

Option 3:
Application of the basic KinesioTaping® Method for the common flexor muscle group using a 2-inch Y strip technique. For review, see medial or lateral epicondylitis.

For both option 2 and 3, a space correction strip as described in option one is applied over the carpal tunnel region.
Option 4:

_Buttonhole_ technique application for space correction:

Measure a Kinesio I strip from the medial and lateral epicondyles of the palmar side to the base of the proximal phalanx, and back to the epicondyles of the humerus on the dorsal side.

Cut a series of 2 to 3 holes (button holes) in the middle of the Kinesio I strip as cut in previous step.

Tear the paper backing of the Kinesio I strip in the location of the button holes and apply over either index, middle, and ring or middle, ring, and little fingers.

Have the patient move into wrist extension with radial deviation and place the Kinesio strip with very light to light tension (15-25%) or paper-off tension in the direction of the medial epicondyle of the humerus.

Prior to any further patient movement, initiate glue activation.
Have the patient move into wrist flexion with ulnar deviation and place the Kinesio strip with very light to light (15-25%) or paper-off tension in the direction of the lateral epicondyle of the humerus. Prior to any further patient movement, initiate glue activation.

Apply optional space correction on dorsum of wrist.

Completed application of Kinesio Taping® Method for carpal tunnel syndrome.
Lymphedema of the Upper Extremity

Lymphedema of the Upper Extremity may result from acute or chronic conditions. In an acute injury, the degree of edema may be too significant for the lymph system to remove in a short period of time. In a chronic condition, the lymph system is not able to channel the fluid in the normal pathways and edema has formed in the dependent extremity.

The Kinesio Taping® Method will assist in reducing edema by application of the lymphatic corrective technique, which lifts the skin to decrease pressure and allows for more normal flow of lymphatic fluids. For more extensive review, see Lymphatic Corrective Technique (pg 39).

The practitioner will need to determine where the lymphatic system has diminished function and by application of the lymphatic corrective technique, channel the fluid to another part of the system which is functioning normally.

Precautions to Kinesio Taping on Lymphedema applications may include: Diabetes, Kidney Disease/Dynamic forms of Lymphedema, Congestive Heart Failure, Thyroid Disease, and possibly pregnancy with associated medical conditions.

Lymphatic drainage will be demonstrated from the distal to the proximal lymph vessel. During practical application, not all sections may be required.

Application of lymphatic corrective technique from the hand to the elbow.

Have the patient place his/her hand in a neutral position and the elbow in extension. Place the base of Kinesio fan strip superior to the medial epicondyle of the humerus and direct the strips across the anterior aspect of the forearm towards the base of the thumb. Apply very light tension (5-15% of available) to the fan tails. The distal tip of the fan tails are applied with no tension.

Optional Second Fan Strip: Forearm

Place a second Kinesio fan strip either slightly below or above the first strip.

Place the base of Kinesio fan strip superior or inferior to the medial epicondyle of the humerus and direct the strips across the posterior aspect of the forearm towards the dorsum of the hand. Apply very light tension to the fan tails. The distal tip of the fan tails are applied with no tension.

For an optional technique for the hand to the elbow, see buttonhole technique at end of this technique application.

Axillary Lymph Node is Functional: Upper Arm

Have the patient move into shoulder abduction and external rotation. Place the base of the Kinesio fan strip near the axillary lymph node.

Direct the tails of the Kinesio fan strip toward the medial aspect of the elbow. Apply very light tension to the fan tails. The distal tip of the fan tails are applied with no tension.
Optional Second Fan Strip: Upper Arm

Place a second Kinesio fan strip either slightly below or above the first strip.

Have the patient move into shoulder adduction and internal rotation. Place the base of the Kinesio fan strip either superior or inferior to the first strip located near the axillary lymph node.

Direct the tails of the Kinesio fan strip toward the lateral aspect of the elbow and/or posterior region near the triceps. Apply very light tension to the fan tails. The distal tip of the fan tails are applied with no tension.

Axillary Lymph Node is not Functional: Upper Arm

Have the patient move into shoulder adduction and horizontal flexion. Place the base of the Kinesio fan strip near insertion of the teres minor and major muscles.

Direct the tails of the Kinesio fan strip over the middle deltoid muscle and toward the medial aspect of the elbow. Apply very light tension to the fan tails. The distal tip of the fan tails are applied with no tension.

Optional Second Fan Strip: Upper Arm

Have the patient move into shoulder abduction and horizontal flexion. Place the base of the Kinesio fan strip near insertion of the teres minor and major muscles, either slightly higher or lower than the first strip.

Direct the tails of the Kinesio fan strip over the posterior deltoid muscle and toward the posterior aspect of the upper arm in the triceps region. Apply very light tension to the fan tails. The distal tip of the fan tails are applied with no tension.

Optional Strip Toward Neck or Mid-Back Lymphatic Nodes.

Place base of Kinesio fan strip on cervical transverse processes. Have the patient move into horizontal shoulder flexion and neck lateral flexion to opposite side. Direct the tails of the fan strip toward the posterior aspect of the shoulder.
Optional Buttonhole Technique for Lower Arm Lymphatic Drainage.

Measure a Kinesio I strip from the medial and lateral epicondyles of the palmar side to the base of the proximal phalanx, and back to the epicondyles of the humerus on the dorsal side.

Cut a series of two to three holes (buttonholes) in the middle of the Kinesio I strip as cut in previous step.

Tear the paper backing of the Kinesio I strip in the location of the button holes and apply over either index, middle, and ring or middle, ring, and little fingers.

Have the patient move into wrist extension with radial deviation, and place the Kinesio strip with very light to light tension in the direction of the medial epicondyle of the humerus.

Prior to any further patient movement, initiate glue activation.

Have the patient move into wrist flexion with ulnar deviation, and place the Kinesio strip with very light to light tension in the direction of the lateral epicondyle of the humerus.

Prior to any further patient movement initiate glue activation.
**Wrist Sprain -- Trifibrocartilage (TFC)**

Wrist sprains are a common acute and chronic injury which occur as a result of an activity. These injuries can either occur from an isolated injury or develop from long term overuse (weight lifting, repetitive hyperextension or flexion). Evaluation of wrist sprains may be difficult, as pain may result from injuries to the trifibrocartilage, posterior and anterior ligaments. Circulation to the carpal bones may be constricted by wrist sprains.

The Kinesio Taping® Technique will include lymphatic correction taping to reduce acute or chronic edema, ligament correction to assist joint laxity, and optional functional taping to limit range of motion.

**Application** of lymphatic correction technique to the dorsum of the hand. For complete review, see lymphatic correction technique (pg 39).

Begin by placing the base of the lymphatic fan cut approximately two inches superior to the ulnar styloid process, and angle the fan strips in approximately 45 degrees toward the thumb. Apply fan strips with very light to light tension (15-25% of available).

Begin by placing the second Kinesio lymphatic Fan strip approximately 2 inches superior to the radial styloid process. Angle the fan strips in approximately 45 degrees toward the little finger. Apply fan strips with very light to light tension (15-25% of available).

The practitioner may determine that lymphatic correction may be more appropriate on the palmar surface of the hand, or on both sides.

**Optional Application of the Basic Kinesio Taping® Method for the Common Flexor Muscle Group Using a Y Technique.**

For review, see medial epicondylitis (pg 105).

This may be applied to reduce spasm in the common flexor muscle group following an injury to the wrist.
Optional Application of the Basic Kinesio Taping® Method for the Common Extensor Muscle Group Using a Y Technique.

For review, see lateral epicondylitis (pg 102). This may be applied to reduce spasm in the common extensor muscle group following an injury to the wrist.

Application of the ligament corrective technique in the dorsum of the hand.

Place the patient's hand in a neutral position with the fingers splayed. Begin by tearing through the paper backing at the center of the Kinesio I strip, approximately 6-8 inches. Apply moderate to severe tension (50-75% of available) and inward pressure directly over the area of pain or ligaments where support is desired.

Move patient's wrist into extension, and apply the tails of the Kinesio strip with no tension. If appropriate, this technique may be applied to the palmar surface of the wrist.

Apply the functional corrective technique to limit either wrist flexion or wrist extension, depending upon injury. For complete review, see functional correction technique (pg 57).

Measure the length of the Kinesio I strip from approximately 4 inches superior to the wrist and to the heads of the metacarpals.

Place the patient's hand in slight extension, and place one base strip approximately 4 inches above the wrist with no tension. Apply the Kinesio I strip with moderate to severe tension (50-75% of available) in the middle and apply the second base onto the heads of the metacarpals with no tension.
Have the patient move his/her wrist into flexion, and apply the Kinesio I strip to the dorsum of the hand.

The practitioner will need to experiment with the correct degree of tension in the tape during application. For less restriction, less tension is required. For increased restriction, more tension is required.

Completed wrist sprain Kinesio Taping® Technique application.
**de Quervain's**

*De Quervain's* is a tendinitis of the adductor pollicis longus and extensor pollicis tendon. It may be related to a narrowing in the tendon abductor sheath or may result from repetitive movements of the thumb.

The Kinesio Taping® Method will assist in reducing edema and pain and will create more space with the application of a mechanical correction.

This technique can be applied using two 1-inch Kinesio I strips or a 2-inch Kinesio Y strip cut at the radial styloid process. The technique demonstrated will use two Kinesio 1-inch I strips.

The practitioner may select to apply a space correction technique in place of the mechanical correction technique, or a fascia correction if deemed appropriate.

**Begin** by placing a 1 inch Kinesio I strip on both the palmar and ventral side of the thumb. It may be helpful to have the two ends meet distal to the tip of the thumb, as this usually aids in the tape application remaining longer.

**Optional: Use a 2-inch Kinesio Y Strip with the Base of the Y on the Distal Tip of the Thumb on the Radial Side.**

*Use* the Y tails around the palmar surface of the thumb to assist with adhesion.

**Optional: Use a Modified “X” Technique.**

*Cut* the appropriate length of 2-inch Kinesio Tex® Tape. In the center of one end, make an approximately 1-inch cut. In the other end, cut the center of the strip, leaving only 1 inch of the Kinesio Tape® Tape uncut. Tear the Kinesio Tape® in the uncut region, with the small cut in the tape distally. Apply this to the proximal phalange without tension. Wrap the distal end of the X cut around the distal phalange. With the remaining end of the X cut, follow the description below.

Move patient's wrist into extension with ulnar deviation and extension at the elbow.

Place the Kinesio I strip along the adductor pollicis (palmar side of thumb) with light (15-25%) or paper-off tension. Leave a space in the anatomical snuff box region or in the region of pain. Direct the strip from the radial styloid process towards the lateral epicondyle of the humerus.

Initiate glue activation prior to any further patient movement.

Have the patient move into wrist extension with radial deviation and extension at the elbow.

Place the Kinesio I strip along the extensor pollicis (dorsum side of the thumb) with light (15-25%) or paper-off tension. Leave a space in the anatomical snuff box region, or the region of pain. Direct the strip from the radial styloid process toward the lateral epicondyle of the humerus.

Initiate glue activation prior to any further patient movement.
Application of a Mechanical Correction Technique with Tension on the Base.

For review, see mechanical correction technique (pg 22). Begin by placing the base of an approximately 4-6-inch-long Kinesio Y strip on the palmar aspect of the wrist. Prior to laying down the base, estimate its location, so when tension has been added the split in the Y cut will bisect with the previously applied tape in the anatomical snuff box region.

With one hand, hold the base of the Kinesio Y strip to ensure no tension will be added to tape end.

Apply moderate to severe tension (50-75%) on the base of the Kinesio Y strip with inward pressure. As the tension is added to the tape and applied to the skin, move the hand on the base up to the point of end tension.

End the tension when the split in the Y bisects with the previously applied tape in the anatomical snuff box region.

Have the patient move into wrist flexion with ulnar deviation, and lay down the tails of the Kinesio Y strip with no tension. The tails should be splayed out to dissipate tension over as large an area as possible.

If applied correctly, a square should form between the two Kinesio Y strip applications over the area of pain.

Completed Kinesio Taping® Technique for de Quervain's.

The practitioner may select to apply a space correction technique in place of the mechanical correction technique, or a fascia correction if deemed appropriate.
Finger Sprain, Radial or Ulnar Collateral Ligament

A sprain to the proximal or distal interphalangeal joint is a common injury resulting from activity. It may result from an axial load on the fingertip, abduction, or adduction force on the joint. This condition is also commonly referred to as a “jammed finger.”

The Kinesio Taping® Method will assist in reducing edema, pain and provide ligament stability.

You can begin by placing an optional anchor in the middle of both the proximal and distal phalanx above or below the joint you are attempting to stabilize.

The anchor is not required. Kinesio Tex® Tape adheres best when placed directly to the skin.

Apply a ligament correction technique to the injured joint. For complete review, see ligament correction technique (pg 32).

Place the base of the Kinesio I strip distal to the joint to be stabilized, with no tension. Angle the Kinesio I strip at a 45-degree angle. With one hand, hold the base so no tension is added.

Apply a ligament correction with moderate-to-full tension (50-100% of available) to the center of the Kinesio I strip. Lay down the center of the Kinesio I strip directly over the area of laxity.
Lay down the remaining Kinesio I strip with no tension.

Repeat the above steps to form a crisscross pattern with two strips, and add a third ligament correction parallel to the injured ligament.

Apply a second set of anchors in the middle of both the proximal and distal phalanx (or above and below the joint you are attempting to stabilize).

Optional: Application of a “Buddy Taping Technique” to the Injured Finger.

Apply an anchor strip below and above the injured joint. A spray adherent may be used to limit tape migration due to moisture which may develop during activity.
Mallet Finger

Mallet Finger is the result of the finger being in an extended position and forced into flexion by a direct trauma. The extensor digitorum tendon is avulsed from the base of the distal phalanx. The tension of the flexor tendon pulls the distal phalanx into flexion, giving the appearance of the head of a mallet.

The Kinesio Taping® Technique will assist by limiting the distal phalanx movement into flexion. If the patient has sustained a mallet finger, which has resulted in the extensor tendon being avulsed, this needs to be treated in a splint, or surgically repaired. If the patient has sustained a mild injury or is recovering from treatment in a splint or surgery, the Kinesio Taping® Method will be beneficial.

Apply the functional correction technique to limit distal phalanx flexion. For complete review, see functional correction technique (pg 37).

Begin by measuring a Kinesio I strip from the palmar surface of the distal tip, over the fingernail and continuing to the metacarpal phalangeal (MCP) joint of the injured finger.

Place one end of the Kinesio I strip on the palmar surface of the injured joint and wrap around to the dorsal surface of the injured finger, with no tension.

With one hand, hold the base which has been applied to the distal phalanx to ensure no tension will be added. Apply functional correction with 50-100% of available tension. Lay down the Kinesio I strip down on the dorsum surface of the injured finger. Apply tension until the Kinesio I strip is approximately 1 inch distal to the MCP joint.

Have the patient move the injured finger into flexion while holding both bases. Activate glue prior to any further movement.

A second functional correction strip may be applied depending upon the size of the individual and the degree of finger movement limitation desired.

Apply anchors at the tip of the injured finger and as close to the MCP joint as possible. This will assist in providing better support and will prevent the Kinesio Tex® Tape from coming off the skin due to the high tension used during application.
Dislocation of the Phalanges of the Fingers

Dislocations of the phalanges occur at a high rate when compared to dislocations in other areas of the body. Dislocations can occur at the metacarpal phalangeal joint (MCP), proximal interphalangeal joint (PIP) or distal interphalangeal joint (DIP). They can dislocate in both the palmar or dorsal direction.

The Kinesio Taping® Technique will provide pain relief, reduce inflammation by use of a lymphatic correction, provide joint stability with a ligament correction, limit flexion or extension with a functional correction.

Apply a lymphatic correction technique to the dorsal surface, palmar surface or both. For review, see lymphatic correction technique (pg 39).

Application shown is from the base of the first proximal phalanx to the distal phalanx.

Apply a ligament correction technique to the region of the dislocation or fracture. For review, see ligament correction technique (pg 33).

If the injury was a dorsal dislocation, apply the ligament correction on the dorsal aspect of the finger. If the dislocation caused laxity to either the medial or lateral collateral ligaments of the finger, apply the correction strip to these regions in a crisscross pattern. For review of this technique, see finger sprain.
Apply a functional correction technique that will limit the motion which caused the injury. Generally, dislocations occur in the dorsal direction. Limiting the joint range of motion in extension will assist with joint stability.

Begin by placing the patient’s finger in a flexed position. Apply KT strip to the superior base at the distal tip of the phalange. The inferior base strip is applied to the corresponding metacarpal head.

Hold both the superior and inferior base strips and have the patient move into finger extension. The degree of joint limitation is determined by the practitioner.

Use strips of Kinesio Tex® Tape to hold the corrective technique in place.

Not shown: an additional Kinesio strip may be used to “buddy tape” the injured finger to the adjacent finger.
Gamekeeper’s or Skier’s Thumb

Gamekeeper’s or Skier’s Thumb is a sprain of the ulnar collateral ligament of the 1st metacarpal phalangeal joint (MCP). Generally, the mechanism of injury forces the thumb into abduction with extension. Without this ligament, it is difficult for the patient to grasp items between the thumb and index finger.

The Kinesio Taping® Technique will assist with reducing edema and pain and will provide ligament stability. For grade two (increased laxity of ligament) and grade three (ligament rupture) injuries, the patient may need to be treated in a cast. Prior to and following cast treatment, the Kinesio Taping® Technique would be appropriate.

Acute Injury Phase 24-72 Hours:

Apply the lymphatic corrective technique to reduce edema resulting from a sprain the MCP joint. Two lymphatic correction strips will be applied. For complete review, see lymphatic corrective technique (pg 39).

Strip One: apply base on the radial side of the thumb inferior to the base of the 1st ray, and angle the fan strip over the MCP joint.

Strip Two: apply base on the radial side of the thumb between the base of the 1st and 2nd metacarpals and angle the fan strip over the MCP joint.

The two strips should form a crisscross pattern.
Apply 25% or paper-off tension.

Post Acute Injury Phase Post 72 hours:

Apply a ligament correction technique to the ulnar side of the 1st MCP joint. For complete review, see ligament correction technique (pg 35).

Apply a ligament correction as described in Sprained Finger (jammed finger) over the ulnar collateral ligament.
Apply a figure-of-8 strip of 1-inch Kinesio Tex® Tape starting on the ulnar aspect of the proximal phalanx. Continue the strip around the palmar surface of the thumb, applying slight inward tension. Be careful not to pull the thumb into an abducted position.

Continue the strip over the MCP joint and over the dorsum of the hand, angling toward the base of the 5th metacarpal. As you cross over the palmar surface of the palm, angle the tape back towards the MCP joint. This strip is to provide adduction pressure to support the joint capsule and to control abduction movement.
Osteoarthritis of the Hip

Osteoarthritis of the hip is degenerative destruction of the articular surfaces within the joint. It may be associated with normal degenerative changes from chronic impact loading caused by high levels of physical activity. The etiology of chronic hip effusion may be unknown, but the resulting chronic joint effusion will cause continuing degenerative changes and decreased muscle function.

The Kinesio Taping® Method will assist by reducing effusion and joint pain.

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective strips. For complete review, see lymphatic corrective technique (pg 39).

Begin by placing the first lymphatic Kinesio fan base at approximately the anterior superior iliac spine. Angle the fan tails at 45 degrees in a posterior and inferior direction.

Place the second lymphatic fans base at approximately the posterior superior iliac spine. Angle the fan tails at 45 degrees in a anterior and inferior direction.

The fan strips should form a crisscross pattern.

Basic Kinesio Taping® Technique for the gluteus medius muscle using a Y strip: This is an insertion-to-origin application.

Begin base of Kinesio Y strip on the lateral surface of the greater trochanter with no tension.

Place the patient in hip flexion, adduction and internal rotation.

Direct the anterior tail towards the anterior inferior iliac spine, with very light to light (15-25% of available) or paper-off tension. Lay the final 1-2 inches down with no tension.

Direct the posterior tail towards the posterior inferior iliac spine, with light, 15-25% of available, or paper off tension. Lay the final 1-2 inches down with no tension. Initiate glue activation prior to any further patient movement.

The iliotibial band attaches to the tensor fascia lata muscle and generally is involved not due to weakness, but to increased tension in the iliotibial band.

The iliotibial band taping example can begin at either the origin or insertion. For this application, the origin-to-insertion technique will be shown.

Begin by measuring the length of Kinesio Tex required. Place the base of the Kinesio I strip superior to the iliac crest with no tension.

A second application method is shown in the iliotibial band friction syndrome.
Place the patient in a stretched position for the iliotibial band. Apply light (15-25% of available) or paper-off tension along the entire length of the iliotibial band.

End the taping application by applying the end of the Kinesio strip slightly below the insertion of the iliotibial band, Gerdy's tubercle.

Completed application of the Kinesio Taping® Method for osteoarthritis of the hip.

Optional application of the star technique to reduce edema or inflammation directly over the area of pain or edema.

For complete review, see star technique in herniated disk lesion. Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective strips.
Trochanteric Bursitis

*Trochanteric* Bursitis is a common condition of the hip which results in inflammation of the trochanteric bursae located on the greater trochanter of the femur. It may also be associated with pain from the gluteus medialis insertion or iliotibial band friction as it passes over the greater trochanter. The Kinesio Taping® Technique will assist in reducing edema and pain.

*Initial* treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective strips.

For complete review, see lymphatic corrective technique (pg 39).

Begin by placing the first lymphatic Kinesio fan base at approximately the anterior superior iliac spine. Angle the fan tails at 45 degrees in a posterior and inferior direction.

Place the second lymphatic fans base at approximately at the posterior superior iliac spine. Angle the fan tails 45 degrees in an anterior and inferior direction.

The fan strips should form a crisscross pattern.

The iliotibial band attaches to the tensor fascia lata muscle and generally is involved not due to weakness, but to increased tension in the iliotibial band.

The iliotibial band taping example can begin at either the origin or insertion. For this application the origin-to-insertion technique will be shown.

Begin by measuring the length of Kinesio Tex® Tape required. Place the base of the Kinesio I strip superior to the iliac crest with no tension.

A second application method is shown in the iliotibial band friction syndrome.

Place the patient in a stretched position for the iliotibial band. Apply light (15-25% of available) or paper-off tension along the entire length of the iliotibial band.
Basic Kinesio Taping® Technique for the gluteus medius muscle using a Y strip. This is an insertion-to-origin application.

Begin base of Kinesio Y strip on the lateral surface of the greater trochanter with no tension. Place the patient in hip flexion, adduction, and external rotation.

Direct the anterior tail towards the anterior inferior iliac spine, with light (15-25% of available) or paper-off tension. Lay the final 1-2 inches down with no tension.

Direct the posterior tail towards the posterior inferior iliac spine, with light (15-25% of available) or paper-off tension. Lay the final 1-2 inches down with no tension.

Initiate glue activation prior to any further patient movement.

Completed application of the Kinesio Taping® Method for Trochanteric Bursitis.

Optional application of the star technique to reduce edema or inflammation directly over the trochanteric bursae.

For complete review, see Star Technique in herniated disk lesion.
Hip Pointer --- Iliac Crest Contusion

**Hip** Pointer is a contusion to the muscular attachments of the abdominal muscles as they insert on the iliac crest. The injury occurs from blunt trauma on an unprotected iliac crest. A hematoma may form causing a pinching action on the muscle attachments. It is generally very painful and can significantly affect an individual's ability to be physically active.

The Kinesio Taping® Technique will assist by reducing effusion, possible hematoma, and pain.

*Initial* treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective techniques. For complete review, see lymphatic corrective technique (pg 39).

Begin by placing the first lymphatic Kinesio fan base approximately 3-4 inches anterior and inferior to the iliac crest. Angle the fan tails at 45 degrees in a posterior direction.

The second lymphatic fan's base is approximately 3-4 inches posterior and inferior to the iliac crest. Angle the fan tails at 45 degrees in an anterior direction.

The fan strips should form a crisscross pattern.

*Apply* a Space Correction Technique to assist in reducing edema. For complete review, see space correction technique (pg 29). This application will be the same as the lumbar star technique.

Begin by tearing the center of the paper backing of a 4-6 inch Kinesio I strip. Apply light to moderate (25-50%) of available tension to the exposed Kinesio Tex® Tape.

Place the Kinesio strip with applied tension directly over the region of pain on the iliac crest. Lay down the ends of the Kinesio I strip with no tension. Have the patient move through as much range of motion as possible when applying the base of the Kinesio I strip.

In an acute iliac contusion, four space correction strips are recommended. As the patient improves, fewer strips may be required.

As the strips are applied, have the patient move through as much range of motion as possible when applying the base of the Kinesio I strip. This is to ensure that no tension will be added to the base.

In acute iliac crest contusions, the iliac crest may be very sensitive and tender. Be careful not to add any inward pressure when applying the space correction technique.
Quadriceps Contusion/Strain

Contusion to the quadriceps muscle, the largest muscle group in the body, can result in the formation of a hematoma. The hematoma may limit the patient’s ability to walk or participate in physical activity. Mild hematomas may only affect the patient for a few days. Significant or severe hematomas may result in the formation of bone-myoitis ossificans within the muscle tissue.

The use of the Kinesio Taping® Method will aid in the reduction of the hematoma, as well as addressing the weakness which may have developed due to injury and inactivity.

The quadriceps muscle may be treated using the basic quadriceps technique to limit muscle weakness. A lymphatic and/or space correction technique may be applied over the basic muscle taping or prior to its application.

The basic Kinesio Taping® Technique can also be used to assist with a strain of the quadriceps muscle resulting from over-extension or over-contraction.

Acute Phase:
Apply lymphatic corrective technique to reduce hematoma resulting from bleeding. For complete review, see lymphatic correction technique (pg 39).

Two strips will be applied. The lymphatic fan strip should start from near the inguinal fold and cross over the anterior aspect of the thigh or area of hematoma. The second lymphatic fan strip should start from as high up on the medial side of the thigh as patient comfort will allow and cross over the thigh to the lateral aspect over the hematoma. The fan strips should create a crisscross pattern over the anterior aspect of the thigh.

Post Acute Phase:
Basic Kinesio Taping® Method application of a rectus femoris muscle using a Kinesio I strip. The Kinesio strip is placed directly over the area of pain.

Begin by placing the base of the Kinesio I strip above the upper rim of the anterior superior iliac spine. The origin of the Kinesio I strip may be lower depending upon the region of the injury.

If using the Kinesio Y strip technique, surround the area of injury with the tails of the Y.

Have the patient move into hip extension. Begin the Kinesio I strip with no tension on the base. Apply light (15-25%) or paper-off tension until the Kinesio I strip reaches the area of hematoma.

Just prior to passing over the area of suspected hematoma, increase tension using the space correction technique. Apply light to moderate tension (25-50% of available) over the area of pain.

After crossing over the area of pain, reduce tension to light. Lay down the last 2-3 inches of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.
Option 1: Application of a Mechanical Correction Strip.

The mechanical correction I strip is placed directly over the injured area. This provides additional proprioceptive stimulation to the muscle for support, similar to wearing a neoprene sleeve.

For complete review, see mechanical correction technique (pg 22).

Begin by tearing the center of an approximately 6-8-inch Kinesio I strip, and peel back the paper backing. Apply moderate to severe tension (50-75% of available) to the exposed Kinesio Strip and apply with inward pressure.

Lay down the ends of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.

A series of 2-3 strips can be used.

Option 2: Application of a Space Correction Strip.

The space correction I strip is placed directly over the injured area. This further assists the removal of edema as well as prevents hematoma formation. For complete review, see space correction technique.

Begin by tearing the center of an approximately 6-8-inch Kinesio I strip, and peel back the paper backing. Apply light tension (25% of available) to the exposed Kinesio Strip and lay down with no inward pressure.

Lay down the ends of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.

The practitioner may select to use a modified star technique by applying 2-3 space correction strips over the area of edema or hematoma.
Adductor or Groin Strain

A strain to the adductor muscle group, commonly referred to as the groin, is the result of over-extension or acute overload of the muscle tissue. It may involve the iliopsoas, rectus femoris, gracilis, pectineus, adductor brevis, adductor longus, or adductor magnus. The practitioner will need to determine which muscle(s) are involved and apply the appropriate Basic Kinesio Taping® Techniques.

The Kinesio Taping® Method will assist in reducing edema and pain and will provide ligament stability. For acute muscle strains, use the Kinesio I strip directly over the area of injury during the first 24-72 hours. Following this period, use the Kinesio Y strip with the tails of the Y surrounding the injured area.

Basic Kinesio Taping® Method application of an iliopsoas (psoas major, psoas minor, and iliacus) muscle using the Kinesio I strip: Kinesio I strip is placed directly over the area of pain.

Begin by placing the base of the Kinesio I strip above the umbilicus at approximately T12.

If using the alternative Kinesio Y strip technique, surround the area of injury with the tails of Y.

Have the patient move into hip extension. Apply light tension (15-25%) or paper-off tension to the Kinesio I strip.

Direct the Kinesio I strip toward the lesser trochanter of the femur. Lay down the last 2-3 inches of the Kinesio I strip with no tension.

Initiate glue activation prior to any further patient movement.

Basic Kinesio Taping application of the common adductor muscle group (gracilis, pectinus, adductor brevis, adductor longus, and adductor magnus) using a Kinesio I strip. The Kinesio I strip is placed directly over the area of pain.

Begin by placing the base of the Kinesio I strip as close as possible to the pubis symphysis and inferior to the ramus of the pubis.

Have the patient move into hip abduction. Apply very light tension (15-20%) or paper-off tension to the Kinesio I strip.

Direct the Kinesio I strip toward the superior aspect of the medial condyle of the femur. If the practitioner is able to determine the specific muscle involved, direct the Kinesio I strip toward the insertion of the involved muscle.
Optional: Application of Either Mechanical Correction or Space Correction Directly over the Area of Pain.

The mechanical correction provides additional proprioceptive stimulation to the muscle for support, similar to wearing a neoprene sleeve.

The space correction further assists in the removal of edema or prevention of hematoma formation from the injured area.

For complete review of both techniques, see Hamstring or Quad Strain.
Hamstring Strain

A strain to the hamstring muscle group (semimembranosus, semitendinosus, or biceps femoris) is one of the most common muscle strains which results from physical activity. This muscle group may be overpowered by the larger quadriceps muscle group or may be injured due to lack of flexibility or over contraction. Many hamstring strains can become chronic in nature.

Begin by applying the Basic Kinesio Taping® Technique for the hamstring muscle strain. During the evaluation of the injury, the practitioner will need to determine which of the hamstring is involved. It has been found to be helpful to apply a space or mechanical correction strip directly over the area of injury.

For acute muscle strains, use the Kinesio I strip directly over the area of injury during the first 24-72 hours. Following this period, use the Kinesio Y strip with the tails of the Y surrounding the injured area.

Apply lymphatic corrective technique to reduce hematoma resulting from bleeding. For complete review, see lymphatic correction technique (pg 39).

Two strips will be used. The first lymphatic fan strip should start medial to the ischial tuberosity and cross over the lateral aspect of the posterior thigh or area of possible hematoma. The second lymphatic fan strip should start lateral to the ischial tuberosity and cross over the medial aspect of the thigh in the area of possible hematoma.

The fan should create a crisscross pattern over the posterior aspect of the thigh using 25% or paper-off tension.

Basic Kinesio Taping® Method application of a hamstring muscle using a Kinesio I strip: Kinesio strip is placed directly over the area of pain.

Begin by placing the base of the Kinesio I strip as close as possible to the origin of the hamstring group with no tension.

If using the Kinesio Y strip technique, surround the area of injury with the tails of the Y.

Have the patient move into hip flexion to place the hamstring on a stretch. If the patient’s range of motion is limited due to injury, additional tension will need to be added to the Kinesio I strip.

Apply light tension (25% of available) to the Kinesio I strip. As the Kinesio Tex® Tape crosses over the area of injury, increase the Kinesio I strip tension to moderate tension (50% of available). This will provide additional space for edema removal. Then reduce tension to 25% over remaining length of Kinesio strip.

Lay down the last 2-3 inches of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.
Application of mechanical correction strip: The mechanical correction I strip is placed directly over the injured area. This provides additional proprioceptive stimulation to the muscle for support, similar to wearing a neoprene sleeve. For complete review, see mechanical correction technique (pg 22).

Begin by tearing the Kinesio I strip in the middle of the paper backing, and peeling back the middle third. Apply the center of the Kinesio I strip with moderate to severe tension (50-75% of available) and inward pressure directly over the injury site.

Lay down the tails of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.

Application of space correction strip.

The space correction I strip is placed directly over the injured area. This further assists the removal of edema and helps prevent hematoma formation from the injured muscle. For complete review, see space correction technique (pg 29).

Begin by tearing the Kinesio I strip in the middle of the paper backing, and peeling back the middle third. Apply the center of the Kinesio I strip with light tension (25% of available) directly over the injury site with the center of the Kinesio strip.

Lay down the tails of the Kinesio I strip with no tension. Initiate glue activation prior to any further patient movement.

Completed application of Basic Kinesio Taping® Method for a hamstring muscle using the Kinesio I strip, with space or mechanical correction strip.

If using a single strip, a space correction strip with 50% of available tension can be used.
Iliotibial Band Friction Syndrome

The iliotibial band friction syndrome is an inflammation of the iliotibial band where it crosses over the lateral femoral condyle or at its insertion on the tibia. The syndrome is generally caused by overuse and is most common in runners, cyclists, and soccer players. It has been associated with individuals who present with pronated feet and genu varum.

The Kinesio Taping® Technique will assist in inflammation reduction and decreased tension in the iliotibial band by application of a muscle taping, tendon correction, and space or mechanical correction.

The iliotibial band is attached to the tensor fascia latae muscle and generally is involved not due to weakness, but to increased tension in the iliotibial band.

The iliotibial band taping application can begin at either the origin or insertion. For this application, the insertion-to-origin technique will be shown.

Begin by measuring the length of Kinesio Tex® Tape required. Place the base of the Kinesio I strip inferior to the insertion of the iliotibial band.

The use of the fan strip is intended to help reduce inflammation and tension in the tensor fascia latae.

Place the patient in a stretched position for the iliotibial band. Apply very light tension (25% of available) along each of the 4-5 fan strip cuts. The superior and inferior strips should be placed around the tensor fascia latae muscle. The inside three strips should be placed over the iliotibial band and tensor fascia latae muscle.

Application of Mechanical Correction with Tension on the Tails.

The practitioner may also apply a Fascia or Space correction. The Mechanical correction is chosen to limit movement of the iliotibial band over the lateral femoral condyle. For complete review, see mechanical correction technique (pg 22).

Begin mechanical correction by placing the base of the Kinesio Y strip inferior and posterior to the lateral condyle of the femoral. Have the split in the Y begin at the patient’s point of pain.
Start with the patient's knee in extension. With one hand, hold the base of the Y to ensure no tension is added to the base. Have the patient move into mid-joint position, and apply moderate to severe tension (50-75% of available) to the tails of the Kinesio Y strip. The upper strip is applied above the point of pain.

Lay down the upper tail in a U shaped pattern after it crosses over the iliotibial band. Approximately the final 1 inch is laid down without tension.

The lower tail is placed below the point of pain. Lay down the tail in a U shaped pattern after it crosses over the iliotibial band. Approximately the final 1 inch is laid down without tension.

The concept is to limit the IT band from moving posteriorly over the lateral femoral condyle during knee flexion.

Completed application of basic Iliotibial band Friction Syndrome Technique.
Application of Kinesio I strip over the length of the iliotibial band and Tensor Fascia Latae muscle.

This strip can be modified for tension over the inflammation for space correction, or increased tension over the tendon sheath for tendon correction, or increased tension directly over the tensor fascia muscle.

Begin by measuring the length of Kinesio Tex® Tape required. Place the base of the Kinesio I strip inferior to the insertion of the iliotibial band with no tension.

Place the patient in a position which stretches the desired portion of the tissue to be treated.

Apply appropriate tension.

Completed Kinesio Taping Application for Iliotibial Band Friction Syndrome.
Shin Splint or Medial Tibial Stress Syndrome

The treatment for shin splints is as varied as the cause of the condition, which is not always known. Many practitioners have started to refer to shin splints as medial tibial stress syndrome. The general cause of pain is an excessive repetitive trauma in the lower leg located on the distal 1/3rd of the medial tibial border. Associated with repetitive stress may be poor arches, muscle weakness, surface changes, and improper footwear, to name a few.

When selecting a Kinesio Taping® Technique for treatment, the practitioner must first evaluate the cause of the pain and then adapt a treatment protocol to treat the symptoms. The treatment protocol may include taping, for muscles, arch, and space correction.

One possible treatment protocol (Basic Kinesio Taping® Method application for the tibialis anterior, and two methods of space correction on the medial border of the tibial) will be described.

Application of basic Kinesio Taping® Method for tibialis anterior. The tibialis anterior is generally associated with shin splints or medial tibial stress syndrome due to its function in plantar flexion and inversion of the ankle and foot.

If the medial longitudinal arch is not providing appropriate support to assist in dissipation of forces resulting from landing or take off, the anterior tibialis may become inflamed to compensate.

Option 1:
Space Correction - Tissue Away

Application of space correction on medial border of the tibia. This method pulls skin away from the medial border of the tibia. Begin by placing the Kinesio Y strip just inferior to the area of pain. Hold the base of the Kinesio strip to reduce unwanted tension on the skin. Apply light to moderate tension (25-50% of available) and pull the skin away from the medial tibial border, laying down the Kinesio strip as it continues to move more inferiorly.
When tension is applied to the point where the Kinesio strip Y’s, slide the hand holding the base to the initiation of the Y cut. Have the patient dorsiflex their ankle, and apply the tails of the Y with no tension in a splayed out pattern.

A 3-inch-wide Kinesio Y strip has been found to be more effective than a 2-inch strip for average to large size patients.

**Option 2: Space Correction - Tissue Towards**

Application of space correction on medial border of the tibia: This method pulls skin toward the medial border of the tibia. The practitioner may select to use the space correction technique applying tension via the tails or via the base. For complete review, see space correction technique (pg 29).

Application of space correction using the tails to create space. Begin by placing the base of the Kinesio strip with the base of the Y cut inferior to the location of pain. Apply light to moderate tension (25-50% of available) to the tails as you surround the area of pain. Lay the last one inch of Kinesio tape down with no tension.

Lay down the tails with no tension in a splayed pattern to limit tension on the skin.
Anterior Compartment Hematoma/Syndrome

An injury to the anterior compartment may result from direct trauma or from a loss of fascia expansion surrounding the four compartments. Each of the four compartments of the lower leg (anterior, lateral, posterior superficial and posterior deep) are surrounded by fascia which expands during exercise. Each compartment contains muscles, arteries, veins, and nervous tissue. When an acute trauma occurs, a hemorrhage may result, decreasing circulation and causing pressure on the nerve. A compartment may also be affected by a decrease in the elasticity of the fascia surrounding the compartment, resulting in increased pressure and numbness.

Acute compartment hematomas are treated by reducing the hemorrhage. Chronic exertional compartment syndromes are treated by reducing the increased pressures within the compartment.

For both the acute and exertional compartment syndrome, a lymphatic correction will be used to reduce pressure within the compartment. The first lymphatic strip is placed with the base at the medial aspect of the knee just superior to the joint line using 25% of available tension.

For complete review, see lymphatic correction application technique (pg 39).

A second lymphatic correction strip may be applied, starting with the base close to the insertion of the Achilles tendon. The fan tails are laid in a crisscross pattern over the first fan strip using 25% of available tension.

With an acute hemorrhage resulting in a hematoma, a space correction technique may be used. This space correction I strip should provide additional space directly above the hemorrhage, allowing for the edema to be removed.

Tear the Kinesio strip paper backing in the middle, and apply light tension (25% of available) to the center of the strip. Apply this central area directly over the hematoma. If appropriate, have the patient move into opposite range of motion, and lay down tails with no tension. A series of two to three strips may be found to be more effective.
Sciatica

Sciatica is an inflammation of the sciatic nerve, which is generally associated with low back pain resulting from neurological symptoms. Sciatic nerve involvement may be the result of inflammation occurring directly to the nerve itself, lumbar disk herniation, or tightness of the piriformis.

The Kinesio Taping® Method will assist by reducing effusion, inflammation, pain and paresthesia. A lymphatic correction will assist with edema reduction, and then the length of the sciatic nerve involvement will be taped along its dermatome.

Two options that are shown: 1) (see disk herniation) use of a star space correction technique to remove lymphatic fluid, and 2) basic Kinesio Taping® Technique for piriformis muscle (see myofascial low back pain).

Application Of Lymphatic Correction Strip

For complete review, see lymphatic correction technique (pg 39).

Begin the first Kinesio fan strip inferior to the ischial tuberosity. Have the patient move into as much hip flexion as possible. Apply the fan strips with light tension (25% of available) or paper-off tension across the region of pain, ending at approximately the sacroiliac joint.

Initiate glue activation prior to any further patient movement.

Begin the second Kinesio fan strip inferior to the popliteal space. Have the patient move into as much hip flexion as possible. Apply the fan strips with light tension (25% of available) across the region of pain, ending inferior to the base of the first strip.

Initiate glue activation prior to any further patient movement.

The sciatic nerve strip can be initiated from either the hip or foot. The importance is that with each segmental application of the sciatica strip, the segment must be placed in a stretched position prior to tape application.

Begin by measuring the length of tape required from the PSIS to the distal point of paresthesia. Measure the length of tape in a position of comfort for the patient.

Beginning at the hip, apply the first 2 inches of the Kinesio I strip, 1-inch width, at the PSIS.

The sciatic strip only needs to be applied as far down the leg as the radiating pain is felt by the patient.
Place the patient in hip flexion with forward flexion of the back. Apply the Kinesio I strip with light (25% of available) or paper-off tension along the middle aspect of the posterior thigh. The Kinesio strip should follow the radiating path of paresthesia.

With the hip remaining in a flexed position, have the patient move his/her knee into extension.

Continue the Kinesio I strip with 25% of available or paper-off tension along the radiating pathway.

While the hip remains in a flexed position have the patient move their ankle into dorsiflexion and inversion.

Continue the Kinesio I strip with light tension (25% of available) or paper-off tension along the radiating pathway.

Lay down the final 2-3 inches of the Kinesio I strip with no tension.

The sciatic strip only needs to be applied as far down the leg as the radiating pain is felt by the patient.
Lymphedema of Lower Leg

Lymphedema of the lower extremity may result from acute or chronic dysfunction. In an acute injury, the degree of edema may be too significant for the lymph system to remove in a short period of time. In a chronic condition, the lymph system is not able to channel the fluid in the normal pathways, and edema has formed in the dependent extremity.

The Kinesio Taping® Method will assist in reducing edema by application of the lymphatic corrective technique. The practitioner will need to determine where the lymphatic system has diminished function and, by application of the lymphatic corrective technique, channel the fluid to another part of the system which is functioning normally.

Precautions to Kinesio Taping on Lymphedema applications may include: Diabetes, Kidney Disease/Dynamic forms of Lymphedema, Congestive Heart Failure, Thyroid Disease, possibly pregnancy with associated medical conditions, and DVT.

Lymphatic drainage will be demonstrated from the proximal to the distal lymph vessel. During practical application, not all sections may be required.

Begin by placing the base of the Kinesio Fan strip on the posterior medial aspect of the knee, with no tension. Be careful of placing strips in the popliteal fossa, as this may cause irritation. Angle the fan strips in an inferior direction.

Have the patient place the knee in extension and the foot in dorsiflexion. Lay down the fan strips with little tension (25% of available) over the area of edema. The distal 1-2 inches should be laid down with no tension.

A second Kinesio Fan strip may be applied either from slightly higher or lower on the posterior medial aspect of the knee, or from the posterior lateral aspect of the knee. Angle the fan strips in an inferior direction. The tails of the two Kinesio fan strips should form a crisscross pattern over the area of edema.

Have the patient place the knee in extension and the foot in dorsiflexion.

Initiate glue activation prior to any further patient movement.

Optional: Third Kinesio Fan Strip

If this optional third fan strip is used, it should be applied first.

Begin by placing the base of the Kinesio fan strip inferior to the insertion of the Achilles tendon into the calcaneous. Angle the fan strips in a superior direction.

Have the patient place the knee in extension and the foot in dorsiflexion.

Initiate glue activation prior to any further patient movement.
Section 8

Knee &
Lower Leg
Patella Tendonitis - 1 strip

This technique for treating patella tendonitis uses an I strip placed from the tibial tuberosity over the patella. It is important during application that little or no tension is applied to the patella in inward pressure to create increased articulation of the patella with the femur.

Several examples will be given in which the Kinesio Taping® Technique will be combined with traditional treatments (Low Dye, longitudinal arch, or orthotics). The practitioner will need to evaluate each patient and apply what is, in their opinion, the best course of treatment. If one method is selected and the results are not as effective as desired, try another method.

Begin by placing the base of the Kinesio I strip inferior to the tibial tuberosity with no tension on the tape. With one hand, hold the base of the tape to ensure no tension will be created.

Option 1: Ligament/Tendon Correction

Apply moderate to severe tension (50-75% of available) from the tibial tuberosity to the inferior pole of patella while the knee is in approximately 30 degrees of flexion.

Slide the hand which was holding the base at the tibial tuberosity to the inferior pole of the patella. Instruct the patient to flex their knee. Apply very light tension (10-15% of available) to the Kinesio strip over the patella to within 2 inches of the end of the strip. Lay down the end of the Kinesio strip with no tension. Be sure to initiate adhesion prior to allowing the patient to extend the knee.

Option 2: Space Correction

Have the patient place their knee in maximum flexion. Apply light tension (25% of available) to the Kinesio I strip over the patella. Lay down the last 2 inches with no tension. Be sure to initiate glue prior to any patient movement.

When the patient extends the knee, the tape should create visible skin convolutions. If there are limited number of convolutions, too much tension has been applied to the tape.
Patella Tendonitis - U Strip

This technique for treating patella tendonitis uses a U shaped application of the Kinesio strip under and around the patella. The function of the U strip is to apply an inward pressure on the inferior pole of the patella to create a “tilting” effect. This “tilting” effect is thought to decrease pressure on the inferior pole of the patella and reduce inflammation and pain. The practitioner should exercise judgment as to the amount of inward pressure, starting with less pressure for initial applications.

This can be used for inferior pole tendonitis (jumper’s knee) or tendonitis on tibial tuberosity. It may also be effective for Osgood-Schlatter syndrome or Larsen-Johansson syndrome.

Begin by tearing the middle of the paper backing on a Kinesio strip approximately 6-8 inches in length. Place the middle of the tape strip with 1/3 to 1/2 width of the Kinesio strip over the inferior pole of the patella. A mechanical correction technique (tension and inward pressure) is applied using moderate tension (50% of available). Push the patella in an inward and inferior motion, in an attempt to “tilt” the patella. For review, see Mechanical Correction Technique (pg 22).

Instruct the patient to move the knee into flexion. As the patient moves the knee into flexion, apply the Kinesio strip around the patella with light tension (25% of available) tension. The medial strip should be placed in the direction of the vastus medialis. The lateral strip should be placed in the direction of the vastus lateralis.

No tension should be placed on either end. While the knee is in the flexed position, be sure to initiate glue adhesion prior to allowing the patient to extend their knee.
Patella Tendonitis: Superior and Inferior Pole

Patella Tendonitis at either the superior pole or inferior pole (jumper’s knee) develops from an overuse of the quadriceps muscle group. The patella acts like a mechanical lever to magnify the forces created by the quadriceps muscle. From repetitive activity, an inflammation may develop.

There will be three examples of methods of taping for patella tendonitis. Examples presented will be for regions of the superior and inferior poles. The practitioner will need to evaluate the patient and determine which technique may be best. If one technique is not showing the desired results, try another application technique.

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Patella Tendonitis: Superior Y Technique

This is a modification of the quadriceps muscle taping. The tape is applied from the origin to the insertion. The split of the Y application begins at the superior pole of the patella instead of the junction of the vastus lateralis and medialis.

Begin the Kinesio Y strip approximately mid-thigh over the vastus medialis muscle. The thigh is placed in a flexed position. Apply light (25% of available) or paper-off tension until the Y in the Kinesio strip reaches the superior pole of the patella. Initiate glue activation prior to any further patient movement.

Have the patient flex the knee to maximum flexion. Apply the tails of the Kinesio Y strip around the medial and lateral borders of the patella.

The tails should be applied with light (25% of available) or paper-off tension. The tip of the tail should end with no tension on the tibial tuberosity. Initiate glue activation prior to any further patient movement.

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Patella Tendonitis: Inferior Y Technique

This technique is applied starting from just below the tibial tuberosity with no tension at the beginning. Light tension (25% of available) is applied on the tape to the inferior pole of the patella.
Have the patient place the knee into maximum flexion. Apply the tails of the Kinesio Y strip around the medial and lateral borders of the patella. The medial tail should end near or on the vastus medialis muscle, while the lateral tail should end on or near the vastus lateralis muscle. The tails should be applied with light tension (15-25% of available). A modification can be used to again split the tail (same tape) and apply a muscle application to either the vastus medialis or lateralis muscle thus creating further support.

Combination of Patella Tendonitis Superior and Inferior Y Techniques

For acute or inflamed patella tendonitis, the practitioner may find better results from combining the two techniques described. Possibly for the first few days or week, a combination may be appropriate. As pain diminishes, the superior or inferior application alone may be sufficient for pain relief.

Also see combination of Patella Tendonitis on Section 10 (pg 237-238).
Patella Tracking Syndrome

Patella Tracking Syndrome is one of the most common conditions of the knee. It may be caused by many factors: patella malalignment, genu varum, genu valgum, genu recurvatum, patella alta, patella baja, or a weak vastus medialis, to name a few. It is a chronic or degenerative condition in which the symptoms of pain and inflammation become more pronounced with increased activity.

Proper evaluation of the underlying cause of patella tracking syndrome is critical to the success of the taping technique applied.

The Kinesio Taping® Technique assists in reduction of edema and pain by providing proprioceptive stimulation through the skin, requiring the surrounding tissues to normalize skin tension. This is accomplished through the use primarily of mechanical corrective techniques.

Optional Muscle Taping for Weakness

Following evaluation, the practitioner may determine muscle weakness to be a causative factor in the patella tracking syndrome. For this example, the vastus medialis is involved.

For an acutely inflamed or overused muscle, use the insertion to origin application technique. For a chronic weakness or weakness resulting from surgery, use an origin to insertion application technique. This example is demonstrating the origin to insertion technique.

Option 1: Patella Tracking Laterally:

Application of a mechanical correction I strip. As a result of the evaluation of the knee, the practitioner determines where the mechanical corrective strip should be applied.

Begin by placing the patient’s knee in 20-30 degrees of extension. Tear the paper backing of a 6-8-inch long Kinesio I strip in the middle. Holding both ends, apply a mechanical correction, using moderate to severe tension (50-70% of available) with inward pressure on the center of the Kinesio strip over the lateral border of the patella. For review, see mechanical correction technique tension on tails (pg 22).

The practitioner may either apply the mechanical correction tension while the knee is in extension, or have the patient move into flexion while the Kinesio strip is being applied. By applying the correction while the knee is actively moved into flexion, it becomes more functional.

Apply the mechanical correction tension around the lateral border of the patella. Tension ends as the Kinesio Tex® Tape passes the superior and inferior poles of the patella.
Lay down the ends of the Kinesio strip with no tension. If the corrective strip was applied with the knee in an extended position, have the patient move into flexion prior to tape ends application.

**Option 2: Patella Tracking Laterally: Tension on Tails**

Application of a mechanical correction with tension on the tails: With this technique, the tension is placed on the tails to use the “recoil effect” of the elastic qualities of the Kinesio Tex to create proprioceptive tension.

Begin by applying the base of the Kinesio strip Y cut on the medial aspect of the patella with no tension. For complete review, see mechanical correction technique (pg 22).

With one hand, hold the base to ensure no tension is added during application. One tail is applied with moderate tension (50% of available) and inward pressure along the inferior pole of the patella. The second tail is applied with similar tension and inward pressure along the superior pole of the patella.

Before the patient moves the knee, make sure to activate the glue.

The last approximately one inch of the tails of the mechanical correction tension on tails technique is applied with no tension.

This is believed to pull the skin from the lateral to medial side of the knee.
Option 3: Patella Tracking Laterally: Tension on Base

Application of a mechanical correction with tension on the base. For this technique, the practitioner may either use the tension in the base of the Kinesio strip or use a manual correction to position the patella in the desired position.

Begin with the first approximately 2 inches of the base of the Kinesio Y cut strip with no tension. With one hand, hold the initial application base to ensure no tension will be added. For review, see mechanical correction tension on base (pg 22).

Apply appropriate tension to create desired proprioceptive stimulation. Moderate tension (50% of available) with inward pressure on the lateral border of the patella would be appropriate. As the tension is applied to the Kinesio strip, move the hand which has been holding the initial base tension up the Kinesio strip.

It is felt that if the entire length of tape is applied to the skin as the tension is applied, it will reduce or minimize the recoil effect of the tape. By laying it down segmentally, it keeps the tension on the skin in each segment. Tension is applied over the crest of the lateral border of the patella.

While holding the tension on the lateral border of the patella, have the patient move the knee into flexion. Lay down the superior tail along the superior border of the patella with no tension. Lay down the inferior tail along the inferior border of the patella with no tension.

Prior to any further patient movement, activate the Kinesio strip glue by rubbing the tape application. This is believed to block lateral movement of the patella.

Completed Kinesio Taping® Method of patella tracking syndrome.
Subluxating Patella

A subluxating patella is an injury which can occur from deceleration with rotation or a direct blow to the border, which generally results in an acute dislocation. Once the patella has dislocated, it is common to have recurring partial dislocation (subluxation).

The Kinesio Taping® Technique helps reduce recurring subluxation by reducing pain and inflammation, providing proprioceptive stimulation to limit lateral patella movement, and unwinding the lateral mechanism to reduce excess tension.

The goal of the Kinesio Taping® Technique is to limit lateral patella movement and reduce lateral restraints tension.

Option 1:

Begin by applying a mechanical correction technique to the lateral border of the patella. For review, see Mechanical Correction (pg 22).

Apply the base of the Kinesio I strip inferior to the joint line with no tension while the knee is in extension. The Kinesio strip should be angled toward the lateral border of the patella.

With one hand, hold the applied base to ensure no tension is added.

Apply moderate to severe tension (50-75% of available) with inward pressure on the lateral border of the patella. The Kinesio strip should be placed with the center of strip on the patella border. As the practitioner begins to apply the Kinesio strip, have the patient move the knee into flexion. The practitioner may want to apply the Kinesio strip while the patient is weight bearing to simulate functional movement. The Kinesio Tex® Tape should cover approximately 2 inches of the lateral border of the patella.

With the patient in full knee flexion, apply the end of the Kinesio strip with no tension. Prior to any further patient movement, activate glue.
To assist with muscle activation, apply a Kinesio strip to the vastus medialis. The practitioner may select either an I strip or a Y strip, from origin to insertion. This is intended to limit lateral movement of patella by a medial pull on the extensor muscle group of the quadriceps.

Option 2:
At the patella, place a mechanical correction tension on base strip from the inferior lateral edge. For review, see mechanical correction tension on base technique (pg 22).

Begin tape with no tension near the proximal head of fibula; with one hand, hold the initial application base to ensure no tension will be added.

Apply appropriate tension to create desired proprioceptive stimulation. A moderate to severe tension (50-75% of available) with inward pressure on the inferior lateral border of the patella would be appropriate. As the tension is applied to the Kinesio strip, move the hand which has been holding the initial base tension up the Kinesio strip.

It is felt that as the tension is applied to the skin, the recoil effects of the tape are minimized. By laying it down segmentally, it keeps the tension in each segment laid down on the skin. Tension is applied until reaching the inferior pole of the patella.

While holding the tension on the lateral border of the patella, have the patient move the knee into flexion. Lay down the superior tail along the superior border of the patella with no tension. Then, lay down the inferior tail along the inferior border of the patella with no tension.

Prior to any further patient movement, activate the Kinesio strip glue by rubbing the tape application.
Continuation of Option 2

Apply a fascia correction technique, using the elastic qualities of the tape, from approximately the musculotendinous junction of the vastus lateralis to the superior aspect of the vastus medialis. For review, see fascia correction technique (pg 27).

Place the base of the Kinesio Y strip lateral to the musculotendinous junction of the vastus lateralis with no tension. With one hand, hold the initial application base to ensure no tension will be added.

Apply light to moderate tension (15-25% of available) to the Kinesio strip while “oscillating” the tape. As the tape is “oscillated,” slide the hand from the base along the Kinesio strip to adhere the Kinesio Tex® Tape to the skin. Slight inward pressure may be added, only to assist in the initiation of the adhesive.

When the hand which was holding the base has been moved to the start of the Y cut, have the patient move their knee into flexion. Lay down the two tails in a splayed pattern to dissipate the force over as wide an area as possible.

Prior to any further patient movement, initiate tape adhesion.

Completed Subluxating Patella Kinesio Taping application.
Chondromalacia Patella

Chondromalacia patella is a softening and degeneration of the under surface of the patella. The exact cause is unknown: generally it is related to patella tracking abnormalities, increased quadriceps angle, abnormal patella alignment, and muscle weakness, just to name a few. The condition is generally associated with inflammation surrounding the patella, medial patella retinaculum pain, and increased symptoms with increased activity levels.

The Kinesio Taping® Method will assist by reducing pain and inflammation and, if indicated, providing proprioceptive stimulation to alter patella tracking.

For additional reference of Kinesio Taping® Technique options, see Patella Tracking Syndrome.

Optional Muscle Taping for Weakness

Following evaluation, the practitioner may determine muscle weakness as a causative factor in the chondromalacia patella. For this example, the vastus medialis is involved.

For an acutely inflamed or overused muscle, use the insertion to origin application technique. For chronic weakness or weakness resulting from surgery, use an origin to insertion application technique.

This example is demonstrating the origin to insertion technique.

The primary therapeutic goal of Kinesio Taping for Chondromalacia patella is to reduce inflammation as a result of the effusion caused by the hyaline cartilage degeneration.

A modified space correction technique will be applied. For complete review, see space correction techniques (pg 29).

Begin by applying a Kinesio I strip to the tibial tuberosity with no tension and the knee in extension. Angle the Kinesio strip so it will be centered around the patella.

With one hand, hold the initial application base to ensure no tension will be added. Apply light to moderate tension, 25-50%, for this technique (less is usually better). As the tension is applied to the Kinesio strip, instruct the patient to move the knee into flexion. As the patient moves the knee into flexion, apply the Kinesio strip around the patella to approximately the patella apex.
Lay down the last approximately two inches of the Kinesio strip down with no tension. Initiate glue activation prior to any further patient movement.

Repeat the above steps on the opposite side of the patella. When the patient moves the knee into extension following application, convolutions should be visible surrounding the patella. If convolutions are not evident, the Kinesio strip was applied with too much tension.

Optional Technique: Mechanical I strip

Once the described technique is applied, the practitioner may determine that a patella alignment correction may be beneficial.

The use of the mechanical correction technique for patella tracking may be appropriate. Application depicted in photo is for lateral tracking using an I strip.

For complete review, see patella tracking technique.

Other patella alignment abnormalities may be present; this is only given as an example of one potential problem.

Optional Technique: Mechanical Correction, Tension on Base

Once the described technique is applied, the practitioner may determine that a patella alignment correction may be beneficial.

The use of the mechanical correction technique for patella tracking may be appropriate. Technique application depicted in this photo is for lateral tracking using tension on the base.

For complete review, see patella tracking technique.
Plica Of The Knee

A plica of the knee is formed by remnants of the synovial walls that make up the three knee cavities during the initial months of fetal development. Resulting in a thickening of the synovial capsule causes folds that are referred to as plicae. This condition occurs in approximately 20% of the population. The plicae may become inflamed and cause joint effusion located near the infrapatellar fat pad.

The Kinesio Taping® Method will assist by reducing edema and pain and limiting patella movement which may increase pressure on the plicae.

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective techniques. For complete review, see lymphatic corrective technique (pg 39).

The location of the lymphatic corrective strips is determined by the practitioner during the evaluation. Generally, the lymphatic fan tails should form a crisscross pattern over the area of effusion using 25% or paper-off tension.

Option 1:

Apply of a modified space correction technique. For complete review, see space correction technique (pg 29).

Begin by applying a Kinesio I strip to the tibial tuberosity with no tension and the knee in extension. Angle the Kinesio strip so it will centered around patella depending upon region of edema.

With one hand, hold the initial application base to ensure no tension will be added. Apply light to moderate tension (25-50% of available). For this technique, less is usually better. As the tension is applied to the Kinesio strip, instruct the patient to move the knee into flexion. As the patient moves the knee into flexion, apply the Kinesio strip around the patella to approximately the patella apex.
Lay down the last approximately two inches of the Kinesio strip down with no tension. Initiate glue activation prior to any further movement.

**Option 2:**

*Apply* a mechanical correction technique to limit medial or lateral movement of the patella to reduce friction on plicae. For this demonstration, a correction technique with tension on the tails will be shown. For complete review, see mechanical corrective technique (pg 22).

Begin by applying the base of the Kinesio strip Y cut onto the medial aspect of the patella with no tension.

With one hand, hold the base to ensure no tension is added during application. One tail is applied with moderate to severe tension (50-70% of available) and inward pressure along the inferior pole of the patella. The second tail is applied with similar tension and inward pressure along the superior pole of the patella.

Before the patient moves the knee, make sure to activate the glue.

The last approximately 1 inch of the tails is applied with no tension.
Osgood-Schlatter and Larsen-Johannson Syndrome

Osgood-Schlatter syndrome is an apophysis of the patella ligament from its insertion onto the tibial tuberosity in an adolescent patient. Larsen-Johannson syndrome is an apophysis of the patella ligament from its origin on the inferior pole of the patella. Both are characterized by localized swelling, pain, and point tenderness of either the insertion or origin of the patella ligament.

There are several Kinesio Taping® Techniques which may provide reduced inflammation and pain; the practitioner will need to determine which technique is best for their patient. If one technique does not provide significant results, another technique may.

Option 1:

For acute pain relief, a mechanical correction strip may be applied in an attempt to "hold down" the apophysis of the tibial tuberosity or inferior pole of the patella. If using this technique for Larsen-Johannson, do not apply too much pressure as to alter patella tracking. For review, see mechanical correction technique (pg 22).

Place the patient's knee in slight flexion. Begin by tearing the paper backing of a 4-6-inch long Kinesio I strip in the middle. Holding both ends, apply a mechanical correction with moderate to severe tension (50-75% of available) and inward pressure to the center of the Kinesio strip over the tibial tuberosity or inferior pole of the patella.

Prior to laying down the Kinesio strip ends, have the patient move the knee into full extension. Lay down the ends with no tension.

Option one may be applied first, and then a second Kinesio Taping® Technique may be applied over that. The patient may find the greatest pain relief during acute pain phases from a combination of taping techniques. Then, as the patient's pain is reduced, only one technique may be indicated.

Option 2:

Apply a patella tendonitis I strip. For complete review, see Patella Tendonitis I Strip Technique (pg 156).
Option 3:
Apply a patella tendonitis superior Y technique. For review, see patella tendonitis (pg 158).

Option 4:
Apply a patella tendonitis inferior Y technique. For review, see patella tendonitis (pg 158).

Option 5:
Apply a patella tendonitis superior and inferior Y technique. For review, see patella tendonitis (pg 158).

Option 6:
Apply a patella tendonitis U strip. For review, see patella tendonitis (pg 158).
Anterior Cruciate Ligament Kinesio Technique

The Anterior Cruciate Ligament (ACL) of the knee is most commonly injured as the result of extension and rotation forces. The ACL may be injured by itself or in combination with the medial collateral ligament, medial meniscus, or lateral meniscus. When the ACL is sprained, there is generally an associated joint effusion which occurs. The joint effusion causes a loss in range of motion and delays the rehabilitation of the injured knee joint.

The acutely injured ACL will be treated by reducing the joint effusion with a lymphatic correction. Following the acute injury, a modified ligament correction technique may be used to provide proprioceptive stimulation to reduce anterior translation of the tibia on the femur.

During the first 24-72 hours, apply a lymphatic corrective technique to the anterior aspect of the knee. Three fan strips should be applied.

The first lymphatic fan strip should start from approximately the medial epicondyle of the femur and wrap across the patella to the lateral aspect of the knee.

The second lymphatic fan strip should start from approximately the lateral epicondyle of the femur and wrap across the patella to the medial aspect of the knee. This will create a fan-like pattern over the anterior aspect of the knee.

For complete review, see lymphatic correction application (pg 39).

The third lymphatic fan strip should start inferior or superior to the popliteal fossa on the posterior aspect of the knee. It should extend inward over the popliteal fossa and end approximately mid-belly of the gastrocnemius muscle.

An optional elastic compression dressing may also be worn to reduce initial effusion. For an example of compression dressing, see medial collateral ligament correction technique (pg 33).

Either during acute phase or post-acute phase, the practitioner may apply a quadriceps superior Y technique from origin to insertion to facilitate muscle contraction.

For complete review, see patella tendonitis technique (pg 156).
Post-acute phase, after 72 hours

Apply a modified ligament correction technique from the tibial tuberosity to both the medial and lateral epicondyle of the femur to limit anterior translation of the tibia on the femur.

Begin by measuring an I strip from approximately 4 inches above the medial epicondyle around the tibial tuberosity to 4 inches above the lateral epicondyle.

Tear the Kinesio Tex paper backing in the middle. Place the middle of the Kinesio I strip onto the tibial tuberosity with no tension.

Place the patient's knee in approximately 20-30 degrees of flexion. Peel back the paper backing, leaving enough so you can grip the tape without placing your hand on the glue. Apply a ligament correction technique with 75-100% of available tension to both strips equally along the medial and lateral collateral ligaments pushing the tibia in a posterior direction.

For complete review see ligament correction technique (pg 33).

Lay down the ends of the I strip with no tension. Initiate glue adhesion prior to any further patient movement.

It may be appropriate to use a 3-inch-wide Kinesio strip for larger or stronger patients.

An optional technique may be to apply a second strip which has an overlap of the first Kinesio strip. This may be required for larger patients or to provide a more significant proprioceptive stimulation.
Medial Collateral Ligament Correction

Following a grade 1 to grade 3 MCL/LCL ligament sprain, use the ligament correction strip across the length of the ligament, applying the tape from distal to proximal. The practitioner may choose to apply a lymphatic correction to assist with edema reduction from the knee region to the thigh or inguinal lymph nodes.

The tension of the Kinesio strip should be greatest over the length of the ligament to provide sensory stimulation to the proprioceptive receptors. The tension transferred to the receptors will provide the perception of a more stable joint. The Kinesio strip should be applied as soon as possible following the injury. After the tape is applied, continue with treatment protocol, including application of ice, elevation, compression, and hinged brace support. The Kinesio strip can be worn during all phases of rehabilitation and can be placed under any additional taping the practitioner feels would be appropriate.

Acute Phase: 24-72 hours

Application of lymphatic corrective technique. For review see lymphatic correction technique (pg 39).

Lymphatic drainage should be directed to posterior medial aspect of knee.

Apply strip one by placing the base of the lymphatic correction on the inferior aspect of the medial condyle of the knee. Direct the fan strips over the medial collateral ligament.

The second lymphatic correction technique should be placed slightly inferior to the first strip. The fans should form a criss cross pattern over the MCL.

Before beginning the corrective strip, first estimate the line of the corrective strip to assist in application. Begin base of ligament correction strip slightly below the tibial tuberosity with no tension on the base.

For review, see ligament correction technique (pg 33).

Place one hand on the base of the correction strip prior to applying tension to the Kinesio strip. Apply desired ligament correction tension (50-75% of available) over the length of the ligament. When the Kinesio strip has passed the end of the ligament, have the patient move into as much knee flexion as possible.

Move the hand holding the initial base strip to the end-of-tension point. Lay the end of the Kinesio strip down with no tension.

Completed application of ligament technique for the medial collateral and lateral collateral ligament; during acute phase of MCL/LCL injury.
Optional compression dressing (TubiGrip, TetraGrip) may also be worn during acute phase.

**Post Acute: After 72 hours**

**Option 1:**

*Completed* application of ligament correction technique as described in acute technique for the MCL ligament acute phase.

**Option 2:**

*Apply* a quadriceps superior Y technique from origin to insertion to assist with quadriceps muscle contraction. For complete review see patella tendonitis (pg 156).

**Option 3:**

*Apply* a hamstring technique from origin to insertion to facilitate hamstring contraction. The practitioner may determine it is desirable for the hamstring to relax; for this technique apply an insertion to origin technique.
Option 4:
Apply a modified mechanical correction technique tension on base, using three tails instead of two. For complete review, see mechanical correction technique (pg 22).

Start with the patient in knee extension. Place the base of the Kinesio strip posterior to the posterior fibers of the medial collateral ligament with no tension. Hold the base with one hand; with the other hand apply 50-100% of available tension, with inward pressure over the MCL. When the Kinesio strip has passed over the ligament, have the patient move into a mid-joint flexion. Lay down the tails with no tension. The tails are splayed out to minimize tension.

Complete application of ligament correction technique as described in acute technique for the MCL ligament acute phase, over the modified mechanical correction technique as described above.
Knee Hyperextension

A hyperextension injury to the knee is a common injury resulting from the knee being forced past 0 degrees of extension (for females normal extension position may be up to +3 degrees). Generally, the knee has marked edema with pain occurring in extension.

The Kinesio Taping® Technique will include a lymphatic corrective taping to reduce acute edema, a basic hamstring muscle taping, and a functional correction to limit knee extension during the acute phase.

Application of the lymphatic corrective technique to the popliteal fossa. For complete review, see lymphatic correction application (pg 33). Two strips will be applied.

Photo on left: Begin strip one inferior to the lateral condyle of the femur and cross over the popliteal space, ending above the region of swelling.

Photo on right: Begin second strip inferior to the medial condyle of the femur and cross over the popliteal space, ending above the region of swelling.

The two lymphatic corrective strips should form a crisscross pattern over the popliteal space, applying 25% or paper-off tension.

Apply the functional corrective technique to limit knee extension.

For complete review, see functional correction technique (pg 37).

The degree of knee extension to limit is determined by the practitioner during evaluation. The desired result would be limitation of knee extension just short of a painful position by the patient.

Place the bases of the functional correction approximately 4 inches above and below the knee; more than one strip may be required. Make sure to hold the two bases when the patient moves into knee extension.

For complete description, see functional correction (pg 37).

Application of the hamstring muscle basic Kinesio Taping® Technique: The desired result will be decreased muscle spasm in the hamstring muscle from overextension during forced knee hyperextension. The hamstring should be taped using the insertion-to-origin method.

Method demonstrated has the taped prior to the hamstring taping.
Meniscus Of The Knee

An injury to the meniscus of the knee generally presents itself with pain during movements of extension and rotation. There will be joint line pain and, in chronic meniscus lesions, a meniscal cyst. An increased incidence of meniscus lesions occur to the medial meniscus due to its attachment to the medial capsule. Injury generally results from knee extension and rotation.

The Kinesio Taping® Method will assist by reducing joint effusion and pain. Optional treatments may include basic Kinesio muscle techniques for muscle weakness.

Acute Treatment

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective techniques. For complete review, see lymphatic corrective technique (pg 39).

The location of the lymphatic corrective strips is determined by the practitioner during the evaluation. Generally, the lymphatic fan tails should form a crisscross pattern over the area of effusion. Applying 25% of available or paper-off tension.

Option For Space Correction

Apply a space correction technique to either the lateral or medical aspect of the knee depending upon the patient’s symptoms. For complete review, see space correction technique (pg 29).

Begin by placing the patient’s knee in full extension. Tear the middle of a 4-6-inch Kinesio I strip's paper backing. Apply light tension (25% of available) to the Kinesio strip, and apply directly over the area of pain as indicated by the patient.

Lay down the two ends of the Kinesio I strip without tension. Initiate glue activation prior to any further patient movement.

A series of two to three strips may be applied. An optimal technique may also incorporate the donut hole technique.
Option for Increased Muscle Contraction of the UMO

Appication of Kinesio strip Y technique for vastus medialis origin to insertion technique. This is to assist a weakened vastus medialis resulting from effusion.

Option for Rectus Femoris

Appication of Kinesio strip Y technique for rectus femoris, superior Y technique: For complete review, see patella tendonitis (pg 156).

Option for Proprioceptive Stimulation Or Stability

Appication of the Kinesio patella tendonitis U strip. For complete review, see patella tendonitis (pg 156).

For additional options see Osteochondrosis of the Knee, Patella Tracking Syndrome, Subluxating Patella, or Chondromalacia Patella.
Osteoarthritis or Chronic Effusion of the Knee

Osteoarthritis is a degeneration of the articular surfaces within a joint. In the knee, it may be associated with normal degenerative changes from chronic impact loading caused by high levels of physical activity. Chronic knee effusion is a primary sign and its cause may be unknown. The resulting chronic joint effusion will cause continuing degenerative changes and decreased muscle function.

The Kinesio Taping® Method will assist by reducing effusion and joint pain. For additional options, see Patella Tracking Syndrome, Subluxating Patella, or Chondromalacia.

Acute Phase - 24 To 72 Hours: Option 1: Application of the Web Cut Strip.

For complete review, see Space Correction (pg 29). Cut the Kinesio strip into 4, 5, 6, or 8 strips. The Kinesio Tex® Tape is cut allowing for each end to remain uncut. There are two techniques for applying the web cut.

Technique 1: Begin by placing the patient in a mid-joint position. Apply one base, remove the web strips, and apply the second base.

Technique 2: Place patient in midjoint position. Tear paper backing off the webcut strip.

Apply very light tension (15-25% of available). Place strips along desired area.

Repeat the above step for medial and lateral space correction. The practitioner may determine that one, two, or all three strips are appropriate. Activate glue prior to movement.

Option 2: Application of Lymphatic Correction Strips

For complete review, see Lymphatic Correction (pg 39). Strip one begins inferior to the lateral condyle of the femur and ends superior and medial to the patella.

Strip two begins inferior to the medialcondyle and ends superior and lateral to the patella. The two strips should make a crisscross pattern.

An optional elastic compression dressing may also be worn to reduce initial effusion.

Apply of the Kinesio Y strip Taping Technique for a hamstring, origin-to-insertion technique.

This strip is applied to decrease hamstring tension resulting from a flexion contracture caused by chronic knee effusion. For review, see Hamstring Technique (pg 143).
Post Acute Phase: Option 1: Patella Tendonitis Superior Y Technique

Application of the Kinesio Taping® Method for a Patella Tendonitis Superior Y Technique, origin to insertion. For review, see Patella Tendonitis (pg 156).

Option 2: Patella Tendonitis Inferior Y Technique

Application of the Kinesio Taping® Method for a Patella Tendonitis Inferior Y Technique, origin to insertion. For review, see Patella Tendonitis.

Option 3: Patella Tendonitis U Strip Technique

Application of the Kinesio Taping® Method for Patella Tendonitis-U Strip Technique: For review, see Patella Tendonitis (pg 156).

This technique can be modified so the strip is shorter and does not go all the way up to the vastus medialis and lateralis muscles. The Kinesio I strip application can end approximately 2 inches above the superior pole of the patella.

Completed application of the Kinesio Taping® Technique for Osteoarthritis or Chronic Effusion of the knee.
Bursitis of the Knee

Bursitis of the knee can result from acute trauma or chronic overuse resulting in inflammation of either the prepatellar or infrapatellar bursa.

Inflammation of the prepatellar bursa generally results from acute trauma. Evaluation of this bursa is generally indicated by edema above the knee (superior to the patella).

The Kinesio Taping® Technique will assist in reduction of edema and pain. During the first 24 to 72 hours of an acute trauma to a bursa of the knee, the primary goal is to limit inflammation; the prepatellar bursa will be demonstrated in this section.

Acute Phase - 24 to 72 hours:
Option 1:
Apply the web cut strip. For complete review see space correction technique (pg 29).

Cut the Kinesio strip into 4, 5, 6, or 8 strips. The Kinesio Tape is cut allowing for each end to remain uncut.

Technique 1: Begin by placing the patient in a mid-joint position. Apply one base, remove the web strips, and apply the second base.

Repeat the above step for medial and lateral space corrections. The practitioner may determine that one, two, or all three strips are appropriate. Activate glue prior to movement.

Technique 2: Tear the paper backing of a 4-6 inch Kinesio strip in the center and peel away the paper backing. Hold one base in each hand and apply very light tension (15-25% of available) or paper-off tension to the fan cuts while trying to separate the fans prior to placement. Place the patient in a mid-joint position, and apply the fan strips with the mid-section of the fan applied to the center of the area to be treated. Lay down the tails without any tension, and activate glue prior to any further movement.

Technique 3: Begin by placing the patient in a mid-joint position. Applying one base, remove the web strips, and apply the second base.

Initiate glue prior to any patient movement. Place in midjoint, gently separate the web, then lay down the web.

Repeat the above step for medial and lateral space corrections. The practitioner may determine that one, two or all three strips are appropriate.
Acute Phase - 24 To 72 Hours:
Option 2:
Two lymphatic correction strips will be applied. For complete review see lymphatic correction technique (pg 39).
Strip one begins below the medial condyle of the femur and ends superior and lateral to the patella, applying 25% of available or paper-off tension.

Strip two begins below the lateral condyle of the femur and ends superior and lateral to the patella. The 2 strips should make a crisscross pattern.
An optional elastic compression dressing may also be worn to reduce initial effusion.

Post-acute Phase - Past 72 Hours
Application of a space correction I strip technique. For complete review, see patella tendonitis I strip technique (pg 157).
This strip acts as a space correction technique to create space between the skin and bursae to allow for edema reduction. For complete review see Space Correction Technique (pg 29).
The Kinesio I strip is started over the tibial tuberosity with no tension and the patient in full knee extension. One hand holds the base to ensure no tension is added to the Kinesio strip.

Light tension (15-25 % of available) is applied to the Kinesio strip while the patient moves from extension into flexion. The Kinesio I strip is applied along the patella ligament and over the patella.
Move the hand holding tension on the tibial tuberosity to the superior aspect of the patella, which was the end of tension point on the Kinesio I strip.
Lay down the remaining approximately 2 inches of Kinesio Tex with no tension. Activate glue prior to any additional movement by the patient. Convolutions should be evident unless too much tension was applied.
Pes Anserinus Bursitis Or Tendonitis

Pes Anserinus Bursitis or Tendonitis is an inflammation to the common insertion into the tibia of the semitendinosus, gracilis, and sartorius muscles. The inflammation is generally caused by overuse and is most commonly caused by running on slopes. It has been associated with individuals who present with genu valgum and weakness of the medial muscles of the knee.

The Kinesio Taping® Technique will assist with pain and inflammation reduction. The three muscles which make up the pes anserinus will be taped with an additional space correction or mechanical correction technique.

Due to the amount of tape which will be applied for this technique, it is important to apply the correction technique first. The deepest layer of Kinesio Tex® Tape applied is the most effective.

Application of modified lymphatic correction technique. For complete review, see lymphatic correction technique (pg 39).

Begin with a fan cut into 4 strips. Place the patient’s knee in extension. The base of the fan strip should be placed inferior to the insertion of the pes anserine muscle group and pes anserine bursae.

The first strip is placed along the line of the adductor magnus muscle with very light (25%) or paper-off tension.

Have the patient move into 20-30 degrees of flexion. The second strip is placed superior to the first, allowing for space between the first and second strip directly over the area of inflammation.

Strip three is placed approximately mid-thigh with the tape angled to end on the lateral aspect. Prior to application of strip four, have the patient move into as much flexion as possible. Strip four crosses over the lower 1/3 of the thigh and should be laid down in a U-shape pattern, ending along the lateral border of the patella.
Completed application of the modified lymphatic correction strip. During initial stages of inflammation or with minimal inflammation, the practitioner may determine that this is the only Y strip required for treatment.

Semitendinosus muscle application with insertion to origin technique using a 1-inch I strip of Kinesio Tex® Tape.

Gracilis muscle application with insertion-to-origin technique using a 1-inch strip of Kinesio Tex® Tape.

Sartorius muscle application with insertion-to-origin technique using a 1 inch strip of Kinesio Tex® Tape.
Completed application of insertion-to-origin taping technique for the muscles which make up the pes anserine, with modified lymphatic technique.

Optional: Application of mechanical correction technique, tension on tails: For review, see Mechanical Correction Technique (pg 22).

The desired effect is to limit the movement of the pes anserine tendon over the pes anserine bursae. The practitioner may select to use a fascia or space correction depending upon their evaluation.

Apply base of Kinesio Y strip on medial border of popliteal space and gather skin under the hand holding the base of the Y.

Apply light to moderate tension (25-50% of available) tension and inward pressure as the skin is gathered under the hand holding the base of the Kinesio Y strip. As the Kinesio strip crosses over the pes anserinus, slide hand holding base to the point of end tension. Have the patient move their knee into flexion. Lay down the tails of the Kinesio Y strip with no tension. The tails should be splayed around the patella to dissipate the tension created.

Prior to any additional movement, initiate glue activation.

Completed application of the pes anserinus bursitis or tendonitis.
Runner’s or Cyclist’s Knee

Runner’s or Cyclist’s Knee is a general term used to describe several conditions of the knee resulting from overuse and overtraining. Examples of related conditions that are commonly referred to as runner’s knee are pes anserinus tendinitis, iliotibial band friction syndrome, and patella tracking syndrome. The practitioner will need to determine which tissues are involved and devise an appropriate treatment protocol.

The Kinesio Taping® Technique will assist by reducing effusion, pain, muscle imbalance, and possible patella tracking malalignment.

Option 1:
Completed Kinesio Taping application for Pes Anserine Bursitis or Tendonitis. For complete description, see Pes Anserine Bursitis or tendonitis (pg 184).

Option 2:
Completed Kinesio Taping application for Iliotibial Band Friction syndrome. For complete description, see Iliotibial Band Friction Syndrome (pg 145).

Option 3:
Completed Kinesio Taping application of Patella Tracking Syndrome. For complete description, see patella tracking syndrome (pg 160).
Section 9

Ankle & Foot
Plantar Fasciitis

Plantar Fasciitis is an inflammation of the plantar aponeurosis. Pain and inflammation are generally felt at its origin on the epicondyle of the calcaneus (anterior aspect of calcaneus).

Two strips are applied to the plantar surface of the foot. Strip one, using a fan cut, will be placed along the length of the plantar aponeurosis with full tension removed. On the plantar surface, full tension can be removed with little or no irritation to the skin, due to skin thickness. Strip two, using a mechanical correction technique, will be placed across the mid-arch to assist with metatarsal arch support. It is highly recommended that both strips be used. The effectiveness of the technique is compromised with the use of only one strip.

This technique can be applied multiple times. Use of water resistant Kinesio Tex® Tape is recommended. During acute inflammation, the technique should include the Achilles tendon and plantar aponeurosis for maximum effect.

Measure the entire length of Kinesio Tex® Tape from the metatarsal heads to approximately 2 inches above the musculotendinous junction of the gastrocnemius and Achilles. On one end, cut a 4-strip-fan technique from the metatarsal heads to the calcaneal tubercle. When first utilizing this technique, remember that all of the tension will be removed from the Kinesio Tex® Tape, so cut your strip a little shorter than measured.

The Kinesio strip paper backing is torn just superior to the fan. The Kinesio strip is begun on the heel with the foot in dorsiflexion.

While holding the tape which has been applied to the heel to ensure no tension will be added to the tape, apply tension over the Achilles tendon. Apply a tendon correction technique using moderate tension (50% of available) over the Achilles. For review, see correction technique (pg 22).

When the Kinesio strip has reached the musculotendinous junction, lay down the end of the Kinesio strip with light tension (25% of available) until the last two inches, which are laid down with no tension. Activate glue prior to any further movement.

Keeping the foot in dorsiflexion, begin by applying severe to full tension (75-100% of available) on one of the five strips which have been cut. Place this strip from the calcaneus to the space between the first and second ray (toe) on the metatarsal head. Make sure you activate the glue before additional strips are placed.
Continue the same process by placing a strip of Kinesio Tex® Tape between the second and third, then third and fourth, and lastly fourth and fifth toes.

The second Kinesio strip is a metatarsal arch mechanical correction. For review, see Metatarsal Arch Technique (pg 210).

Have the patient move into foot dorsiflexion, and apply the base of the Kinesio I strip with no tension near the 5th metatarsal base on the lateral aspect of the foot. The edge of the Kinesio strip begins on the base of the 5th and finishes up the shaft of the bone.

Prior to tape application you may want to initially estimate the path of the Kinesio strip to assist in proper placement. The Kinesio strip is angled for the tarsal metatarsal joint on the medial aspect of the foot.

Have the patient relax their foot. Apply light to moderate tension (25-50% of available) from the base of the 5th metatarsal to the tarsal navicular joint region. The Kinesio strip is applied using the mechanical correction technique, with tension and inward pressure. The amount of tension and inward pressure is determined by the practitioner and the size of the patient.

When applied correctly, the patient’s foot should show signs of “crinkles” in the metatarsal arch region.

Completed Plantar Fasciitis Kinesio Technique.
Achilles Tendonitis or Tenosynovitis

Achilles’ Tendonitis is an inflammation to the Achilles tendon which is formed from the gastrocnemius and soleus muscles. The tendonitis is generally located within the distal 1/3 of the Achilles tendon close to its insertion into the calcaneus. The inflammation generally occurs from overuse activity.

Achilles Tendonitis will be treated with three Kinesio strips. The first strip will be a tendon correction placed on the Achilles tendon. If the tendonitis is in acute phase, the practitioner may want to combine the tendon correction strip with the plantar fascia strip. Since the Achilles tendon and the plantar fascia are a continual layer of connective tissue, both may need to be treated to be most effective. The second strip will be a Y strip for the gastrocnemius muscle. The optional third strip is placed upon the plantar surface of the foot to anchor the two previous strips and aid in increased tape application length.

Begin by measuring a strip of Kinesio Tex® Tape from the musculotendinosus junction of the soleus and Achilles tendon to the base of the metatarsal head on the plantar surface of the foot. Cut one end of the Kinesio strip with a fan technique for placement on the plantar aponeurosis. Tear the paper backing just past the end of the fan cut and place this on the heel of the patient. Remember to make sure the Kinesio strip is long enough to go approximately two inches beyond the musculotendinosus junction.

Apply the Kinesio fan strip onto the base of the plantar surface.

For review, see Plantar Fasciitis Technique (pg 190).

Place the foot in dorsiflexion. With one hand, hold the Kinesio strip which has been placed on the calcaneus to limit any tension in this region. Apply a tendon correction technique with light to moderate (25-50% of available) to the Kinesio strip over the Achilles tendon. At the musculotendinosus junction, decrease tension to light (25% of available) or paper-off tension. Lay down the tail of the Kinesio strip with no tension.
Begin the second Kinesio Y strip slightly over the anterior aspect of the calcaneus.

Maintain the ankle and foot in a dorsiflexed position. Apply the medial strip of the Y cut around the medial head of the gastrocnemius. This is an insertion-to-origin technique using very light to light tension (15-25% of available) or paper-off tension.

If during the evaluation of the Achilles Tendonitis, the practitioner determines there is muscle weakness, an-origin-to-insertion application would be appropriate.

The third strip is placed on the plantar surface of the foot to assist in the adhesion of the gastrocnemius Kinesio strip application. This strip is optional as it does not add to the effectiveness of the technique. It does, however, assist in holding the gastrocnemius strip in place, which may increase the length of time the technique can be worn.

For this tape application, the practitioner may select the water resistant Kinesio Tex® Tape to limit the detrimental effects of the high moisture concentration in the foot region.
Completed Achilles Tendonitis Kinesio Taping application.

Acute Achilles tendonitis with plantar Fasciitis included.

Chronic or optional Achilles tendonitis application.

**Optional:** Application of a mechanical correction along the inferior surface of the calcaneus. Place the patient’s ankle in a neutral position, and place the center of an approximately 6-8-inch Kinesio I strip over the origin of the plantar fascia.

Apply moderate to severe tension (50-75% of available) to the Kinesio I strip in an attempt to elevate the calcaneous in the ankle mortise.

Have the patient move the ankle into plantar flexion and apply the two ends of the Kinesio I strip with no tension.
Retrocalcaneal Bursitis

Retrocalcaneal Bursitis is an inflammation to the retrocalcaneal bursae located behind the insertion of the Achilles tendon and the calcaneous. It may also be referred to as a “pump bump”. Pressure from footwear may cause the inflammation.
The Kinesio Taping® Technique assists in reducing edema and pain.

Application for Acute Injury

Initial treatment for inflammation or edema is provided by applying two Kinesio lymphatic corrective technique strips.

For complete review, see Lymphatic Corrective Technique (pg 39).

Begin by placing the first lymphatic Kinesio fan base approximately 3-4 inches superior and medial to the retrocalcaneal bursae. Angle the fan tails at 45 degrees in an inferior and lateral direction.

The second lymphatic fan base is applied approximately 3-4 inches superior and lateral to the retrocalcaneal bursae. Angle the fan tails at 45 degrees in an inferior and medial direction. Apply 25% of available or paper-off tension.

The fan strips should form a crisscross pattern.

Application for Chronic Injury

Apply a space correction technique to assist in reducing edema.

For complete review, see Space Corrective Techniques (pg 29).

Begin by tearing the center of the paper backing of a 4-6-inch Kinesio I strip. Apply light to moderate tension (25-50% of available) to the exposed Kinesio Tex® Tape. Place the Kinesio strip with applied tension directly over the retrocalcaneal bursae.

Lay down the ends of the Kinesio I strip with no tension.

This technique can be applied either horizontal or vertical to the retrocalcaneal bursae.
Sever's Syndrome or Apophysitis of the Calcaneus

S severe's syndrome is an inflammation of the insertion of the Achilles tendon into the calcaneus. This insertion point is a traction epiphysis; it may result in a partial avulsion of the epiphysis or cause degeneration from decreased circulation.

The Kinesio Taping® Method will assist in reducing edema and pain.

There are two Kinesio Taping® Techniques which may provide reduced inflammation and pain; the practitioner will need to determine which technique is best for his/her patient. If one technique does not provide significant results, another technique may.

An option which is not shown is to apply the Achilles tendon Kinesio Taping® Technique.

For acute treatment, or during periods of increased inflammation, the practitioner may choose to apply a lymphatic correction technique over the area of inflammation. For complete review, see lymphatic correction technique (pg 39).

Photo on left: application of lymphatic correction from superior medial aspect of the calcaneal apophysis to the inferior lateral aspect.

Photo on right: application of lymphatic correction from superior lateral aspect of the calcaneal apophysitis to the inferior medial aspect.

For acute pain relief, a mechanical correction strip may be applied in an attempt to "hold down" the apophysitis of the calcaneus.

Place the patient's knee in extension with ankle dorsiflexion. Begin by tearing the paper backing of a 4-6-inch long Kinesio I strip in the middle. Holding both ends, apply a mechanical correction with moderate to severe tension (50-75 % of available) with inward pressure to the center of the Kinesio strip over the insertion point of the Achilles into the calcaneus.

For complete review, see mechanical correction technique (pg 22).

Have the patient remain in knee extension and ankle dorsiflexion, and lay down the ends with no tension.

This technique may be applied first, and then a second Kinesio Taping® Technique may be applied over it. The patient may find the greatest decrease in pain during acute pain phases from a combination of taping techniques. Then, as the patient's pain is reduced, only one technique may be indicated.
Lateral Ankle Sprain

A sprain to the lateral ligaments of the ankle (anterior talofibular, calcaneofibular, and posterior talofibular) is the most common location for a sprained ankle. Lateral ankle sprains are generally considered to account for approximately 90% of all ankle sprain injuries. The most commonly injured ligament in the ankle is the anterior talofibular.

Treatment of a lateral ankle sprain consists of edema reduction in an acute injury, maintenance of muscle strength, proprioceptive stimulation, and prophylactic taping to reduce recurrence. The treatment of an acute ankle sprain should be thought of as occurring in stages. Acute, 24-72 hours: minimize edema. Post-acute, when acute post traumatic symptoms subside: return patient to pre-injury level of activity.

The following is derived from the article, “A New Approach to the Management of Ankle Sprains”, by Jayson Goo, MA, ATC, Head Athletic Trainer at the University of Hawaii. If your profession does not allow you to use electrical modalities, eliminate those steps from your treatment protocol.

Acute (0-24 Hours)

**RICE** (Rest, Ice, Compression, and Elevation)

**Crutches:** Proper fitting and instructions

**Electric Stimulation:** First 24 hours: Microcurrent 0.3Hz. for 10 minutes followed by 1 Hz for 10-20 min.

**Corrective Kinesio Taping:** Anterior, Posterior, Medial, and Lateral Lymphatic drainage strips. If the patient wears footwear which may affect the application of the Kinesio strips, modify the lymphatic correction appropriately.

**Home Care Instructions:** Patient should be sent home with crutches, appropriate compression (elastic bandage or compression dressing), and, if indicated or allowed, pain medication. When at home, the patient should keep the ankle elevated and apply ice for 20 minutes once per hour. If it is not possible to ice the ankle, it is recommended that the patient keep the ankle elevated and apply continual compression. If compression and/or elevation become painful, have the patient cycle periods of compression and elevation. Instruct the patient to gently plantar and dorsiflex their ankle in a pain free range of motion. If the patient is able to, have them spell the alphabet with their toes. The patient should sleep with a compressive dressing, single thickness, from below the knees and extending over the toes (TUBIGRIP or TetraGrip)

Acute (24-72 Hours)

**Electric Stimulation:** 24 hours to post-acute: Interferential or Pre-mod at 80-150 Hz.

**Lower Leg Lymphedema Massage:** 10 minutes anteriorly, 5 to 10 posteriorly, 5 to 10 minutes anteriorly

**Range of Motion (ROM):** Active to active resistive as tolerated, 3 X 12 plantar flexion and dorsiflexion. For inversion sprain, eversion. Inversion if it is an eversion sprain.

**Whirlpool:** Cold Whirlpool while wearing compression, 10 to 20 minutes

*Repeat the above treatment protocol several times per day if possible. Continue RICE.*

CLINICAL THERAPEUTIC APPLICATIONS OF THE KINESIO TAPPING® METHOD Page 197
Acute (0-72 Hours) Treatment Of Lateral Ankle Sprain

Lateral view of lymphatic corrective technique. For review, see Lower Leg Lymphedema (pg 153).

Medial view of lymphatic corrective technique to the anterior, posterior, medial and lateral aspects of the lower leg.

Use of appropriate compression over the lymphatic corrective technique. A “horseshoe” made of 1/2 inch orthopedic felt in a U shape has been applied over the lateral malleolus. Covered by a light compressive dressing (TUBIGRIP, TetraGrip)

Post Acute (When Traumatic Symptoms Subside)

**Electric Modalities:** As indicated prior to treatment

**Lower Leg Lymphedema Massage:** 5 to 10 minutes posteriorly, 5 to 10 minutes anteriorly

**Corrective Kinesio Taping Application:** Once the edema/swelling has been reduced, may only use anterior lymphatic drainage strip.

**Contrast Whirlpool:** Contrast treatment initially from cold to warm whirlpool. May start patient in cold whirlpool for 4 minutes and hot for 1 minute, repeat cycle 5 times and end in cold whirlpool. As edema is reduced, use 3 cold - 2 hot, next 2 1/5 cold - 2 1/5 hot, next 3 hot and 2 cold, next 4 hot and 1 cold. Each
treatment pattern is used for 1 to 2 days and, as edema is reduced, can initiate more hot than cold whirlpool treatments.

**Range of Motion (ROM):** Active movements as listed in acute treatment.

**BAPS (balance) board:** Clockwise rotations, counterclockwise rotations, dorsi/plantar flexion, inversion and eversion.

**Progressive Resistance Exercises (PRE):**
- Graduating resistance as tolerated by patient
  - 3 x 20 dorsiflexion
  - 3 x 20 dorsiflexion/external rotation
  - 3 x 20 dorsiflexion/internal rotation (eversion sprains only)
  - 3 x 20 plantar flexion
  - 3 x 20 plantar flexion with femur internally rotated
  - 3 x 20 plantar flexion with femur externally rotated

**Slantboard:** 3 minutes, use a board with increasing angle of inclination to stretch posterior compartment muscles (gastrocnemius, soleus), which become shortened due to lack of movement.

**Stabilization:** Stand on toes of injured foot for a total of 3 minutes, with the longest repetition being no longer than 1 minute.

**Cardiovascular Training:** Minimum of 30 minutes daily.

**Open Kinetic Chain Exercises:** When able to walk with normal gait, may begin straight line jogging and sport specific exercises as indicated by patient tolerance.

**Electric Modalities:** As indicated following treatment.

**Kinesio Taping® Method Application:** Basic Kinesio Taping for muscles as indicated by mechanism of injury or weakness. Application of Correction Techniques to assist limitation of injury.

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**Post - Acute (When Acute Treatment Symptoms Subside)**

Apply lymphatic corrective technique to lateral aspect of the ankle.

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**Post - Acute Basic And Corrective Technique Application**

Basic Kinesio Technique application for gastrocnemius muscle to assist in plantar flexion range of motion and limit muscle weakness.

As the patient progresses, a tendon correction may be applied over the Achilles tendon to assist with movement.
Basic Kinesio Technique application for tibialis anterior muscle to assist in dorsiflexion and limit muscle weakness.

Basic Kinesio Technique application for peroneus longus and/or brevis muscle to assist in ankle eversion and limit muscle weakness.
Medial Ankle Sprain

A sprain to the medial ligaments of the ankle (deltoid) occurs as the result of ankle eversion. This involves the large thick deltoid ligament located on the medial aspect of the ankle and the stability of the ankle mortise during eversion motion.

Treatment of medial sprains consists of edema reduction during acute phase of injury, maintenance of muscle strength, proprioceptive stimulation, and prophylactic taping to reduce recurrence. For a complete treatment protocol, refer to lateral ankle sprains.

A common occurrence with medial ankle sprains is the loss of the medial longitudinal arch resulting from injury.

A prophylactic traditional athletic taping can be applied to limit re-injury. For complete description, see Lateral Ankle Sprain Combination Technique.

Apply a lymphatic corrective technique to the medial aspect of the ankle joint. For complete review, see Lymphatic Corrective Technique (pg 39).

Use a basic Kinesio Technique application for posterior tibialis muscle to assist in inversion range of motion and limit muscle weakness.
Two modifications can be made to the basic technique. **One**, apply a metatarsal arch technique to assist in maintaining the metatarsal arch and medial longitudinal arch. For complete description, see metatarsal arch technique (pg 210).

**Two**, apply an Achilles tendonitis technique to assist in reducing stiffness which may result from the patient’s inability to move their ankle during acute injury phase. For complete review, see Achilles Tendonitis Technique (pg 192).
Peroneal Tendon Subluxation

A subluxation of the peroneus longus and brevis tendons can result following an inversion injury to the ankle. These two tendons pass through a common groove located on the posterior lateral aspect of the fibula. They are held in the groove by the peroneal retinaculum. During forced inversion this retinaculum may rupture as the result of significant peroneal tendon contraction to limited forced inversion.

The Kinesio Taping® Technique will use a mechanical correction to apply resistance to the subluxation of the peroneal tendons from their common groove.

Prior to Kinesio Tex® Tape application, place the patient in ankle dorsiflexion and eversion. Instruct the patient to hold the ankle in this position. Place one hand on the posterior lateral aspect of the lateral malleolus in the region of the peroneal aponeurosis. Apply a plantar flexion and inversion force, feeling for a subluxation of the peroneal tendon on the malleolus.

Begin by placing the Kinesio Y strip on the anterior aspect of the lateral malleolus with no tension on the base, anterior to the location of the subluxing peroneal tendon. Have the patient move into dorsiflexion and eversion.

The base of the Kinesio Y strip is applied with no tension. Apply very light tension (15% of available) up to the point of the peroneal tendon subluxation location. Apply a mechanical correction technique with 50-75% of available tension to the tails. The superior tail is placed slightly above the peroneal subluxation. No tension is applied to the last approximately one inch of the tail. For complete review, see Mechanical Correction Technique (pg 22).

The inferior tail of the mechanical correction strip is placed slightly below the peroneal subluxation. No tension is applied for the last approximately one inch of the tail.
Optional: Application of the peroneal tendon subluxation technique with a space correction for edema during acute phase or chronic phase.

Begin with a Kinesio strip with a “donut hole” cut out, which will surround the lateral malleolus over the base of the 5th metatarsal. Apply the base with no tension.

Have the patient move into plantar flexion with inversion. Apply light to moderate tension (25-50% of available) to the Kinesio strip over the area of the peroneal aponeurosis. After the tape has been applied over the area of edema, lay down the remaining tape with very light (25% of available) or paper-off tension. The ends are laid down without tension.
Hallux Valgus

Hallux Valgus is associated with forefoot varus, which is evident from the 1st ray splaying in a varus direction. The cause of hallux valgus is generally associated with footwear that is too narrow or too short or has high heels. This condition is also recognized as hereditary and is more common in women than men.

The elastic qualities of the Kinesio Tex® Tape will be used to pull the great toe into a varus position and provide for pain relief from edema reduction.

Best results will be seen with the patient wearing the technique continually for several weeks to months.

Two options will be shown; the practitioner should try each technique to determine which application is most effective for each patient.

Option 1:

Begin by placing the base of a Y strip on the great toe, with the split in the Y cut slightly above the 1st metatarsal phalangeal joint. Apply light to moderate tension (25-50% of available) to the lower strip in a varus direction, with the tail running slightly below the 1st ray. The second strip is applied slightly above the 1st ray with similar tension. No tension is applied to either the beginning or end of the Y strip.

This may be modified by using two 1-inch Kinesio I strips in place of the 2-inch Kinesio Y strip.

Place a second Y strip on the plantar surface of the metacarpal phalangeal joint, with no tension. With one hand, hold this base strip with no tension.

Using a mechanical correction technique, apply a mechanical correction with moderate-to-severe tension (50-75% of available) first in an upward, then lateral direction. The intention is to pull the 1st metacarpal phalangeal joint into a varus position. The degree of tension will need to be determined by the practitioner.
Option 2:
Begin by placing a Kinesio Y strip base near the tarsometatarsal joint with no tension. With the superior tail, apply a mechanical correction (25-50% of available) surrounding the metatarsal phalangeal joint to pull it into a varus position. With the inferior tail, apply similar mechanical tension with the desire to pull the metatarsal phalangeal joint into a plantar direction.

A second Kinesio Y strip is applied with the base starting at approximately the lateral edge of the 5th metatarsal head. A mechanical correction is applied with the tension bringing the 1st metatarsal into a plantar flexed and varus position.

A second Kinesio Y strip, slightly smaller, may be placed over the first Kinesio Y strip to further assist in varus tension.

The next strip applied is a Kinesio strip with a “donut hole” cut-out, and two to three tails cut into the last 1 1/2 inches of the strip. This strip is trying to affect the rotational component of Hallux Valgus. The base of the donut hole strip is placed superior to the 1st MCP joint. The donut hole is placed over the MCP joint with mechanical tension.

The practitioner may select to assist this movement by applying plantar flexion and abduction force to the 1st ray using moderate to severe tension (50-75% of available).

Lay the remainder of the donut hole strip down with little or no tension on the plantar surface of the foot.
Hammer Toe

Hammer toe can be a congenital abnormality or it can be caused by improperly fitting footwear. The most common location for a hammer toe is the second or third toe; if more than one toe is involved it is generally referred to as clawed toes. It manifests itself as overly tightened flexor tendon and overstretched extensor tendons.

The Kinesio Taping® Technique will assist by reducing edema and pain and limiting flexion of the phalanx.

Apply the functional correction technique to limit distal phalanx flexion. For review, see Functional Correction Technique (pg 37).

Begin by measuring a Kinesio I strip from the plantar surface of the distal tip, over the toe nail and continuing to the metatarsal phalangeal (MTP) joint of the hammer toe.

Place one end of the Kinesio I strip on the plantar surface of the injured joint and wrap around to the tip of the dorsal surface of the hammer toe, with no tension.

With one hand, hold the base which has been applied to the distal phalanx tip to ensure no tension will be added. Place the patient’s toe into as much flexion as possible. Apply severe-to-full tension (75-100% of available) to the Kinesio I strip, laying down the Kinesio I strip on the dorsum surface of the hammer toe. Apply tension until the Kinesio I strip is approximately 1 inch below the MTP joint.

Lay down the remaining approximately 1-inch with no tension.

A second functional correction strip may be applied, depending upon the size of the individual and the amount of toe movement limitation desired.

Apply anchors at both the tip of the hammer toe and as close to the MTP joint as possible. This will assist in providing better support and will prevent the Kinesio Tex® Tape from coming off the skin due to the high tension used during application.
Dislocation of Toe

Dislocated phalanges are a fairly common injury to physically active patients. Although they are not common in comparison to overall injuries which result from being physically active, they are generally very painful and few treatment options currently exist.

Anytime a dislocation occurs, it is important to refer the patient to a physician to evaluate the injury. The Kinesio Taping® Technique will provide pain relief, reduce inflammation by use of lymphatic correction, provide joint stability with ligament correction, and use a functional correction to limit flexion or extension.

The practitioner may enhance the patient's comfort by recommending a stiff-soled shoe or boot to minimize forefoot movement.

Apply a lymphatic correction technique to the dorsal surface, plantar surface, or both.

For complete review, see Lymphatic Correction (pg 39). The lymphatic correction should form a crisscross pattern over the area of specific patient pain or area of greatest joint effusion. Apply light tension (25% of available).

Apply a ligament correction technique to the region in which the dislocation or fracture is located. For complete review, see ligament correction (pg 33).

If the dislocation was dorsal, apply the ligament correction using severe to full tension on the dorsal aspect of the toe. Apply the correction strip to these regions in a crisscross pattern.

For a more complete description, see Dislocation of Finger (pg 128).

Photo on left: an application of a functional correction to limit toe flexion. For complete review, see Functional Correction.

Photo on right: an example of a completed Kinesio Taping® Technique for a dislocated toe.

The practitioner may select to modify the technique by adding a “buddy” taping technique.

For complete review, see Finger Dislocation.
Turf Toe - Hyperextension of Great Toe

Turf Toe is the hyperextension of the metatarsophalangeal joint (MTP). It is generally caused by the toe being hyperextended or forced into an extended position. This may result from pushing off during activity, or having the shoe “stick” to the surface, as may occur with artificial turf (Astroturf).

The patient will present with pain on toe extension, swelling, and possible discoloration of the MTP joint. They will have pain in weight bearing and toe push off. The desired outcome of the Kinesio Taping® Technique is to limit toe extension and provide support of the MTP joint. Pain in the joint will also be reduced by reducing edema, and joint motion will be reduced by application of a functional correction.

Begin by moving the great toe into extension to determine the position where the joint becomes painful. Prior to tape placement, the practitioner should place the joint in a non-painful position and, using the elasticity of the tape, minimize joint motion past the painful point.

Place the base of the first Kinesio I strip tape which should be 1 inch in width, at the distal tip of the great toe. Apply moderate-to-severe tension (50-75%) on the Kinesio strip as the tape is applied from the tip of the great toe to the MTP joint and down to mid plantar surface. Two to three strips will be required, with each successive strip moving in an overlapping pattern toward the medial aspect of the MTP joint.

Apply a figure 8 strips of 1-inch Kinesio Tex® Tape starting on the inferior aspect of the 1st MCP toe. Continue the strip around the dorsal surface of the great toe, applying slight inward tension but be careful not to pull the toe into a varus position. Continue the strip over the MTP joint and over the dorsum of the foot, angling for the base of the 5th metatarsal. As you cross over the plantar surface of the foot, angle the tape back toward the MTP joint. This strip is to provide plantar flexion pressure to assist the joint capsule and to control joint movement.

Optional: Apply a functional correction application to limit toe movement into extension.

For complete review, see Functional Correction Technique (pg 37).
Metatarsal Arch

The metatarsal arch is located at the head of the metatarsals and helps dissipate forces resulting from movement. The size of this arch can be reduced either through acute injury or chronic overuse. When this arch is not providing sufficient support, the metatarsal heads will absorb more force during activity than they are accustomed to. Calluses may form, and stress fractures may develop.

Using a mechanical correction technique, an I strip will be placed across the mid-arch to assist with metatarsal arch support.

The practitioner may want to use the water resistant Kinesio Tex® Tape due to the amount of moisture present in the arch region.

Begin by placing a Kinesio Y strip with the base located inferior to the insertion of the plantar fascia with no tension. With one hand, hold the base to ensure no tension is added. With moderate to severe tension (50-75% of available) apply one tail along the first metatarsal to the MCP joint, the last approximately one inch is applied with no tension. The second tail follows the 5th metatarsal with base placement on the MCP joint.

Initiate glue activation prior to any further movement.

Have the patient relax the foot. Apply light to moderate tension (25-50% of available) from the base of the 5th metatarsal to the tarsal navicular joint region. The Kinesio strip is applied using the mechanical correction technique, with tension and inward pressure. The amount of tension and inward pressure is determined by the practitioner and the size of the patient.

More than one Kinesio strip may need to be applied, depending upon the size of the patient.

Completed Metatarsal Kinesio Technique.

When applied correctly, the patient’s foot should show signs of “crinkles” in the metatarsal arch region.
Interdigital (Morton’s) Neuroma

Morton’s neuroma is an enlargement of the myelin sheath which surrounds an interdigital nerve located between the heads of the metatarsals. The myelin sheath becomes enlarged and entraps the nerve, causing intermittent numbness. The most common location for this condition is the 3rd interdigital nerve, which is located between the third and fourth toes.

Treatment usually consists of widening the space between the metatarsal heads, thus reducing pressure on the interdigital nerve. This can be done by having the patient wear loose fitting shoes, elevating the metatarsal heads directly under the neuroma, and reducing of inflammation.

The Kinesio Taping® Technique assists in reduction of inflammation or edema.

Photo on left: Optional application of modified plantar fascia strip with possible smaller fan strips in the area of the neuroma. For complete description, see Plantar Fasciitis (pg 190).

Photo on right: Kinesio I strip is cut with a button hole technique. The Kinesio Tex® Tape is cut with two or three diamond shaped holes in the middle of the Kinesio strip, large enough to allow for a toe to fit within the space. For complete description of button hole technique, see carpal tunnel syndrome (pg 111).

Apply the Kinesio I strip with light to moderate tension (25-50% of available) on the dorsal surface of the foot while toes are in flexion. This provides for the skin stretch required to create convolutions.

Have the patient move the toes into extension, and apply the remainder of the Kinesio strip onto the plantar surface of the foot, with light-to-moderate tension (25-50% of available).

An optional anchor may be placed to hold the buttonhole strip in place.
Section 10

Combination Tapings
Achilles Tendonitis Combination Technique

The Achilles Tendonitis Kinesio Taping® Method will be combined with the traditional Achilles tendon taping technique. The traditional Achilles tendon technique is designed to both limit foot dorsiflexion and assist in foot plantar flexion. This is accomplished by using an elastic tape such as Elastoplast or Elastikon. Utilize by anchoring the Kinesio Taping® Technique and filling in with thinner elastic tape, (Lightplast or Sheerlight).

It will be useful to have the patient wear the Kinesio Taping® Technique at all times and apply the traditional Achilles tendon technique during activity. After several days, only the Kinesio Taping® Technique may be necessary.

Completed application of the Kinesio Achilles tendonitis technique. For review, see Achilles Tendonitis Technique (pg 192).

Begin by placing the foot in a neutral position. Move the foot into a dorsiflexed position until the patient indicates where the pain begins. The practitioner will want to tape the foot in a slightly more plantar flexed position to limit the patient's ability to move into a painful position.

Place a lubricating pad over the heel and lace region of the ankle to minimize friction. Apply prewrap (underwrap) over the pads and Kinesio Taping® Technique.

Place anchors both on the plantar surface and slightly above the musculotendinous junction of the Achilles and gastrocnemius. It is preferable that the anchors be a thin elastic tape to allow for expansion of the muscles during exercise. If nonelastic white tape is used, only use strips which go 1/2 way around the muscle, then complete the anchor with a second strip going around the muscle.
Using a 2-inch elastic tape (Elastoplast or Elastikon), begin by placing the base of the tape on the anchor on the plantar surface of the foot. Have the patient relax their foot. Apply tension to the elastic tape, pulling the foot into plantar flexion. The amount of tension to add is the amount needed to allow for enough dorsiflexion to be physically active but enough to allow for movement into a painful position. Attach the elastic strip of tape onto the anchor located slightly above the musculotendinous junction.

Repeat the above step two to three times depending upon the size of the patient. If the patient seems too large for two to three strips of 2-inch elastic tape, a 3-inch elastic tape may be used.

Have the patient move the foot into a neutral position (90 degrees). Use a thin elastic tape, such as Lightplast or Sheerlight, to cover in the area and anchor the already applied strips. Be careful not to apply too much tension with the elastic tape that normal tissue expansion is constricted during exercise.

A nonelastic white tape can also be used to cover up or fill in. Only use 1/2 strips around the joint to limit constriction of the muscle complex during activity.

Completed combination of Kinesio Achilles Tendonitis Technique and traditional Achilles' tendonitis taping technique.
Acromioclavicular Joint Combination

This technique will combine the Kinesio Taping AC joint technique with external protection. Following the application of the Kinesio Taping® Technique for the AC joint and appropriate rest and rehabilitation, the practitioner may determine that additional protection is required for the patient for return to activity.

The external protection may be in the form of a commercially produced AC pad, which usually includes a cut-out or raised area (donut) directly over the AC joint. A second option is the fabrication of a pad out of a thermoplastic heat sensitive material, in which a pad or donut is placed directly over the AC. Following the application of the protective pad, additional tape is applied to restrict movement of the pad during activity. The practitioner may select to use additional Kinesio Tex® Tape or a thicker elastic tape such as Elastikon or Elastoplast to hold the pad in place.

Completed application of the Kinesio AC joint technique. For complete review, see Kinesio AC joint application (pg 63).

Application of a commercially available AC protective pad. This particular pad is available with straps to hold the protective padding in place.

To fabricate a thermoplastic heat sensitive protective pad (orthoplast), begin by cutting a piece of material which is larger than the area to be treated. According to the product directions, apply appropriate heat source to soften material.

Heat the thermoplastic material in an appropriate heat source, causing the rigid material to soften.
Place a small foam pad directly over the AC joint and hold in place with tape. The foam should be approximately 1/2 inch thick.

Place the center of the thermoplastic material directly over the pad located over the AC joint. Apply pressure to the thermoplastic material to fit the contours of the skin.

Do not press so hard as to cause pain or further injury to the AC joint.

Apply a closed cell foam on the under surface of the thermoplastic material. Make sure to leave a “donut” or space directly over the raised area which was formed by the foam applied over the AC joint earlier. The foam material should extend about 1/2 inch over the edge of the thermoplastic material.

Around the edges of the thermoplastic material and the closed cell foam, apply an elastic tape to help maintain contact between the foam and plastic material.
Apply several strips of tape over the fabricated thermoplastic pad, making sure to have enough adhesion to the surrounding skin. The additional tape is required to minimize pad migration during activity and/or contact.

Strips of Kinesio Tex® Tape or another elastic tape may be used. Examples of other tapes may include Elastoplast or Elastikon.

Completed combination taping using Kinesio AC Joint Taping and external protection.
Adductor Strain Combination Technique

Combination of the Kinesio Taping® Technique and use of a neoprene sleeve or elastic wrap may be found to be helpful in both the acute and chronic adductor strain.

A strain to the adductor muscle group may result from over-extension or over-contraction. If the muscle is acutely inflamed or weakened, use the insertion-to-origin technique. If the muscle is chronically weakened, use the origin-to-insertion method.

The use of the neoprene sleeve or elastic wrap may assist in limiting pain due to pressure created by elastic qualities of the products. Pressure around an injury limits pain (possibly due to the initiation of the gate control theory of pain).

The duration of tape application will be directly related to the patient's care during application and removal of the neoprene sleeve or elastic wrap.

Completed application of the basic Kinesio Taping® Method application for an adductor strain, origin-to-insertion, with space corrective technique. For review, see adductor strain application (pg 141).

Application of neoprene sleeve wrap over the Kinesio Taping® Method application.

Application of elastic wrap over the Kinesio Taping® Method application. Use a 6-inch double length (10 yd) elastic bandage. Apply a spray adherent to reduce elastic wrap migration. Start application from the farthest point from the heart of the area to be covered. Do not apply with too much tension, this will compromise circulation.
Elbow Hyperextension Combination Technique

Elbow Hyperextension combination taping will combine the Kinesio Elbow Hyperextension Technique with traditional nonelastic white or, if desired, elastic tape (Elastikon or Elastoplast). The use of an elastic tape is not intended to repair an injured ligament or replace appropriate rehabilitation; it is intended to provide proprioceptive stimulation and psychological assurance.

The nonelastic white tape or traditional elastic tape is intended to limit elbow extension past the point of the patient’s pain. This is accomplished through the use of a fan or check-rein applied over the antecubital fossa. Care must be taken to not restrict the biceps or forearm muscles from expansion during physical activity. If expansion is limited, cramping may result.

Completed application of the Kinesio Hyperextension Technique. For complete application review, see elbow hyperextension technique (pg 100).

The elbow should be clean, shaven and cleansed of any oils or lotions, placed in a position in which any further extension will cause pain. Lubrication would be appropriate in the antecubital space. Spray adherent should be applied to limit migration of the tape. An underwrap (prewrap) may be applied, however it is highly recommended that the anchors be directly applied to the skin. Apply anchors approximately mid-biceps and mid-forearm using a thin elastic tape (Sheerlight or Lightplast). If white tape is used be careful to allow for expansion of muscle tissue during activity.

Begin placement of check-rein strips starting from the medial lateral aspect of mid-forearm to the medial aspect of mid-biceps, pulling in an upward direction. The strips should be placed in a series which, when completed, will form a fan or checkrein.

Nonelastic white tape may be preferable for fan use, since it does not allow for any increased motion following application.
Begin placement of second check-rein strip from the medial aspect of mid-forearm to the lateral aspect of mid-biceps, pulling in an upward direction.

The third strip is started from below the ante-cubital fossa in the mid-forearm to the mid anterior aspect of the biceps. The strips should be placed in a series, which when completed will form a check-rein.

Generally a minimum of two check-reins are applied. For a larger patient, a third may be required.

Anchor the check-rein application by using thin elastic tape (Lightplast or Sheerlight), starting from the mid-forearm and ending at the mid-biceps. Enclose all open and exposed areas with the light elastic tape.

Remember that when the light elastic tape is used to “fill in” the exposed areas, do not apply too much tension, as this may compromise circulation.

Completed combination of Kinesio Elbow Hyperextension Technique with traditional nonelastic or elastic tape.

Optional: application of a neoprene sleeve to assist in limitation of elbow extension.
Hamstring Strain Combination

Combination of the Kinesio Taping® Technique and use of neoprene sleeve or elastic wrap may be helpful for both acute and chronic hamstring strain.

Begin by applying the Basic Kinesio Taping® Technique for the hamstring strain. During the evaluation of the injury, the practitioner will need to determine which of the hamstring group is involved (semimembranosus, semitendinosus, or biceps femoris). It may be helpful to apply a space or mechanical correction strip directly over the area of injury.

The use of the neoprene sleeve or elastic wrap may assist in limiting pain due to pressure created by the elastic qualities of the products. Pressure around an injury limits pain possibly due to the initiation of the gate control theory of pain.

The duration of tape application will be directly related to the patient’s care during application and removal of the neoprene sleeve or elastic wrap.

Completed Application of Basic Kinesio Taping® Application of a Hamstring muscle with additional Space or Mechanical Correction strip.

The correction strip is placed directly over the injured area.

Application of neoprene sleeve over the Kinesio Taping® Application.

Application of an elastic wrap over the Kinesio Taping® Application.
Hip Pointer or Iliac Crest Contusion Combination

This technique will combine the Kinesio Taping® Technique for Hip Pointer or Iliac Crest contusion with external protection. Following the application of the Kinesio Taping® Technique for hip pointer or iliac crest and appropriate rest and rehabilitation, the practitioner may determine that additional protection is required for the patient.

The external protection may be in the form of a commercially produced hip pointer pad or Acromioclavicular pad, which usually includes a cut-out or raised area (donut) directly over the iliac crest. A second option is the fabrication of a pad out of a thermoplastic heat sensitive material to be placed directly over the iliac crest. Following the application of the protective pad, additional tape is applied to restrict movement of the pad during activity. The practitioner may elect to use additional Kinesio Tex® Tape or a thicker elastic tape such as Elastikon or Elastoplast.

Completed Application of the Kinesio Taping® Technique for Hip Pointer or Iliac Crest.

For complete review, see hip pointer or iliac crest (pg 138).

Application of a commercially available AC protective pad. This particular pad is available with straps to hold the protective padding in place.

The pad is used directly over the iliac crest and may require the use of an elastic tape to maintain its position.

Place a felt or foam donut over the contusion on the ilium. Pad should be slightly larger than the area of pain.
To fabricate a thermoplastic heat sensitive protective pad (orthoplast), begin by cutting a piece of material which is larger than the area to be treated.

According to the product directions, apply appropriate heat source to soften the material.

Place the center of the thermoplastic material directly over the pad on the iliac crest. Apply pressure to the thermoplastic material to form the plastic material to the contours of the skin.

Do not press so hard as to cause pain or further injury to the iliac crest.

Place a closed-cell foam pad over the plastic material leaving a "hole" over the raised area directly over the injured tissue. The foam should extend a minimum of 1/4 inch over the edge of the plastic material.
Around the edge of the closed cell foam and the plastic material, place a 2-inch strip of tape. This is to limit the separation of the foam from the plastic material.

Apply several strips of tape over the fabricated thermoplastic pad, making sure to have enough adhesion to the surrounding skin. The additional tape is required to minimize pad migration during activity and/or contact.

Strips of Kinesio Tex® Tape or another elastic tape may be used. Examples of other tape include Elastoplast or Elastikon.

Completed combination taping using Kinesio Hip Pointer or Iliac Crest Contusion Taping and external protection.
Knee Hyperextension Combination

Knee Hyperextension Combination Technique will combine the Kinesio Knee Hyperextension Technique with traditional nonelastic white or, if desired, elastic tape (Elastikon or Elastoplast). The use of an elastic tape is not intended to repair an injured ligament or replace appropriate rehabilitation; it is intended to provide proprioceptive stimulation and psychological assurance.

The non-elastic white tape or traditional elastic tape is intended to limit knee extension past the point of the patient’s pain. This is accomplished through the use of a fan or check-rein applied over the popliteal fossa. Care must be taken to not restrict the hamstring or gastrocnemius muscles from expansion during physical activity. If expansion is limited, cramping may result.

Completed application of the Kinesio Hyperextension Technique.

For complete review, see Knee Hyperextension Technique (pg 177).

The knee should be clean, shaven and cleansed of any oils or lotions and placed in a position in which any further extension will cause pain. Lubrication would be appropriate in the popliteal space. Spray adherent should be applied to limit migration of the tape. An underwrap (prewrap) may be applied; however, it is highly recommended that the anchors be directly applied to the skin.

Apply anchors approximately mid-thigh and mid-calf using a thin elastic tape (Sheerlight, Lightlast). If white tape is used, only apply 1/2 strips to allow for expansion of muscle tissue during activity.

Begin placement of strips starting from the mid-calf to the mid-thigh, pulling in an upward direction. The strips should be placed in a series, which when completed will form a fan or check-rein.

If a traditional elastic tape (Elastikon, or Elastoplast) is used, make sure all tension is removed prior to tape application.

Non-elastic white tape may be preferable for use in the fan, since it does not allow for any increased motion following application.
Begin the second strip on the inferior posterior medial aspect of the calf below the knee. The strip should be angled across the popliteal space and end on the posterior lateral aspect of the thigh.

Begin the third strip on the inferior posterior lateral aspect of the calf below the knee. The strip should be angled across the popliteal space and end on the posterior medial aspect of the thigh.

Normally, two to three strips are used for each of the three strips. The number depends upon the size of the athlete and the degree of knee extension limitation desired.

**Two options for completion**

*Option One:* Anchor the fan application by using nonelastic tape or traditional elastic tape. Only anchor above and below the knee joint.

If white non-elastic tape is used, only apply 1/2 circular strips to allow for muscle expansion during activity.

*Option Two:* Anchor the fan application by using thin elastic tape (Lightplast or Sheerlight) starting from the mid-calf and ending at the mid-thigh. Enclose all open and exposed areas with the light elastic tape.

Remember that when the light elastic tape is used to “fill in” the exposed areas, do not apply too much tension, as this may compromise circulation.
Lateral Ankle Sprain Combination

A sprain to the lateral ligaments of the ankle (anterior talofibular, calcaneofibular, and posterior talofibular) is the most common location for a sprained ankle. Lateral ankle sprains are generally considered to account for approximately 90% of all ankle sprain injuries. The most commonly injured ligament in the ankle is the anterior talofibular.

Treatment of a lateral ankle sprain consists of edema reduction in the acute injury, maintenance of muscle strength, proprioceptive stimulation and prophylactic taping to reduce recurrence. The treatment of an acute ankle sprain should be thought of as occurring in stages. Acute, 24-72 hours, minimize edema. Post-acute, when acute post traumatic symptoms subside: aim to return patient to pre-injury level of activity.

The following is derived from an article, “A New Approach to the Management of Ankle Sprains”, by Jayson Goo, MA, ATC, Head Athletic Trainer at the University of Hawaii. If your profession does not allow you to use electrical modalities, eliminate those steps from your treatment protocol.

Optional: Application of ligament correction for anterior talofibular ligament, using a figure of 8 pattern and one lateral heel-lock around the ankle. Begin the non-elastic white athletic tape on the medial aspect of the ankle at approximately the tarsal navicular joint. Apply light tension (25% of available) across the plantar surface of the foot. Aim the non-elastic white athletic tape for the anterior aspect of the lateral malleolus.

Application is shown over pre-wrap (underwrap).

As the non-elastic white athletic tape rounds the lateral aspect of the ankle, hold the tape onto the skin with one hand. Over the anterior talofibular ligament, apply a ligament correction technique with 75-100% of available tension over the ligament. Move the hand which was holding the tension on the lateral aspect of the foot to the superior aspect of the lateral malleolus.
Decrease tension to light tension (25% of available) once you pass the anterior aspect of foot.

Continue the non-elastic white athletic tape onto the medial aspect of the ankle with an angle which crosses back over the initial starting point of the strip. The strip continues back onto the plantar surface of the ankle and angles towards the lateral aspect of the heel.

As the non-elastic white athletic tape angles from the plantar surface onto the lateral aspect of the heel, again increase tension to ligament correction, using 75-100% of available tension over the posterior talofibular ligament. End the non-elastic white athletic tape by finishing on the medial aspect of the ankle near the superior aspect of the medial malleolus, forming a figure of 8 pattern.
Medial /Lateral Collateral Ligament Combination

The use of an elastic tape is not intended to repair an injured ligament or replace appropriate rehabilitation. It is intended to provide proprioceptive stimulation and psychological assurance. The following description is the combination of the Kinesio ligament corrective technique and prophylactic elastic taping of the injured ligament. It is recommended that the patient wear the Kinesio Tex® Tape at all times and only during practice or competition should the prophylactic taping be applied.

At any time if the patient indicates that they are not confident and have not been able to demonstrate functionally their ability to perform, participation in activity should not be recommended.

Completed application of the Kinesio Ligament Corrective Technique.

For complete review, see medial collateral ligament application (pg 174).

The knee should be clean, shaven and cleansed of any oils or lotions and in approximately 30 degrees of flexion. Lubrication in the popliteal space is advised to limit friction. Spray adherent should be applied to limit migration of the tape. An underwrap (prewrap) may be applied, however, it is highly recommended that the anchors be directly applied to skin. Apply anchors approximately mid-thigh and mid-calf using a thin elastic tape (Sheerlight, Lightplast).

If white tape is used, only apply strips in 1/2 circumference to allow for expansion of muscle tissue during activity.

Beginning below the knee, place the first strip medial to the tibial tuberosity and directed at the medial epicondyle of the femur. An attempt should be made to follow the pathway of the medial collateral ligament. Nearly all of the tension should be removed from the elastic tape over the length of the ligament.
The second strip should be placed from the posterior lateral aspect of the calf and directed to the anterior aspect of the femoral condyle.

The third strip should be placed from below the tibial plateau directly below the insertion of the MCL to the superior aspect of the femoral condyle. This pattern should be repeated at least twice. For a larger athlete, the pattern should be repeated three times.

Upon completion of support strips, the complete tape application needs to be covered to minimize migration and unravelling during activity. A light elastic tape should be selected (Lightplast, Sheerlight) and care should be taken not to apply tape with too much tension, which could limit circulation and cause cramping. If white non-elastic tape is used to cover, use only half strips to limit constriction of tissue.

Begin to apply the elastic tape from the calf region to the knee. This will assist in limiting the possibility of applying the tape too tightly, limiting circulation during activity.

The practitioner may want to have the patient also wear a neoprene sleeve or brace over the tape application. If appropriate, the patient may also require a hinged prosthetic device.
Medial/Lateral Epicondylitis Ligament Combination

The use of an elastic tape is not intended to repair an injured ligament or replace appropriate rehabilitation. It is intended to provide proprioceptive stimulation and psychological assurance. The following description is the combination of the Kinesio ligament corrective technique and prophylactic elastic taping of the injured ligament. It is recommended that the patient wear the Kinesio Tex® Tape at all times and only during practice or competition should the prophylactic taping be applied.

At any time, if the patient indicates that they are not confident and have not been able to demonstrate functionally their ability to perform, participation in activity should not be recommended.

The practitioner should select one of the Kinesio medial or lateral epicondylitis taping techniques as described.

Photo on left: option 1 of medial epicondylitis Kinesio Taping® Technique.
Photo on right: option 1 of lateral epicondylitis Kinesio Taping® Technique.

Photo on left: Application of a "cho-pat" type strap inferior to the medial or lateral epicondyle of the humerus. The use of this strap is believed to act as a shock absorber and limit the stress placed on the common muscle group.
Photo on right: This technique may be simulated by using Kinesio Tex® Tape. Apply a mechanical correction directly over the area of pain, using moderate to severe tension (50-75% of available) over the area of pain with inward pressure. Lay down the tails with no tension. This will simulate the cho-pat strap tension, limiting stress on the common muscle group.

Application of neoprene sleeve over the Kinesio Taping® Technique for Epicondylitis. The use of the neoprene sleeve is believed to increase temperature in the region and decrease pain by apply pressure to the region.

The length of time the Kinesio Taping® Technique may remain in place is directly related to the care the patient uses in putting on and taking off the neoprene sleeve.
Medial Ankle Sprain

A sprain to the medial ligaments of the ankle (deltoid) occurs as the result of ankle eversion. This affects the large thick deltoid ligament located on the medial aspect of the ankle and the stability of the ankle mortise during eversion motion.

Treatment of medial sprains consists of edema reduction in the acute injury, maintenance of muscle strength, proprioceptive stimulation, and prophylactic taping to reduce recurrence. For a complete treatment protocol, refer to lateral ankle sprains (pg 197).

A common occurrence with medial ankle sprains is the loss of the medial longitudinal arch resulting from injury (pg 197).

A prophylactic traditional athletic taping can be applied to limit re-injury. For complete description, see lateral ankle sprain combination technique.

Application of ligament correction for the deltoid ligament shown over optional underwrap (pewrap). It is important for the practitioner to be careful in applying the ligament correction to the medial aspect. Do not place the ankle joint into too much inversion, as this may cause the patient to injure the lateral aspect of their ankle during recovery. Begin by applying a mechanical correction technique with the middle of the Kinesio I strip on the base of the calcaneus with no tension.

With one hand, hold the Kinesio strip which has been applied to the plantar surface over the calcaneus. Apply a ligament correction, moderate to severe tension (50-75% of available) up over the medial malleolus and continuing up the shaft of the tibia.

Apply tension while maintaining the ankle in a neutral position to minimize plantar flexion and inversion.

Move the hand which was holding the Kinesio strip up above the medial malleolus and initiate tape adherence. Apply tension while maintaining the ankle in a neutral position to minimize eversion.

Apply a modified figure of eight technique as described in the lateral ankle sprain. For complete description, see lateral ankle sprain combination (pg 197).

The modification is to reverse the angle of pull. Instead of beginning on the medial aspect of the foot, begin on the lateral aspect of the foot, applying tension to the medial aspect of the ankle in the region of the deltoid ligament.
Metatarsal Arch Combination: Low Dye

There are two options for combination taping with the Kinesio Taping® Technique. One, combining the Kinesio Metatarsal Arch Technique with a Low Dye Arch Technique. Second, combining the Kinesio Metatarsal Arch Technique with a traditional Metatarsal Arch Taping.

The Low Dye arch support can be used for the medial, lateral, and metatarsal arches located on the plantar surface of the foot. If the practitioner finds this technique successful, he/she may want to investigate the appropriate use of an orthotic to assist in the long term care of the patient.

Low Dye Technique

Completed Application of the Kinesio Metatarsal Arch Technique. For complete review, see metatarsal arch technique (pg 210).

To begin, you may place optional pieces of moleskin cut to match the 1st and 5th metatarsal heads, with a strip also on the heel region. These strips are to provide skin protection from multiple tape applications.

Place a 1-1 1/2-inch strip of non-elastic athletic tape on the distal head of the 5th metatarsal. Bring the strip of tape around the heel. Place the thumb of one hand between the second and third heads of the metatarsal on the plantar surface. Push the thumb up and flatten out the metatarsal arch. Reach around to the dorsal surface with the index and middle finger to the metacarpal phalangeal joint. Apply inward pressure to the first metatarsal, placing it in a pronated position.
Place the free end of the athletic tape onto the distal head of the 1st metatarsal. This process may be repeated depending upon the size of the patient. For smaller patients, one strip is generally enough. For larger patients, two strips may be needed.

Begin on the plantar surface of the 1st metatarsal head, angle the strip around the heel, and return to the 1st metatarsal head. Repeat this process until a strip is applied to each metatarsal head, or until the metatarsal heads are covered with tape.

One-inch nonelastic tape is used. For a smaller patient, only 4 strips may be required. For a larger patient, 5 strips may be needed.

Apply support strips using 1 1/2 inch athletic tape. Begin the strip by placing it on the lateral aspect of the hind foot, anterior to the calcaneus. With a slight medial pressure, pull across the plantar surface to the medial aspect of the foot. Repeat this process until the plantar surface is covered to the heads of the metatarsals.

Finish the Low Dye by wrapping the arch with a thin elastic tape (Lightplast, Sheerlight) to secure the completed tape job. You may elect to use a white athletic tape for this anchoring. Begin by placing a 1 1/2 inch athletic tape on the posterior medial aspect of longitudinal arch near the calcaneus. Cross the plantar surface to the lateral aspect of the foot. Repeat 3-5 times depending on the size of the patient.
Metatarsal Arch Combination, using Traditional and Kinesio Taping

The technique will combine the two metatarsal arch tapings previously described. The practitioner may select to apply the Low Dye Technique, the Metatarsal Arch Technique, or even the Longitudinal Arch Taping Technique, as described in the Metatarsal Arch Technique (pg 210).

Begin by placing an optional layer of protection for the arch area by applying a prewrap or underwrap over the Kinesio metatarsal arch taping.

Begin a series of 1 to 1 1/2 inch nonelastic athletic tape strips on the medial aspect of the arch. The series of strips should begin at approximately the base of the metatarsal phalangeal joint of the first metatarsal. Place slight tension on the tape as you cross over the plantar surface of the metatarsal arch region. It should produce a slight crinkling of the skin on the plantar aspect when applied correctly. Apply a total of 3 to 4 strips, depending upon the size of the patient.

Application of too much tension may cause cramping or numbness.

Completed combination taping using Kinesio Metatarsal Arch Taping and Traditional Metatarsal Arch Taping.
**Patella Tendonitis Combination Taping/Bracing**

The practitioner may desire to use a combination of the Kinesio Taping® Technique for patella tendonitis and commercially available straps or braces. Some patients may desire additional assistance in the acute inflammation phase or may feel a decrease in pain from the external pressure provided by bracing.

The use of the external strapping or bracing may assist the patient during practice or competition. It is recommended that the patient wear the Kinesio Taping® Technique under any other treatment protocol and when not involved in activity.

At any time, if the patient indicates they are not confident and have not been able to demonstrate functionally their ability to perform, participation in activity should not be recommended.

The practitioner should select one of the Kinesio patella tendonitis taping techniques as described.

Application of a cho-pat type strap over the inferior pole of the patella and directly over the patella ligament. The use of this strap is believed to act as a shock absorber and limit the stress placed upon the patella ligament.

This technique may be simulated by using either Kinesio Tex or an Elastoplast/Elastikon 1 inch tape. Take a piece of the tape, measure around the knee and double the length and add an extra 1 to 1 1/2 inch. Double the tape over itself, leaving only the extra 1 to 1 1/2 inch exposed. Wrap this strip around the knee just below the patella to simulate the above strap.

Application of a neoprene knee sleeve over the Kinesio Taping® Technique for patella tendonitis. The use of the neoprene sleeve is believed to increase temperature in the region and decrease pain by applying pressure to the region.

The length of time the Kinesio Taping® Technique may remain in place is directly related to the care the patient uses in putting on and taking off the neoprene sleeve.
Patella Tendonitis - Combination of Kinesio Corrective Techniques

The practitioner may decide to combine components of the three patella tendonitis techniques. A few examples will be given below. It is important to remember that it is the skill and experience of the Kinesio practitioner which guides the successful use of the Kinesio Taping® Technique.

Combination of the interior Y technique and the I strip.

Combination of the U strip and the inferior Y technique.

Combination of the superior Y technique and the I strip. It is best to apply the superior Y technique first, as this will allow the ends of the Y application to be applied directly to the skin to maximize adhesion.
Plantar Fasciitis Combination Technique

The practitioner may find that for acute plantar Fasciitis, or with patients that are larger than average, they may need to combine the Kinesio Taping® Technique with a plantar fascia moleskin strip or longitudinal arch taping. A third combination could be used: the application of the Low Dye technique as described in the metatarsal arch combination taping technique (pg 210).

Additional therapies may include the use of a donut placed on the heel in the region of pain, heel lift to elevate the heel and shorten the Achilles tendon, and placement of a rigid orthosis in the shoe.

It is recommended that the patient wear the Kinesio Taping® Technique under any other treatment protocol.

Completed application of the Kinesio plantar Fasciitis technique. For review, see Plantar Fasciitis Technique (pg 190).

Plantar Fascia Mole Skin Strip

The plantar fascia moleskin strip can be purchased commercially, or made from moleskin which comes in a roll. The strip should be 2 to 3 inches (5 cm to 7.5 cm) wide, and length should be from insertion point of Achilles tendon to metatarsal heads. Each side of the moleskin strip should have a V cut approximately 1 inch from base.

Place the V shape end above the insertion point of the Achilles tendon into the calcaneus.

Place the thumb of one hand between the second and third heads of the metatarsals on the plantar surface. Push the thumb up and flatten out the metatarsal arch. Reach around to the dorsal surface with the index and middle finger to the metatarsal phalangeal joint. Apply inward pressure to the first metatarsal, placing forefoot in pronated position.
Place the plantar fascia moleskin strip along the plantar surface to the heads of the metatarsals, while maintaining forefoot in pronated position. Lay down the remainder of the moleskin strip.

The moleskin strip will need to be held on the plantar surface of the foot by using a thin elastic tape (Lightplast or Sheerlight).

For comfort, a pre-wrap (underwrap) may be applied first.

Longitudinal Arch Taping Technique

Begin by placing an anchor strip starting from the distal 1st metatarsal phalangeal joint head and ending distally on the 5th metatarsal phalangeal joint. This strip should be applied with minimal or no tension.
Using a 1 inch athletic tape, begin one strip on the base of the plantar surface of the first metatarsal head. Angle the tape to go 45 degrees across the base of the foot, going around the heel, across the foot, and returning to the base of the 1st metatarsal head.

Repeat this process, applying a strip of tape to the 2nd, 3rd, and 4th metatarsals.

Apply support strips by using 1 1/2 inch athletic tape. Begin the strip by placing it on the lateral aspect of the rear foot, anterior to the calcaneus. With a slight medial pressure, pull across the plantar surface to the medial aspect of the foot. Repeat this process until the plantar surface is covered to the heads of the metatarsals.

Cover the longitudinal arch taping with a thin elastic tape, Sheerlight or Lightplast. Prior to application of the tape, place a small piece of prewrap on the dorsum of the foot. This will protect this sensitive area and limit irritation and possible blistering. Covering can also be accomplished by using white non-elastic tape. For review, see metatarsal arch taping (pg 210).
**Quadriiceps Strain/Contusion Combination**

*Combination* of the Kinesio Taping® Technique and use of a neoprene sleeve or elastic wrap may be helpful in both the acute and chronic quadriiceps strain/contusion.

A strain of the quadriiceps muscle group may result from over-extension or over-contraction. If the muscle is acutely inflamed or weakened, use the insertion-to-origin technique. If the muscle is chronically weakened use the origin-to-insertion method.

A contusion to the quadriiceps muscle group needs to be treated with caution. As the largest muscle group in the body, the quadriiceps have a significant blood supply, and injury may result in formation of bony deposits in the muscle (myositis ossificans).

The use of the neoprene sleeve or elastic wrap may limit pain via pressure created by the elastic qualities of the products. Pressure around an injury limits pain possibly due to the initiation of the gate control theory of pain. The length of tape application will be directly related to the patient’s care during application and removal of the neoprene sleeve or elastic wrap.

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**Completed** application of the Basic Kinesio Taping Application of a quadriiceps strain, origin-to-insertion, with space corrective technique. The practitioner may select to use either the basic application, the lymphatic correction, or both. For complete review, see quadriiceps contusion/strain (pg 139).

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Application of neoprene sleeve over the Kinesio Taping® Method application.

Application of elastic wrap over the Kinesio Taping® Method application. Use a 6 inch double length (10 yd) elastic bandage. Apply a spray adherent to reduce elastic wrap migration. Start application from the farthest point from the heart of the area to be covered. Do not apply with too much tension, as this may result in compromised circulation.
Shin Splint or Medial Tibial Stress Syndrome Combination

Combining the Kinesio Taping® Technique with traditional treatments may provide both acute pain reduction and long term positive benefits for shin splints or medial tibial stress syndrome.

Several examples will be given in which the Kinesio Taping® Technique will be combined with traditional treatments (low dye, longitudinal arch, or orthotics). The practitioner will need to evaluate each patient and apply what is, in their opinion, the best course of treatment. If one method is selected and the results are not as effective as desired, try another method.

Completed application of the Kinesio Taping® Technique for shin splints. Two examples are given.

Photo on left: Space Correction pulling away from medial border of tibia.

Photo on right: Space Correction using the base of the Y to pull tissue to the medial border of the tibia.

For complete review, see shin splint application technique (pg 148).

Application of the Kinesio Taping® Technique for shin splints in combination with a low dye technique.

For complete review, see low dye technique, as described in metatarsal arch combination technique (pg 210).

Photo on left: Application of the Kinesio Taping® Technique for shin splints in combination with the longitudinal arch technique. For complete review, see longitudinal arch technique, as described in Plantar Fasciitis combination technique (pg 192).

Photo on right: Application on the Kinesio Taping® Technique for shin splints in combination with orthotics.
Turf Toe Combination Technique

This technique will combine the Kinesio Turf Toe Technique with the use of a moleskin turf toe strap. The moleskin strap is shaped like a T and is designed to limit great toe extension. This is accomplished by the non-elastic qualities of the moleskin and the placement of the strap with the toe in a slightly flexed position. Turf Toe is a very painful condition and return to activity should be based upon the individual's ability to perform functional tasks with minimal or no pain. In addition to the taping techniques, the practitioner may want to place a rigid foot insert made of metal or plastic to limit the extension movement of the first MTP joint.

Completed application of the Kinesio Turf Toe Technique. For complete review, see turf toe technique (pg 209).

Place the patient's great toe in a slightly flexed position which should be prior to the initiation of pain. Place the top of the T moleskin strap on the distal end of the great toe.

The turf toe strap can be purchased pre-made or made out of a sheet of moleskin. It should be approximately 8 inches in length, and 1 to 1 1/2 inch in width, depending upon the size of the patient.

Place the turf toe moleskin strap down the dorsal aspect of the 1st metatarsal shaft. After the strap has been applied, have the patient move their toe into extension to evaluate whether or not the toe is in the proper position.

Be careful not to place the toe in too much of a flexed position, as this may place the toe in a position of risk for a fracture due to excessive motion limitation.
Anchor both ends of the strap. At the toe, an additional Kinesio strip may be used. On the plantar surface, a thin elastic tape, such as Lightplast or Sheerlight may be used.

Optional: Place a support pad made out of closed cell foam under the 1st metatarsophalangeal joint. The pad should have a “cut out” area for the metatarsophalangeal joint to drop down into. This will assist in decreasing pressure on this joint.

Optional: Place a metal plate insert into the forefoot of the patient’s shoe. The metal plate will reduce toe extension and limit joint motion. This will help reduce pain by limiting joint motion.
Valgus Laxity of the Elbow Combination

A chronic valgus laxity of the elbow may develop from repetitive valgus forces being applied to the elbow during overhead activities. The use of an elastic tape is not intended to repair an injured ligament or replace appropriate rehabilitation. It is intended to provide proprioceptive stimulation and psychological assurance. The following description is the combination of the Kinesio Ligament Corrective Technique and prophylactic elastic taping of the injured ligament. It is recommended that the patient wear the Kinesio Taping at all times and only during practice or competition should the prophylactic taping be applied.

At any time, if the patient indicates they are not confident and have not been able to demonstrate functionally their ability to perform, participation should not be recommended.

Completed application of Valgus Laxity of the Elbow with optional biceps brachii. For complete description of application technique, see valgus laxity elbow (pg 96).

The elbow should be clean, shaven and cleansed of any oils or lotions and in approximately 30 degrees of flexion. Lubrication in the antecubital space would be appropriate to limit friction. Spray adherent should be applied to assist in limiting migration of the tape. An underwrap (preshrink) may be applied, however it is highly recommended that the anchors be directly applied to the skin. Apply anchors approximately mid-forearm and mid-humerus using a thin elastic tape (Sheerlight, Lightplast). If white tape is used, only apply strips in 1/2 circumference to allow for expansion of muscle tissue during activity.

Begin below the elbow, placing the first strip from the mid-anterior forearm and directed at the medial epicondyle of the elbow. Nearly all of the tension should be removed from the elastic tape over the length of the ligament.

The second strip should be placed from the posterior medial aspect of the forearm and directed to the lateral mid-forearm of the biceps muscle region.
The third strip should be placed from mid-forearm inferior to the medial epicondyle to superior to the epicondyle in the mid-humerus region. This 3-strip pattern should be repeated at least twice. For a larger athlete, the pattern should be repeated three times.

Upon completion of support strips, the completed tape application needs to be covered to minimize migration and unraveling during activity. A light elastic tape should be selected (Lightplast, Sheerlight), and care should be taken to not apply tape with too much tension, as this may limit circulation and cause cramping. If white nonelastic tape is used to cover, use only half strips to limit constriction of tissue.

Begin to apply the elastic tape from the mid-forearm to the mid-humerus. This will help avoid applying the tape too tightly, limiting circulation during activity.

The practitioner may want to have the patient also wear a neoprene sleeve or brace over the top of the tape application. If appropriate, the patient may also require a hinged prosthetic device.
Wrist Sprain Combination Technique

Wrist Combination Taping will combine the Kinesio Wrist Technique with traditional non-elastic white tape. The use of the non-elastic white tape is not intended to repair an injured ligament or replace appropriate rehabilitation; it is intended to provide proprioceptive stimulation and psychological assurance.

The non-elastic white tape is intended to limit unwanted wrist flexion or extension in a painful range of motion. There are two commonly used traditional techniques to limit wrist movement: circular strips around the wrist and use of a fan or check-rein.

With both techniques, have the patient place the injured wrist in slight flexion or extension (opposite position from the limited motion desired), with fingers extended and spread to limit compression of the hand, resulting in compromise of circulation.

Completed application of the Kinesio Wrist Sprain Technique. For complete review of application, see wrist sprain (pg 120).

Option 1:
Hand is placed in neutral or slight flexion with fingers extended and spread. Prewrap (underwrap) is optional. Begin the 1 1/2 inch white tape on the dorsum of the hand, wrap tape around the palmar side, and return to the dorsum of the wrist.

Repeat the above procedure 3-5 times as indicated by the size of the patient and degree of restriction desired. The degree of tension is determined by the degree of restricted movement and patient tolerance.
Option 2: Tape through the palm.

*Place* the hand as described in option one. Begin by placing anchors 2-3 inches below the wrist and mid-palm of spread hand.

Place the patient's hand in slight flexion (if desired result is to limit extension). Apply fan strips starting at wrist and extending to mid-palm, 4-6 depending upon size of athlete.

Finish by re-anchoring the fan or check-rein.

For more complete description of fan or check-rein application, see elbow or knee hyperextension combination technique (pg 177).
LYMPHATIC TAPING
MALLEOL FINGER
MCL
MECHANICAL TAPING
MEDIAL EPICONDYLITIS
MENISCUS KNEE
METATARSAL ARCH
MORTONS NEUROMA
MYOFASCIAL
NECK SPRAIN
OSGOOD-SCHLATTER
OSTEOCHONDRITIS
OSTEOARTHRITIS
PATELLAFEMORAL
PERONEAL SUBLUXATION
PLANTAR FASCITIS
PILCA OF KNEE
QUADRICEP STRAIN
RETROCALCANEAL
RIB
ROTATOR CUFF
SC JOINT
SCIATICA
SCOLIOSIS
SEVERS SYNDROME
SHIN SPLINTS
SHOULDER INSTABILITY
SI JOINT
SPONDYLOSIS
THORACIC OUTLET
TMI
TROCHANTERIC BURSITIS
TURF TOE
WRIST SPRAIN