1 PATIENT & ASSESSMENT DETAILS

PATIENT **Mr. Sample Posture**	AGE **31 yrs**	SEX **Male**	HEIGHT / WEIGHT · BMI **172 cm / 68 kg · 23.0**
CONSENT **Obtained – 12/10/2026**	ASSESSMENT DATE **12/10/2026**	CLINICIAN **Dr. A. Sample (PT)**	ASSESSMENT **Static Posture Analysis**
FRAMES ANALYSED **4 of 4**	REPORT ID **RX-P20261012-SP-102935**	CHIEF COMPLAINT **Neck and upper-back ache after desk work**	

2 CLINICAL IMPRESSION

MOVEMENT FINDINGS (FOR CLINICAL INTERPRETATION)

Negative Q angle (left)

With rounded (protracted) shoulder (bilateral). Common underlying causes to consider: Genu varum; Medial knee osteoarthritis; Tibial varum.

HEAD & NECK	FRONTAL LEVEL	KNEES
L 63.8° · R 62.1°	**3 / 3 level**	**L (−) 6.5° · R (+) 2.9°**
Craniovertebral angle	Head · shoulders · pelvis	Q angle

3 FINDINGS AT A GLANCE

#	FINDING	SIDE	SEVERITY	MATCH
F1	**Negative Q angle** Tibial tuberosity medial to the extended ASIS–patella line – examine for genu varum	Left	—	Strongly consistent
F2	**Rounded (protracted) shoulder** Acromion forward of C7 (left side: possible)	Bilateral	Major	Strongly consistent

14 measurements



Normal 11 · Minor 1 · Major 2

4 OPTIONS TO CONSIDER (CLINICIAN DECISION)

F1 **Quadriceps and hip strengthening**
Negative Q angle · left · STRONG EVIDENCE

F2 **Pectoralis minor stretching combined with lower / middle trapezius and serratus anterior strengthening**
Rounded (protracted) shoulder · bilateral · MODERATE EVIDENCE

This report is generated from 2D video / photographic measurements and rule-based interpretation against published reference values. Marker placement: manual selection by the assessor (4 frames). Generated by Rollaxis Research & Education Edition for teaching, learning and research only – not for clinical diagnosis or treatment.

SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

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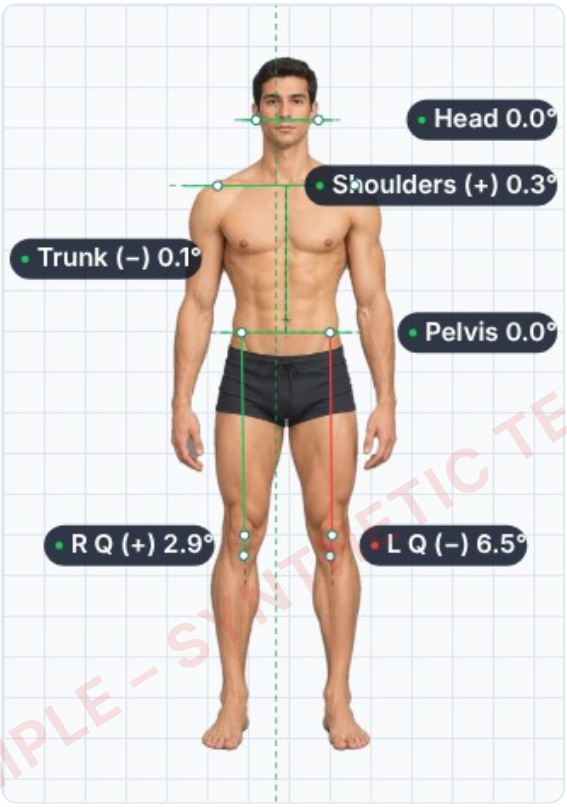
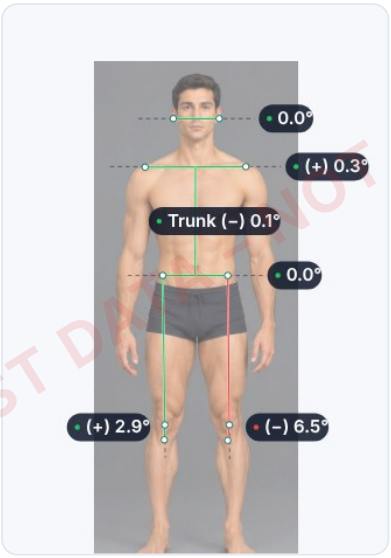
5 FRONT (ANTERIOR) VIEW

MEASURE	MEASURED		REFERENCE RANGE	RESULT
Head tilt (ear-lobe line)	0.0°		(−) 2° to (+) 2°	Normal
Shoulder level (acromion line)	(+) 0.3°		(−) 2° to (+) 2°	Normal
Pelvic level (ASIS line)	0.0°		(−) 2° to (+) 2°	Normal
Trunk shift (frontal plane)	(−) 0.1°		(−) 2° to (+) 2°	Normal
Q angle	**L: (−) 6.5°**	R: (+) 2.9°	Men ≤ 15° · Women ≤ 20°	L Major 6.5° R Normal

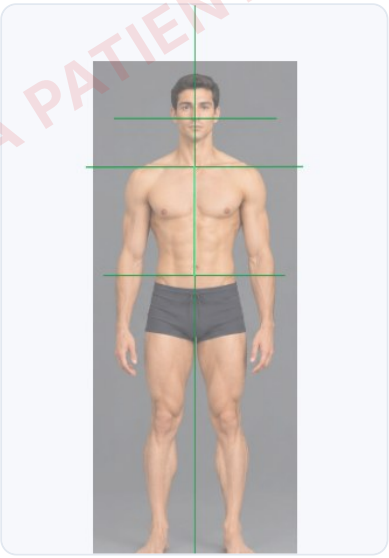
BODY MODEL



ANGLE DEVIATIONS



PLUMB LINES



SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

Head tilt is within the reference range.
Shoulder level is within the reference range.
Pelvic level is within the reference range.
Trunk position is within the reference range.
Left Q angle below 0° (Major Deviation).
Right Q angle is within the reference range.

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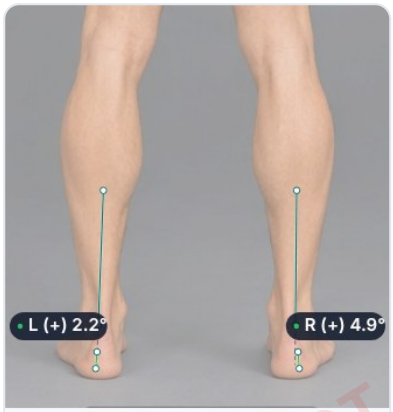
6 BACK (POSTERIOR) VIEW

MEASURE	MEASURED		REFERENCE RANGE	RESULT
Rear-foot angle	L: (+) 2.2°	R: (+) 4.9°	(−) 5° to (+) 5°	L Normal R Normal

BODY MODEL



ANGLE DEVIATIONS



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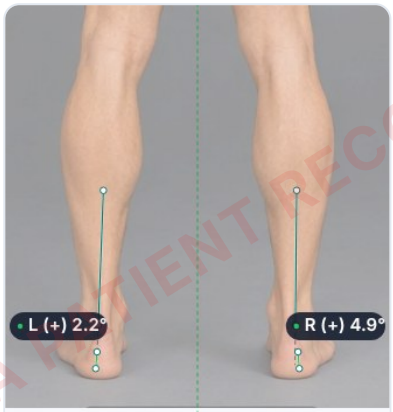

Left rear-foot alignment is within the reference range.
Right rear-foot alignment is within the reference range.

SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

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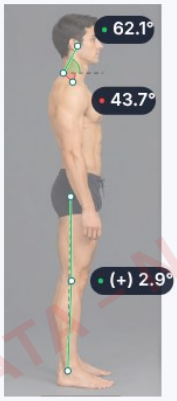
7 RIGHT SIDE VIEW

MEASURE	MEASURED	REFERENCE RANGE	RESULT
Craniovertebral angle (CVA)	62.1°	≥ 50°	Normal
Shoulder angle	**43.7°**	≥ 52°	Major 8.3°
Knee sagittal alignment	(+) 2.9°	(−) 5° to (+) 5°	Normal

BODY MODEL



ANGLE DEVIATIONS



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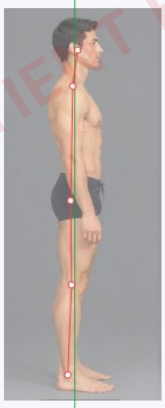


Craniovertebral angle is within the reference range (right view).
Right shoulder protracted (rounded shoulder) (Major Deviation).
Right knee sagittal alignment is within the reference range.

SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

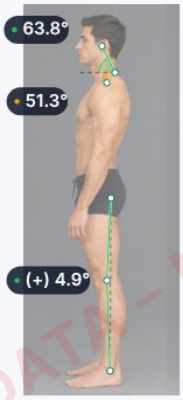
8 LEFT SIDE VIEW

MEASURE	MEASURED	REFERENCE RANGE	RESULT
Craniovertebral angle (CVA)	63.8°	≥ 50°	Normal
Shoulder angle	51.3°	≥ 52°	Minor 0.7°
Knee sagittal alignment	(+) 4.9°	(−) 5° to (+) 5°	Normal

BODY MODEL



ANGLE DEVIATIONS



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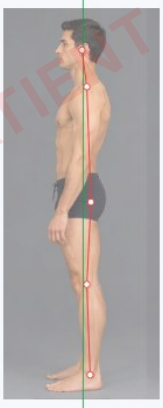


SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

Craniovertebral angle is within the reference range (left view).
Left shoulder protracted (rounded shoulder) (Minor Deviation).
Left knee sagittal alignment is within the reference range.

Photographs in this sample show an AI-generated human model – not a real person.

9 ALL MEASUREMENTS AGAINST NORMAL

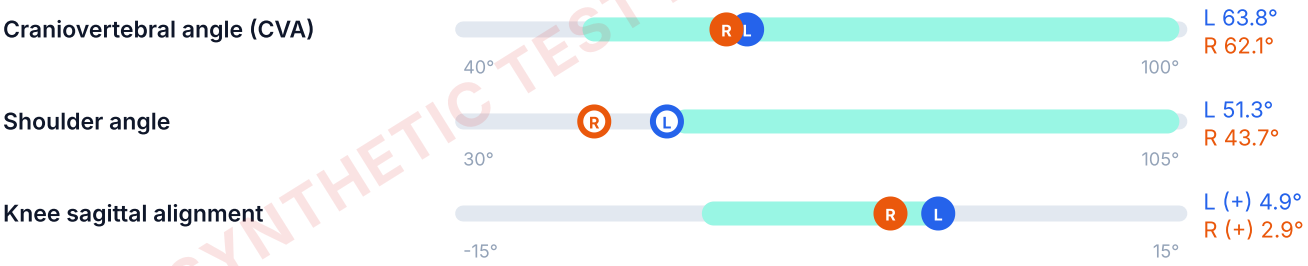
Anterior



Posterior



Lateral



Left · Right · Single value · Normal range · outside normal

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10 INTERPRETATION & MANAGEMENT

F1 Negative Q angle

Strongly consistent

Left · Tibial tuberosity medial to the extended ASIS–patella line – examine for genu varum

The tibial tuberosity lies medial to the extended ASIS–patella line (Q angle below 0°).
Reported associations in the literature (not an individual risk prediction): Medial knee loading (osteoarthritis risk)

WHAT WE MEASURED

- ✓ Q angle below 0°
  Left q angle: (−) 6.5° (ref Men ≤ 15° · Women ≤ 20°)

CONSIDER CAUSES

Genu varum · Medial knee osteoarthritis · Tibial varum

SUGGESTED CLINICAL EXAMINATION

Intercondylar distance · Knee OA screening

TREATMENT OPTIONS (CLINICIAN DECISION)

STRONG EVIDENCE **Quadriceps and hip strengthening**
Exercise is first-line for knee osteoarthritis.

MODERATE EVIDENCE **Footwear review; lateral wedges are not recommended routinely**

STRONG EVIDENCE **Weight management if relevant**

F2 Rounded (protracted) shoulder

Strongly consistent

Bilateral · Acromion forward of C7 (left side: possible)

The shoulder sits forward of C7 (scapular protraction), often with a tight pectoralis minor.
Reported associations in the literature (not an individual risk prediction): Shoulder impingement symptoms, neck and upper-back pain

WHAT WE MEASURED

- ✓ Shoulder angle below 52°
  Right shoulder angle: 43.7° (ref ≥ 52°)
- ✓ Shoulder angle below 52°
  Left shoulder angle: 51.3° (ref ≥ 52°)
- – Forward head posture

CONSIDER CAUSES

Pectoralis minor tightness · Lower / middle trapezius and serratus weakness · Thoracic kyphosis

SUGGESTED CLINICAL EXAMINATION

Pectoralis minor length (supine acromion height) · Scapular dyskinesis test · Shoulder impingement tests if symptomatic

TREATMENT OPTIONS (CLINICIAN DECISION)

MODERATE EVIDENCE **Pectoralis minor stretching combined with lower / middle trapezius and serratus anterior strengthening**
A postural exercise programme reduced forward head and rounded shoulder (Lynch 2010).

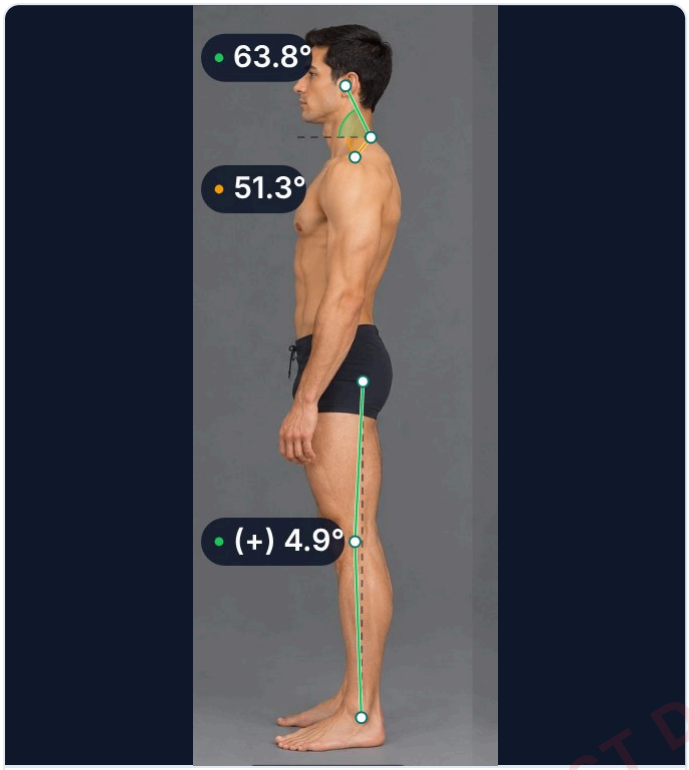
EXPERT OPINION **Thoracic extension mobility**

EXPERT OPINION **Scapular setting cues during daily tasks**

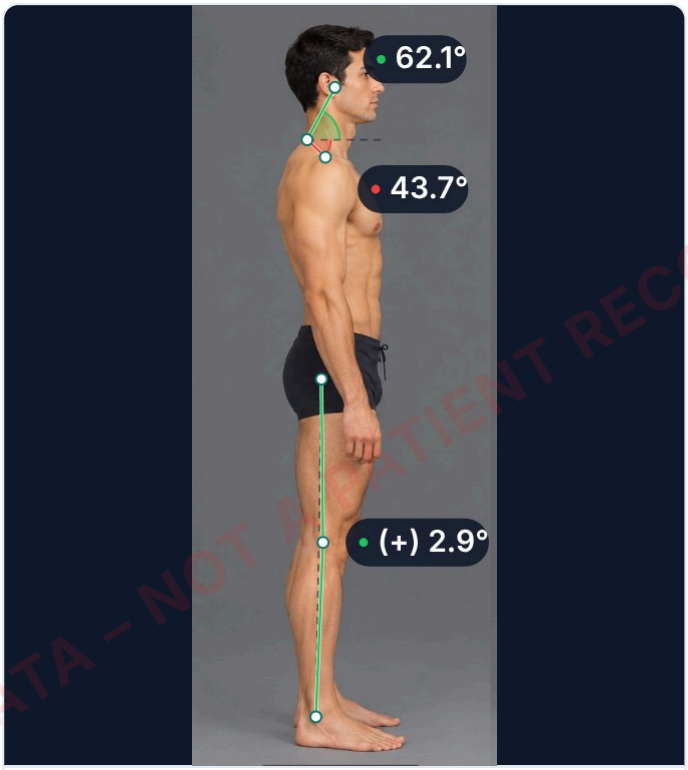
SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

11 PATIENT PHOTOGRAPHS

Original frames with the analysis markers, lines and angles drawn on the photograph.



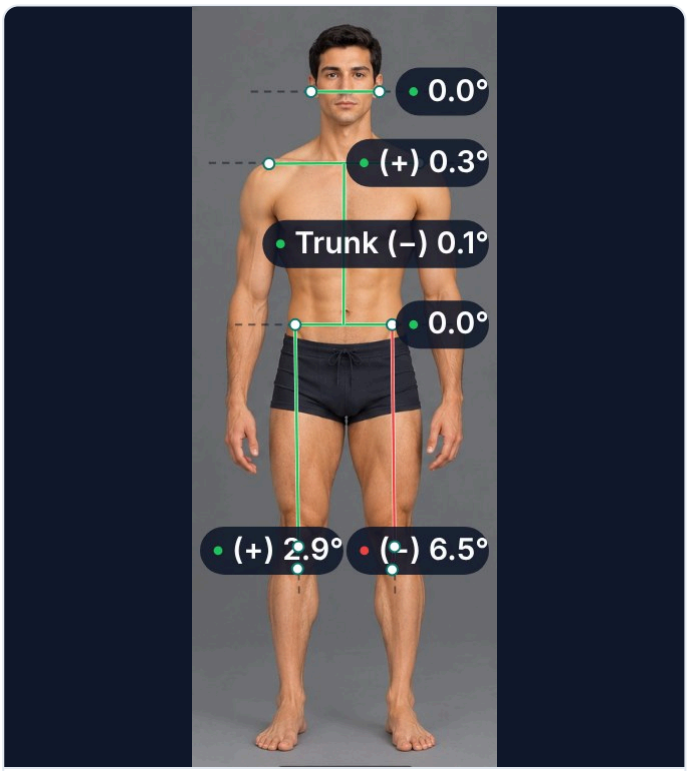
Left lateral view ANNOTATED photo



Right lateral view ANNOTATED photo



Posterior view ANNOTATED photo



Anterior view ANNOTATED photo

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12 SCREENED AND NOT PRESENT

Forward head posture · Increased Q angle · Genu recurvatum · Flexed-knee standing posture · Pronated (everted) rear foot · Supinated (inverted) rear foot · Pronation–valgus alignment chain · Upper-crossed posture pattern · Lateral head tilt · Uneven shoulder height · Pelvic obliquity · Lateral trunk shift · Frontal-plane asymmetry – screen for scoliosis

13 NOT ASSESSABLE WITH THIS PROTOCOL

Sagittal pelvic tilt and lumbar lordosis · thoracic kyphosis angle · scapular winging · rotation in the transverse plane · leg length (measure clinically)

14 HOW TO READ THE ANGLES

Head tilt, shoulder level and pelvic level: (+) the right side is lower, (−) the left side is lower. Trunk shift (+) shoulders displaced to the right. Q angle: tibial tuberosity relative to the extended ASIS–patella line. Rear foot (+) eversion / (−) inversion. Craniovertebral angle (CVA): tragus–C7 line to horizontal; a smaller angle means more forward head posture. Shoulder angle: C7–acromion line to horizontal. Knee sagittal alignment: (+) flexed, (−) hyperextended.

15 METHOD

Relaxed barefoot standing photographed (still images) from the front, back and both sides at about 3 m, camera at pelvis height and level. Markers placed on bony landmarks and verified by the assessor.

16 REFERENCES

1. Sheikhhoseini R et al. Effectiveness of therapeutic exercise on forward head posture: a systematic review and meta-analysis. J Manipulative Physiol Ther 2018;41:530-9.
2. Lynch SS et al. The effect of a postural intervention on forward head and rounded shoulder posture in elite swimmers. Br J Sports Med 2010;44:376-81.
3. Negrini S et al. 2016 SOSORT guidelines: orthopaedic and rehabilitation treatment of idiopathic scoliosis during growth. Scoliosis Spinal Disord 2018;13:3.
4. Willy RW et al. Patellofemoral pain clinical practice guideline. J Orthop Sports Phys Ther 2019;49:CPG1-95.
5. Sobel E et al. Reevaluation of the relaxed calcaneal stance position. J Am Podiatr Med Assoc 1999;89:258-64.
6. Loudon JK et al. The relationship between static posture and ACL injury in female athletes. J Orthop Sports Phys Ther 1996;24:91-7.
7. Janda V. Muscles and motor control in cervicogenic disorders. In: Grant R (ed). Physical Therapy of the Cervical and Thoracic Spine. Churchill Livingstone; 1994.

Evidence labels: **STRONG EVIDENCE** systematic review / RCTs · **MODERATE EVIDENCE** smaller trials or consistent studies · **EXPERT OPINION** clinical consensus.

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17 SUMMARY AND CONCLUSION

Mr. Sample Posture, a 31-year-old male patient, underwent static posture analysis on 12/10/2026 with a chief complaint of "Neck and upper-back ache after desk work". Of 14 measurements, 11 (79%) were within normal limits, 1 showed minor and 2 showed major deviation from the reference values. The findings are most consistent with **negative Q angle (left)**, together with rounded (protracted) shoulder (bilateral). Contributing factors to examine include genu varum, medial knee osteoarthritis, pectoralis minor tightness, lower / middle trapezius and serratus weakness.

18 REGIONAL SUMMARY

REGION	STATUS	KEY DEVIATIONS	MEASURES
Head & neck	Normal	Within normal limits	3/3 normal
Shoulders	Major	Shoulder (L/R)	1/3 normal
Trunk	Normal	Within normal limits	1/1 normal
Pelvis	Normal	Within normal limits	1/1 normal
Knee	Major	Q angle (L)	3/4 normal
Ankle & foot	Normal	Within normal limits	2/2 normal

19 KEY TAKE-HOME POINTS

- Primary finding: **Negative Q angle (left)** – The tibial tuberosity lies medial to the extended ASIS–patella line (Q angle below 0°).
- 1 finding is bilateral; the others are one-sided – compare with symptoms on that side.
- Reported associations in the literature (not an individual risk prediction): Medial knee loading (osteoarthritis risk).
- 2 major deviations should be reviewed clinically first.

20 OPTIONS TO CONSIDER (CLINICIAN DECISION)

F1 **Quadriceps and hip strengthening**
Negative Q angle · STRONG EVIDENCE

F2 **Pectoralis minor stretching combined with lower / middle trapezius and serratus anterior strengthening**
Rounded (protracted) shoulder · MODERATE EVIDENCE

21 FURTHER ASSESSMENT & FOLLOW-UP

SUGGESTED CLINICAL EXAMINATION

- Intercondylar distance
- Knee OA screening
- Pectoralis minor length (supine acromion height)
- Scapular dyskinesis test

RE-ASSESSMENT

Repeat this analysis at follow-up with the same set-up to measure change; differences smaller than the measurement error (about 5° for 2D joint angles and up to about 8° for frontal-plane knee angles (Munro 2012); 0.10 for ratios; 3% for distances) should not be over-interpreted.

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22 PHYSICAL EXAMINATION & HISTORY

23 FINAL DIAGNOSIS

24 MANAGEMENT PLAN & FOLLOW-UP

RE-ASSESSMENT DUE

REFERRAL TO

Assessed by (name, qualification)

Signature & date

Reviewed by

Signature & date

SAMPLE – SYNTHETIC TEST DATA – NOT A PATIENT RECORD

25 PATIENT CONSENT RECORD

Consent given by	Mr. Sample Posture
Date & time recorded	12/10/2026, 09:05:00
Recorded by	Dr. A. Sample (PT)
Purpose	Video / photographic recording and computer-assisted analysis of movement and posture for teaching, learning and research.
Use of anonymised data in teaching materials / publications	Not agreed

26 INTENDED USE

For research and education use only. Rollaxis is not a medical device. Its measurements, interpretations, provisional diagnoses and management options are teaching and research examples and must not be used to diagnose or treat any person.

Rollaxis Research & Education Edition is software for teaching, learning and research in human movement science. It measures two-dimensional (2D) joint and segment angles, timing and alignment from video recordings and photographs of posture, walking, running, a bodyweight squat and the Landing Error Scoring System (LESS) jump-landing task, using skin markers placed and confirmed by the user, and compares the measurements with published reference values. To support teaching, its reports also show worked examples of clinical reasoning – interpretation of the findings, provisional diagnoses and management options with their published evidence – generated by fixed rules from the literature. It is intended for students, educators and researchers in physiotherapy, sports science and medicine, in teaching laboratories, classrooms and approved research studies. It is not a medical device and is not intended for the diagnosis, prevention, monitoring, treatment or alleviation of any disease, injury or disability in an individual; its output must not be used as the basis for clinical decisions.

27 WARNINGS AND LIMITATIONS

Measurements are 2D projections of 3D movement and are affected by camera position, height, distance and tilt, lens distortion, patient rotation, clothing, frame rate and marker placement; rotations about the long axis of the limb are not measured. Check every marker, including automatic suggestions, before using a value. Differences smaller than the measurement error should not be interpreted as change. Reference values come from published adult populations and may not apply to every patient; they are not paediatric values. Stop the test if the patient reports pain, dizziness, chest discomfort or instability. Rule-based interpretations, provisional diagnoses and management options are teaching examples, not clinical advice. Use only the version supplied by the publisher on a computer protected as described in the user manual.

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28 PERSONAL DATA PROTECTION (DIGITAL PERSONAL DATA PROTECTION ACT, 2023)

Sample Physiotherapy Clinic is the **Data Fiduciary** for the personal data in this report, including images and health information. The data were collected with the consent recorded above, for the specified purpose only, and are stored on the institution's computer. Rollaxis does not transmit patient data; licence activation sends only the licence key, a computer identifier, the computer name and the software version to the publisher's licence server. The data principal (patient) may withdraw consent at any time, and may request access to, correction of or erasure of their personal data, or raise a grievance, by contacting Sample Physiotherapy Clinic. Withdrawal does not affect processing done before it. Data are kept only as long as needed for this purpose or as required by law for clinical records. For a child (under 18 years), verifiable consent of the parent or lawful guardian is required.

29 RESPONSIBILITIES

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30 USER DECLARATION

I confirm that the participant gave consent, that I have reviewed the measurements in this report, and that this report was produced for teaching, learning or research and will not be used as the basis for diagnosis or treatment of the participant.

Name, designation & institution

Signature & date

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