

Receptor-based assessment

*5 questions to ask before you
intervene*

A working checklist for clinicians whose patients plateau on standard pathways. Not a protocol. A reasoning tool that adds a layer underneath your existing assessment.

By Dr. Alex Atiakshev

P-DTR teacher with P-DTR Global • 15+ years of clinical practice

atiakshev.com

A common pattern in clinical practice

You have run a clean assessment. The patient responded for a session, maybe two. Then the symptom returned, or shifted, or never quite resolved.

This is a common pattern. It does not mean your assessment failed. It means the layer you are working on sits downstream of the actual driver.

This checklist gives you 5 questions. Ask them in order. The answer to question 5 tells you whether to keep going on your current pathway, or whether to add a layer underneath it.

The questions are receptor-based. They look at the inputs your patient's nervous system is reading - skin sensors, joint position sensors, muscle stretch sensors, balance, vision - and how those inputs shape the response you are seeing in tissue.

This is the working frame I have used over 15+ years of clinical practice and that I now teach with P-DTR Global - the international body for Proprioceptive Deep Tendon Reflex training.

Is the symptom site the same as the driver site?

Most clinical assessment is symptom-led. Patient says shoulder. You assess shoulder. You find dyskinesia at the scapula, weak external rotators, painful arc. You address what you find.

Sometimes that is enough. Often it is not.

The first question to ask: where the patient feels the symptom and where the actual driver lives - are they the same place, or different places?

A driver is the input that, when changed, changes the response at the symptom site. Drivers can live anywhere on the body. They commonly sit one or two segments upstream of the pain.

HOW TO TEST

Provoke the symptom with the patient's standard movement. Then load a candidate input from a distant location (foot, opposite hand, jaw, eyes). Reassess. If the original symptom changes when you load a distant input, the driver lives somewhere else, not at the symptom site.

Which receptor class is misreading?

The body has multiple input streams that feed the nervous system: skin sensors (cutaneous), joint position sensors, muscle stretch sensors, tendon load sensors, inner-ear balance (vestibular), and visual.

Each is a separate gate.

A misreading at one gate biases the entire downstream firing pattern. You cannot reliably correct a downstream pattern if the upstream gate is sending a wrong signal.

HOW TO TEST

Screen each receptor class one by one. Light skin contact for cutaneous. Joint position holds for proprioceptive. Muscle stretch loads. Eye tracking for visual. Head tilt for vestibular. The class that, when loaded, changes the symptom response is the gate that is misreading.

Is the response immediate or delayed?

Receptor-driven responses change tissue output within the same session. If you load an input that turns out to be the driver, the muscle response, joint coordination, or pain provocation will shift in front of you.

Slow responses (over days or weeks) are usually adaptation, not direct receptor-driven change.

This question matters because it tells you whether you have actually identified the driver or whether you are seeing something else (placebo, fatigue, regression to mean).

HOW TO TEST

Take a baseline measure of the symptom (range, pain provocation, manual muscle test, sway-meter, whatever you have). Load the candidate input. Re-take the same measure. Compare. If the measure shifts within the session, you have found the gate. If it does not shift, the candidate is not the driver. Keep screening.

Does the response hold under load?

A receptor correction that holds under low load but fails under high load is incomplete. The clinical pattern will return when the patient returns to their normal load environment (training, work, daily activity).

This is why a session-end measurement is necessary but not sufficient. You also need to verify the correction under loaded conditions before you call the work done.

HOW TO TEST

After the receptor input is addressed, retest the symptom under graded load - bodyweight, then resistance, then ballistic where appropriate. If the correction holds across load, you have a usable result. If the correction breaks at higher load, the gate is partially addressed or there is a second gate you have not yet found.

What does this tell you about the underlying system?

This is the question most clinicians never ask.

The first four questions identify the immediate driver and verify the correction. Question 5 asks: what does the pattern of receptor misreading tell you about the patient's wider system?

Repeated foot input drivers across patients with knee, hip, or shoulder symptoms = the integration is foot-loaded.

Repeated visual input drivers across patients with neck, jaw, or balance symptoms = the integration is visually loaded.

These patterns are not random. They reflect how an individual's nervous system has built up over years of work, sport, injury, and habit.

When you start asking question 5, your assessment moves from a per-symptom protocol to a per-system frame. That is the level of practice receptor-based reasoning is built for.

How to use this checklist

Apply it with your next 5 patients who have plateaued on standard care.

For each case, run the 5 questions in order. Note where the answers land. Track the pattern across patients.

Within 5 cases, you will see whether receptor-based reasoning adds a layer your current pathway is missing. If it does, the next step is a structured introduction to the method - the foundation of what P-DTR teaches.

ABOUT • THE AUTHOR

Dr. Alex Atiakshev

P-DTR teacher with P-DTR Global • 15+ years of clinical practice

Founder of Pro Prio Lab. Co-teacher of P-DTR Foundation seminars in Germany. Holds patents in receptor-based assessment methods (RU2805788, RU2855656, EA049483). Granted in their respective patent jurisdictions and in the Eurasian Patent Organization. Trained directly under Dr. Jose Palomar, the developer of the Proprioceptive Deep Tendon Reflex (P-DTR) method.

NEXT • IF THIS CHECKLIST IS USEFUL

Two paths if the receptor-based frame fits your practice.

01 • ONE-DAY WORKSHOP

Introduction to P-DTR

A short structured introduction. Online or in-person. Notify-me list.

atiakshev.com/landing-introduction

02 • FOUNDATION COURSE

P-DTR Foundation

Full clinical training. Five modules over eight months. Notify-me list.

atiakshev.com/landing-foundation

Educational material for licensed clinicians. Not a treatment protocol. Individual results vary by patient, presentation, and clinician technique. Dr. Atiakshev does not hold a US medical license. Clinical care for US patients within the United States would be performed by a US-licensed practitioner.