



Using the CARE Case Report Checklist Information for TRE[®] Providers (Including Level I, Level II, and Trainers)

The CARE Case Report Checklist is a standardized format the TRE[®] community is utilizing to report clinical observations and outcomes. One of the strengths of the TRE[®] community is the diversity of backgrounds who practice and teach TRE[®]. There is importance to this, but also a challenge in designing a research tool that will “fit for all.”

What follows is a guideline for conducting and writing TRE[®]-related Case Study Research in the standardized CARE Checklist format. The format can be utilized for a wide variety of conditions. Your choice of case study subjects will be related to your own scope of practice within your chosen profession/discipline. Research can be addressed no matter what your profession by following the Case Report Guidelines. If you are a massage therapist, chiropractor or clinical psychologist the same CARE Checklist format can be utilized.

The TRE[®] Research Work Group will select high quality case reports, groom and submit for publication to peer-reviewed journals. You will have an opportunity to review your case report before submission for publication.

Completed case reports, client consent, author(s) name and contact information should be submitted to:

TRE[®] Research Work Group
c/o Nkem Ndefo
nkem@trelosangeles.com

If you have questions about this process, contact Nkem Ndefo nkem@trelosangeles.com

First Steps

1. Obtain Informed consent from client (attached) and submit with case report
2. De-identify the case report (no full names) – Ex. Use a number or initials



Introduction

1. Brief background summary of this case

Patient Information

1. Demographic information (such as age, gender, ethnicity, occupation) – Use standard intake form
2. Main symptoms of the client (his or her chief complaints) - Self-reported
3. Medical, family, and psychosocial history including co-morbidities
4. Relevant past interventions and their outcomes. - List previous treatments and what was effective/ineffective for the client.

Clinical Findings

1. Describe the relevant physical examination (PE) findings.

Timeline

1. Depict important milestones illustrating your diagnoses and interventions (Table or figure)

Diagnostic Assessment

1. Diagnostic methods appropriate to your scope of practice and needs of client - Ex. Physical exam, laboratory testing, imaging, standard and widely accepted questionnaires. If you need help selecting appropriate questionnaires or instruments, please contact the TRE® Research Work Group.
2. Diagnostic challenges – Ex. financial, language, or cultural
3. Diagnostic reasoning including other diagnoses considered
4. Prognostic characteristics (such as staging in oncology) where applicable



Therapeutic Intervention

1. Types of intervention – Ex. supervised TRE[®], independent TRE[®], other concurrent modalities (Note – Use of TRE[®] alone makes for a stronger case report)
2. Administration of intervention (TRE[®] session length, frequency, etc.) – Ex. TRE[®] with certified practitioner 1:1 for “x” minutes plus independent TRE[®] for “x” minutes “x” times per week
3. Changes in intervention (with rationale) - Would be dependent on the individual and their unique response to the intervention. Ex. if someone became overwhelmed during TRE[®], then the clinical indications and parameters would need to be adjusted (i.e. shortened sessions)

Follow-Up and Outcomes

1. Clinician- and patient-assessed outcomes - Evaluate both clinician and patient’s desired outcomes
2. Important follow-up test results - Utilize the same assessment methods you initially used and compare results
3. Intervention adherence and tolerability – Note what method this was assessed. Ex. self report from client (verbal and/or written diary) and observed attendance at weekly sessions
4. Adverse and unanticipated events - Ex. worsening of symptoms, illness or other events which altered the outcome of the case report
5. Discussion of the strengths and limitations in the management of this case. What went well and what were the challenges.
6. The rationale for conclusions (including assessment of possible causes)
7. The main “take-away” lessons of this case report
8. Client perspective and experience - Have the client explain results/experience in their own words.