MEMBER PROGRESS & STRATEGY REPORT

What your bones are actually doing

Every system we measure, what they mean together, and the six things we would change first — in order.

MEMBER	Margaret S.
REPORT DATE	August 2026
CLASSIFICATION	Returning member — reassessment
JOURNEY STAGE	Phase 1 — Foundation (0–6 months)
PREPARED BY	Ryan Brown, Board Certified in Functional Nutrition

SAMPLE REPORT · ILLUSTRATIVE MEMBER · NOT A REAL PERSON

CONTENTS

What is in this report

Fourteen sections. The first tells you how to read the rest.

The colour system

Every finding carries a colour. It is not a grade — it tells you how much of your attention the finding deserves, and in what order.

BAND	MEANING	WHAT WE DO ABOUT IT
CLEAR	Minimal concern	Monitor on the normal cadence. Nothing to act on.
WATCH	Subclinical — below the threshold that gets noticed elsewhere	Track deliberately. This is where problems are cheapest to fix.
INVESTIGATE	Moderate burden, likely affecting your results	Identify the cause before adding more load or more supplements.
PRIORITY	Significant — and it outranks everything below it	Address first. Progression is paused until it moves.

Why there is no overall score

A single number ranks people. It does not tell anyone what to do — and worse, it hides the findings that matter most. Someone can produce excellent force while three separate systems are failing underneath, and an averaged score will quietly call that "good."

So we report each dimension on its own and pay attention to the **mismatches** between them. Strong but slow is a different plan from slow because nothing is being absorbed. The mismatch is the finding; an average would have erased it.

Reading order

Threat and Safety outrank Stimulus. Good force production does not earn more load while something is blocking the response or the body cannot take it symmetrically. Where sections conflict, the more conservative one wins.

Where each number came from

Anything not instrumented is labelled self-reported rather than presented as measurement. If a number is missing, it is because we have not measured it — not because it did not matter.

SOURCE	WHAT IT GIVES US
Spectrum session data	Trigger achievement and loading progression, session by session
Force and balance testing	Peak force, rate of force development, left/right symmetry
REMS — and DEXA where it exists	Bone density and bone quality. Compared only against the same modality
InBody	Skeletal muscle mass, phase angle, visceral fat
Intake, 96-symptom screen & brain assessment	History, medications, gut, sleep, hormones, exposures, processing speed

SECTION 02 · EXECUTIVE SUMMARY

Where Margaret stands

Margaret is 63, twelve years post-menopausal, with a low-trauma wrist fracture at 58 and a DEXA two years ago she was told was "a little low" with no follow-up. She has been walking for exercise and was told that was enough.

96	12	0	6
SYMPTOMS SCREENED	SYSTEMS ASSESSED	SINGLE SCORES GIVEN	ACTIONS, IN ORDER

The three findings that matter

FINDING	BAND	CONSEQUENCE
Her force is normal. Her rate is not. She reaches force slowly, and has been repeating the identical session for months.	INVESTIGATE	The stimulus is landing far softer than her attendance suggests.
Three threat categories are open — nutritional, hormonal and medication.	PRIORITY	Outranks load progression. Substrate first.
19% left/right asymmetry in lower-limb force production.	PRIORITY	Progression paused until it closes.

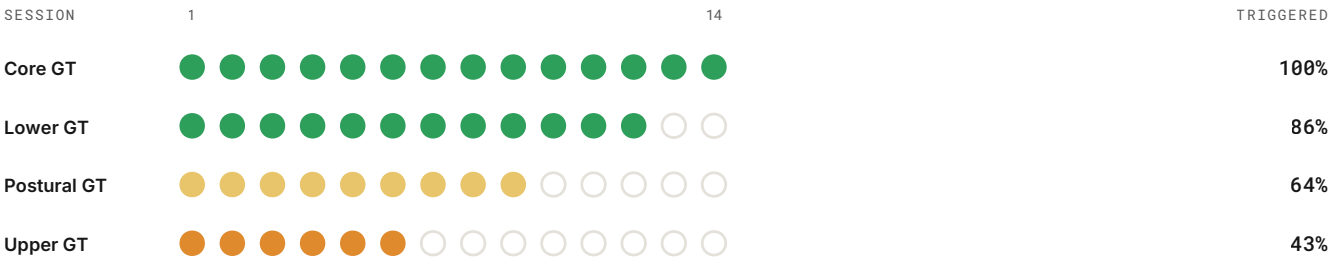
The one-sentence version. Margaret is not failing at OsteoStrong — she is being held back by three things that have nothing to do with the machines, and until those move, more load is wasted effort.

"Stability is success — then we build."

This is the part that used to go unsaid. Someone with her history who holds steady for a year has done something real. We measure enough now to prove that, rather than ask her to take it on faith.

Did the load actually land?

Attendance is not the same as loading. On each device we record whether the session crossed the trigger threshold that produces an adaptive signal — and at what quality. This is the difference between showing up and being loaded.



FILLED = LOAD CROSSED THE ADAPTIVE THRESHOLD

DEVICE	SESSIONS	TRIGGERED	PHASE INTERPRETATION	BAND
Core GT	14	100%	Rebuild response — consistent	CLEAR
Lower GT	14	86%	Transition → rebuild	CLEAR
Postural GT	14	64%	Rebuild response — inconsistent positioning	WATCH
Upper GT	14	43%	Recruitment pattern still normalising	INVESTIGATE

What the pattern says

Margaret triggers reliably through her core and lower chain and unreliably through her upper chain and posture. That is a recruitment and positioning problem, not an effort problem — and it is fixable in weeks, by changing how she is set up rather than how hard she tries.

Accommodation. Her loading has sat within 2% of her own trailing median for eleven straight sessions. Bone cells respond to novel load and quietly stop responding to identical load. Consistent attendance with unchanging load is the most common way for good effort to produce a flat result.

Change by system

Improvement in force applied at each device since her baseline. This is mechanical performance — it is not bone density, and we are careful never to present it as though it were.

Lower GT — +74%

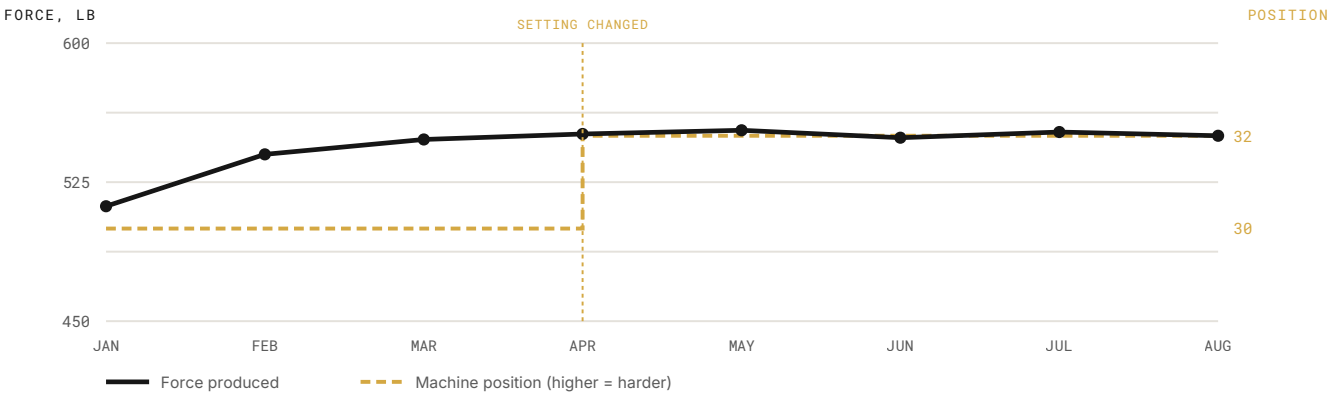
Core GT — +41%

Postural GT — +22%

Upper GT — +4% INVESTIGATE

Why the Upper GT line is flat

Force alone is misleading unless you also plot the machine setting. Here both are on one axis for the upper chain — and the setting has barely moved, so the flat line is a real plateau rather than the cost of being graduated to something harder.



UPPER GT · FORCE PRODUCED AGAINST MACHINE POSITION, EIGHT MONTHS

Interpretation

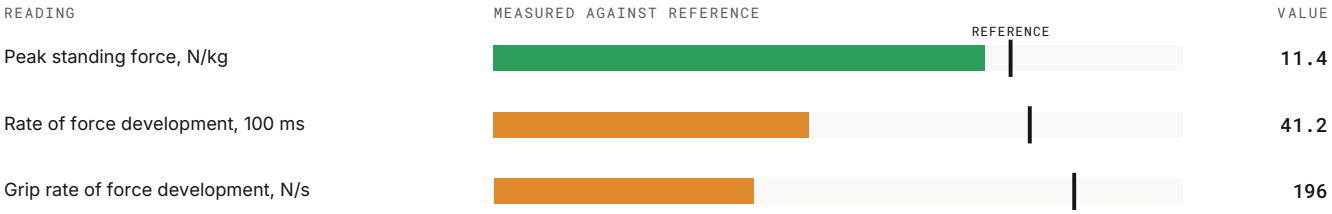
The lower chain is her strongest adaptation channel and should keep progressing. The upper chain has barely moved — consistent with the trigger data on the previous page, and pointing at the same cause: positioning and recruitment, not capacity.

What this does not tell us. Force improvement is evidence that her muscles and nervous system changed. Bone works on a much slower clock and cannot be meaningfully remeasured for about a year. Feeling stronger is real and worth having — it is simply not yet proof that bone followed. Anyone who tells you otherwise is selling something.

SECTION 05 · STIMULUS

Magnitude, rate, novelty

Three gates. Each one can stop the assessment, and we report the vector rather than collapsing it into a number — because two people reaching the same force in half a second and in four seconds have not had the same session.



BAR = MARGARET. VERTICAL RULE = AGE-MATCHED REFERENCE.

READING	MARGARET	REFERENCE	INTERPRETATION	BAND
Peak standing force, bodymass-relative	11.4 N/kg	12.0	Within range. Magnitude is not her problem.	CLEAR
Rate of force development, 100 ms	41.2 N/s/kg	70.0	Low. She reaches force slowly, so the signal is blunted.	INVESTIGATE
Grip rate of force development	196 N/s	438	Same pattern from a second instrument.	INVESTIGATE
Escalation vs. her own trailing median	0.98×	> 1.00	Accommodated — the load is no longer novel.	INVESTIGATE

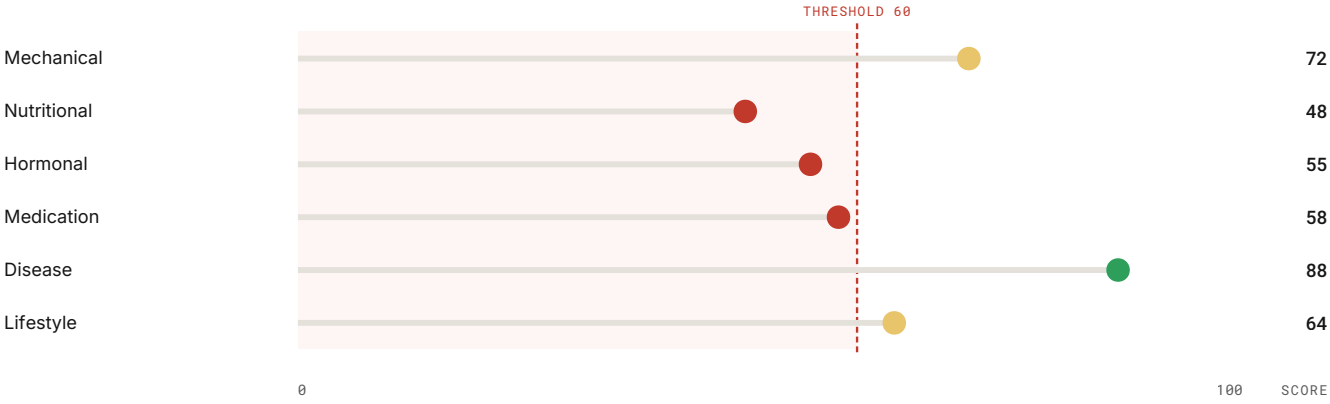
Why this page exists. Across our members, rate of force production varies about three and a half times from lowest to highest, while peak force varies about one and a half times. Reporting peak force alone averages away the variable that actually differs between people — and it is the variable Margaret is failing.

Provenance: force-time data captured at fixed time windows. Where a value is inferred rather than measured directly, this report says so.

SECTION 06 · THREAT

Is anything blocking the response?

A perfect mechanical stimulus can land in a body that cannot act on it. Six categories, each read on its own — what matters is not the total, but which are open and whether they can be changed.



ANYTHING LEFT OF THE RULE IS AN OPEN DRAG ON THE RESPONSE

CATEGORY	READING	OPEN FINDING	CHANGEABLE	BAND
Mechanical	72	Prior low-trauma fracture; low activity intensity	High	WATCH
Nutritional	48	Vitamin D 21 ng/mL; protein intake ~45 g/day	High	PRIORITY
Hormonal	55	12 years post-menopause, never discussed	Medium	PRIORITY
Medication	58	Daily PPI, 4 years, never reviewed	High	PRIORITY
Disease	88	None identified	—	CLEAR
Lifestyle	64	Sleep 5–6 h — self-reported, not instrumented	High	WATCH

Threat stack — open

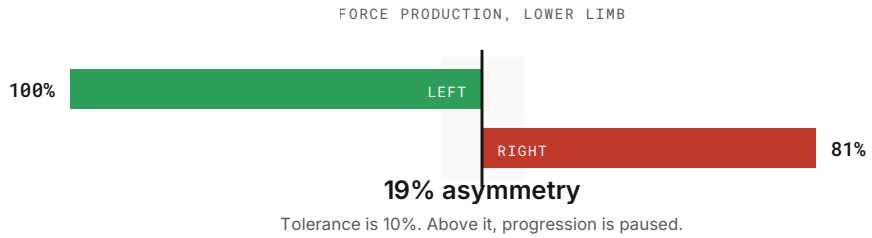
Three categories sit below 60. That outranks everything in Sections 03 to 05. Adding load to a body short on vitamin D, short on protein, and four years into an acid blocker is pushing on a locked door — and it is the single most likely reason a committed member sees a flat result.

All three are **highly changeable**. That is the good news on this page: a high threat score built from modifiable factors is not a prognosis, it is a work plan.

SECTION 07 · SAFETY

Can this body take the load?

The only section that can halt the protocol outright.



EACH LIMB AS A SHARE OF THE STRONGER SIDE.

FINDING	LEFT	RIGHT	CONSEQUENCE	BAND
Force production, lower limb	100%	81%	19% asymmetry — above threshold. Progression paused.	PRIORITY
Balance, eyes closed	Below age reference		Fall risk contributes to fracture independently of density.	INVESTIGATE
Pain, current	None reported		No screening gate triggered.	CLEAR

Why this outranks the number she came in asking about. Loading a 19% asymmetry builds the strong side and quietly loads the weak one. Closing it first is not caution — it is the difference between eight months of work counting and eight months of work being spent unevenly.

Screening gates: no maximal effort with uncontrolled hypertension, acute vertebral fracture, unresolved acute back or hip pain, or inside the post-fracture window.

Bone does not live on its own

Bone is built out of what the rest of the body has spare. So we stopped assessing it in isolation: a full intake — history, medications, surgeries, gut, sleep, hormones, environmental exposures — and a 96-symptom screen across eight systems.

SYSTEM	BURDEN	BAND	WHAT IT MEANS FOR HER BONES
Energy & vitality	14	WATCH	Tracks with the protein and vitamin D findings.
Digestion & gut	26	INVESTIGATE	Absorption. You can eat calcium and protein and still not get them.
Brain & cognitive	21	INVESTIGATE	Matches the slow force production — same finding, second direction.
Hormones & mood	29	INVESTIGATE	Twelve years post-menopause with nothing ever discussed.
Inflammation & immune	18	WATCH	Chronic inflammation suppresses bone formation directly.
Recovery & resilience	22	INVESTIGATE	Recovery is when bone adapts. Poor recovery wastes good sessions.
Bone & joint	17	WATCH	Her reason for coming — and not her highest score.
Cardiometabolic	11	CLEAR	Stable. Not a priority for her.
Total symptom burden	**158**	INVESTIGATE	**High burden — comprehensive rather than single-target intervention.**

The point of this page. Margaret came in about her bones. Her two highest burdens are gut and hormones — both upstream of bone. Load the skeleton all you like; if absorption is poor and the hormonal signal is absent, the raw material never arrives. This is the layer that used to be missing, and it is usually where the answer is.

What is holding the skeleton up

MEASURE	MARGARET	BAND	READING
Skeletal muscle mass index	Low for age	INVESTIGATE	Muscle pulls on bone. Less pull, less signal — independent of anything we do here.
Phase angle (cellular health)	Below reference	WATCH	Cell membrane integrity — a broad marker of how well tissue is maintained.
Visceral fat area	Mildly elevated	WATCH	Metabolically active and pro-inflammatory. Ties to the inflammation screen.

Why we care about muscle in a bone report

The largest forces your skeleton ever experiences come from your own muscles, not from gravity or impact. Low muscle mass is therefore a bone problem before it is an appearance problem — and it is one of the few findings that improves quickly and visibly at any age.

Measured on InBody at intake and repeated on the same clock as everything else, so change is read against her own numbers rather than a population chart.

Brain, sleep and stress

Force production is a nervous-system output before it is a muscular one. If the drive is slow, the load is slow — so we assess it directly rather than assuming it.

Processing speed — 47th percentile for age

Rate of force development — 31st percentile for age

Two instruments, one finding. Her reaction time is consistent with her low rate of force development, which means the ceiling on her loading is partly neurological — and neurological ceilings move faster than skeletal ones.

Sleep

Five to six hours with regular waking between 2 and 4 AM. That is a cortisol pattern rather than a sleep-hygiene problem, and cortisol is directly bone-relevant: it suppresses formation and accelerates resorption.

INVESTIGATE

Sleep is currently self-reported, not instrumented. It is treated as a lead to follow, not as data.

Supportive modalities

Where the findings warrant it we use light and sound sessions, red light, PEMF and LIMFA alongside the loading work. These are selected from what the assessment shows — not offered as a package, and not sold as a substitute for load.

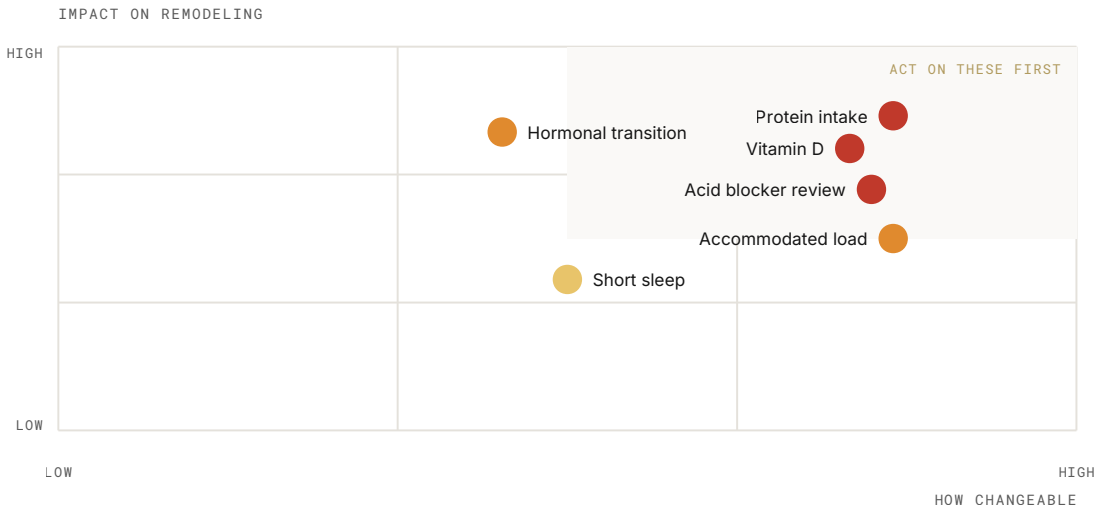
Where progress is draining away

You can pour effort into a bucket with holes in it and conclude the effort does not work. This page lists Margaret's holes, largest first, so the order of the plan is obvious rather than arbitrary.

#	DRAIN	EFFECT ON REMODELING	BAND
1	Protein intake ~45 g/day against a target of 80–100 g	Bone matrix is roughly half protein by volume. This is a raw-material shortage.	PRIORITY
2	Vitamin D 21 ng/mL, with K2 and magnesium status unknown	Absorption and mineral placement both impaired.	PRIORITY
3	Four years of daily acid suppression, never reviewed	Reduces absorption of exactly the minerals she needs most.	PRIORITY
4	Unaddressed hormonal transition	The strongest single driver of post-menopausal bone loss.	INVESTIGATE
5	Accommodated loading — same session, eleven times	Adaptive signal fades as load stops being novel.	INVESTIGATE
6	Short sleep with a 2–4 AM waking pattern	Recovery is when adaptation is consolidated.	WATCH

Which hole to plug first

Ranked by how much it is costing her against how much of it she can actually change. We deliberately do not put a percentage on each one — nobody can honestly say a protein shortfall costs 22% of a response — but the order is defensible.



TOP RIGHT = BIGGEST RETURN FOR THE LEAST RESISTANCE.

Longevity overlay

DOMAIN	SCORE	NOTE

Muscle & strength capacity	2 / 3	Capacity present; rate is the limiter.
Metabolic & visceral health	2 / 3	Mildly elevated visceral fat.
Hydration & inflammation	2 / 3	Phase angle below reference.
Recovery capacity	1 / 3	Short sleep, poor recovery scores.
Total	**7 / 12**	**Status: build capacity before progressing load.**

SECTION 12 · IMAGING

REMS, DEXA, and how they compare

ITEM	STATUS
Prior DEXA	Two years ago, reported as "a little low". No score provided to her, no follow-up arranged.
REMS baseline	Recommended at intake — density and quality, with a fragility output.
Comparison interval	Minimum twelve months. Anything sooner cannot distinguish change from noise.
Sites monitored	Lumbar spine, femoral neck, total hip.

The rule we will not break

We never compare a REMS value to a DEXA value. They measure different things by different physics, and a difference between them tells you about the machines, not about the person. Serial comparison happens within one modality — ideally the same device, same operator, recorded against both.

> **What her old DEXA actually told her.** "A little low" is not a result. A T-score is a number with a direction and a follow-up interval attached. Two years passed with neither. That is not her fault, and it is the most common gap we see.

REMS additionally reports bone quality — the microarchitecture that determines whether bone breaks — which density alone does not capture. It is radiation-free, which is what makes annual comparison practical.

Six things, in order

#	ACTION	WHY IT IS IN THIS POSITION	RECHECK
1	Protein to 80–100 g/day; correct vitamin D, with K2 and magnesium	Raw material. Loading without it produces signal and nothing to build from.	90 days
2	Review the PPI with her prescriber	Four years of impaired absorption, never revisited. We do not change medication — we make sure she knows what to ask.	Next visit
3	Close the 19% asymmetry before adding load	Protects the weak side and makes every later session count.	6 weeks
4	Address absorption before adding more supplements	Her second-highest symptom burden. Nutrients she cannot absorb never reach bone.	90 days
5	Prepared hormone conversation with her physician	Twelve years post-menopause and never discussed. We do not prescribe; we make sure she walks in able to ask the right question.	Next visit
6	Train rate, not just magnitude — and break the accommodation	The specific fix for her actual loading finding: positioning, novelty, upper-chain recruitment.	8 weeks

Tier 1 — next 14 days

Protein target agreed and started. Upper GT positioning reset. Vitamin D, K2 and magnesium status confirmed. PPI question written down for her next appointment.

Tier 2 — next 90 days

Asymmetry closed. Trigger consistency above 85% on all four devices. Muscle reserve improving. Symptom burden re-screened.

Tier 3 — twelve-month view

Measurable skeletal resilience, reduced fragility risk, and enough understanding of her own system that she could manage it anywhere — including somewhere that is not here.

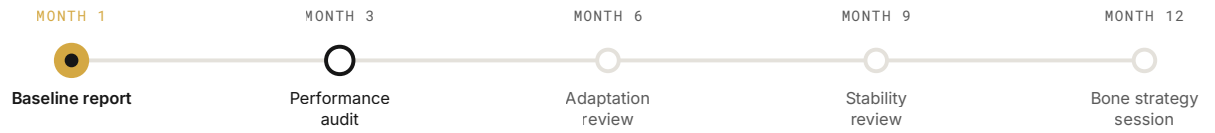
Supplements, where indicated, are chosen against what her intake and screen actually showed and dosed for her — not a shelf of bottles handed to everyone.

How this gets checked

A plan nobody rechecks is a wish. Each measure has its own clock, set by how fast the underlying biology can move.

ASSESSMENT	FREQUENCY	WHY THAT INTERVAL
Spectrum review, force & balance testing	Monthly	Trigger quality, accommodation drift, rate and symmetry all move within weeks.
InBody	Every 4–6 weeks	Muscle and fluid shifts are visible on this scale.
Symptom screen & bucket review	Quarterly	Systems move slower than sessions do — and are the drains closing?
REMS or DEXA	Annually	Bone cannot be meaningfully remeasured sooner.

Milestones



Outcome guarantee readiness

Not yet eligible. Three threat categories are open and an asymmetry flag is active. We do not attach a guarantee to a body that is not ready to respond — that would be a sales device rather than a commitment. Readiness is reviewed at the Month 3 audit against the criteria printed in this report.

What Margaret leaves with. Not a score. A written explanation of why her numbers did what they did, six things to change in order, and the reasoning behind every one — taught, through the Academy, so she could carry it to any program, including one that is not ours.

"Data, not fear, guides your path forward."

Scope

Recommendations are based on wellness coaching, biomechanical loading data and lifestyle factors, and support informed conversations with healthcare providers. This report is educational only — not medical advice, and not a replacement for professional evaluation, diagnosis or treatment. Vital Edge and OsteoStrong coaches do not diagnose or treat medical conditions. Always consult your provider before changing medication or supplementation.