

Neck, Shoulder, Upper Back and Arm

Head and neck safety, partnering load, shoulder instability, and upper-body overuse

Kinesphere Lab Editorial Team

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What this guide helps you do. Use this guide for pain or injury from falls, partnering, lifts, overhead work, acrobatics, floorwork, and repeated port de bras, with special rules for concussion, neck injury, shoulder instability, and nerve symptoms.

Scope. Educational guidance for dancers, families, and teachers. It supports safer decisions and clearer communication; a clinician determines diagnosis and individualized restrictions.

Contents

1	How to use this guide	2
2	Know the region	2
3	Find the symptom pattern	3
4	Common neck, shoulder, upper-back, and arm patterns	4
5	What to do today	5
6	Upper-body-specific class modifications	6
7	Returning to dance	6
8	Reducing recurrence	7
9	Bring this information to an assessment	8
10	Evidence scope and limitations	8
	Selected evidence and guidance	8

1 How to use this guide

This guide is designed for a dancer who has pain now, or who keeps developing the same problem. Its job is to help you describe the pattern, make a safe class decision, and communicate clearly with a parent, teacher, or clinician. It cannot determine the diagnosis from symptoms alone.

Key idea

Use four observations together: **exact location, how it began, which movement provokes it, and what happens later that day or the next morning.** One symptom by itself is rarely specific enough.

1.1 The four-question check

1. **Where?** Point with one finger. A one-fingertip spot on bone is more concerning than broad, symmetrical muscle soreness.
2. **When?** Sudden fall, twist, pop, collision, or landing; or gradual pain that built over several classes.
3. **What load?** Walking, stairs, plié, relevé, turnout, extension, jumps, pointe, floorwork, lifts, or repeated rehearsal.
4. **What response?** Better after warm-up, steadily worse with repetition, painful at rest, or worse the next morning.

MODIFY

Mild but recurring or movement-specific pain: remove the painful element and tell a teacher, parent, or guardian.

STOP

Pain changes technique, grows with repetition, causes limping, weakness, swelling, loss of motion, or instability.

SEEK CARE

Focal bone pain, deformity, inability to use or bear weight, locking, neurologic signs, rest/night pain, or a serious fall.

SEEK MEDICAL CARE

A dancer who is a minor should tell a parent or guardian about a significant injury. Urgent evaluation is appropriate for deformity, inability to use or bear weight on the part, rapidly increasing swelling, an open wound, a cold or pale limb, persistent numbness, progressive weakness, or serious head, neck, or spine symptoms.[1]

2 Know the region

The neck supports and positions the head; the shoulder is a highly mobile joint stabilized by the labrum, capsule, rotator cuff, and shoulder-blade muscles; the upper back and arms transmit force during lifts and weight bearing. Upper-extremity injuries are less common in classical ballet than lower-extremity injuries, but the burden rises in modern, contemporary, breakdance, acrobatics, pole, and partnering because the arms may support body weight or another dancer.[2–4]

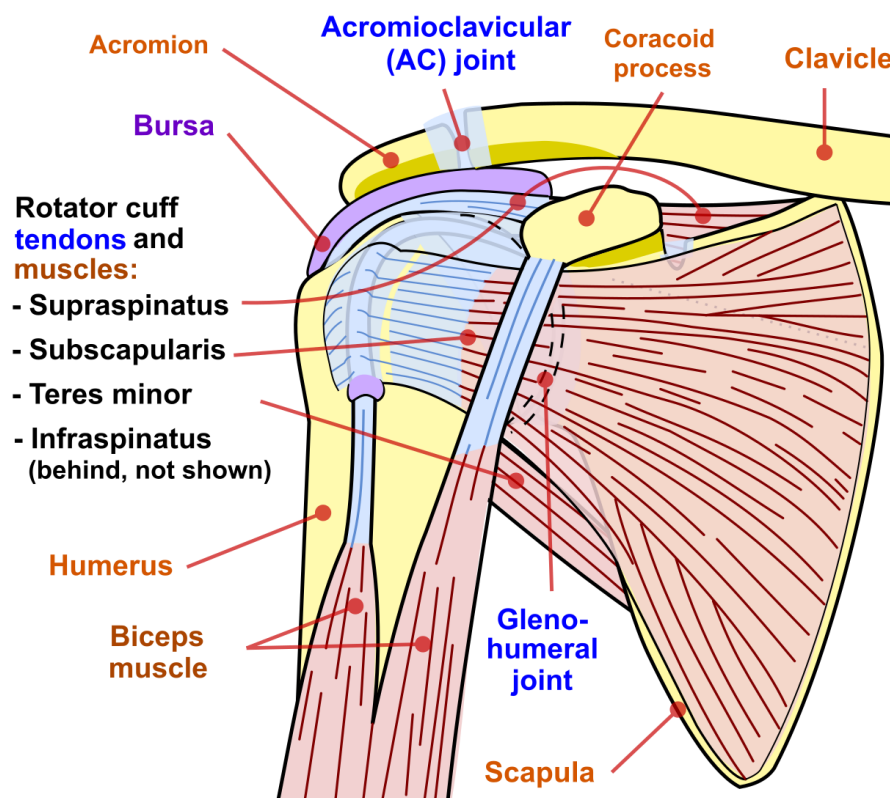


Figure 1. Shoulder anatomy, including the glenohumeral and acromioclavicular joints, rotator-cuff tendons, bursa, clavicle, scapula, and humerus. Source: National Institute of Arthritis and Musculoskeletal and Skin Diseases; SVG contributors Angelito7 and Jmarchn, public domain, via the [Wikimedia Commons source page](#); white background and crop added.

SEEK MEDICAL CARE

After a head impact, remove the dancer from activity. Suspected concussion means no same-day return to dance, even if symptoms improve quickly. Worsening headache, repeated vomiting, seizure, increasing confusion, unequal pupils, marked drowsiness, weakness, numbness, or neck pain after major trauma requires emergency care.[5]

3 Find the symptom pattern

Location and behavior	Pattern it can resemble	Dance clues	First decision
Headache, dizziness, fogginess, nausea, balance or vision change after impact	Concussion pattern	Fall, collision, failed lift, acrobatic impact	Remove from dance; no same-day return; medical assessment
Neck pain after major fall or with numbness/weakness	Cervical spine or nerve injury	Head-first impact, axial load, whiplash	Immobilize as appropriate and seek urgent/emergency care

Broad neck/upper-back ache	Muscle overload	Port de bras, spotting, lifts, prolonged rehearsal, tension	Modify load and restore comfortable movement; assess persistent symptoms
Shoulder slips, feels dead, or appears out of place	Subluxation/dislocation or instability	Catching partner, fall, overhead support, recurrent looseness	Stop and seek prompt care; do not force it back into place
Pain lifting arm with weakness	Rotator cuff or shoulder overload	Overhead port de bras, lifts, floorwork, hand support	Reduce load and assess persistent weakness
Deep shoulder click/-catch after traction or instability	Labral or joint pattern	Partner pull, fall, repeated weight bearing	Stop provoking load and seek assessment
Top-of-shoulder pain after direct fall	AC joint or clavicle injury	Shoulder-first landing or collision	Stop weight bearing; assess deformity and tenderness
Elbow/forearm pain with floorwork or gripping	Tendon, joint, or muscle overload	Handstands, freezes, lifts, repeated gripping	Reduce weight-bearing and grip load; assess persistent pain

4 Common neck, shoulder, upper-back, and arm patterns

Concussion after head impact

Possible symptoms. Headache, dizziness, nausea, visual difficulty, sensitivity to light/noise, slowed thinking, confusion, balance change, unusual emotion, or sleepiness. Loss of consciousness is not required.

Action. Remove from dance and tell an adult. No same-day return. Follow a healthcare-guided return-to-school and return-to-activity process.[5]

Emergency signs. Worsening neurologic symptoms, repeated vomiting, seizure, increasing confusion, severe drowsiness, weakness/numbness, unequal pupils, or major neck pain.

Neck and upper-back muscle overload

Usually feels like. Broad tightness or ache after spotting, port de bras, lifting, prolonged rehearsal, or guarded posture.

Do today. Reduce rapid head turns, overhead load, and painful lifting. Keep gentle comfortable motion unless trauma or neurologic symptoms require protection.

Seek care when. Pain follows a significant fall, radiates into an arm, causes numbness or weakness, or persists/worsens.

Shoulder instability, subluxation, or dislocation

Usually feels like. The shoulder slips, shifts, gives way, feels dead, or becomes visibly out of position after a fall, catch, or overhead load.

Action. Stop activity. Do not have a teacher or peer force the shoulder back into place. Seek prompt or emergency care depending on deformity, pain, and circulation/nerve symptoms.[6]

Return principle. Recurrent instability needs rehabilitation of shoulder and scapular control plus gradual exposure to the exact partnering or floorwork demands.

Rotator-cuff and scapular overload

Usually feels like. Pain with lifting the arm, overhead positions, floor support, or lowering a partner, sometimes with weakness or loss of control.

Do today. Reduce overhead and weight-bearing load. Avoid forcing painful arm range. Persistent weakness or night pain warrants assessment.[6, 7]

Labral or internal shoulder pattern

Usually feels like. Deep pain, clicking, catching, instability, or pain after traction, dislocation, or a failed lift.

Do today. Stop hanging, heavy partnering, handstands, and repeated clicking. Seek assessment when mechanical symptoms persist.

AC joint, clavicle, upper-arm, or elbow trauma

Usually feels like. Focal pain after direct contact or a fall, sometimes with swelling, bruising, deformity, or limited arm use.

Action. Stop weight bearing and lifts. Deformity, inability to use the arm, numbness, a cold hand, or severe swelling requires urgent evaluation.[1]

5 What to do today

5.1 Protect the irritated area from repeated testing

- ✓ End the movement that reproduces sharp, focal, unstable, or escalating pain.
- ✓ Tell the teacher exactly which movements provoke symptoms. Replace those movements rather than silently reducing their quality.
- ✓ Keep ordinary movement that is comfortable and does not worsen symptoms later, unless a clinician has instructed complete rest or protection.
- ✓ Record location, onset, swelling, bruising, clicking, weakness, and the next-morning response.
- ▲ Avoid repeatedly hopping, forcing range, stretching hard, rolling directly over a focal bone spot, or “checking” the injury every few minutes.
- ▲ Do not use pain medicine, tape, or a warm-up as proof that the tissue is ready for full dancing. Symptom masking can hide worsening load intolerance.

Why this matters

A short period of protected cold may reduce discomfort after an acute injury if skin sensation is normal and the cold source is wrapped. It does not accelerate every type of healing and it is not a readiness test. Swelling, function, location, and response to load matter more than whether the area feels temporarily numb.

5.2 Communication script

Practical script

“The pain is at [exact location]. It began [suddenly / gradually] during [movement]. It is [better / the same / worse] with walking and is [better / worse] the next morning. I also notice [swelling, bruising, weakness, clicking, locking, numbness, or none]. I need to remove [specific movement] until this is assessed or settles.”

6 Upper-body-specific class modifications

MODIFY AND REPORT

Possible substitutions include lower port de bras, no lifts, no overhead support, no handstands or floor freezes, marking partnering pathways without load, and lower-body technique that keeps the injured arm supported. A dancer with suspected concussion should not participate physically or use vigorous visual/vestibular practice until medically guided.

STOP THE PROVOKING ACTIVITY

Stop if the shoulder slips, arm strength suddenly drops, pain radiates with numbness, neck symptoms follow a fall, the dancer cannot safely catch a partner, or technique requires shrugging and trunk compensation.

SEEK MEDICAL CARE

Emergency evaluation is appropriate for serious head/neck warning signs, deformity, a cold or numb hand, progressive weakness, or inability to use the arm after trauma. Prompt assessment is appropriate for recurrent instability, persistent weakness, mechanical catching, and pain that limits sleep or daily function.[1, 5]

7 Returning to dance

Return should be based on function and symptom response rather than the number of days since the pain began. Dance-medicine literature supports staged progression from basic movement to dance-specific demand rather than a direct jump into full class.[8]

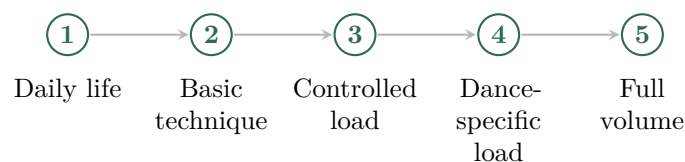


Figure 2. General return sequence. Advance only when the current step is controlled and does not create a meaningful symptom increase later that day or the next morning. Region-specific restrictions take priority.

Key idea

A stage is tolerated only when symptoms remain acceptable **during the activity, later that day, and the next morning**. New swelling, limping, altered alignment, loss of control, or a clear pain increase means the load exceeded current capacity.

7.1 Neck, shoulder, upper-back, and arm progression

1. Comfortable daily arm use, neck motion, and sleep; concussion recovery follows a separate medical protocol.
2. Low-load shoulder-blade, rotator-cuff, trunk, and grip control as prescribed.
3. Port de bras below shoulder height and non-weight-bearing class participation.
4. Full overhead range without pain, weakness, or compensation.
5. Light closed-chain support against a wall or barre, then floor support when permitted.
6. Solo floorwork, hand support, and low-load partnering.
7. Progressive catches, lifts, acrobatics, freezes, or overhead partnering.
8. Full choreography and repeated performance volume with a reliable safety margin.

Common mistake

Being able to lift the arm once does not prove readiness to catch a partner or support body weight. Return requires repeated force, timing, confidence, and control under fatigue.

8 Reducing recurrence

No single stretch, shoe, or screening test prevents every dance injury. The most useful prevention system combines load management, technique, physical capacity, recovery, and early communication.[2, 9]

1. **Track meaningful load changes.** New pointe work, more jumps, longer rehearsals, harder flooring, a role change, a growth spurt, and added cross-training can all increase tissue demand.
2. **Build capacity outside choreography.** Strength, balance, landing control, trunk control, and gradual exposure give tissues a larger margin before fatigue changes technique.
3. **Use available range rather than forcing an ideal.** Turnout, extension, pointe range, and back extension should come from the joints that possess that motion, with control.
4. **Recover enough to adapt.** Sleep, rest days, and regular meals and snacks support repair. Recurrent bone-stress injuries, persistent fatigue, declining performance, delayed or disrupted menstrual function, or other signs of under-fuelling deserve confidential medical and nutrition support.[10, 11]
5. **Report early.** A small, repeatable symptom is easier to modify than a pattern that has already changed walking, class technique, or sleep.

9 Bring this information to an assessment

Exact location	_____
Date and mechanism of onset	_____
Sudden or gradual	_____
Dance movements that provoke it	_____
Walking, stairs, sleep, or rest symptoms	_____
Swelling, bruising, clicking, locking, weakness, numbness	_____
Recent change in class, rehearsal, pointe, jumps, floorwork, lifts, or cross-training	_____
What improves it; what worsens it the next morning	_____
Prior injury to the same area	_____

Key idea

Bring shoes or equipment associated with the symptoms when useful, and bring a short video only if recording was safe and the movement did not require provoking a potentially serious injury again.

10 Evidence scope and limitations

This guide prioritizes dance-medicine reviews, pediatric and sports-medicine guidance, clinical practice guidelines, and authoritative professional resources. Research on dancers is uneven across genres and body regions; evidence from related weight-bearing or artistic sports is used only where the mechanical demand is clearly similar. Individual diagnosis, imaging, treatment, and return restrictions belong to a qualified clinician who can examine the dancer.

Key idea

Medical review date: July 2026. Suggested review cycle: every two years, or sooner when a major guideline changes. Kinesphere Lab should obtain review by a physician or physical therapist with dance-medicine experience before studio-wide clinical distribution.

Selected evidence and guidance

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