Background: The patient is a 20-year old female college student who complains of intense sacroiliac joint and buttock pain after completing a sit-to-stand transfer from her desk while in her dorm. The patient reports hearing a "pop" and feeling “a rush of numbness” down her left leg immediately upon onset. In addition to the lower extremity neuropathy, the patient reports a loss of motor control in the distal left lower extremity. She denies past medical history of spine, pelvis and lower extremity pathology. The patient was assessed by an ATC who detected a posterior rotation of the left innominate. The patient was initially treated by the ATC using quadriceps muscle energy techniques and manual therapy to the sacroiliac joint. Following initial care provided by the ATC, the patient continued to have periodic bouts of sacroiliac joint and lower extremity pathology. As a result, the patient was referred to an orthopedist for follow-up care. The physician ordered an abdominal CT scan to rule out peritoneal dysfunction and a Lumbar/Sacral MRI to rule out a space-occupying lesion in the lumbar spine. Both diagnostic tests were negative and the patient was treated with rest and oral medications for pain and muscle spasm. Several weeks later, the patient was referred to a neurosurgeon due to increased lower extremity neurological signs and symptoms. Evaluation by the neurosurgeon resulted in performance of an EMG and a Nerve Conduction Velocity Exam to assess left lower extremity neurologic function. The patient’s left lower extremity now demonstrated clonus, decreased sensation and strength in the L4 – S1 myotomes and diminished patellar and Achilles tendon reflexes. Both the EMG and Nerve Conduction Velocity Exams were evaluated as normal. A full body MRI performed to assess for the presence of CNS pathology, such multiple sclerosis, was also unremarkable. Differential Diagnosis: Differential diagnosis in this patient included ruling out a herniated nucleus pulposus, a CNS lesion, sacroiliac joint dysfunction, and a malignant or benign tumor. Treatment: After all diagnostic testing returned with unremarkable findings, the patient was referred to a pain management specialist for further evaluation and care. This physician prescribed oral muscle relaxers, Tizanidine, and the patient underwent her first SI block injection. Following the injection, the patient experienced mild relief of spine pain and neurological symptoms left lower extremity. Two months later, the patient underwent a second SI block injection to confirm the results from the earlier procedure. The patient again experienced mild relief of pain and neurological symptoms over the course of several days. Two months following the second injection, the patient underwent a radio frequency ablation (RFA) procedure to cauterize the sciatic nerve. One month after the RFA procedure was performed, the patient reported a complete resolution of all symptoms. This time, the patient was placed in an SI belt to provide support for the sacroiliac joint. The patient began a new program of rehabilitation that included a lower extremity flexibility program, neural tension exercises, and dynamic lumbar stabilization exercises. Uniqueness: This case demonstrates a unique mechanism and presentation for sacroiliac joint pain. Although SIJ pathology is common in college-aged women, the presence of lower extremity neurologic symptoms and clonus is rarely seen. Conclusions: Sacroiliac joint dysfunction can refer pain and cause significant neurologic deficits in the lower extremity. A thorough assessment of the patient’s underlying causative factor is crucial in the development of a successful treatment plan.