COLLECTED
PAPERS OF THE MEMBERS
OF THE
INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY

PRESENTED DEC. 3rd THROUGH 5th, 1980

SHELDON C. DEAL, N.D., D.C.
CHAIRMAN, I.C.A.K.

* - Diplomate

INTRODUCTION

By

Sheldon C. Deal, D.C., N.D.

Chairman

This tenth collection of papers by the members of the International College of Applied Kinesiology represents 52 papers written by 34 authors.

These papers will be presented by their authors to the general membership at the Winter meeting to be held in Saint Maarten on December 3, 4 and 5, 1980. The authors welcome comments and further ideas on their findings either in Saint Maarten or you may write them directly as their addresses are included in the Table of Contents.

These papers do not represent the official educational material of the International College of Applied Kinesiology, but rather areas of special interest to the individual members which have been under research. The papers are presented in an unedited form.

The papers are being mailed out to the members well in advance of the Saint Maarten meeting. This will allow the membership at large to read the papers in advance which will save time at the Winter meeting and hopefully stimulate more questions from the members and more demonstrations from the individual authors.

We the members of I.C.A.K. can be proud of the amount of research being conducted and feel fortunate to have it at our fingertips in the form of these Collected Papers. It cannot help but be an asset to our health and also to the health of our patients.

Herbert C. Anderson, D.C.

VERTEBRAL SUBLUXATIONS

ABSTRACT. Many subluxations of the spine can be the results of Visceral irritation. Applied Kinesiology provides a diagnostic evaluation of the Viscera for over activity or under activity of each specific organ and its relationship to vertebral subluxations.

In Applied Kinesiology we learn that the health is a structural chemical, psychological triangle - we see patients who are out of balance structurally, usually a vertebral or cranial correction affords quick relief. Most of the patients we see have a chemical, psychological or structural problem.

In checking patients with Cervical, Dorsal and Lumbar problems that still complain of discomfort, we started to investigate the Viscera. Which comes first, the chicken or the egg or vertebral subluxation or Visceral irritation? When T.L. to Cervical, Dorsal and Lumbar spine and having cleared all subluxations, many times the patient would still complain of nagging irritating pain and not able to T.L.

When checking the acupuncture alarm system, and when this is negative to T.L.,the Lung - Heart - Cir Sex - Thyroid, we would then double T.L. Heart alarm to Occiput - Atlas = Axis - 3-4-5 C and then we would find the micro subluxation that persisted.

We then would challenge the Vertebral level while holding the alarm circuit to determine laterality, superiority or inferiority, to make correction of the vertebral subluxation.

We would do the same for the Dorsal - Lumbar and Sacrum, T.L. the alarm circuit against the vertebral level. Through trial and error, we arrive at many conclusions in Applied Kinesiology. All vertebral correction would be made still holding the alarm circuit.

HERBERT C. ANDERSON, D.C.
25 Curtis Street
Medford, Mass. 02155

John V. N. Bandy, D. C.

TECHNIQUE AND ITS RELATION TO RUNNING INJURIES

Abstract:

By teaching running patients proper technique, we can help prevent recurrence of injuries.

In applied kinesiology we have worked long and hard to create treatment techniques which last. Those who have treated runners extensively have no doubt found that lasting treatments can be hard to come by. The problem of repairing a semimembranosus and having it hold for multiple forty-mile weeks only to break down again during the first fifty or sixty mile-week, has led my good friend, Alan Beardall, to develop extensively detailed treatments for specific muscles and divisions of muscles. These treatments have been very helpful, but runners continue to break down at an alarming rate. This problem led me to explore the origin of running injuries. After talking to many coaches and quality runners, and watching miles of film, I am convinced that as many as 80 or 90 percent of all running injuries are the result of faulty technique. In order to help our patients to stay injury-free, we have taken to relating to them the following information.

There has been a great deal of faulty information taught about running. None of the information is more damaging than that related to technique. The following ideas are used by the best runners and coaches in the world to obtain more speed with less effort and reduce injuries. The elements of technique we are going to discuss are: relaxation into good posture, foot plant, stride length, toe-off and arm action. The

first element of technique to master is running posture. Running posture, like standing posture, requires two basic elements - balance and relaxation. Standing, the knees must be relaxed (not locked backwards), the pelvis centered between the malleoli and the shoulders and the weight centered on the foot. Now, lean forward at the ankles and this posture will resemble running posture. Notice how the weight is balanced on the foot. The heel is on the floor but the weight is solidly on the ball of the foot. This is the way the foot should bear weight at the time of foot plant. This allows the gastrocnemius and soleus (the strongest muscles in the body) to absorb a large amount of the shock and also sets the stage for activation of the stretch reflex in the calves at toe-off. The stretch reflex occurs when a muscle is stretched hard as it is loaded and results in the partly involuntary and extremely forceful contraction which requires little effort. In order to accomplish this foot plant, the average runner will initially have to shorten his or her stride length. Reaching with the lead leg is the most common technique flaw we find. It often comes from the misconception that foot plant should start with the heel. The problem with heel striking and overstriding is that is causes the knee to become the primary shock absorbing joint, it puts a large amount of stress on the low back, and decreases running efficiency in that by placing the foot forward of the center of gravity, the runner is actually slowing him or herself down with each step.

To learn good technique assume the posture we have discussed. Lean forward at the ankles and notice the feeling of the feet on the ground. Begin running and try to duplicate that feeling. At first it may be helpful to use an exceptionally short stride to get the feeling of the planting of the foot under the center of gravity. As the foot plant begins to feel natural, stride length can be lengthened by concentrating on pushing with

the trail leg and consciously toeing-off with a good plant or flexion of the foot, which will keep the rear foot on the ground a little longer. It may also be helpful to learn technique while running alone because when running with other runners there is a tendency to "fall in step" and for some reason we tend to fall into the slower cadence which increases stride length. We have found that this is particularly a common problem in women who habitually run with men. The women are generally shorter but are matching the men stride for stride and producing injuries.

The last element we will discuss is arm action. The arms counterbalance the legs to maintain balance in running. The movement of the arms should promote relaxation in the neck, shoulders and upper body. The arms swing from the shoulders with a medial deviation of the hands as they move forward. The hands should not cross the center line of the body. There is also a need for the angle at the elbow to increase as the hands move backwards and decrease as the hands move forward. Once the elements of good technique have been mastered, all that remains is to develop a smooth, natural rhythm. It should also be pointed out that as pace increases there is an increase in leg speed, stride length and arm and leg action, but the elements of technique we have discussed remain the same.

The above is an extremely basic discussion of technique. It is void of vital mechanical explanation, but not of vital mechanical basis. The hope is that it wil enable a doctor to help running patients be more efficient and thereby, less injury prone.

John V. N. Bandy, D.C.

REHABILITATION OF MUSCLE PULLS

Abstract:

An athlete can lose less training time and heal more completely when a good rehabiliation program is added to the usual applied kinesiological treatment regime.

The word "pulls" in the title of this paper is the common terminology used to describe a variety of muscle injuries. For the purpose of this paper we will subdivide and clarify pulls into two categories. We will designate those muscle injuries which involve bleeding with obvious bruising of the skin around the muscle as tears and those injuries without bleeding or bruising of the skin as strains.

When a muscle is injured it is generally best to apply ice for twenty minute intervals - that is, on for twenty minutes and off for twenty minutes. This will inhibit swelling and other factors which complicate injuries. It is my opinion that it is best to wait twenty-four hours before treating a strain kinesiologically and forty-eight hours before treating a tear. This rule we often break at track meets and other events but it is important to understand that treating a fresh injury and sending an athlete back to compete is always a risk. The first step in repairing a muscle injury is to find out why the muscle pulled. I am thoroughly convinced that a muscle will not pull unless it is "turned off." It may or may not be weak in the clear but at the time of injury that muscle was turned off. Treatment for the muscle may be very simple or it may be a complicated mass of compensation, muscular reactivity or other biomechanical nightmares. But the well-versed Applied Kinesiologist

should not find many muscles he cannot fix. The rehabilitation programs that follow begin after the muscle is intact.

A hamstring injury will be used to illustrate but the program can be used for any muscle by making the obvious substitutions.

Hamstring Strain Rehablitation

Day 1: & Day 2: A.M. - 3 sets of ten hamstring curls using one-half of the weight capability of the well leg; slow easy stretching for 3-5 minutes; 20 minutes of ice.

P.M. - Weights, stretching and ice

Day 3: A.M. - Weights, stretching and ice

Afternoon - Jog 20 minutes on the grass

P.M. - Weights, stretching and ice

Day 4: A.M. - Weights, stretching

Afternoon - Jog 10 minutes; if no pain, half speed striding on grass for 10 minutes

P.M. - Weights, stretching

Day 5: A.M. - Weights, stretching

Afternoon - 10 minutes jogging; 10 minutes half speed strides, 10 minutes three-quarters speed strides

P.M. - Weights, stretching

Day 6: A.M. - Weights, stretching

Afternoon - 10 minutes jogging followed by 20 minutes of three-quarters speed strides accelerating to full speed strides towards the end

P.M. - Weights, stretching

Day 7: A.M. - Weights, stretching

Afternoon - Normal workout

P.M. - Weights, stretching

At this point most strains should be full speed with no pain. We usually

examine the patient after Day 2 and Day 6 to be certain that the muscle has remained intact.

Hamstring Tear Rehabilitation

Day 1: & Day 2: A.M. - 3 sets of ten hamstring curls using one-fourth of the weight capability of the well leg; stretching slow and easy for 3-5 minutes; ice 20 minutes on, 20 minutes off, 20 minutes on

P.M. - Weights, stretching and ice

Day 3: & Day 4: A.M. - Weights - one-half weight capability of well leg; stretching; ice for 20 minutes

P.M. - Weights, stretching and ice

Day 5: & Day 6: A.M. - Weights, stretching and ice

Afternoon - Jog 20 minutes on the grass

P.M. - Weights, stretching and ice

Day 7: & Day 8: A.M. - Weights, stretching and ice

Afternoon - Jog 10 minutes; if no pain, half speed strides for 10 minutes

P.M. - Weights, stretching and ice

Day 9: & Day 10: A.M. - Weights, stretching and ice

Afternoon - 10 minutes jogging; 10 minutes half-speed strides, 10 minutes three-quarters speed strides

P.M. - Weights, stretching and ice

Day 11: & Day 12: A.M. - Weights and stretching

Afternoon - Jog 10 minutes and 20 minutes of strides working up to full speed

P.M. - Weights and stretching

Day 13: & Day 14: A.M. - Weights and stretching

Afternoon - Regular workout

P.M. - Weights and stretching

Most tears should be full speed with no pain by the end of two weeks.

However, there may still be some bruising of the skin which should present no problems. We usually examine patients after Day 2 and Day 4 for signs of further bleeding and after Day 12 to see that the muscle is remaining intact.

We have been using this rehabilitation program for three years and have found it to be extremely effective. The only notable exceptions to the one and two week time periods are those regarding muscles we have difficulty getting or keeping intact.

CROSS K-27* AND DORSUM HAND THERAPY LOCALIZATION

Abstract

In the summer 1980 collected papers of the Internation College of Applied Kinesiology David Walther, D.C., presented a paper titled "An Approach in the Treatment of Schizophrenia."[1] One of the primary ideas in this article was the demonstration of the cross or opposite K-27 therapy localization which is in contrast to the normal therapy localization demonstrated by George Goodheart, D.C., and other kinesiologists and is known as an ipsilateral K-27 therapy localization. This paper suggests that there is a relationship between cross K-27 therapy localization and dorsum hand therapy localization and that the master points[2, 3] of acupuncture may serve as treatment for resolution of both problems.

Discussion

For purposes of brevity normal therapy localization using the palmar surface of the hand will be abbreviated "TL" while other forms of TL will be described, e.g. dorsum TL.

An area of complaint of a patient that does not respond to TL, but does respond to dorsal TL, has been found fascinating and at the same time frustrating. When this does occur we have normally accepted this fact and proceeded with dorsal TL and fixed whatever we found. But certainly there must be a difference between these two phenomena.

In an optimum state of health areas of TL do not exist. Therefore, TL's are aberrant states of health. Since most people express some areas of TL,

---

*K-27 is an acupuncture point on the body located inferior to the proximal aspect of the clavicle. In Kinesiology it is considered 1) the general neurolymphatic for the entire spine musculature, 2) a primary point where energy switching occurs and 3) house or associated points.[4]

and fewer people present dorsal TL, it might be thought that dorsal TL is a step down from an earlier state of tissue dysfunction, or at least a disease with different characteristics.

This presentation suggests that there is a clinical correlation between cross K-27 TL and an area within the body that expresses dorsal TL. It also suggests that if the area of dorsal TL is corrected, the cross 27 will also be resolved. Dr. Walther's treatment of the cross K-27 includes 1) improper cloacal synchronization, 2) gait involvement, 3) cranial, 4) pelvic structural faults and 5) nutritional deficiencies.[1] I would like to add to this one more possiblity...an acupuncture electromagnetic deficit that is outside of gait involvement. This involves the use of the acupuncture system with the master points of the eight strange flows, as defined by Teagarden and Felix Mann.[2, 3]

In an interesting and useful paper contained in the summer 1980 collection Katherine Hovey, D.C., presents a paper titled "The Use of the Eight Strange Flows."[2] This article discusses the acupuncture or master points, as defined by Teagarden, that are "channels which enable a body to regulate excess or deficiencies of Chi" and that "by releasing the tension of the points that are associated with the strange flows energy is made available to the organ meridian system with a potential of increasing vitality and health." These channels are divided into eight separate divisions with a specific acupuncture point as illustrated in the following Chart:

CHART I

Teagarden[2]	Acupuncture Pt.	Felix Mann[3]	Acupuncture Pt.
1. Yin Great Regulator	CX6	1. Yin Linking Vessel	CX6
2. Yang Great Regulator	T5	2. Yang Linking Vessel	T5
3. Yin Great Bridge	K6*	3. Yin Heel Vessel	K3*
4. Yang Great Bridge	B62	4. Yang Heel Vessel	B62
5. Penetrating Channel	Sp4	5. Penetrating Vessel	Sp4
6. Belt Channel	GB4	6. Girdle Vessel	GB41
7. Conception Vessel	K6*	7. Conception Vessel	L7*
8. Governing Vessel	B62*	8. Governing Vessel	Si3*

*Authorities disagree on which point is involved

These points when digitally or acupuncturally stimulated allow energy to set itself in an area with a dorsal TL or what may be called an area of reverse polarity.

The differences between the master acupuncture points of Teagarden and of Felix Mann needs discussing. Teagarden lists K6 as his point for #3 while Mann lists K3. Teagarden lists K6 for the Conception Vessel and Mann lists L7. Teagarden lists for the Governing Vessel B62 while Mann lists Si3. Using Applied Kinesiology procedure the confusion disappears very quickly. In this mode of reverse polarity K6 is always the dominant acupuncture point for the Yin Great Bridge. However, Mann appears to be correct with Si3 for the Governing Vessel as it appears to be the dominant acupuncture point there.

The Conception Vessel is listed by Teagarden as K6 and by Mann as L7... neither of these points can be confirmed as treating points for the Conception Vessel. The point that appears to be present and TL's in aiding and resolving this problem is L5. Please see the following chart developed with the use of Applied Kinesiology procedures to resolve this problem.

CHART II
(by Alan G. Beardall, D.C.)

1. Yin Great Regulator	CX6	5. Penetrating Channel	CX6
2. Yang Great Regulator	T5	6. Belt Channel	GB41
3. Yin Great Bridge	K6	7. Conception Vessel	L5
4. Yang Great Bridge	B62	8. Governing Vessel	Si3

You will note that the Yin Great Bridge is listed as K6, the Conception Vessel as L5 and the Governing Vessel as Si3. We have found through our work that these points will TL consistently under these specific circumstances.

Demonstration and Correction

1. Test an intact muscle

2. Place the right hand on the left K-27 and place left hand on the right

K-27 (palmar TL); repeat step 1...if this produces a weak muscle, the test is positive.

3. Confirm this by fingertip diagnosis (see "Conclusions" in this article).

4. Test either Gluteus medius or Tensor fascia lata. If intact, proceed by placing the dorsum surfaces of the hands on areas of complaints until the diseased area is located.

5. Palpate area and mark point of greatest pain.

6. Confirm that this is a master acupuncture problem by maintaining dorsum TL and two-pointing to all master points (see Chart II).

7. If the problem fails to two-point to master points, consider other causes (Walther, page 466.)

Treatment

1. While maintaining dorsum TL, approximate thumb and little finger. If this test if positive or two-points, sedate all master points. If this test is negative, points need tonification or rapid stimulation.

2. Treat all master points, then pulse into marked area of complaint. See #5 in foregoing section .

3. Following correction there should be a considerable change of pain and a negative cross K-27 challenge.

Conclusion

If any one of the following conditions appears in the patient's symptomatology or in one's diagnostic procedures, one might think of using the master points of acupuncture: 1) any area of symptomatology which is negative to normal TL but is positive to reverse or dorsal hand TL, 2) a positive cross K-27 TL. If the fingertip diagnosis is being used as outlined by Robert Perolman, D.C., in his book Fingertip Diagnosis,[5] the proper challenge for this

reverse polarity is to approximate the medial aspects of the junction of the proximal and distal phalanges of the thumb while testing an intact muscle to yield the appropriate response. Using this procedure we have had good clinical response in areas that occasionally had given us trouble. We pass this on to you for the benefit of your patients.

BIBLIOGRAPHY

1. Collected papers of ICAK Summer 1980, David S. Walther, D.C., "An Additional Approach in the Treatment of Schizophrenia," pp. 457-467.

2. Collected papers of ICAK Summer 1980, Katherine Ayers Hovey, D.C., "The Usefulness of the Eight Strange Flows in Balancing Body Energy," pp. 281-294.

3. Felix Mann, Atlas of Acupuncture, William Heinemann Medical Books, 23 Bedford Sq., London, 1972.

4. Walther, David S., D.C., Applied Kinesiology, the Advanced Approach in Chiropractic, p. 54, Systems D.C., 1976.

5. Perolman, Robert H., D.C., Fingertip Diagnosis, 4125 Hollywood Blvd., Hollywood, Florida.

NATURAL EMOTIONAL CONTROL

> Our need to harmonize, the inter relating tone between the physical structure and nutritional chemicla state. And the emotional conscious center is graphically apparent the Tràid of Health, the complete whole person balanced and centered, giving and recieving with awareness and purpose is the ideal of man.

It is IMPARATIVE that in applied Kinesiology we respond to this inherent human need, that the emotional side of the triangle is given the attention and expertise that the other two portions of the Triad are given. Here in discuss is an approach to orinate the Dr. to the symphony of interrelating systems with his patient and to provide information for the patients use from the only and accurate source there is, the patients own body.

In addressing this obvious need in many a patients life to find a reasonable prodedure to effectively determine which thought patterns are dominant in their life response. We have formulated the following, relationships between the Meridan system and parent thoughts.[2]

In advancing our progress of attempting to discover our patients STOPPER or HANG UP or OBSESSION or ADDICTION, we offer the following research chart for your use in researching these patterns with those of use already working in this direction, that we may speedily formulate and effective differential diagnostic system of dealing with our patients emotional difficulties. Focusing our attention to the whole man and the Triad of Health.[3]

Application:

Once recidivism has forced our attention to a specific meridan, the process is straight forward, AK procedure;

1. Test the appropriate muscle related to the circuit in question.
2. Note Meridan and negative parent thought pattern on the chart.
3. Select an alternate strong indicator muscle.
4. Have patient repeat a statement

   A._____is not the way I feel. Test using strong indicator muscle.

   B._____ is the way I feel, and retest in the same fashion.
5. If a difference is noted between A and B above proceed to check chart and use one drop of the appropriate Bock Flower Remedy on tongue and repeat step 4B. If indicator muscle is strengthen after B.F.R. you have obtained. If not then go to next step.
6. Temperal Tap both sides while patient repeats the opposite or positive feeling (like I feel calm, I feel calm, I feel calm. Five or six times and then retest 4A and B.) If you obtained you have your answer and proceed in the usual customary fashion. If you did not obtain your on the wrong meridan and proceed all steps above.
7. Finally when you have obtained retest step one above and the muscle should be strong.

Rational:

This simple method can single out and the major energy effecting parent thought so we can deal with it. We have found 30 days, 4 drops of B.F.R. 3 times per day effective. In some cases you may find their surface emotional needs involve 3 or 4 meridan. We check each meridan as outlined above and combine not more than 4 Bock Flower Remedies per prescription.

Further testing in 30 days may reveal a new set of parent thought findings with maybe only one repeater and possibly two new ones. At that time we concentrate mostly on the recidivism in the repeating meridan using the usual and customary AK procedures untill the causing disturbance has been located, discussed with the patient and a treatment program instituted to effectively convert this parent thought pattern in the patients life thought path. One of the most effective short cuts we have found is Temeral Tap with affirmation of the positive parent thought, which we call CONVERSION.

We have found the above procedure to be very effective in most cases. The relationship between the chemistry though patterns and the meridan system are of a high order in mans healing consciousness. I have added the system of relating different emotionally charged words called 'Parent Thoughts" By Dr. Fredrick Bailes and relating these positive constructive thoughts to meridan. We have provided this chart to serve you in testing. We keep the chart on the wall in the treating rooms forrimmediate referral during testing.

By Dr. Jon R. Blossom, D.C.

MERIDAN	MUSCLE	POSITIVE EMOTION	NEGATIVE EMOTION	BACH FLOWER REMEDY
Large Intestine	Fascia Lata	Forgiveness	Guilt	Gorse
Spleen	Trapezius	Security	Worry	Elm
Triple Warmer	Teres Minor	Calmness Elation Blessed	Anxiety Depression Grief	Scleranthus
Bladder	Peroneus	Peace	Impatience	Heather
Small Intestine	Abdominals	Happiness	Sadness	Chicory
Stomach	Pectoralis Major-Clavicular	Openness Pleasant Satisfaction	Greed Disgust Disappointment	Agrimony
Heart	Subscapularis	Calmness	Anger	Wild Rose
Kidney	Psoas	Sexual Auth.	Sex/Indecision	Gentian
Lung	Deltoid	Concern Understanding	Contempt Disdain	Vervain
Liver	Pectoralis	Satisfied	Unhappy	Cerato
Circulation (Sex)	Abductors	Forgiveness Self-Respect Faith	Remorse Regret Jealousy	Heather
Gall Bladder	Anterior Deltoid	Calmness Acceptance	Rage Fury	Holly
Thymus	TL	Loving	Lack of Love	Vine

BIBLIOGRAPHY

Bailes, Frederick, "Help for Human Problems", McGraw-Hill, New York.

Selye, Hans, "The Stress of Life", McGraw-Hill, New York, 1975.

Bach, M.D., Edward, "The Twelve Healers", and "The Flower Remedies", The Bach Center, Mount Vernon, Wallingford, Oxon, U.K.

Diamond, M.D., John, "Unpublised Papers"

Tallman, M.D., Frank F., "Treatment of Emotional Problems in Office Practic", McGraw-Hill, New York, 1961.

Cheraskin, M.D., E., and Ringsdorf, Jr., M.D., W.M., "Psychodietetics, Food as the Key to Emotional Health", Stein and Day, New York, 1974.

RATIONAL APPROACH TO INSTRUMENTATION
with
Neurovascular analysis in the AK Procedure

By Dr. Jon R. Blossom

Neurovascular Analysis has come into the Chiropractice practice as a new dimension in diagnosis and analysis. Instrumentation and Chiropractic are old acquaintance's and the psychological historically and conceptually rest comfortably on the chiropractic physician. Our need to monitor physical changes in the disease to health process, our interest in differential diagnosis and our necessity to determine MMI, are but a few if important logical approaches in the growth of the composite chiropractic professional mind.

I have out lines and offered some detail in the use of NVA in AK pracitce after 8 years intergrading this "New" noninvasive examination in our clinical procedure. I have given below some systems.

First a Specific Purpose Statement:

The vascular analyzer made by Vascular Diagnostic Instruments of Philadelphia is used in our clinics to.

1. Determine and record the state of neuro-vaso-tone perferably.
2. To determine and record the state of vascular tree and outward into the capillary bed.

3. To determine and record if, and how severe, and arterio or venus disease process is present.
4. To determine and record and differentially compare the peripheral vascular vaso spastic or vaso dialtory balance in each limb and each digit.
5. To come to a careful and definitive diagnosis relating to the existing state of the patients health or sickness when considering the neuropathy and autonomic and sympathetic neurovaso control, which is our modus operandi, our territory, our domain in the health field.
6. To monitorprogress (changes) so that we can have clinical statistical backing, for theraputic utilization of our entire health treatment, corrective procedures as the patient passes through different phases of recovery and rehabilitation to MMI.
7. To use the VA as a basis of dismissal or a continuance of maintance therapy procedures.
8. To file records toward preperation of reporting all of the above to 3rd party payers, attorneys and so forth, when questions arise to the need of utilization usual customary procedures and patient response.

The following is the usual and customary methods that I have been applying using NVA in actual practice and 2 clinics for eight years.

First visit after appropriate preliminary interview and history, recommendations are made which include NVA screening, AK exam etc.

Patient is screened with NVA Plethmograph and recorded in the area of suspicion, example, Pleth. on fingers only if my findings included cervical, thoracic problems or TMJ or cranial fault. Feet - if low back, catagories or leg pains, diabetes, or other symptoms would need to be ruled out or identified. If I see evidence of pathology or vaso insufficiency in any digit. The test is repeated and if still positive further NVA tests are recommended to indentify and differentiate.

At this point I would use the full aray of expertise in NVA Scalenecus Anticus. The five minute reactive hyperemia test, leg or arm range of motion vascular studies, muscle test. that have obtained are retested with Pleth. on appropriate digit to relate AK to neurovasco disorder. At this point if pathological indicator warrant then Dopler arterial invus studies are considered and wave forms (heart valves studies, etc.). Expecially during postural blood testing finally if cranial problems are discovered and identified it is imperative to do the dopler vascular studies of the neck and head, which would round out and give excellent basis for treatment or referral.

In eight and one-half years of experience in vascular analysis I have previously written on this subject on several occasions. I clearly recognize that we in the ICAK only bearly understand the significant of NVA. I, implore you if you do not have this particular instrument to lease one, which will

add to your theraputic and diagnostic interest in AK procedures. What we do works, we know it and the body knows it. With vascular analysis we can prove it.

BIBLIOGRAPHY

Kappert, A. and Winsor, T., "Diagnosis of Peripheral Vascular Disease", University of Iowa.

Ciba, "Vascular Analysis of the Head, Neck, and Shoulders".

Homewood, A.E., "The Neurodynamics of the Vertebral Subluxations", St. Petersburg, Valkyrie Press, Inc., 1977.

Peterson, D.C., Andrew, "Segmental Neuropathy, The First Evidence of Developing Pathology," Canadian Memorial Chiropractic College.

McDowell, R.J.S., "Nerve Control of Blood Vessels", Department of Physiology, Kings College, University of London.

THE PATIENT'S POINT OF VIEW

By Dr. Jon R. Blossom

The patient's personality and response to basic life experiences can be discovered from x-rayanalysis. Whether they are aggressive or passive or conformist Or motivator/manipulator types, all have their own Point Of View' and come to us for our recommendations in health care. How well we recognize how they percieve things - Their Point of view' can predict therapeautic cooperation.

Why can a patient get you best professional care for sometime show slow response, quit, go to 'another' doctor, no more qualified than you and respond very well. They often become a lifetime advocate of this 'other' doctor. Why do some patients come to us only for relief, yet others in the same family will cooperate to the fullest extent of their ability? Is it just the way some patients are? Is it just the way of some doctors? Why is it some doctors get a better response with a certain type of patient and bomb out with other patient in the same condition?

Alone at night with our own thoughts, in our solitude we sense there is to often a mismatch between our probessional ability and experience and, certain patients' response to our charisma and professionality. What could we have said ..... How could we have approached them differently? Is it us? Is it them? "What the hell we can not win them all." We sometimes react.....but still we care, do we not? We care about them all...every one of them is important. They are all our mother, father, sister, brother, child, our neighbor on this small planet.

Some are easy, cooperative, some aggressive, suspicious or conspicuous..... yes they are very differnt but there is a common thread of similarity in each of them.

'Them' is the life bloodof our practice. 'They' pay our bills, they enhance

our professional image, and theyrefer. So, the bottom line is that we need them and they need us. So.....how are we going to better understand them.

Doctor Lowell Wards, of Long Beach CA, has developed a very definite system of x-ray analysis with several unigue features, one of which I shall explain here. Dr. Ward state that if a patient adapts to the stress of life leans them forward (anterior) of their Center of Gravity, they are propotionally Aggressive in temper. If they lean backwards (posterior) of their center of gravity they are proportionally Passive.

I have discovered and have added another dimension to this formula. I call it the put past and view.

If the patient is standing, (by measurement), left of center of gravity, that is, their head, (when stress adaptation is calculated), is left of their center of gravity, they are propotionally in the right hemisphere. 25% of my practice is Right Hemisphere Dominant. If they are standing with their head right of center of gravity when adaptative changes are ruled out they are Left Hemisphere Dominant.

As you know, Right Hemisphere Dominant people are creative, flexible, feeling, lossly structured, and emotionally sensitive. The word fantasy describes them well. They often say "there is nothing wrong with me. I do not know why I am here, there is nothing wrong with me," while they are in your office. Left hemisphere Dominant people are logical, detailed, methodicall, precise, rigidly structured people. The amount of definition seems to be proportionate to the number of millimeters of right of left anterior/posterior in the final measurements. Shown here below in fig. 1 are the facts of the formula in a graph of patient who comes to us as right anterior looking down from the top, constructed from A-P and Lateral (14x36), weight bearing series of x-rays.

The LA patient is standing left anterior, meaning they are Right Hemisphere Dominant and aggressive types. They will decide for themselves, they will be concerned much by what you say especially, if you PACE them well, but they are most

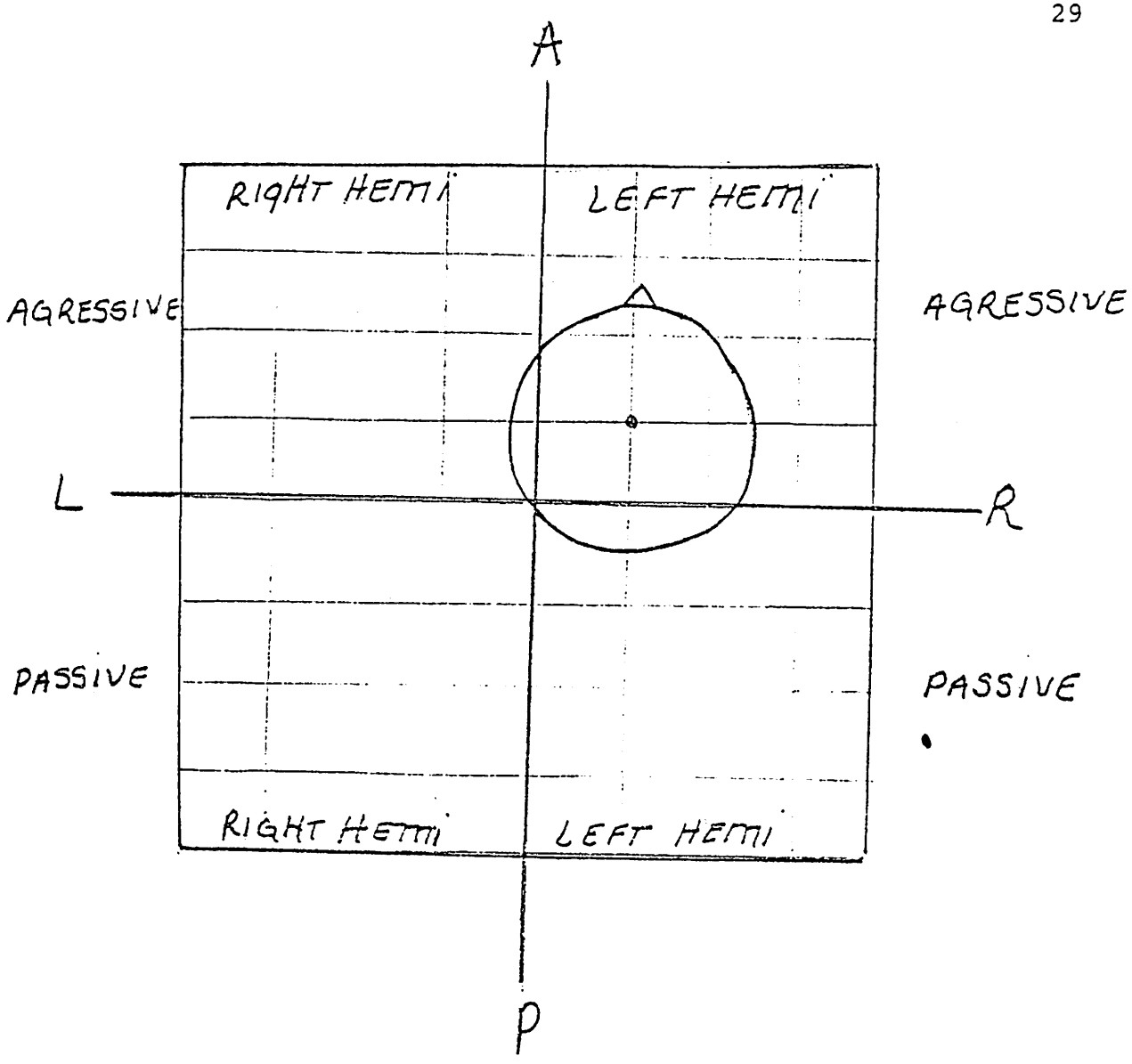


Figure 1

The person above is listed from x-ray measurments as anterior right. If viewed from above he would stand as shown. More weight on right foot.

likely to see if you are concerned by what they say. If they like you and you seem not too rigid or pushy, they will come for a time until they get symptomatic relief. With great effort and finesse on your part, they may return with some regularity. Better collect you fees at once for most likely you may never see them again. They are oftem the macho-types, but because they are usually tribial chieftans. If they really like you they will send you their entire tribe, which will be composed of LH passive. Listed below. The LA type woman are usually mouthy, and very aggressive, independant.

The LP of left posterior is Right Hemisphere Passive and is easily frightened and imagines all sorts of hidden meanings behind what you say, is difficult to get trusting cooperation, their classic psychosis is anxiety neurosis and phobias. These can be very cooperative, but are always very secretive and rarely confide the whole story to anyone until they have tested your trust-ability to the maximum. These are often the 'battered women'

The RA or right anterior is a Left Hemisphere Aggressive, very dominant, stiff headed, rigid, knows it all, doesn't want to know anything that would require a change of opinion, they can never feel they are sorry for anything, are inflexible of the paraniod wusually found as accountants, electronic engineers, line management, foremen, Highway Police or Jewish mothers. The RA doesn't easily accept your new suggestions but they respond well to a strong presentation of the facts, and you charism and leadership as their doctor. Dr. George Goodheart put forth a good example of the kind of professional approach that would appeal to the left hemisphere aggressive.

The RP or right posterior is a Left Hemisphere Passive. They are often secretarys, bookkeepers, teachers, young executives and young mothers' whose children have no cavities, wear braces, take music lessons and were in cub scouts. They are bery conforming types often tribial. They are very cooperative once they decide or are told you can be trusted and will, once they accept you as their

doctor, do what yousay to the letter, forever, or until you loose them because of your craziness.

I hope these findings are helpful to you as they have been to me, and to many of my patients who can now accept my recommendations because I better understand their 'Point of View'. If you do consider this as important you will better be able to serve.

To use these definitions, measure cases you have in your practice now, and chart their position and observe them. Check with your receptionist or head nurse and get their reaction too. Soon it will be apparent. Each person is in their stress adapted state when they appear in our office. To better we use the full scope of our AK training and experise to center and balance them. Only when we are centered can they or we have the full use of all our facilities and be aggressive or passive, fun or logical as we wish. Remember the further away from center the more deep seated the hang ups and the more defensive will they be of THEIR POINT OF VIEW.

The background of the writer for this type monograph includes, the usual profession school and Seminar and understanding that 27 years fo practice provides but also, the writer has taken advanced POST graduate studies at the University of Utah, 1973-1974 and University of Virginia School of Business, 1976 and further as personally studied under the famous writer and researcher Dr. George Odiorne, the father of MBO "Management by objectives" and Dr. Paul Herzberg, a free spirit and world renown researcher of business economics and human potential. The writer has further advanced his studies in this field, by teaching seminars in the business community on Value System Analysis. And is currently teaching a series including B.S.A.

BIBLIOGRAPHY

Dr. Lowell Ward, "The Dynamics of Spinal Stress," O & S Press, Long Beach, Ca., February 1977.

Dr. Charles L. Hughes, Dr. Vincent S. Flowers, Ph.D., Drs. M. Scott & Susan Myers, "Values for Working", Centers for Values Research, Dallas Research.

Dr. John Diamond, "Seven Findings in each Meridan", Valley Cottage, New York, unpublished manuscript.

Dr. Richard Bandler, and Dr. Grinder, "Structure of Magic", Orem, Utah.

Dr. George Goodhart, "Collected Papers", 1974-78.

Dr. George Odiorn, "Managment by Objectives", University Press, Ann Arbor, MI.

Dr. Paul Hurzberg, "Work and the Values of Man", and "Activity Trap", University Press, Ann Arbor, MI.

HOW TO RESIST STRESS

BORRMANN CHIROPRACTIC OFFICE
331 N. Sawyer Oshkosh, WI 54901 Ph. 414-231-8880

HOW TO RESIST STRESS

WHAT IS STRESS?

It has be defined as the non specific response of the body to any demand made upon it. It has also been defined as anxiety or apprehension set off by a threat to some value that the indvidula holds essential to his existence. Or to it another way, their is fear due to a threat to a person's security and peace of mind. All stress requires the common feature of adaptation (fitting your life into the stress).

IS ALL STRESS BAD?

Many psychologists and doctors believe that there is positive energy stress (PES) such as exercise, being excited over a new job, or excited over a new project, or a new relationship with another person such as getting married, engagement ect. These are stresses that are easy for us to bring under control. This is stress at its best.

Than their is negative energy stress (NES) such as constant fear, anxiety, apprehension, guilt, anger, worry, rejection. Stresses that we apparently have no control over. These lead to exhaustive chemical and hormonal imbalances in the body which can result in the malfunctioning of organ and or tissues in the body, which in turn leads to illness or disease (heart attack, cancer, strokes, physical and mental disturbances). This is stress at its worse.

WHAT HAPPENS TO THE BODY WHEN SUBJECTED TO STRESS?

Dr. Hans Selye, M.D. states in his book The Stress of Life that the body responds to stressthrough a natural system known as the General Adaptation Syndrome (GAS). When this system is set off by stress it stimulates the nerve cells in the brain which in turn stimulates a area in the brain called the hypothalamus. When this area is stimulated it causes a release of a hormone called CRH which in turn causes the pituitary gland to secreate another hormone called ACTH. This hormone stimulates the adreanl glands to release the anti-stress hormone adrenalin. Simple? Wait, there is more. The adrenals not only produce adrenalin they produce another hormone called cortisone at the same time. Cortisone is the body's own

natural pain and infection remedy. Cortisone is released by the area of the adrenal called the adrenal cortex, because it cannot tell or determine just which hormone is specifically needed when stimulated by stress.Adrenalin or cortizone.

This mechanism was designed as our "fight or flight" mechanism. That is to say if you are frightened by a noise while walking down a dark street or in your home, your body prepares you for fighting or running. You tense, become more alert, heart beat accelerates, breathing quickens, strength increases. The greater the secretion of these hormones the greater the preparation. People have been known to run for miles, mothers tear off car doors or lift cars off there loved ones when under the influence of massive secretions of these hormones. This is classified emergency stress. It happens and than it subsides, the person feels sudden relief and also feel very drained of energy for a period of time. The adrenal gland has a chance to recuperate as well as the other organs and tissues of the body.

However, when your body is put under constant stress not the "flight or fight" mechanism but constant low stress situations such as not being able to keep your appointements, you don't have a new dress for the party, your boss does not appreciate you, the roof leaks, car payments are due, your husband isn't paying attention to you, people are talking about me my husband wants a divorce, my daughter wants to live with her boy friend, I am pregnant again. Or, chemical stress through the use of processed foods, polluted foods, chemicals in our foods (dyes, preservatives), chemicals in the air ect.

If this type of stress continues over a long period of time your adrenals cannot rest. Your body can no longer cope and becomes easily fatigued, cant sleep, becomes edgy, irritable, drops things, cries easily, menstrual irregularities (painful or irregular), depression or feel like you are having a nervous breakdown and many others.

HOW TO RESIST STRESS

HOW DO WE GET STRESS?

Dr. Arnold Fox M.D. whw has become one of the recognized nation's experts in the field of stress discovered that most patients who entered hospitals or who were in ill health and went to a doctors office were usually victims of:

(1) poor health habits
   a. diet in excess of junk foods resulting in malnutrition.
   b. diet lacking in essential nutrients resulting in malnutrition.
   c. smoking
   d. drinking
(2) emotional stresses (repressions of fears, guilts, rejection, and being double minded or indicision).
(3) lack of spirit (Dr. Fox called the spirit "that energy that gives meaning and purpose to our lives).

Dr. Fox asked himself the question, "why do patients do injury to themselves, many times to the point of destruction?" If we study the above three we find that these habits involve "choice". We all have been given the ability to choose what we should eat or what we should read or what we should drink or what we should think.

I believe that the bible has the answers to this question of Dr. Fox expecially those involving emotional stresses and lack of spirit. In Romans 7:18 it states that in me dwelleth no good thing: for to will is present with me; but how to perform that which is good I find not. We see in Ephesians 6:12 that we are involved with not only poor health habits but powers that influence our thinking. We wrestle not against flesh and blood (its not always poor health habits, diet smoking and drinking that create our problems), but against principalities, against powers, against the rulers of the darkness of this world against spiritual wickness in high places (I believe that this is the spirit that Dr. Fox talks about, when he says "lack of spirit". We lack the spirit to resist the stresses from these principalities and powers that can influence our lives.

In 1 Peter 5:8 we see who is the ruler of these principalities and powers, spiritual wickness in high places. it says we should be sober and vigilant (we should be aware of these powers and spiritual wickness in high places), because your adversary the devil, as a roaring lion, walketh about, "seeking" whom he may devour. Notice it doesn't say he will destroy everyone, he is "seeking" whom he may devour. Looking for a weakness in our habits, emotions our spiritual life, that he can reinforce or deceive us into thinking what we are doing is right for us,while in reality it will destroy us. I think John 10:10 explains very well the purpose of the thief (devil). He comes only to steal, to kill and to destroy. How is this done? how can we be deceived into doing the things we do not want to do. II Corth. 4:4 gives us a clue. In whom the God (satan) of this world hath "blinded" the minds of them which "believe not", lest the light of the glorious gospel of Christ is the image of God, should shine unto them.

Dr. Fox noticed that all these patients with poor health habits, emotional stresses and lack of spirit had one symptom in common, they were ANXIOUS OR DEPRESSED. This seemed to be the result of "lack of spirit", caused by worry, to worry is to fear, being fearful leads to depression. At the root of these symptoms lies and uneasy mind and or double mindedness. And at the root of an uneasy mind or double mindedness is lack of wisdom. James 1:5-8 gives us the two principles necessary to resist an uneasy mind (double mindedness) which leads to ANXIOUS or DEPRESSION. In verse 5 to 8 it states "if any of you lacks "wisdom", he should ask God, who gives generously to all without finding fault, and it will be given to him. But when he asks, he must BELIEVE and not DOUBT, (here are the two principles BELIEVE and DOUBT NOT), because he who DOUBTS is like a wave of the sea, blown and tossed by the wind. That man should not think he will receive anything from the Lord; he is a DOUBLE-MINDED man, UNSTABLE IN ALL HE DOES. Uneasy in our mind or double-mindedness makes us unstable in all that we do. Why the uneasyness? I believe Matthew 6:24-25 gives us the answer. "No one can serve two masters: for either he will

hate the one and love the other, or he will hold to one and despise the other. You cannot serve God and mannon (money). For this reason I say to you, do not be anxious for your life, as to what you should eat, (do not let the stresses of diet, weight losing, weight gaining, maintaing health or youth ect; become your mannon (God), or what you should drink; (do not let alcohol or any other drink become your mannon (God), or for your body, as to what you shall put on (do not let clothing become your mannon (God). Is not life more than food, and the body than clothing? You remmember on page three we see under emotional stresses repressions of fear, guilts and rejection (lack of love) which are all associated with lack of self worth or condemanation not realizing who we are in Christ Jesus.

HOW DO WE RESIST THE STRESSES OF GUILT, REJECTION (LACK OF LOVE)?

I believe Romans 8:1 gives us one the finest answers to guilt and or self condemnation, it says: "There is therefore now no condemnation to them which are in Christ Jesus, who walk not after the flesh, but after the Spirit. All those poor health habits, emotional stresses and lack of Spirit that Dr. Fox speaks about those that we walk after by choice and can result in death or as the Bible says sin and death. However, we find in Romans 8:2 that the law of the Spirit of life (Dr. Fox found that those patients who lacked spirit were in ill health) in Christ Jesus made made me free from the law of sin and death. In Romans 8:35 it asks the questions who shall separate us from the love (Spirit) of Christ? shall tribulation (stresses, or distress (depression), persecution (guilt feelings, or famine (poor health habits), or nakedness (rejection of love), or peril (anxiousness), or sword (fears). These questions I believe covers all the poor health habits, emotional stresses and lack of spirit that Dr. Fox found in his research study of patients who entered hospitals and went to doctors offices. Further on in Romans 12:1-2 it gives the remedy for healing these ills. In Romans 12:1 it gives the cure for poor health habits. I beseech you therefore, brethren, by the mercies of God, that ye present

your bodies a living sacrifice, holy, acceptable unto God, which is your reasonable service. I believe this is saying that you should not allow any habit to control your life whether it is food, alcohol, smoking, excercise programs, meditation programs, work ect. In Romans 12:2 it gives the cure for emotional stresses (worry, depression, guilt feelings, and double mindedness). And be not confromed to this world; but be ye transformed by the renewing of your mind, that ye may prove what is that good, acceptable, and perfect will of God. I believe this is saying that you should not allow your self determination to dictate what is good and acceptable but to allow the will of God to guide your decisions.

Their is another great healer of guilt and rejection. FORGIVENESS. We find several scriptural verses that tell us how forgiveness can be of assistance to our emotional health and for the reneqing of our minds. I John 1:9 states that if we confess our sins, He is faithful and just to forgive us our sins and to cleanse us from all unrighteousness. We know from this verse that we can be forgiven, of God's word is true. Jeremiah 31:34 adds to this by saying that God will not only forgive our iniquitys but will remember our sins no more. God not only forgives but he forgets we ever committed them. In the Lord's prayer (Matthew 6:12-15) we ask God to forgive our debts, as we forgive our debtors, for if we forgive men their trespasses, your heavenly Father will also forgive you. But if ye frogive not men their trespasses, neither will your Father forgive your trespasses. Here we see their is a condition to forgivness, we must forgive in order to be forgiven. Ephesians 4:32 continues with this thought be ye kind one to another, tenderhearted, forgiving one another, even as God for Christ's sake hath forgiven you.

All of these scripturastell us we can successfully resist stress by applying prevenative health care not only to our bodies but also to our soul (mind, double mindedness) and our Spirit (feeding our Spirit with the word of God). By understanding that nothing can separate us from the love (Spirit) of Christ if we but transform and renew our minds to what is good and acceptable and perfect will of God and

present our bodies a living sacrifice unto what is good and acceptable for reasonable service for our body, soul and Spirit. We could than help shape a society in which, instead of dying old early in life, we could live to be young in later life.

When we look at the destructive habits that effect our bodies, soul and spirit we find it spells out the five letter word D E V I L.

D - diet excess or lack of proper food and drink.
E - emotions and senses, living to satify our senses and emotions.
V - vitality, that lack of Spirit that gives meaning and purpose to our lives.
I - ill health, that results with the abuse of the above three.
L - lack of love, we live our lives with out love and subsitute hate, anger, malice and envey.
The old saying "living like the devil" fits this way of life.

However when we look at the principles that prevent these destructive habits on the body, soul and spirit we find it spells out the three letter word G O D.

G - Grace. Corth. 9:8 having all sufficiency in everything, you may have an abundance for every good deed.
Rom. 6:14 for sin (stress, guilt, anxiousness, depression ect.) shall not be master over you for you are not under the law but under grace.
Corth. 12:9 my grace is sufficient for you for His power is perfected in weakness.
Eph. 2:8 For by grace are ye saved through faith (believe), and that not of yourselves, it is the gift of God, not of works, lest any should boast.
O - Offering. John 3:16 For God so loved the world, that <u>he gave</u> his only begotten Son, that <u>whosoever</u> believeth in him should not perish, but have everlasting life. Notice God gave first before He expected any thing to occur.
D - Deliver. John 3:17 For God sent not his son into the world to condemn the world; but that the world through him might be

saved.
John 3:8 He that comitteth son is of the devil; (living like or for the devil as we described under the five letter word devil) for the devil sinneth from the begining. For this purpose the Son of God was manifested, that he might destroy the works of the devil.

What are we saying with these destructive habits and God's principles? In these destructive habits you will notice that they are centered around the individual himself or herself. Things or pleasures have become the destructive elemements in their lives. In the principles of God rather than destroying the body, soul and spirit we find we have master over sin (destructive habits through His free gift of grace. We find that we are to give of ourselves first and to love one another first as He loved us first, and gave the best of Himself,His Son. We are not to get involved with things and pleasures and to make them the center of our lives. Romans 12:3 says it this way For I say, through the grace given unto me, to every man that is among you, not to think of himself more highly than he ought to think; but to think soberly, according as God hath dealt to every man the measure of faith. And in Romans 12:9 Let love be without dissimulation. Abhor that which is evil; cleave to that which is good. We are to resist evil (sin-destructive habits) as it says in Romans 12:21 Be not overcome of evil, but overcome evil with good. And in Romans 12:17 Recompense to no man evil for evil. Provide things honest in the sight of all men.

We have been speaking about how we can resist the stresses of emotions and lack of spirit and how they can begin. And how we can use God's word to resist. Now let us talk about the type of person that may suffer from stress.

STRESS CLASSIFICATIONS

At the International Symposium on Mangement of Stress. Stress was classified into three types and how they effect the individual.

HOW TO RESIST STRESS

(1) The type A individual: those that externalize their stress. These are the patients who are hard driving, excitable, volatile, success oriented at all costs, career person, clockwatcher, appointment watcher. They allow themselves no relaxing time. They constantly put themselves under short term stress which turns into long term stress. The adrenals over work constanly pouring adrenaline into their system. They may eventually suffer from heart attacks, obesity, hypertension, ulcers, colitis, gastritis, indigestion, strokes, ect.

These people are striving to be successful either business wise or self wise (which would include housewives that maintain the perfect house, give the best parties, wear the best dresses, have the best children, cook the best meals ect). How do we resist this type of stress? I believe this type of stress revolves around personal attitute or self attitute or to say it another way self and things are important to me to the point of self destruction. What does God's word say about this type of striving stress? Proverbs 23:4 states Do not wear yourself out to get rich; have the wisdom to show restraint. And in Matthew 6:19-21 it says Do not store up for yourselves treasures on earth, where moth and rust destroy, and where thieves break in and steal. But store up for yourselves treasures in heaven, where moth and rust do not destroy, and where thieves do not break in and steal. For where your treasure is, there your heart will be also. This thought continues in verse 24. No one can serve two masters. Either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve both God and Money. Matthew continues with the answer to this problem in verse 33. But seek first his kingdom and his righteousness, and all these things will be given to you as well.Therefore do not worry about tomorrow, for tommorrow will worry about itself. Each day has enough trouble of its own. God always lives in the present now. With God there is no tommorrow, or yesterday only now. We should always live in that present now, for we are always one heart beat away from eternity and God's

righteous judgement.

(2) The type B individual: are those that are resistant to stress react calmly to it. These people can handle short term stress as well as long term stress. They rest after each stressful peroid and live their life with optimism. calmly, and participate moderately in all things. There was no further discussion on this type of individual as to what their diets were or to their beliefs.

(3) The type C individual: those that internalize their stress. This type is recognized as the cancer type. They tend to repress their feelings and keep them inward (anger, hate, impatience, jealously, malice, envey, ect). This causes the adrenals to be stimulated by the hypothalamus (the emotional control center in the brain) to produce a cortisone type hormone which depresses the body's immume system as well as other systems which leaves the body open to attack to cancer, arthritits, colds, flu, depression, impotence, rapid aging, ect.

I must make note that in the type A and C individual they did not discuss the type of diet these people were on or what their beliefs were.

HOW DO WE RESIST STRESS OF THE SPIRIT?

Since man lives in a body that has a soul and a spirit I believe that all of these areas must be treated. We must investigate the life style that we are in to find any destructive habits that we might have in the areas of body, soul (mind) and spirit.

If you remmember Dr. Fox felt that if the persons spirit was in depression (he called it lack of spirit) it was one of the basic causes of ill health. What spirit is it that is lacking? I believe I John 4:12-13 gives us the answer: If we love one another God dwelleth in us, and his love is perfected in us. Hereby know we that we dwell in Him, and He in us because He hath given us of

His SPIRIT (HIS LOVE. A LOVE THAT NEVER FAILS. THAT RESISTS ALL STRESS

WHAT ARE THE FRUITS OF THIS LOVE?

Love is: patient....is kind....does not envy....does not boast.... is not proud....is not rude....is not self-seeking....is not easily angered....does not delight in evil....rejoices with the truth.... always protects....always trusts....always hopes....always perseveres.. never fails....I Corinthians 13:4-8

For the spirit to be successful in resisting stress their must be a absolute dependence upon the reliance in the Word of God. To have FAITH - HOPE and LOVE in the acceptance of Christ as the substitute for sin and our Saviour.Whereby one receives salvation (born again experience). And in the fulfillment of the promises of God for our righteousness, sonship, healing, enternal life and answers to our every day prayers.

HOW DO WE RESIST STRESS OF THE SOUL (MIND)?

Man's soul, feelings, emotions, free will and 5 senses. Taste, touch, smell, sight, and hearing. We use our free will to satisfy our five senses and or fleshy appetites. To resist this stress of the mind which involves our free will,centers around our imaginations. For as a man thinks so is he and so he reacts to his or her environment. 2 Corinthians 10:5 states that we should bring into captivity every thought to the obedience of Christ. To say it another way. We must demolish arguments and every pretension that sets itself up against the knowledge of God, and we should take captive every thought to make it obedient to Christ. That includes any thinking which is contrary to virtue, love, purity faith and hope. I think Hebrews 4:12 gives us complete answers to all of our stress problems including the body. The word of God is living and active. Sharper than any double-edged sword, it penetrates even to dividing soul and spirit, joints and marrow; it judges the thoughts and attitudes of the heart.

It continues in verse 13, with Nothing in all creation is hidden from God's sight. Everything is uncovered and laid bare before the eyes of him to whom we must give account.

HOW DO WE RESIST STRESS OF THE BODY?

Man must eat in order to live and he must drink water in order to live. Again man uses his soul (mind) which is his free will to choose what he will eat as he determines what he should think. Now, comes the question does the body dictate to the mind what it wants to eat or does the mind dictate to the body what it is going to eat. If we consistently choose these high stress foods we lower the ability of our body to resist mental (soul) and spiritual (lack of spirit) stress.

STRESSFUL FOODS: Coffee, tea, alcohol, tobacco, sugar, white flour, salt, refined carbohydrate foods, cooked fats, fried foods, food additives, food coloring, preservatives, prepared foods (pre-cooked) smoked foods, over cooked foods, soft drinks, diet soft drinks, powdered coffee and de-caffinated coffee, mustard, pepper (black), and any food that you would be allergic to.

STRESSFUL CHEMICALS-PLASTICS RELATED TO CANCER:
Benzo-Pyrene (tobacco smoke), lipid peroxides (oleo-margine), hair dye,Di-ethylstilbesterol (DES), female estrogen hormone found in meats, birth control pills, menopause shots, vinyl chloride (plastic containers bags, wrappings), anti-perspirants, nitrosamine-nitrites found in meats (forms nitrosamines when cooked), pesticides and or any other chemicals that are used around the house for cleaning.

We must learn to not only indentify our stressors but also how to manage them and in many cases to stop using them or at least to use them only occasionally. Foods should only be eaten that will add the nutritional elements necessary for your health of body, soul and spirit. One should always ask about a food or drink whether this food or drink will add to my health or subtract.

HOW TO RESIST STRESS

To resist stress adequate amounts of nutrients must be supplied. With adequate nutrients the body can manufacture the necessary hormones to balance body chemistry and repair any damage to the adrenals and other hormone secreting glands that could have malfunctioned because of the demands placed on them with continued stress.

B vitamins and vitamin C are essential for the conversion of starches, proteins and cholesterol into usable energy. A deficiency in any one creates a deficiency in all and will in time seriously affect a person's energy level as well as lead to emotional problems, depression and if severe enough, a total nervous breakdown. The adrenals need the B vitamin pantothenic acid (B5) along with the the B vitamin niacin or niacinamide (the niacinamide does not create flushing as does niacin, if this flushing disturbs you use the niacinamide), and also vitamin C. These nutrients are necessary to the adrenal cortex to produce adrenalin and cortisone. A lack of these nutritional elements can result in adrenal exhaustion very quickly even when no stress is involved.

The mineral calcium is needed to assist B-complex vitamins in calming the nervous system. The mineral magnesium is needed to assist carbohydrate utilization and calcium absorbtion, as well as assisting calcium and the B-complex vitamins in preventing muscle cramping and or spasms and to maintain a calm nervous system.

Many patients suffer from insomnia because of the stress they are under or because of the lack of the amino acid l-tryptophan, which is needed for the production of the hormone serotonin, which is responsible for natural sleep. Tryptophan is also needed by the B-complex group, especially B6. Lack of Tryptophan aggravates B6 deficiency. If necessary the body can convert tryptophan to niacin. Niacin and B6 essential to prevent pellagra and nervousness and or anxiousness. On the following pages we have listed VITAMIN, MINERAL FORMULATIONS for stress, and GLANDULAR CONCENTRATES, ENZYMES and HERBS useful in resisting stress.

VITAMIN FORMULATION TO RESIST STRESS

This formulation also resists aging by improving the oxygen supply to the body.

Vitamin A	10000	to 15000	I.U.	per day.
Vitamin B1 (thiamine)	10	to 50	Mg.	per day.
B2 (riboflavin)	10	to 50	Mg.	per day.
B3 (or niacinamide)	15	to 100	Mcg.	per day.
Vitamin B6 (pyridoxine)	10	to 50	Mg.	per day.
Vitamin B12 (cyanocobalamin)	25	to 100	Mg.	per day.
Folic acid	75	to 100	Mcg.	per day.
Pantothenic acid	50	to 300	Mg.	per day.
PABA (Para-Aminobenzoic Acid)	30	to 300	Mg.	per day.
Biotin	25	to 50	Mcg.	per day.
Choline	100	to 500	Mg.	per day.
Inositol	100	to 500	Mg.	per day.
Vitamin C	1000	to 5000	Mg.	per day.
Bioflavonoids	100	to 300	Mg.	per day.
Vitamin D	1000	to 2000	I.U.	per day.
Essential Fatty Acids	10	to 30	grams	per day.
Vitamin E (d-Alpha tocopherol)	100	to 1600	I.U.	per day.

MINERAL FORMULATION TO RESIST STRESS

Calcium	1000	to 2000	Mg.	per day.
Phosphorus	1000	to 2000	Mg.	per day.
Magnesium	400	to 800	Mg.	per day.
Manganese	5	to 20	Mg.	per day.
Potassium	30	to 50	Mg.	per day.
Zinc	15	to 40	Mg.	per day.
Iron	10	to 25	Mg.	per day.
Copper	0.5	to 2	Mg.	per day.
Iodine	0.15	to -	Mg.	per day.
Chromimum	1.0	to 2.0	Mg.	per day.
Selenium	0.02	to 0.03	Mg.	per day.

GLANDULAR CONCENTRATES USEFUL IN RESISTING STRESS

These concentrates have been found useful in assisting organs in resisting stress due to mental as well as physical stresses.

Thymus concentrate	60	to	140	Mg.	per day.
Spleen concentrate	15	to	250	Mg.	per day.
Adrenal concentrate	15	to	80	Mg.	per day.
Hypothalmus concentrate	15	to	30	Mg.	per day.
Liver concentrate	15	to	455	Mg.	per day.

ENZYMES USEFUL IN RESISTING STRESS

These enzymes useful in assisting digestion and improving the oxygen supply to the body.

Superoxide Dismutase Enzyme	50	to	-	Mg.	per day.
Protease Enzyme	150	to	-	Mg.	per meal.
Amylase Enzyme	140	to	-	Mg.	per meal.
Lipase Enzyme	25	to	-	Mg.	per meal.
Cellulase Enzyme	10	to	-	Mg.	per meal.

HERBS THAT HAVE BEEN FOUND USEFUL IN RESISTING STRESS

These herbs may all be mixed together (one teaspoonful of each) or mix at least 4 or 5 together and make into a tea. Put mixture of tea into a cup and pour boiling water over tea and let steep for 10 to 15 min. Drink one cup in the morning and one cup at night. Black cohosh, Blue cohosh, Comfrey, Camomile, Catnip, Celery, Dill, Garden sage, Ginseng(Siberian), Hops, Valerian root, Garden parsley, Red clover, Rosemary, Vervain, Peppermint and Lady Slipper, Kelp,

If you mix all the herbs together take two teaspoons of this mixture and prepare as you would the 4 or 5 teas we mentioned above. Drink one cup of this tea morning and evening.

WHAT ABOUT EXERCISE?

Exercise is a valuable tool to aid in the release of excessive stress. However, many times we are to tired to begin a exercise program. In these cases we advise you follow the dietary recomendations we listed on the previous pages for several weeks or until you receive enough energy to begin your exercise program. Begin with the maximum dosages and after your energy is were you wish it reduce to the minimum dosage.

IN CONCULSION

We have tried to give you as much spiritual information on how to handle stress as well as nutritional helps to resist stress in all three areas of man's nature BODY, SOUL and SPIRIT.

I believe with these tools we can not only control stress - even if we can't totally avoid it, but we can also strengthen our spiritual life. By eating properly and using specific vitamin, mineral, glandular, enzyme and herbal formulations we can maintain the body's own restorative powers to not only resist the LOW GRADE STRESS but HIGH GRADE STRESS as well.

By using these tools that God has given us we can be sure that when stress does raise its ugly head your mind as well as your body and spirit will be prepared to handle the stress efficiently.

STRESS SELF-EVALUATION QUESTIONNAIRE

INSTRUCTIONS: Circle the number to the right of it which you think best characterizes yourself and your behavior at the present time. There are no right or wrong answers. Do not spend too much time over each answer. Add up all of the numbers that you have circled. Scores between 30 and 50 indicate a low degree of stress. If you scored under 30, you are either virtually without stress or may have misunderstood some of the questions. Scores between 51 and 70 indicate a moderate degree of stress. Scores between 71 and 99 indicate a high degree of stress.

		DOESN'T OCCUR	OCCURS SLIGHTLY	OCCURS MODERATELY	OCCURS OFTEN
1.	I often lose my appetite, or eat when I am hungry?	1	2	3	4
2.	Do minor problems and disappointements upset you?	1	2	3	4
3.	My decisions tend to be more impulsive than planned?	1	2	3	4
4.	I tend to feel unsure about my choices and change my mind often?	1	2	3	4
5.	Do you find it difficult to get along with people?	1	2	3	4
6.	Are people having trouble getting along with you?	1	2	3	4
7.	The muscles of my neck, back or stomach frequently get tense.	1	2	3	4
8.	Do the small pleasures of life fail to satisfy you?	1	2	3	4
9.	I have thoughts and feelings about my problems that run through my mind for much of the time?	1	2	3	4
10.	Are you able to stop thinking about your anxieties?	1	2	3	4
11.	I have a hard time getting to sleep, wake up often feel most of the time?	1	2	3	4
12.	Do you fear people or situations that never used to trouble you?	1	2	3	4
13.	I feel the urge to cry or to excape and get way from many of my problems?	1	2	3	4
14.	Are you suspicious of people, mistrustful of your friends?	1	2	3	4
15.	I tend to let anger build up and then explosively release my temper in some aggressive or destructive way?	1	2	3	4
16.	Do you have the feeling of being trapped?	1	2	3	4
17.	I have nervous habits (tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands, etc.)	1	2	3	4

		DOESN'T OCCUR	OCCURS SLIGHTLY	OCCURS MODERATELY	OCCURS OFTEN
18.	Do you feel inadequate, suffer the tortures of self doubt?	1	2	3	4
19.	I often feel fatiqued, even when I have not been doing hard physical work.	1	2	3	4
20.	I have regular problems with constipation, diarrhea, indigestion, and or nausea.	1	2	3	4
21.	I lose interest in sex quite often.	1	2	3	4
22.	I get angery very easily?	1	2	3	4
23.	I have nightmares, bad dreams and or unhappy dreams.	1	2	3	4
24.	I tend to worry over things more often than not?	1	2	3	4
25.	I tend to drink to much? It calms my nerves.	1	2	3	4
26.	I tend to smoke to much? It calms my nerves.	1	2	3	4
27.	I tend to drink more than 3 cups of coffee per day?	1	2	3	4
28.	I am on tranquillizers or other drugs to calm my nerves?	1	2	3	4
29.	I feel anxious for no apparent reasons?	1	2	3	4
30.	I am short tempered and irritable with people for no reason?	1	2	3	4
31.	When I have to wait or I am delayed for any reason I get very impatient, many times angry?	1	2	3	4
32.	I dont feel as if I living up to my expections of myself either because I have taken on more than I can handle or I have set unrealistic goals for my self?.	1	2	3	4
33.	When I talk my speech becomes tense, weak or rapid words run together.	1	2	3	4
34.	I tend to have bouts of depression for no reason?	1	2	3	4
35.	I have had thoughts of taking my own life or leaving my husband, wife, children, parents. I just cant the situation I am in attitute? I feel like I am going to have a nervous breakdown?	1	2	3	4

TOTALS

T.M.J. AND HYPERTENSION

By

John D. Campbell, D.C.

ABSTRACT: In an effort to isolate specific causes of essential hypertension, therapy localization to the carotid pulse was utilized. When a positive therapy localization was encountered, the free hand was then used to therapy localize the Temporal Mandibular Joint. A significant number of patients have shown that the Temporal Mandibular Joint is a frequent cause of essential hypertension.

As I reported in a paper presented to the I.C.A.K. in 1977, therapy localization to the carotid pulse with one hand yielded a weakening of a previously strong indicator muscle in cases of abnormal blood pressure.[1] The free hand can then be utilized to therapy localize different areas of the body in an effort to find an area which would negate the positive therapy localization response.

At that time I stated that no one area seemed to be more involved than another. Since then further investigation has shown a large percentage of Temporal Mandibular Joint involvement associated with essential hypertension.

Standard correction of the involved musculature of the T.M.J. by spindle cell correction is frequently all that is required to correct the hypertensive state. This is, of course, assuming you have corrected all other factors related to the dysfunction of the T.M.J. (Hyoid, subluxations of the spine, lymphatics, etc.).[2]

PATIENT EXERCISE

1. Open the patient's vertical by placing tongue depressors between the molars without them touching the buccal cusps of the upper molars.

2. Test a middle deltoid to make sure that you have not increased the vertical by too much.

3. Have the patient slide their mandible forward, again using the deltoid to check for proper position.

4. Have the patient continue to bite gently on the blades for a few minutes each day.

5. If the patient feels at all light headed, just have them remove the tongue depressors from their mouth and gently push back on the mandible a few times.[3]

Have the patient continue with this exercise for one month. If at the end of that time there is still an imbalance of the T.M.J., they should be refered to a dentist to be fitted with an appliance.

You may wish to check their blood pressure on a weekly

basis while they are doing the jaw exercises and every two weeks for a few months after they stop the jaw exercises.

REFERENCES

1. Campbell, John D. Collected Papers of the Members of the I.C.A.K., "Therapy Localization and Blood Pressure", Winter, 1977.

2. Goodheart, George J., D.C. Applied Kinesiology 1976 Workshop Procedure Manual, privately published, 1976.

3. White, James E. D.O. and Odaffer, R.G., D.O. "A Screening Test for TMJ Dysfunction", paper submitted to: American Osteopathic Association Research Conference (1979).

ENERGY AND THE EYES

BY

JOHN D. CAMPBELL, D.C.

ABSTRACT: THERE IS EVIDENCE THAT THE EYES MAY BE RECEPTORS OF ENERGY. AS SUCH THEY MAY DRAW IN ENOUGH ENERGY TO MAKE MUSCLES TEST STRONG IN THE CLEAR YET A WEAKNESS IS INDICATED BY TEMOPRAL SPHENODIAL LINE PALPATION.

DURING APPLIED KINESIOLOGICAL EXAMINATION OF MANY PATIENTS IT WAS NOTED THAT A MUSCLE WOULD TEST STRONG ONE MOMENT THAN TEST WEAK A MOMENT LATER. THIS OCCURED EVEN THOUGH NOTHING HAD BEEN DONE TO THE PATIENT BETWEEN TESTS.

OBSERVATION OF THE PATIENT SHOWED THERE WAS NO THERAPY LOCALIZATION AND EXTREME CARE WAS TAKEN TO MAKE SURE THE MUSCLE WAS BEING TESTED THE SAME WAY EVERY TIME.

IT WAS FINALLY NOTED THAT IF THE PATIENT CLOSED HIS EYES THE STRONG MUSCLE SUDDENLY BECAME WEAK.

AT FIRST IT WAS THOUGHT TO BE RELATED TO THE FUNCTION OF THE PINEAL GLAND.[1] RE-TESTING THE MUSCLE WITH THE EYES CLOSED AND PLACING PINEAL SUBSTANCE SUB-LINGUALLY RESULTED IN NO CHANGE, THAT IS THE MUSCLE STILL TESTED WEAK WITH THE EYES CLOSED AND STRONG WITH THE EYES OPEN.

THERAPY LOCALIZATION TO VARIOUS ASSOCIATED REFLEX POINTS WHILE THE EYES WERE OPEN ALSO PRODUCED A WEAKENING OF THE MUSCLE. (THE FIFTY ONE PERCENTER)[2] .

IF THE ASSOCIATED REFLEX POINT WAS THERAPY LOCALIZED WHILE THE EYES WERE CLOSED THE MUSCLE REGAINED STRENGTH.

IN SPEAKING TO DR. GOODHEART ABOUT THIS PHENOMINA, HE SUGGESTED TESTING WITH LEAD COVERING THE EYES TO DETERMINE IF AN EXOGENOUS SOURCE OF ENERGY WAS CAUSING THIS REACTION.

TWO LEAD DISKS WERE FASHIONED SO AS TO COVER THE EYES YET ALLOW FREEDOM OF MOTION OF THE EYE LIDS.

PATIENTS FOUND TO HAVE MUSCLE WEAKNESS ONLY WITH THE EYES CLOSED WERE TESTED WITH THE LEAD DISKS PLACED OVER THEIR EYES. THEY WERE INSTRUCTED TO KEEP THEIR EYES OPEN DURING THE MUSCLE TESTING. WHEN THE PREVIOUSLY STRONG MUSCLE WAS NOW TESTED IT WAS FOUND TO BE WEAK.

IN ORDER TO DETERMINE WHETHER LIGHT NOT BEING ALLOWED TO REACH THE EYE WAS A FACTOR THE DISKS WERE REFORMED SO AS TO ALLOW LIGHT TO ENTER INDIRECTLY FROM THE SIDES.

THE MUSCLE WHICH WEAKENED WITH THE EYES OPENED, BUT COVERED WITH THE LEAD DISKS, REMAINED WEAK EVEN THOUGH LIGHT WAS ALLOWED TO INDIRECTLY REACH THE EYES.

DETERMINATION OF HOW MUCH OF AN ENERGY FILTERING EFFECT THE EYE LIDS HAVE, THE EYE CLOSED TESTING WAS

RE-DONE WITHOUT UTILIZING THE LEAD DISKS.

AS BEFORE THE MUSCLE THAT WAS STRONG IN THE CLEAR WEAKENED WHEN THE EYES WERE CLOSED. INSTRUCTING THE PATIENT TO KEEP THE EYES CLOSED, THE MUSCLE WAS RE-TESTED EVERY TEN SECONDS. SO FAR ALL THOSE THAT HAVE BEEN TESTED HAVE REGAINED THE ORIGINAL MUSCLE STRENGTH AFTER APPROXAMATELY THIRTY SECONDS.

CONCLUSION:

THE EYES MAY BE ANOTHER AVENUE FOR ENERGY TO ENTER THE BODY. AS ENERGY RECEPTORS THEY MAY BE PROVIDING THE ENERGY NEEDED TO STRENGTHEN SUB-CLINICLY WEAK CIRCUTS THUS PRODUCING THE "FIFTY ONE PERCENTER" [3].

REFERENCES

1. GOODHEART, GEORGE J., D.C. APPLIED KINESIOLOGY 1979 WORKSHOP PROCEDURE MANUAL, PRIVATLY PUBLISHED, 1979.

2. GOODHEART, GEORGE J., D.C. APPLIED KINESIOLOGY 1976 WORKSHOP PROCEDURE MANUAL, PRIVATLY PUBLISHED, 1976

3. IBID.

FINDING RELATIVE LEVELS OF CHROMIUM IN THE PATIENT.

By Hugh G. Carruthers, D. C., Diplomate, I.C.A.K.

ABSTRACT: A set of simple kinesiological tests are available to rapidly and accurately determine if your patient possesses a biologically sufficient amount of the trace mineral chromium, or if this element is present in excessive proportions.

Chromium is a trace mineral which is quite necessary in the metabolism of sugar and regulation of sugar levels within the body. In many cases of funtional or reactive, hyperinsulinism, chromium may be the "missing link" between success and failure with regard to clinical outcome. It is therefore necessary for the practitioner to be able to simply and accurately assess relative levels of this important element within the patient from time to time without having to wait for the results of a blood or hair mineral assay from the laboratory.

This test is accomplished by selecting any strong, convenient test indicator muscle (TIM), therapy localize a certain point on the anterior torso (using the fingertips of either the doctor or the patient) and restesting the TIM. The point in question lies along the anteromedial border of the left rib cage in the left upper abdominal quadrant. It corresponds to the location of acupuncture point GB24 on the left; this is because the point in question is located over the tail of the

pancreas, which is the home of the isles of Langerhans, the beta cells of which manufacture and secrete insulin, of which chromium is a vital component.

If the TIM becomes weak upon retesting after therapy localizing this point, the patient is deficient in chromium. Placing a tablet of yeast with chromium (Nutritional Biological Labs, Sivad, etc.) in the patient's mouth and having him or her wet it thoroughly with saliva (but without necessarily chewing the tablet) will promptly restore normal strength to the TIM. This differentiates between a nutritional deficiency and an excess of energy within the left gallbladder meridian. In fact, for purposes of demonstration of this phenomenon (for skeptical patients, or during a lecture demonstration or television appearance), you may have the test subject remove the wet tablet, rinse the mouth thoroughly with water and perform the test a second time. The TIM will once again become weak upon therapy localization of the area over the tail of the pancreas.

In order to test for excess levels of chromium (which can also be corroborated by a tissue mineral assay via hair analysis), have the patient apply a double therapy localization using both hands simultaneously while you test any previously strong muscle of the neck or lower extremities. If the TIM in this case becomes weak, it is indicative of chromium excess.

Using this set of test indicators, you may perform a running monitor on relative chromium levels in cases

of blood sugar dyscrasias each week or each month, at your discretion, during the active phase of a patient's treatment program.

As a final notation, we have adopted a technique employed by Sheldon Deal, D. C., N.D. He has the patient refrain from ingestion of any nutrients on the day the test is to be performed. This ensures greater accuracy in quantitative determinations.

IS THE PATIENT "SWITCHED" OR NEUROLOGICALLY "CRISS-CROSSED?"

By Hugh G. Carruthers, D. C., Diplomate, I.C.A.K.

ABSTRACT: There is a simple, rapid and accurate way to determine whether or not each patient is switched, in advance of any treatment, without having to resort to the heavy rubbing of K27.

Some practitioners of Applied Kinesiology routinely "unswitch" each patient prior to any muscle testing by employing the technique of a hard, brisk rubbing for a second or two of the acupuncture point K27. In fact, some offices even have an assistant perform this procedure before the doctor has an opportunity to examine the patient. In view of certain recent developments of technical research published by the International College of Applied Kinesiology such as the left/right brain splitting mechanism (Goodheart), contralateral limb testing for gait reflexes (Beardall), et cetera, this writer feels that it is important to know in advance whether or not a patient is or is not "switched."

The technique for this investigation is simple and rapid, yet effective. Use any strong lower extremity muscle as a test indicator muscle (TIM). Have the patient therapy localize the left K27 with the fingertips of the right hand and, conversely, TL the right K27 with the fingertips of the left hand. If the TIM remains strong, the patient is neurologically balanced. But if the TIM becomes weak, this indicates that the patient is in fact, "switched."

Having determined the patient's status (which requires all of about 5 seconds), you may take appropriate clinical action.

A PROPOSED FORM OF RECORD KEEPING FOR A BUSY KINESIOLOGICAL PRACTICE

By Hugh G. Carruthers, D. C., Diplomate, I.C.A.K.

ABSTRACT: Accurate, complete record keeping can become a time-consuming, laborious chore, especially if clinical notes on each patient are kept by written comments in long-hand. As a practitioner becomes increasingly more busy, he or she has a tendency to drift away from record keeping. At the very least, this does not allow good clinical follow-up; at the very worst, no records can be disasterous in case of a malpractice action. The Boy Scout motto is "Be Prepared!" In order to help you do that, we have devised an office patient record form which has gone through a series of time-tested metamorphic alterations until it has achieved the final form which you see, here. You are invited to copy this and utilize it in your own office; we are not in the business of selling forms.

Precise and rapid record keeping is vitally important for any practitioner in the health sciences. What was done to each patient on every visit to the office, or on each house call? If you see any substantial number of patients, there is literally no way that you can remember individual forms of treatment application from visit to visit.

The patient record form depicted on the succeeding pages is one which has evolved over a long number of years in our office. Rather than having to sort through a chart in search of a particular page, we put this together as one unit, light blue in color for easy identification and location, twelve pages in length and center stapled. It is now a pleasure to quickly and accurately chart a patient's daily symptoms, treatment and progress.

The first two pages are used at the time of initial consultation and examination. They serve as ready reminders of that person's original condition. Credit must be given to Flavian Santavicca, Jr., D. C., Boca Raton, Florida, with regard to the examination record for this is an adap-

tation of his original clinical examination form.

The third page is a running commentary on how the patient feels from visit to visit.

Fourth and fifth pages deal strictly with kinesiological examinations, organ systems, cranial faults, spinal fixations, nutritional and acupuncture components of the patient's involvement.

The center-fold two pages (six and seven) are the "stars of the show!" The subject of Applied Kinesiology is so complex and still expanding with new knowledge that many doctors are frightened away from considering its use in their practice. A systematized, organized method of record keeping may well be the factor which could change that prevalent attitude. This one form, shown on these two pages, is the heart of any kinesiologist's record keeping system.

The next two pages (eight and nine) deal with skull, spinal, pelvic and extremity adjusting plus the deep pressure pain control techniques such as Nimmo or Rolfing.

The remaining three pages (ten, eleven, twelve) may be kept intact or may be altered to suit your individual practice. You may wish to include a laboratory testing record or a nutritional chart in this area.

Our symbols and abbreviations are listed below; you may feel free to adopt them to your practice if you should care to do so. They have served us well. The succeeding pages of this paper will be displayed opposite each page of the record form so that detailed instructions can be enumerated.

The writer is proud of this recording form. He also feels honored at having this opportunity to share it with the members of the International College of Applied Kinesiology, an organization which he

feels is becoming the intellectual "elite corps" of the chiropractic and allied health professions.

SYMBOLS and ABBREVIATIONS

LT	Left side	HYD	Hyoid bone activity
BIL	Bilateral	LIL	Ligamentous interlink
RT	Right side	GAIT	Gait reflex activity
□	If ⊕ leave space blank	MST	Myofascial sheath technique
⊖	Weak in the clear	LRT	Lingual respiratory technique (centering)
⊕	Strong in the clear	MPT	Master point tapping (SP21/K27)
△	Excess energy (alarm pt. weakness)	TT	Temporal tapping
⊖ →	Switched; criss-crossed; reversed	CEPH	Cephalic reflexes (ant/post)
<⊕	Became stronger after treatment	CLOC	Cloacal reflexes (ant/post)
<⊖	Became weaker after treatment	LIMB	Limbic reflex and technique
<○	Remained the same; no change	P	Pitch correction
NDL	Needle insertion	R	Roll correction
EAP	Electroacupuncture	Y	Yaw correction
TAB	Acutab, Ion-Tab, et cetera	OCUL LOCK	Ocular lock correction
MAG	Magnet application (North/South)	K27	Master switching point; check if used
NMR	Neuromuscular reflex (orig/insert)	BRAIN SPLIT	Cerebral hemisphere dominance
NLR	Neurolymphatic reflex activation	HUM	Humming elicitation
NVR	Neurovascular reflex activation	MT	Multiplication tables elicitation
DIG ACUP	Digital acupressure activation	CRAN	Cranial respiratory fault correction
CAT I II III	Category pelvic/spinal correction	SAC	Sacral respiratory fault correction
RMT	Reactive muscle testing	INS	Inspiration assist
SCR	Spindle cell reflex activity	EXP	Expiration assist
GTR	Golgi tendon reflex activity	CRAN FAULT	Cranial fault adjustment

SYMBOLS and ABBREVIATIONS (continued):

FIX	Fixation correction (check)	VERT	Vertebral or pelvic adjustment
NUTR SUPP	Nutritional supplementation	SPECIAL	Notation, comment, new techniques

The following items were forgotten and not included on the present chart. The abbreviations may be used as needed by listing them in the "Special" column whenever appropriate to do so:

CSR	Cranial stress receptor activation (check Inspiration/Expiration assist under CRAN)
LR-HD	Lymphatic retrograde drainage, head down
NIP	Nasal ionization polarity (record + or - on LT or RT under CRAN INS or EXP)

The following items may be used for recording purposes when indicated, or may be used while taking class notes during seminars:

PTM	Primary test muscle (psoas for kidney, subscapularis for heart, etc.)
TIM	Test indicator muscle (any convenient muscle which is strong in the clear)
ITC	In the clear (strong or weak upon initial testing without TL or respiration assist)
TL	Therapy localization (patient finger tip contact which alters strength of PTM or TIM)
LE RI FBR	Left external / right internal frontal bone rotation cranial fault
RE LI FBR	Right external / left internal frontal bone rotation cranial fault
FIA	Forced inspiration assist cranial fault
FEA	Forced expiration assist CF (adjust only inspiration assist cranial faults)
PAR	Parietal descent cranial fault
LTB	Left temporal bulge ("banana head") cranial fault
RTB	Right temporal bulge ("banana head") cranial fault
SAG	Sagittal suture cranial fault
GLAB	Glabellar cranial fault (nasal versus oral breathing)
LAMB	Lambdoidal suture cranial fault

UNIV	Universal cranial fault (also check for spastic ileocecal valve)
ZYG	Zygomatic arch cranial fault (check for weak ileocecal valve)

The abbreviation key for the several muscles employed in Applied Kinesiology, listed in order of appearance on the kinesiology examination page, is provided below:

SAC-SP	Sacrospinalis	PERON	Peroneus tertius
CARP	Carpal tunnel (Opponens)	TIB ANT	Tibialis anticus
U TRAP	Upper trapezius	TFL	Tensor fascia lata
LEV SCAP	Levator scapula	RHOMB	Rhomboideus
Q FEM	Quadriceps femoris	G MED	Gluteus medius
REC	Rectus abdominis	ADD	Adductor group
TRANS	Transversus abdominis	SPLEN	Neck extensors (splenius cap.)
SCM	Sternocleidomastoideus	M TRAP	Middle trapezius
SCAL ANT	Scalenus anticus	L TRAP	Lower trapezius
TRI	Triceps brachii	INFRASP	Infraspinatus
COR	Coracobrachialis	T MAJ	Teres major
DELT	Deltoideus (middle)	Q LUM	Quadratus lumborum
T MIN	Teres minor	POP	Popliteus
SUBSCAP	Subscapularis	TOE FLEX	Toe flexors
SERR ANT	Serratus anticus	HAMS	Hamstrings
PMS	Pectoralis major sternal	ILIACUS	Iliacus (weak ileocecal valve)
PMC	Pectoralis major clavicular	PIRIF	Piriformis
L D	Latissimus dorsi	G MAX	Gluteus maximus
SUPRASP	Supraspinatus	Special Group:	
PSOAS	Psoas major	TMJ	Temporomandibular joint
GRAC	Gracilis	TEMP	Temporalis
SART	Sartorius	HH	Hiatal hernia

Page One - CONFIDENTIAL HEALTH INDEX

The vital indices of the patient are displayed at a glance on the front cover of the form. It should be obvious that M/F denotes male or female. Current status refers to posture, stance, equilibrium, gait, body type, level of pain or discomfort if present, psychological affect and/or attitude, etc.

The primary motivating health problems (those which are most important to the patient) are listed under Entrance Complaints. Have your CA ask the patient what they believe to be their current height and weight before they are actually measured. Many people shrink as degenerative changes progress.

There seems to be some confusion with regard to the Derifield leg test. Leg length deficiency is the criterion. If a patient in the prone posture exhibits a ¼" deficiency of the left leg and it appears to remain "short" upon flexion of both legs to 90 degrees (at the knee), we record that as ¼" - (one quarter inch negative Derifield) in the left column and a check mark (✓) in the right column. If another patient presented a 3/8" inch deficiency of the right leg while prone but the "short" leg became the "long" leg when the knees were flexed to 90 degrees, then we record that as a check (✓) mark in the left column and 3/8" + (three eighths inch positive Derifield) in the right column. A negative Derifield denotes the need for an ilium adjustment; a positive Derifield indicates a counter-rotational torquing of the pelvis and the need for an ischial adjustment. These can, of course, be tested by challenge and/or therapy localization. If the patient turns his or her head to one side and the legs become even in length, we record BAL (balanced) in the appropriate left or right column toward which the head is turned. We find that there is a high correlation in these cases with a Category I pelvis involvement.

Under the heading of Spinal Palpation, vertebral lettered listings are recorded appropriately left or right. Insofar as muscular palpation is concerned, we "X" the correct side of the appropriate spinal level in tension.

CONFIDENTIAL HEALTH INDEX:

Name _____ Clinic No. _____ Chart No. _____

Stated Age _____ M / F Current status _____

Entrance Complaints: Date _____

1. _____

2. _____

3. _____

Indicated height _____ Current height _____ Indicated weight _____ Current weight _____

Blood pressure: left _____/_____ right _____/_____ Pulse pressures _____/_____ Pulse rate _____ bpm

Respiratory rate _____ Spirometry _____ cc: _____ % for male/female of your height.

Axial balance Lt. _____ Rt. _____ Ragland test: reclining _____/_____ standing _____/_____

Cardiac ausculation _____

Pulmonary auscultation _____

Smoke? _____ Lingual dye clearance time elapse (Vitamin C test) _____ seconds

Alcohol? _____ Social Drugs? _____

Deep Tendon Reflexes:

_____

_____

_____

Range of Motion:	**Cervical**	**Thor-Lum**
Flex - Ext	____ – ____	____ – ____
Rotation Lt - Rt	____ – ____	____ – ____
Lat Flex Lt - Rt	____ – ____	____ – ____

Leg Length Tests:	
Derifield	____ – ____
Cervical	____ – ____
Ely exam	____ – ____

Spinal Palpation:

Vertebral			Muscular	
Lt	Rt		Lt	Rt
		Occ		
		C1		
		2		
		3		
		4		
		5		
		6		
		7		
		T1		
		2		
		3		
		4		
		5		
		6		
		7		
		8		
		9		
		10		
		11		
		12		
		L1		
		2		
		3		
		4		
		5		
		Sac		
		Coc		
		Ilium		
		Isch		

Kinesiology (prone) or Other Special Testing:

_____

_____

_____

Kinesiology (supine) or Other Special Testing:

_____

_____

_____

Orthopedic/Neurological	**Left**	**Sagittal**	**Right**
Lasegue			
Goldthwait			
Braggard			
Leg lowering			
Leg cross			
Babinski			

Side lying tests _____

_____

Tentative Diagnosis _____

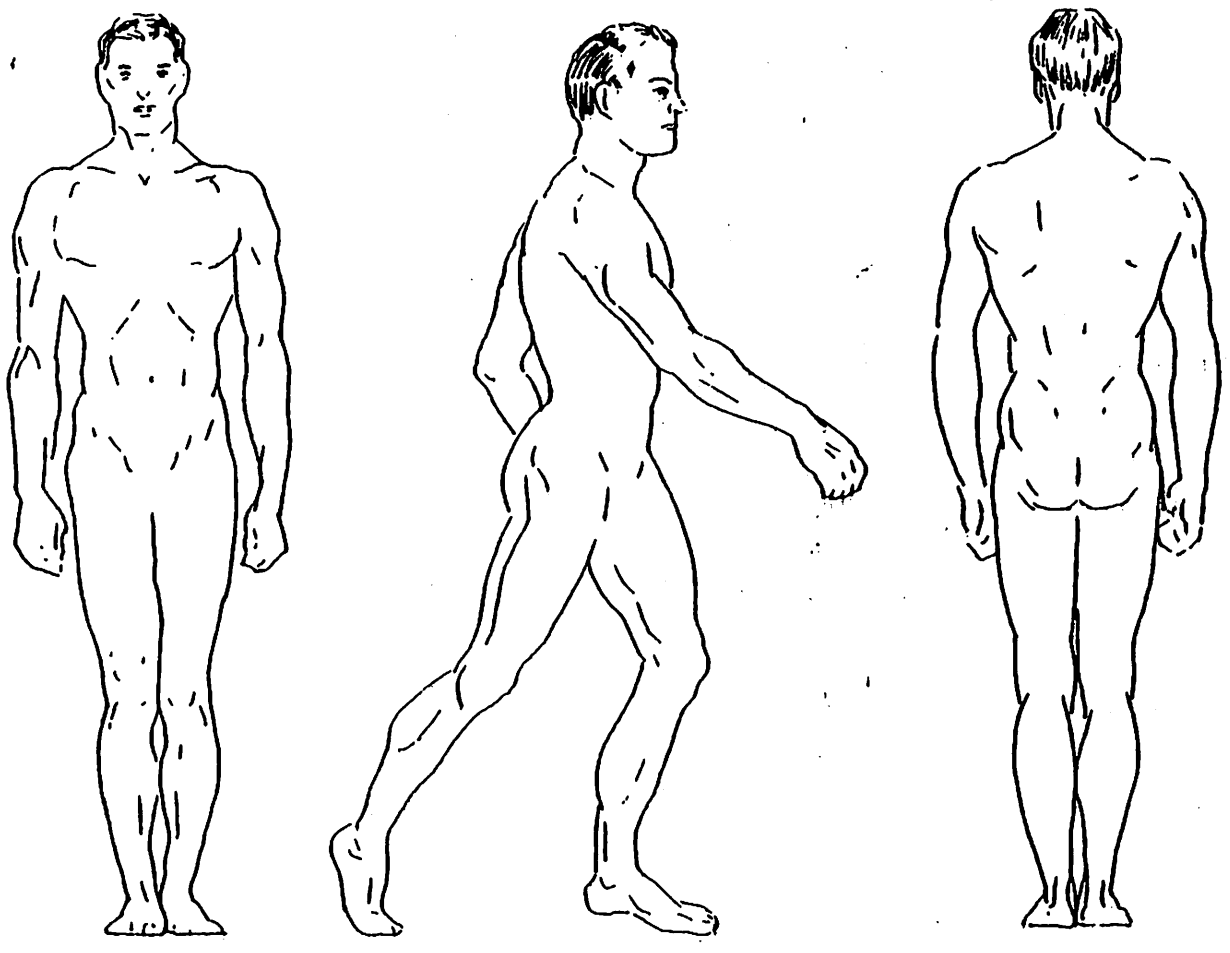
_____

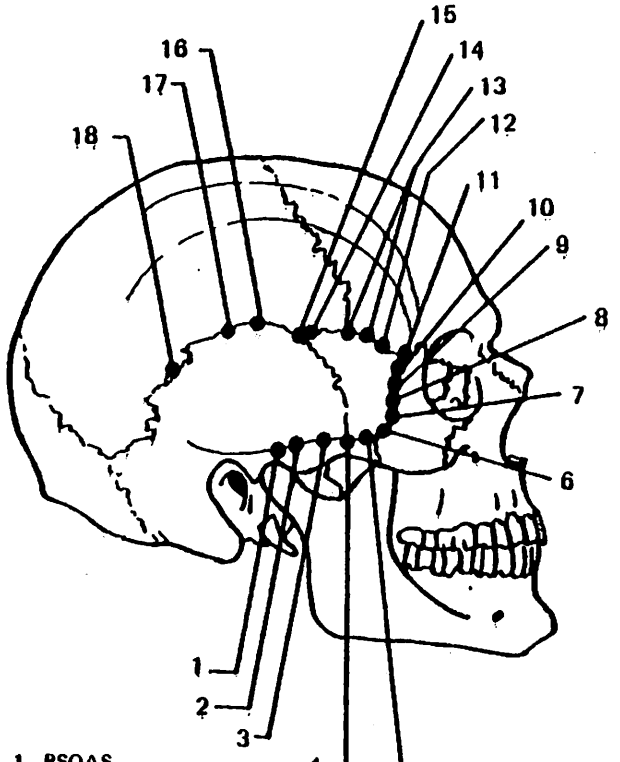
Comments _____

_____

Signature of Examiner: _____

SENSORY ABNORMALITIES





1. PSOAS
2. PSOAS
3. QUADRICEPS
4. GRACILIS & SARTORIUS
5. PECTORALIS MAJOR STERNAL
6. HAMSTRINGS
7. QUADRATUS LUMBORUM
8. GLUTEUS MAXIMUS
9. TENSOR FASCIA FEMORIS
10. PIRIFORMIS – ADDUCTORS AND GLUTEUS MEDIUS
11. NECK FLEXORS & EXTENSORS
12. SUBSCAPULARIS
13. DELTOID & ANT. SERRATUS
14. CORACOBRACHIALIS & POPLITEUS
15. PECTORALIS MAJOR CLAVICULAR
16. LATISSIMUS DORSI
17. ABDOMINAL MUSCLES
18. MIDDLE TRAPEZIUS

Color-code as follows using felt pens: Pain: RED Numbness or Hypesthesia: GREEN Tingling: ORANGE Anesthesia: BLUE

DIALOGUE ON ABNORMAL SENSATION (Indicate side, segment, area or extremity):

Spontaneous Pain _____

Hyperesthesia _____

Numbness _____

Tingling _____

Anesthesia _____

Positional _____

Vibratory _____

Page Two - SENSORY ABNORMALITIES

This page is completed at the time of case history recording or at the time of the initial examination. It becomes a visual reference of subjective complaints.

Use colored felt markers. You may wish to diagram a sciatic radiculitis and paresthesia, for instance, by drawing parallel red and orange lines which approximate the patient's description of symptom location. We also suggest marking the proximal and distal extremes of symptomatology with an "X" in the appropriate color. As an example, pain and tingling may both begin in the right gluteal musculature and course down the posterior thigh. But while the pain may terminate at the popliteal fossa, the tingling may extend all the way to the toes; these factors should be recorded.

It is not sufficient to merely state that the patient had "headaches;" it is best to accurately depict the exact location on the drawings provided.

You may wish to circle or "X" in red any tender areas found on the temporosphenoidal line. (Indicate left or bilateral if such should happen to be the case.)

Written commentary or dialogue may be noted on the appropriate line following the descriptive terminology. Spontaneous pain is an unpleasant conscious awareness on the part of the patient; it is usually the motivating factor which brings that person into the office. It may be dull, sharp, deep, superficial, burning, stabbing, et cetera; it can occur only at certain times of the day. These factors should be noted.

Areas of hyperesthesia are usually not spontaneously subjective to the patient but are elicited only upon palpation, probing, et cetera.

Page Three - SYMPTOM CHART

Some chiropractors have been educated to disregard symptoms. However, a daily running account of how the patient felt on each and every visit can be very valuable information in medicolegal cases or in the event (God forbid) of a malpractice action. The neurotic hypochondriac can also be encouraged from time to time by illustrating that certain complaints, recorded previously, are no longer present.

Rather than redundantly listing on separate lines "left shoulder pain," "right shoulder pain," we graphically illustrate the side of involvement by placing an "X" on the appropriate side of the box. If a complaint happens to be, let's say, neck pain and the exact location changes from visit to visit, we mark the top of the box with an "X" for upper neck pain and the bottom of the box for lower neck pain.

Degree of severity may be visually characterized from visit to visit simply by overscoring a complaint when it is severe or pronounced, and underscoring when it is mild, becoming better or almost nonexistent. When a complaint finally disappears, we mark that box with a zero and do not continue to mark it unless it returns at some future time. In that manner, you can see at a glance those complaints which are most prevalent. When a patient had a complaint which was present a day or two previously but not currently, we place the "X" within parentheses. If a patient feels better all over, we write their descriptive terminology longitudinally in the column under that particular date (feels good, terrific, etc.).

This page literally reduces the recording of daily complaints and/or symptoms to a matter of seconds, rather than having to laboriously write out each item in long hand.

 shoulder pain (left)

 ankle pain (right)

 complaint is severe

 complaint is mild

 occurred yesterday/last week

 no longer present

HYD	LIL	GAIT	MST	LRT	MPT	TT	CEPH	CLOC	LIMB	P	R	Y	OCUL LOCK	K 27	BRAIN SPLIT HUM	BRAIN SPLIT MT	CRAN INS	CRAN EXP	SAC INS	SAC EXP	CRAN FAULT	FIX	VERT	NUTR SUPP	SPECIAL

SYMPTOM CHART

Year

Month

Day

Symptoms or Condition

*Fixation Indicator **Cranial Fault Indicator ***Sacral Fault Indicator

Patient Posture	Anatomical Area Tested	Date Lt.	Bilat.	Rt.	Related Organ	Fixation and/or Cran/Sac Fault	Alarm Point	Luo Point	Associated Point	Tonify Sedate	Supplemental Nutrition
Standing	Unilateral Rhomboerg				Brain						Ribonucleic acid
	Sacrospinalis				Cystitis (Scoliosis)		Cv3	B58	B28	B67-Li1 B65-G41	ACP
Sitting	Carpal tunnel				Wrist Ileocecal valve		G25	K5	B23	K7-L8 K1-Liv1	Ostogen (calcium) Betaine hydrochloride
**	Upper trapezius				Eye & Ear	FIA / FEA cranial fault	G25	K5	B23	K7-L8 K1-Liv1	F & G complex
	Levator Scapula				Stomach		Cv12	S40	B21	S41-Si5 S45-Li1	
	Quadriceps femoris				Small Intestine		Cv4[2]	SI7	B27	Si3-G41 Si8-S36	D
**	Rect/trans. abdominis				Doudenum (Narcolepsy)	Sagittal suture if Rectus is weak				S41-Si5 S45-Li1	E, Duodenal tissue
Supine **	Sternocleidomastoideus				Paranasal sinuses	Frontal bone rot if weak bilaterally	Cv12	S40	B21	S41-Si5 S45-Li1	Niacinamide & B6
**	Scalenus anticus				Paranasal sinuses	Parietal descent if unilateral	Cv12	S40	B21	S41-Si5 S45-Li1	B6 & Niacinamide
	Triceps				Gall bladder		G24	G37	B19	G43-B66 G38-Si5	
	Coracobrachialis				Lungs		L1	L7	B13	L9-Sp3 L5-K10	Pneumotrophin, C
*	Deltoideus				Lungs	Cerv-dors junction if weak bilaterally	L1[9]	L7	B13	L9-Sp3 L5-K10	Pneumotrophin, C
	Teres minor				Thyroid		Cv5[6]	Tw5	B22	T3-G41 T10-S36	Organic iodine Thytrophin
	Subscapularis				Heart		Cv14	H5	B15		G. Cardiotrophin Magnesium
	Serratus anticus				Lungs		L1	L7	B13	L9-Sp3 L5-K10	Pneumotrophin, C
	Pect. major sternal				Liver		Liv14[8]	Liv5	B18	Liv8-K10 Liv2-H8	A, Cholacol, Hepatrophin, Lecithin
**	Pect. major clavicular				Stomach	Temporal Bulge if weak bilaterally	Cv12[11]	S40	B21	S41-Si5 S45-Li1	Unilat: B & G Complex Bilat: Betaine HCL, Zypan, Phosfood
	Latissimus dorsi				Pancreas		Liv13[12]	Sp4	B20	Sp2-H8 Sp5-L8	A, F, Betafood, Complex F Pancreatrophin
	Supraspinatus				Brain fatigue	(Concention vessel)	H3		B17		Neurotrophin Ribonucleic acid
*	Psoas major				Kidneys	Jammed occiput if weak bilaterally	G25[4]	K5	B23	K7-L8 K1-Liv1	A, E, Renatrophin
	Gracilis				Adrenals		Cv17	P6	B14	P9-Liv 1 P7-Sp3	Orenamin, Drenatrophin Antronex, Allerplex
	Sartorius				Adrenals		Cv17	P6	B14	P9-Liv1 P7-Sp3	Orenamin, Drenatrophin Antronex, Allerplex
	Peroneus tertius				Bladder		Cv3[3]	B58	B28	B67-Li1 B65-G41	B complex Calcium lactate
	Tibialis anticus				Urethra		Cv3	B58	B28	B67-Li1 B65-G41	B complex Calcium lactate
	Tensor fascia lata				Colon		S2S[10]	Li6	B25	Li11-S36 Li2-B66	Unilat: Zymex, Lactic acid yeast, K Bilat: Ferrofood
Side lying	Rhomboid										
	Gluteus med/min.				Uterus Seminal vesicles		Cv17	P6	B14	P9-Liv1 P7-Sp3	E, Utrophin/Prostate tissue
	Adductor				Climacteric (Elbow pain)	(Governing vessel)	Gv16		B16		E
Prone *	Neck extens. simultan.				Paranasal sinuses	Lumbar fixation	Cv12	S40	B21	S41-Si5 S45-Li1	Niacinamide & B6 Organic iodine
*	Neck extens. unilat.				Paranasal sinuses	Ilium fixation	Cv12	S40	B21	S41-Si5 S45-Li1	Niacinamide & B6 Organic iodine
*	Neck extens. bilat.				Paranasal sinuses	Sacral fixation	Cv12	S40	B21	S41-Si5 S45-Li1	Niacinamide & B6 Organic iodine
	Middle trapezius				Spleen		Liv13	Sp4	B20	Sp2-H8 Sp5-L8	C complex
*	Lower trapezius				Spleen	Dors-lum junction if weak bilaterally	Liv13	Sp4	B20	Sp2-H8 Sp5-L8	C complex
	Infraspinatus				Thyroid		Cv5	Tw5	B22	T3-G41 T10-S36	Organic iodine Thyroid tissue
*	Teres major				Acid/Alkaline imbalance	Bilat. Dorsals Unilat. L5-S1					Organic minerals (kelp) Phosfood
	Quadratus lumborum				Veriform appendix						
*	Popliteus				Cholecystic duct	Lower cervical if weak bilaterally	G24[7]	G37	B19	G43-B66 G38-Si5	Cholacol
*	Toe flexors					Ribs					
***	Hamstrings				Rectum	Sacral respiratory fault					E, Betaine Hydrochloride Wheat germ oil perles
**	Iliacus				Ileocecal valve	Zygomatic-tempor- al suture fault	G25	K5	B23	K7-L8 K1-Liv1	Fat soluble Chlorophyll Comfrey pepsin
*	Piriformis				Uterus Seminal vesicles	Iliac respiratory fixation	Cv17	P6	B14	P9-Liv1 P7-Sp3	E, Utrophin/Prostate tissue
*	Gluteus maximus				Prostate/Broad lig. Testes/Ovaries	Upper cervical if weak bilaterally	Cv17[5]	P6	B14	P9-Liv1 P7-Sp3	E, Orchic tissue/Ovatrophin

☐ Switched ☐ TMJ ☐ Hyoid Bone ☐ Hiatal Hernia ☐ Is ☐ Is not centered

Page Four - COMPLETE KINESIOLOGY EXAMINATION

Next is the record for the initial and subsequent kinesiology examinations. It is self-explanatory. And as such, it may be photocopied and submitted to an attorney or an insurance adjuster as part of an initial or progress report. Thus, it helps them to gain a little better grasp of why you use muscle testing (. . . if they take the time to read it . . .).

We use the symbols ⊖ (weak), ⊕ (strong) and △ (excess) in the appropriate column under Left, Bilateral or Right according to the patient's test result. We do not mark a box at all if a particular muscle is normally strong; we only use the symbol ⊕ when there is a hidden problem and the strong muscle becomes weak upon therapy localization or challenge.

Certain important status considerations are listed at the bottom of the page, and each box is marked when appropriate to do so. We do not, for instance, routinely "unswitch" the patient prior to initiating the examination. We believe that it is of value for both the doctor and the patient to be aware that they have been living in an altered or reversed state, and that this is one of the factors which has contributed to the chronicity of their condition.

(NOTE: In the process of rearranging some of the information listed herein during the typesetting process, we inadvertently deleted the Tonification/Sedation points for the Subscapularis muscle. Tonification points are HT9 - LIV1; never sedate the heart meridian!)

The nutrients listed herein are those of Standard Process Laboratories. You may, of course, substitute the equivalent products of any of the other fine, recognized manufacturers of nutritional supplementation.

Page Five - ALARM POINT CHALLENGE

The author of this paper is a certified acupuncturist with over seven years of clinical experience using this Oriental form of therapy. He also successfully defended in court his right, and the right of his colleagues in Arizona, to utilize acupuncture in all of its various forms, including needle piercing. He has utilized various methods of acupuncture diagnosis including akabane, ryodoraku, pulse palpation, pulse therapy localization, local point palpation, and formula (recipe book) treatment for a particular condition.

Against that background of training and experience, he can state unequivocally that the combination of Applied Kinesiology muscle testing and therapy localization of the alarm points is by far the most accurate and the most favorable form of acupuncture insofar as lasting clinical response is concerned.

An alarm point challenge test can be performed on a patient in five to ten minutes. Tabulate and record those muscles which are weak in the clear and those which appear to be strong in the clear but are, in fact, in excess with regard to Ch'i energy. Use either the Law of the Five Elements or the Midday/Midnight Law to transfer excess energy into deficient meridians in order to obtain perfect harmony and balance within the body. Then stand back and watch absolute miracles happen!

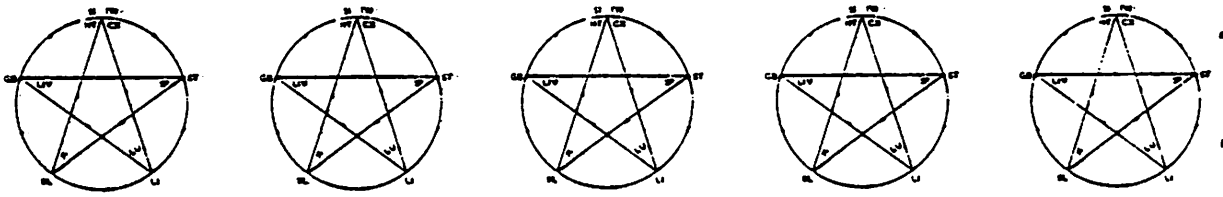
As the body changes, new energy patterns will develop and must be balanced. Space is provided herein for five such tests, if that many are required, as you progress with the patient.

The small Five Element charts at the bottom of each test column are used to graphically depict the exact location of deficient meridians (◯) and those which are in excess (△). If a meridian is imbalanced (strong on one side, weak on the other), it is recorded as  .

ALARM POINT CHALLENGE

HORARY FLOW	ALARM	LUO	ASSOC.	TON.	SED.	SOURCE	ACCUM.	FIRE	EARTH	METAL	WATER	WOOD
Lung	LU1	LU7	BL13	LU9	LU5	LU9	LU6	LU10	LU9	LU8	LU5	LU11
Large Intestine	ST25	LI6	BL25	LI11	LI2	LI4	LI7	LI5	LI11	LI1	LI2	LI3
Stomach	CV12	ST40	BL21	ST41	ST45	ST42	ST34	ST41	ST36	ST45	ST44	ST43
Spleen	LIV13	SP4	BL20	SP2	SP5	SP3	SP8	SP2	SP3	SP5	SP9	SP1
Heart	CV14	HT5	BL15	HT9	HT7	HT7	HT6	HT8	HT7	HT4	HT3	HT9
Small Intestine	CV4	SI7	BL27	SI3	SI8	SI4	SI6	SI5	SI8	SI1	SI2	SI3
Bladder	CV3	BL58	BL28	BL67	BL65	BL64	BL63	BL60	BL54	BL67	BL66	BL65
Kidney	GB25	K5	BL23	K7	K1	K6	K4	K2	K6	K7	K10	K1
Circulation - Sex	CV17	CX6	BL14	CX9	CX7	CX7	CX4	CX8	CX7	CX5	CX3	CX9
Triple Warmer	CV5	TW5	BL22	TW3	TW10	TW4	TW7	TW6	TW10	TW1	TW2	TW3
Gall Bladder	GB24	GB37	BL19	GB43	GB38	GB40	GB36	GB38	GB34	GB44	GB43	GB41
Liver	LIV14	LIV5	BL18	LIV8	LIV2	LIV3	LIV6	LIV2	LIV3	LIV4	LIV8	LIV1
Conception Vessel	HT3	CV1	BL17									
Governing Vessel	GV16	GV1	BL16									

DATE														
TEST MUSCLE	MER	LT	BIL	RT	LT	BIL	RT	LT	BIL	RT	LT	BIL	RT	LT	BIL	RT
Quadriceps Femoris	SI															
Deltoideus	LU															
Teres Minor	TW															
Subscapularis	HT															
Pect. Maj. Sternal	LIV															
Pect. Maj. Clavicular	ST															
Latissimus Dorsi	SP															
Psoas Major	K															
Peroneus Tertius	BL															
Tensor Fascia Lata	LI															
Popliteus	GB															
Gluteus Maximus	CX															
Supraspinatus	CV															
Adductors	GV															



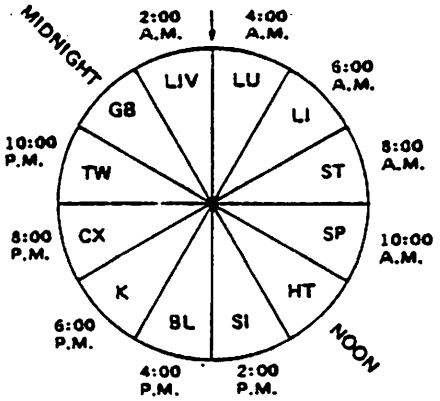
ALARM POINTS

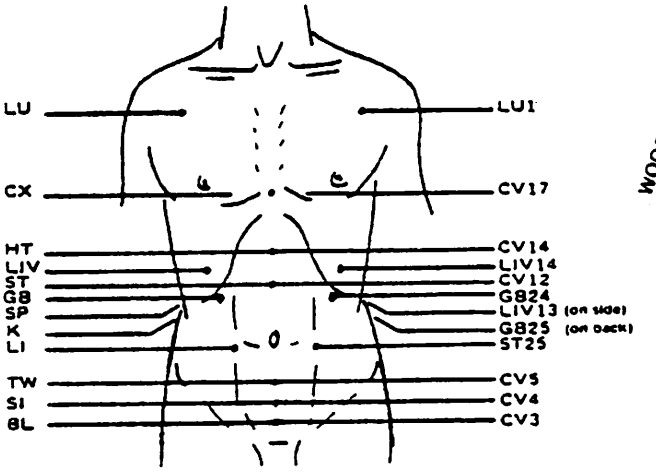
CV ——— HT3 — (Elbow)

GV ——— GV16 — (Occipital - Nuchal Junction)

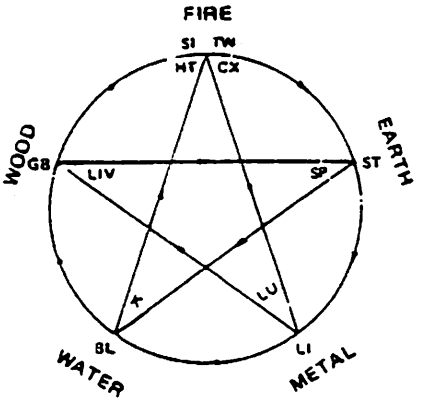
LAW OF MIDDAY - MIDNIGHT

HORARY CYCLE BEGINS AT 3:00 A.M.





LAW OF THE FIVE ELEMENTS



Pages Six and Seven - KINESIOLOGY WORK SHEET

The center-fold two pages of this total form are of vital importance to the practicing kinesiologist, rapidly checking-off appropriate columns to indicate the type of treatment rendered on any given visit. Also, relatively up-to-date techniques are listed in abbreviated form which may help to "jog" the memory of the practitioner. (As indicated previously, Cranial Stress Receptor - CSR - and Lymphatic Retrograde Drainage, Head Down - LR-HD - were erroneously omitted in this first edition of the work sheet. You may list them in the "Special" column when indicated.

The column most frequently used is that of DEFICIENT MUSCLE, indicating either a weakness in the clear or an imbalance (weak on one side, excess on the other). The EXCESS MUSCLE column is reserved for those cases in which, for example, the DELTOIDS were excess bilaterally and the TENSOR FASCIA LATA (TFL) were deficient bilaterally. Another example of use of the EXCESS MUSCLE column is in the case of Reactive Muscle Testing (RMT); the "fifty one percent muscle" is listed in this column while the muscle which appears to be strong in the clear is listed in the DEFICIENT MUSCLE column. A third example of use of this column is the listing of those muscles which appear strong on initial testing but become weak on rapid stretching, and which require myofascial sheath flushing technique.

We also use the EXCESS MUSCLE COLUMN to listd in parentheses any convenient strong test indicator muscle which is employed for evaluation purposes only, and does not directly enter into the mechanism being treated. For instance (PSOAS) or (HAMS) or (PMC).

Only Kinesiology/Acupuncture (K-A) listings are made here; any formula treatment acupuncture is recorded on its own page (10 of 12).

DATE M	DATE D	DATE Y	EXCESS MUSCLE	LT	BIL	RT	DEFICIENT MUSCLE	LT	BIL	RT	ACUP POINT	TYPE	TIME	NDL	EAP	TAB	MAG	NMR	NLR	NVR	DIG ACUP	CAT I-II-III	RMT	SCR

G	HYD	LIL	GAIT	NST	LAT	MPT	TT	CEPH	CLOC	LIMB	P	R	Y	OCUL LOCK	K 27	BRAIN SPLIT HUM	BRAIN SPLIT MT	CRAN INS	CRAN EXP	SAC INS	SAC EXP	CRAN FAULT	FIX	VERT	NUTR SUPP	SPECIAL

ADJUSTING RECORD

Year																																
Month																																
Day																																
Mastoid																																
Occiput																																
Condyle																																
Atlas																																
Method																																
Axis																																
Method																																
C3																																
C4																																
C5																																
C6																																
C7																																
T1																																
T2																																
T3																																
T4																																
T5																																
T6																																
T7																																
T8																																
T9																																
T10																																
T11																																
T12																																
L1																																
L2																																
L3																																
L4																																
L5																																
L6																																
Sacral base																																
Sacral apex																																
Coccyx																																
Ilium																																
Ischium																																
Pubes																																
Basic																																
Femur Head																																
Leg comp. differential																																

Page Eight - ADJUSTING RECORD

This is another "gem" for rapidly and accurately recording all of your adjustments. The author devised this formin 1963 and, with some alteration, has been using it continuously since that time. Examples of listing nomenclature are given below:

PRL	Rotational adjustment, spinous right contact on the left (sp pull-over)	PLR	Rotational adjustment, spinous left contact on the right (sp pull-over)
X	Laterality adjustment contact on the left	X	Laterality adjustment contact on the right
X	Straight posterior adjustment	A	Anterior adjustment
PL TM	Spinous contact on the left thumb move	PR TM	Spinous contact on the right thumb move
PL	Lumbar spinous pull-over roll position, left side down	PR	Lumbar spinous pull-over roll position, right side down
X	Lumbar mamillary contact up from underneath (PRL-M)	X	Lumbar mamillary contact up from underneath (PLR-M)
•	Non-crepitational adjustment (LEFT) incident with respiration	•	Non-crepitational adjustment (RIGHT) incident with respiration
• •	Bilateral contact respiratory non-crepitatioinal adjustment	•	Sagittal contact respiratory non-crepitational adjustment
X	Moved easily and well	X	Moved a little or with difficulty
○	Intended crepitational adjustment but did not move at all	↑	Occipital fixation (jamming) on right (arrow on left for left occipital fix)
ASL A/P	Atlas side posture toggle recoil adjustment (left; ant or post)	ASR A/P	Atlas side posture toggle recoil adjustment (right; ant or post)

We record the following longitudinally in the appropriate date column: "Supine Lift" for upper dorsals; "Lift" for standing mid-dorsal adjustment; and "Elbow Lift" (E. L.) for standing lower dorsal adjustment.

In the space marked "Leg comparison differential," the top line denotes left half inch deficiency; the bottom line represents right half inch; the center line is zero, or balanced; mid lines are one quarter inch.

NEUROMUSCULAR "TRIGGERPOINT" THERAPY

Year																																
Month																																
Day																																
Face																																
Throat																																
Occiput																																
Ant. cerv.																																
Scalenus																																
Post. cerv.																																
Trapezius																																
Shoulders																																
Upper arms																																
Elbows																																
Forearms																																
Wrists																																
Hands																																
Scapulae																																
Rhomboids																																
Erectors																																
Lumbosac.																																
Sacrum																																
Gluteus Medius																																
Piriformis																																
Post. thighs																																
Knees																																
Calf muscles																																
Achilles																																
Chest																																
Sternum																																
Axillary																																
Abdomen																																
Psoas																																
Iliacus																																
Tens. fasc.																																
Pectinius																																
Ant. Thighs																																
Gracilis																																
Iliotibials																																
Tib. anticus																																
Ankles																																
Dor. of feet																																
Pln. of feet																																

ACUPUNCTURE THERAPY RECORD

Date			Remarks

Page Nine - NEUROMUSCULAR "TRIGGERPOINT" THERAPY

This page is utilized for recording applications of either pressure and/or "Rolfing" type techniques. In addition, space is provided for the recording of adjustments of the extremity joints (elbow, knee, wrist, ankle, etc.).

The symbols employed consist primarily of an "X" to denote triggerpoint, or neuromuscular, therapy and an "A" to designate an adjustment.

If the treatment on any given date is unilateral, the symbol is recorded on either the left or the right side of the square. If we employ a firm, steady, deep pressure on certain areas, then the "X" is placed on the appropriate side; if both sides of the body are treated equally on that visit, two "X's" are placed side-by-side; if a stripping or gliding method is used, we "X" the entire square. These two methods of identification quickly differentiate the type of technical application used on any given date.

If we adjust both feet, we place a large "A" within the entire square designated as "Dorsum of feet" and/or "Plantar surfaces of feet." Should the patient also require adjustments of the ankles, we also similarly mark an "A" all across the entire appropriate square.

If a triggepoint area is very painful or if an articulation adjusts easily with great crepitation, we designate that event by overscoring the symbol (drawing a line over the symbol but still within the square). If the area is only mildly painful or if the articulation adjusts only a little, we underscore the "X" or the "A." If we attempt to treat an area with pressure and find it not painful at all, or if an attempted adjustment produces no crepitation, we identify that by recording a "0" (zero) in the appropriate area.

Page Ten - ACUPUNCTURE THERAPY RECORD

Some state laws forbid the use of acupuncture in any of its various forms. If you should happen to be located in such an area, you may wish to designate this page as "MERIDIAN THERAPY."

After recording the date of treatment, we write in FORM for formula treatment or AURIC for auriculotherapy. Then we list the points used, the appropriate side or bilateral, if that should be the case, the time devoted to the treatment on that particular day, and whether we used needles (NDL), electroacupuncture (EAP) or acutabs (TABS).

Page Eleven - PROGRESS NOTES

Comments expressed by a patient in regard to his or her response to treatment can be extremely valuable. A casual remark such as "That last treatment you gave me was very (good) or (bad)" can help the conscientious physician to evaluate the efficacy of any form of treatment. This assists in management and direction of the patient in any case.

Space is provided herein for brief notations. We would suggest recording verbatim statements, comments or phrases expressed by the patient.

If you should happen to believe that this is unimportant or unnecessary, then you are invited to have a typesetter create a new page in this space to record, for instance, all of your laboratory findings.

PROGRESS NOTES

Date	Remarks

SPECIAL EXAMINATIONS

Date			Remarks

Page Twelve - SPECIAL EXAMINATIONS

On any given date, brief comments can be made by the technical assistant in your office concerning the taking of a specimen for blood testing (and, obviously, the type of test which you ordered); urinalysis; tissue mineral assay by hair; circulatory examination such as photoelectric plethismography, Doppler ultrasound or skin surface thermometry; electrocardiography; phonocardiography; audiometry; postural survey; orthopedic and/or neurological evaluations; or a Papanicolau smear.

Also included on this page would be notations concerning the referral of a patient to another physician or radiologist for diagnostic consultation; name, specialty, purpose of referral, et cetera.

For good clinical follow-up, we suggest making brief notations on the appropriate line of any significant findings when the report comes back to your office.

A NEW APPROACH TO SWITCHING
AN ESSENTIAL PART OF PELVIC CORRECTIONS

by Earl L. Colum D.C.

The Switching mechanism and its correction, discovered by Dr. George Goodheart, has proven to be a valuable tool in the treatment of patients problems. The treatment is, using hard vibratory pressure over the umbilicus and bilateral K27. Later a coccygeal contact was included.

These contacts worked in reorganizing muscle patterns, the correction of Ocular Lock and the weakening of an indicator muscle produced when reading backwards. In some cases it was found on later testing that the original problem had returned. This can again be treated with the same positive results. Asimple test for a positive correction is to have the patient jump up and down at least eight times. Retest. If the problem returns it means something in addition has to be done.

For many years Ihave maintained there should be a direction and phase of respiration on ALL contacts used in making osseous corrections, neurovascular, neurolymphatic, golgi, spindle cell, acupuncture points and meridians.

To confirm this opinion I have with futility tried to challenge the umbilicus or have the patient try to Therapy Localize (TL) in different ways without success. This was always done with the patient laying or sitting.

It has now been found that the umbilicus will TL but only when standing. Once this has been elicited the patient can then be challenged in any position. The standing TL to the umbilicus is done with the palmar surface of the fingers and then the volar surface of the hand. Avoid using the tips of the fingers. One or both contacts may be positive.

The sartorius muscle is closely associated with a posterior innominate subluxation. The pain on palpation over the lower portion of the muscle on the inner thigh is aprime indicator for this lesion.

A posterior ischium demonstrates pain over the lower portion of the tendon-sheath of the tensor fascia lata.

These two lesions have other clues to their presence besides the weakness and pain over the above mentioned muscles.

However it has always been aperplexing problem when finding a weak sartorius or tensor fascia lata, with the appropiate pain on palpation indicating an osseous lesion, but examination of the pelvis by palpation would not correllate.

2. SWITCHING AND PELVIC CORRECTIONS - Colum

Adjusting according to muscle weakness and pain would relieve the pain and restore the muscle to normal strength. However in many cases the distortion of the pelvis would not always be corrected which could be the cause of reoccurring problems.

Using the normal Applied Kinesiology therapies readily corrects most pelvic distortions, eliminating the patients complaint to the satisfaction of both patient and doctor.

For those of us who admit to having some failures let us consider the following to help us to a higher level of success.

On rare occassions apatient will demonstrate muscle weakness and pain over both the sartorius and tensor fascia lata and will challenge to both a posterior innominate and a posterior ischium on the same side. ????

More frequently a patient, with or without pain, is seen where the postural state, muscle weakness, structual exam, signs and symptoms do not correlate. Patients with this problem need switching.

Being able to therapy localize and challenge the umbilicus.

1. Demonstrates the need.
2. Shows which direction the problem is moving.
3. Is precise and longer lasting.
4. Eliminates the routine RUB & PRAY before each exam or treatment.

A situation that is commoly found is when a weak sartorius with the indicator pain for a posterior innominate on the right, which can be Challenged, and a long leg on the same side.

Proceedure:

A. Therapy localize umbilicus which should be positive weakening an intact muscle and then challenge for direction and respiration, (these are the usual findings & steps for correction with a sartorius involvement.), with the patient standing. The direction over the umbilicus would be clockwise, inspiration assisted, & palmar which wouldmove the problem from the right to the left side. (patient may remain standing or lay down)
With the patient having apositive palmar TL to the umbilicus. A second contact is made to the coccyx which negates the TL weakness and means the two should be treated together.

3. SWITCHING AND PELVIC CORRECTIONS - Colum

Challenging the two together you will find that each direction is clockwise if you would face the patient A & P. As you stand to the side of the patient your hands should be moving in opposite directions.

YOU are nowready to treat; With the double contact on the umbilicus and the coccyx. Have the patient take a deep breath in and hold. Move the hands in the determined direction, in a circular motion two or three times. Patient exhale. Repeat three times. Light contact.

B. Maintain umbilical contact and with the other hand contact right K27. Patient takes deep breathin and hold. Both hands will now be moving in the same direction, clockwise. Repeat.

C. Maintain umbilical contact and move right K27 to left K27. Treat three times, breath in and clockwise.

D. Maintain umbilical contact. Move left K27 to coccyx. Treat umbilical contact in the same direction but now the coccygeal contact MUST be done COUNTER CLOCKWISE. Both hands moving in a mirrored fashion. Treat with breath in three times.

This is the basic pattern. If original contact to umbilicus was counterclockwise use umbilical contact plus coccyx, LK27, RK27 & coccyx. Palmar or volar by TL and respiritory phase at time of challenge.

E. The weak sartorius and signs will now be on the left. Challenge the innominate for respiratory phase and the adjust with respiration. This will change the pain and weakness but not necessarily the pelvic distortion.

F. Frequently the Rectus Femoris spindle cell mechanism must be treated. Usually the fibers on the right side must be approximated with inspiration and those on the left separated with inspiration. Please challenge for direction and respiration.

G. Now test abdominal muscles and treat as indicated. Usually left rectus weak.

H. Check spindle cell of lower sacrospinalis and treat if indicated.

I. NOTE: If the original contact (TL) to the umbilicus was with the volar surface of the patients hand the challenge and treatment by the doctor MUST be made withVOLAR contacts too.

This same method, palmar and volar TL, challenge for direction and respiratory assistance applies in treating Sp21 & K27. One side may be palmar and the other volar, Sp21, which must be matched with the proper K27. The other K27 may then show positive on double contact TL. AMEN

HIDDEN FIXATIONS FOR ILEOCECAL VALVE & ALLERGY

by Earl L. Colum

Part of this paper will refer to what we now know as a fixation, three vertebrae locked together. Its documentation and treatment is credited to Dr. George Goodheart and is used therapeutically by Applied Kinesiologists worldwide..Some of the other material presented will overlap and be part of the above mentioned fixation. Also will be described another type of fixation and its treatment, still involving groups of three vertebrae, and also two other sets of bones, atlas occiput and 5th lumbar-sacrum.

Methods of correcting fixations:

I. By accident.

II. As described by Dr. George Goodheart.

III. a. Using a circular motion over the spinous processes of the vertebrae in fixation. b..over the lateral portion of atlas occiput and over the area between transverse process of 5th lumbar and sacrum.

IV. Using a bilateral circular motion over the transverse processes of the vertebrae.

V. Treating the cephalic-caudal fixation.

Explanation of corrections:

I. If you fix it by accident, you didn't know it was there. So why worry.

II. If you can't find it and fix it as per Goodheart, you shouldn't be here.

III. Challenge area as indicated by bilateral muscle weakness or patient's complaint. You should find three vertebrae in a row that have a positive challenge in the same direction. If inspiration helps, it will be the top two vertebrae involved. Expiration would be the bottom two. If the weakening challenge were from right to left, with inspiration, the top bone must be moved left and the middle bone to the right..This may be done by pressing the two bones counterclockwise at the same time with inspiration.

If challenged right to left with expiration strengthening, the bottom bone would be moved left and the middle bone right, with pressure on the two spinouses. Move them clockwise with expiration. This also can be adjusted with a torque thrust.

This will abolish the muscle weakness and or the typical complaint of fixation (tightness).

a. The same effect and results can be obtained by using a continuous circular motion over the bones involved with the proper respiration. Three or four breaths with five or six circles per breath.

b. The very common atlas occiput and fifth lumbar sacral fixation can be elicited by having the patient extend his chin to the ceiling (as far back as possible) and test a muscle. Be sure the patient does not take a breath in: as that is usually the respiratory phase associated with this part of the lesion and will strengthen the muscle before you have a chance to find it weak. Next have the patient look down with a breath in (expiration is the respiratory assist) and test indicator muscle.

Many people will have both lesions. Inspiration assisted lesion on the right and expiration on the left. When the patient is standing and has a weak latissimus on one side (usually left) and a weak lower trapezius on the other side (usually right), note: if either or both latissimus and or trapezius are weak bilateral and you fix the associated fixations, the left latissimus and right lower trapezius will still remain weak. This will now require switching the right lower trapezius to the left side.

Both muscles are now weak and on the left side. To confirm the inspiration lesion on the right, challenge the transverse of the atlas forward and the mastoid posterior. This should weaken an indicator muscle and be negated with inspiration. Challenge left side, atlas transverse posterior, and mastoid

anterior will be expiration assist.

If only the atlas-occiput fixations (R&L) are treated, this alone will correct the weakness of the latissimus and lower trapezius. An important factor to consider when treating sugar handling problems and often overlooked.

The direction of treatment is, for inspiration, a circular motion, and light contact, as if to move the atlas forward and the mastoid backward. Expiration is reversed, atlas back and mastoid forward.

The Lovett brother is done at the same time. Challenge R&L fifth lumbar and sacrum one at a time. Inspiration on the right would be a clockwise direction, and the expiration on the left would also be clockwise.

With patient's breath in, treat right side counterclockwise over mastoid and atlas, and clockwise over fifth lumbar transverse and sacrum at the same time. Repeat three or four times: On the left with expiration, counterclockwise over mastoid and atlas, and clockwise over left transverse of fifth lumbar and sacrum.

Occasionally on a later visit, you may find a fixation has reoccurred. Rechallenge for direction and respiration, but use manual pressure to treat. The fifth lumbar sacral fixation will challenge the right sacrum anterior and the left fifth lumbar anterior (inspiration). The expiration lesion will challenge on the same side.

IV. The bilateral contact over the transverse processes is an essential step in eliciting the hidden c-c fixation, but also has its own therapeutic merit.

The area to be challenged may be determined by previously treated areas of fixation, bilateral muscle weakness (and Lovett brother), alarm points, combinations of different muscle weaknesses (latissimus-lower trapezius, tricep-psoas, pectoral sternal-sartorius), and nutritional. This procedure can also

be done immediately after number II as per Goodheart, or III as described.

The direction of challenge is usually clockwise on the right and counterclockwise on the left. This may be done at the same time or separately. Both challenges will and should have the same phase of respiration when being treated together. Use all four fingers of each hand over the area of transverse processes, which will cover several vertebrae. Confirm direction and respiration. With the patient's breath in, make five or six circles with each hand. Repeat two more times. This will abolish the muscle weakness and positive challenge.

V. Previous to finding the above (IV) it was only on rare occasion to find a vertebrae that would have a positive challenge both to the right and left with no phase of respiration associated. In a previous presentation I had stated that the vertebrae must be then challenged cephalic and or caudal on the spinous process and treated in that direction with the proper phase of respiratory assistance. This lesion is now very common and challenged and treated in the same manner.

The ileocecal valve is a nemisis for doctor and patient. The following may be of help in detecting and treating this condition and is the normal procedure used in my office. Over 95% of the patients on the first examination demonstrate this condition, an open valve. The patient is ALWAYS seated. Challenge the Rectus Femoris (patient raises foot off floor-doctor pushed down on knee) both right and left. When weak check for respiratory assistance. If found, correct immediately. Challenge pectoralis clavicular together which will be weak. Therapy localize ileocecal valve against quadriceps-strengthens. Challenging down on ileocecal area weakens indicator muscle. Check for respiratory assist-inspiration. Treat in the same downward direction with inspiration. Both quadriceps and pectorals are now strong.

Stomach neuro lumphatic treated lateral with inspiration. Stomach

alarm point treated upward with inspiration.; Stomach neurovasculars treated on patient's right counterclockwise and left clockwise, with inspiration. With patient supine both tensor fascia lata weak, therapy localize and challenge (valves of Houston ? left lower quadrant of abdomen) and treat usually down with inspiration. With patient prone check iliacus (opposite direction for piriformis). Rarely bilateral but would indicate normal fixation of upper lumbar. Treat 12th dorsal to third lumbar. If subluxation, always right weak. Challenge and treat 12th dorsal or 1st lumbar to right with inspiration.

The fixation for the ileocecal valve is at the level of the 1st lumbar. Treating this area will remove the therapy localization and challenge to the valve area whether on the first visit or in reoccurring situations. Certainly one would not neglect to treat the other areas already known to be beneficial.

In the reoccurring situation the valve may be therapy localized and challenged. Instead of treating again, challenge the 1st lumbar area R&L. If positive treat as usual for subluxation or fixation. If challenge is negative or was positive and corrected, use the circular motions over the transverses, the hands at the same time moving in opposite circular directions. Test indicator and find respiratory phase.

If negative, do opposite direction. When direction and respiration are determined, treat three times with respiration, making five or six revolutions with the hands, with each breath. This will strengthen the quadriceps and pectorals. Therapy localize valve area. If positive, the quads will weaken again. Challenge the first lumbar area again. One vertebrae at a time. Now one of the bones in the area will challenge R&L with no respiration assist. On the spinous now challenge from below upward and determine respiration assist. On the same spinous challenge downward and find respiration assist. Treat with direction and respiration, with thumb or finger contact. When

treating cephalically have the patient bend the head forward. When treating caudally have the patient raise the head. Therapy localize and the challenge will now be negative.

When therapy localizing or challenging a volar contact may be needed. This would mean that when treating to also use a volar contact. Usually after using this contact challenging will be negative for c-c fixation.

ALLERGY. Most of those familiar with Applied Kinesiology know the value of the product Antronex (Standard Process) used in the treatment of allergies. In those people who need Antronex you will find a weak right Pectoralis Sternal and a left Sartorious..

The following may explain one reason for a reoccurring posterior innominate. Many times the Sartorius may be found weak with an apparent subluxation of the sacroiliac. But when challenging the lesion to determine the phase of respiratory assist, a negative response is noted. In all cases of sartorius weakness, challenge the right pectoralis sternal. If both are weak they will respond to Antronex. If the Innominate needed adjusting and was treated successfully, therapy localize right liver alarm point. If positive, the sartorius will weaken again.

The area of fixation and or subluxation to be checked in this case would be dorsal 6, 7, and 8. Challenge the area R to L and L to R. If only a subluxation is found it is usually a Left to Right challenge with an inspiration assist. Before adjusting, challenge in a circular motion over the right and left transverses. On the right you will find a clockwise challenge with inspiration, and on the left a clockwise challenge but with expiration. Treating the left side with direction and respiration will strengthen the sartorius, and treating the right will strengthen the pectoral sternal. Do this before adjusting the vertebrae to the right with inspiration. Now challenge in a circular direction bilaterally for fixation.

If the right liver alarm point is therapy localized positive, check 9 and 10th dorsal also in the same manner.

If a fixation exists, treat as per Goodheart and follow with III, IV, and V as described earlier.

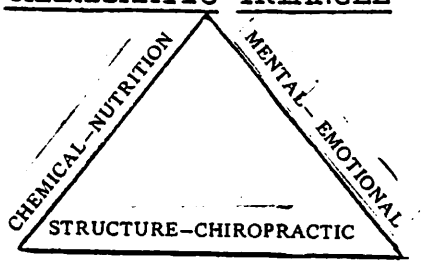
This method of treating subluxations and fixations can be applied to any area of the spine. Thanks to the patient with difficult problems, from them we learn new techniques for the benefit of all.

CHARISMATIC TRIANGLE

By Frederick J. Dieterle B.S.,D.C.
Diplomate I.C.A.K.
For Winter Conference 1980

CHARISMATIC TRIANGLE

The word of God is Spiritual Food



God's peace which surpasses all understanding

The Holy Spirit as Comforter

" And these signs shall follow them that believe .... They shall lay hands on the sick & they shall recover: Mk 16:17,18

ABSTRACT

The introduction of spiritual and scriptural concepts into an A.K. Christian practice has produced clinically consistent and greatly increased therapeutic and physiologic responses to treatment. The actualization of the body's potential will be maximized by knowledge of truth and faith which bridges the gap between us and our Creator (the source of all healing); through himself in Jesus Christ (the flood gate) allowing the Rivers of Living Water to flow through us. Scientific evidence abounds to the cause and effects of our programming ie. raising hands above our heads as in praise or acceptance gesture, increases thymus activity in a beneficial way. Biochemical secretions can be measured within seconds to be, beneficial or toxic based on positive and harmonious thoughts versus negative and disruptive thoughts or experiences.

PREFACE

The idea for this paper arose from a recent meeting in Malibu of the "Institute on Healing of the Whole Person" a charismatic Christian group of which several A.K. diplomates are members: John Thie, Bill Borrmann, and myself, founded by Jerry Lala D.C. from Minnesota. It was inspired from our family's experience in Arizona where the good Lord has blessed us richly as well as our radio and lecture ministries on health in the Valley of the Sun.

"My People Perish for Lack of Knowledge" Hos.4:6 refers to knowledge of God which can be applied to knowledge of our bodies and the rules we must follow to keep it clean, healthy and whole "Your body is the Temple of the Holy Spirit" Cor. 6:19. This knowledge takes many forms ie. Applied Kinesiology, Chiropractic, Nutritional metabolics, and scriptural precepts for the care of our bodies, soul and spirit (Blue print or owner's manual).

It is extremely difficult to develop parameters and guidelines to measure results but consider over a period of nine months to one year, 80 - 90 patients who are getting fair to good results each of which has multiple structural, muscular, accupuncture, as well as nutritional imbalances - your basic basket case. You sense a spiritual disharmony and stress factor, you then lead to a brief sharing and prayer, the patient returns the next visit glowing with praise about the great results. Upon verification by A.K. of previous constant and recurring problems that they are diminished by 90% or all together non-existent. Our experiences showing that these patients will hold adjustments for indefinite periods of time. This experience has repeated itself countless number of times that is why we feel so strongly the desire to incorporate this aspect of healing into the whole.As long these patients maintain a reasonable frequency of reading scripture centering their thoughts, a good health profile is maintained.

PROCEDURE

The following procedure is an example of a possible application test for the emotional centers in the usual fashion using a strong indicator muscle, prod these centers in the circuit by mentioning specific areas of stress, namely marriage, finances, fears, worry and then test the indicator muscle for weakening. Second, have the patient relive specific circumstances relating to these areas initially screened. Thirdly, supply an appropriate scripture which matches the specific problem or need. The greater the specificity of scripture and the greater the patient's receptivity, close checking with A.K. reveals that you can clear out visceral and accupuncture circuits relating to emotions etc. for greater periods of time.

It should be stated that a great percentage of our patients are Christians and many are born-again spirit filled. In our profession, we often feel the need to discern between truth and counterfeit as there are many practices and procedures where the origin is or bordering on the occult, spiritualism, devonation, amulets and etc. these being expressly prohibited by the word of God. Knowledge at what price? My good friend, Bill Borrmann, recently wrote an excellent paper on "Kinesiology and the Occult". I find no difficulty with thoses A.K. procedures which I use in my practice and get exeellent results with. We have developed a format of health related

scriptures, A.K. and nutrition which work quite well with the general public. We have had the priviledge of witnessing several instances of genuine miraculous healings. An obvious one is the case of the current Miss America, where medical records substaniate clearly that her leg grew three and a half inches during a Kenneth Hagan revival meeting. To us, this approach signifies, primarily, an event such as the finding of the "Game plan" half way through the game.

CONCLUSION

It appears clearly that Kinesiology is an excellent system of body language which can evaluate the physical body's response to being in or out of synch. with it's programming, namely to seek God and benefit immensely by his game plan. We give credit and glory in all ways to our Lord who makes everything possible and happen in our lives and we thank our friends in I.C.A.K.and our profession,for their friendship and support.

BIBLIOGRAPHY

1. Goodheart, George J., 542 Michigan Bldg. Detroit, Michigan 48226
Applied Kinesiology Workshop Manuals 1972, 1975, 1976, 1977, 1978, 1980

2. Josephson, Elmer, F. H. Revell Co. Old Tappan, New Jersey
God's Key to Health & Happiness

3. Living Bible, Tyndale H. Publishers, Wheaton, Ill.

Pain Control Used as a Differential Diagnosis

Lorraine M. Dumas

The purpose of this paper is to correlate some of the approved methods of pain control and to demonstrate how they can be used as a method of differential diagnosis. For matters of simplification the procedure is first charted followed by an explanation of the various methods and techniques.

Diagnosis	Method	Procedure
1. Spinal Trauma	Resistance and Contraction (R&C)	Upper cervical, dorsal and lumbar control
2. Direct Trauma	Cervical Specific	Pin-pointing pain adjusting vertebra; Condylar control
3. Visceral	Occipital Fibers	Nodular and vertebral Adjustment
4. Structural	Trapezius Indicators	Nodular and vertebral control of cervicals
5. General	Paravertebral Block	Indentation of Musculature

During the course of the examination and complete history of the patient, you determine the method of pain control to explore. If, for example, the patient has experienced trauma and the pain is along the spine, palpate the vertebral level of pain and then palpate its Lovett Reactor as explained in the R&C method. If pain is relieved, follow through with entire procedure. If, however, the patient complains of pain other than in the spine proper, palpate the related dermatomal

level for the control vertebra as described in the Cervical Specific Method. If that procedure does not reduce pain, trauma is not the causative agent. The next step is to palpate the occipital fibers for a nodule. If you find a nodule, palpate the related vertebra for a nodule on the transverse process and, if found, palpate the anterior reflexes[1] of that organ for pain. If painful, the diagnosis for cause of pain is visceral and, therefore, the appropriate procedure for that category will give the patient immediate relief. If, however, there is no pain on palpating the involved viscera, it is not responsible for the pain the patient is experiencing. The trapezius line is then palpated and if a nodule is found, palpate the appropriate vertebral level and a painful spinous process confirms the diagnosis of structural misalignment as the causative pain factor. If none of the above procedures prove effective in control of the pain, use the Paravertebral Block Procedure. It is possible the pain is due to facilitation with residual manifestation of a previous distortion or visceral malfunction whether corrected or not. This procedure eliminates aberrant neurological inpulses at the nerve root exit.[2]

R and C[3]

This method is used in low back pain to determine if the pain is due to a lumbar subluxation or to a cervical subluxation forcing a lumbar to subluxate in compensation. Palpate the lumbar in question with pressure in whatever direction is

necessary to produce the most severe pain. Hold that position and with the other hand palpate the Lovett Reactor to that lumbar. If pressure on the cervical vertebra reduces the lumbar pain, the cervical vertebra is the subluxation and the one to be adjusted. The reverse might be true if the patient complains of a cervical problem. If the pain is in the dorsal area, the control is on the opposite side of the same vertebra. Contact pain side increasing the pain. On the opposite side of the same vertebra press superiorly, inferiorly or medially to find the direction which relieves the pain. When this is accomplished, goad the vertebra in that direction and adjust.

Cervical Specific [4]

This method is valuable and very effective in shoulder, arm, hand and upper trunk pain. The patient is asked to pin-point the area of most intense pain. Contact this point very lightly with the pad of the index finger and palpate the vertebral level indicated by the dermatomal distribution. For example, if the deltoid is involved, check C5-6. Press medially into the transverse process of C5 or C6 while the other hand lightly touches the area of most intense pain. If pressing medially into C5 reduces the pain, that is the control vertebra. Press heavily into the control until pain reduces significantly. Remove the contact from the pain area but continue holding control area. Palpate the atlas and axis with pressure. If medial pressure on the atlas (or axis) reduces pain at the control level, goad for a few seconds and then adjust from lateral to medial. It is not necessary to hear an audible

release. If there is still some residual pain, place one finger on site of pain and goad condyle on same side until all pain is controlled.

Occipital Fibers[1]

These indicators are located along the occipital plate of the cranium. This line begins at the asterion and runs along the occipital ridge to the external occipital protuberance and is equally divided into 7 positions each of which represents certain vertebral levels.* When palpating this line, note any painful nodule and its position on the line. Then palpate the transverse process of the related vertebral levels, one of which will also have a painful nodule. Since each vertebral level represents a specific organ, the cause of the pain can be determined by identification of the malfunctioning organ. This pain can be controlled by contacting the painful nodule on the occipital plate with one finger of one hand and the other hand lightly contacting the nodule on the TP with the pad of the finger. The contact on the occipital plate is a heavy goading pressure. Both contacts are continued until the transverse contact feels moist. (I have also noted reddening in the area). When this is accomplished proceed with a soft tissue contact on the anterior portion of the patient's body in order to break any patterned reflex. One hand contacts the anterior reflex[1] for the involved organ while the other hand lightly contacts the patient's shoulder. The contact on the anterior reflex deepens progressively and is held until all pain under the contact point

has disappeared. Finally, in the area of visceral involvement, press firmly with one or two fingers in a superior direction while simultaneously asking the patient to resist your attempt to pull his arm footward from a perpendicular position.

Trapezius Indicators[1]

The trapezius is another valuable diagnostic tool which like the occipital plate, is divided into an imaginary line beginning at the acromioclavicular V and continuing to the first dorsal. This line is also divided into 7 positions each having a specific vertebral level.** Palpate the trapezius line and note any nodulation and its position on the line. Then palpate the specific vertebral involvements causing pressure on the spinous process in a side to side movement. If there is pain upon this motion, that vertebra is the major one involved. Contact is on side of pain while at the same time contacting atlas and pressing medially. If pain is alleviated, the atlas is the control. If not, press axis medially and pain should diminish. The axis would then be the control. While holding atlas or axis, contact the spinous process on the side of pain and hold until pain subsides. When this is accomplished, adjust that vertebra.

Paravertebral Block[3]

This method is particularly helpful for vague muscular aches and pains involving a large portion of the trunk. Palpate

bilaterally below the area of complaint along the intertransverse spaces about 2½ inches lateral to the spinous processes. Press thumbs down and move medially. If resistance of muscles is equal, move up to the next level until there is resistance on one side and shallowness on the other side. When this is found, hold the side of resistance with firm pressure and on the side of shallowness goad the tissues in a headward to footward direction until the side of resistance weakens and the side of shallowness strengthens. This technique can be used all the way up the spine to T1 and down to L5 removing all the vertebral spasms.

If accurately diagnosed, each of these techniques is an effective and efficient method of alleviating pain allowing the patient immediate comfort as well as allowing the doctor the necessary time for corrective care of chronic problems.

* Occipital Line

Position #1	T 1,2,9,10
Position #2	T 3,11,12
Position #3	T 4,5, L1
Position #4	T 4, L2
Position #5	T 7, L3
Position #6	T 8, L4
Position #7	T 9, L5

** Trapezius Line

Position #1	T 1,12, L5
Position #2	T 2,11, L4
Position #3	T 3,10, L3
Position #4	T 4, 9, L2
Position #5	L1
Position #6	T 5, 8
Position #7	T 6, 7

REFERENCES

1. DeJarnette, Dr. M.B. Chiropractic Manipulative Reflex, privately published, Nebraska.

2. DeMann, Dr. Lawrence E. Lectures at SOT seminars in Omaha, Nebraska.

3. DeJarnette, Dr. M.B. Sacro Occipital Technique, privately published, Nebraska 1977.

4. DeJarnette, Dr. M.B. Pain Control, privately published. Nebraska.

TEMPORAL-SPHENOIDAL REM ALPHA WAVE ENHANCER TECHNIQUE

Lorraine M. Dumas

Chiropractic Manipulative Reflex Technique (CMRT), also called Bloodless Surgery, is a manipulative technique developed by Dr. DeJarnette in order to correct organ dysfunction for the purpose of ridding the organ of its congestion and furnishing it with new circulation with its oxygen and nutrients.

Dr. Rees has done intensive research with the temporal-sphenoidal ring designating certain T. S. areas as being associated with specific viscera and functions.

He found that in order to achieve optimum results in temporal-sphenoidal work that it was necessary to have the patient in a very relaxed state of mind, a state in which he would show a preponderance of alpha brain waves if an electroencephalograph were hooked to his cranium. The alpha level of awareness is called the REM (rapid eye movement) level. This is a sort of twilight zone between fully awake and normal sleep. In this state, Dr. Rees found that phenomenal results could be obtained.

In order to set up "REM" the patient is lying supine and instructed to close his eyes and look upward inside the eyelids

as though he were trying to see the inside of his forehead. In a short time the eyes start to flutter in "REM" and at that same time the alpha wave discharge begins. The patient is cautioned to keep his eyes closed and to continue to look upward because the alpha wave output ceases instantly when eyes are opened.

With the patient doing "REM" and producing alpha waves, you can pick up the alpha wave output in any temporal-sphenoidal active point and shunt that healing force to any organ you wish to recharge or normalize. You then instruct the brain to continue this biological shunt until it is automatically done during sleep as it normally should be.

Dr. Rees further states that when a vital function is in trouble, the matching vital function point on the T.S. ring puts out more alpha waves than the rest of the side plate bone. The brain is trying to transmit life force over the electro magnetic field surrounding the body, and the brain is trying to help that organ in trouble. But the brain has lost its ability to find the entrance (alarm) point and like an interrupted memory tract needs to be shown how to regain this ability.

Through trial and error Dr. Rees found that specific nutrients, when chewed, could determine the severity of organ dysfunction.

He also found that specific nutrients could increase the alpha wave output at specific T.S. points and that the patient did not have to swallow the nutrient for the alpha wave enhancing effect.

Another research breakthrough was the fact that specific nutrients help the body to remember the electro magnetic pathway to the particular entrance point of the organ in need.

The specific nutrition test that was developed from this research is used to determine how severe the organ dysfunction. If chewing a specific indicated nutrient clears the organ problem in twenty seconds there is no need for CMRT.

Dr. Rees has also found that if the T.S. ring is active on one side only, a nutritional correction will probably clear the area, but even if bilateral, the specific nutrient is the first step in treatment.

If chewing a tablet clears all reflex areas in twenty seconds you proceed directly to the last step, the "REM" Alpha Wave Enhancer Step.

If, however, more than twenty seconds are needed to neutralize the reflex areas on the body so that they are less painful, then the full bloodless surgery procedure for specific T.S. areas is needed.

REFERENCES

1. Rees, Dr. M. L. Temporal Sphenoidal and Bloodless Surgery, privately published.

2. Rees, Dr. M. L. Lectures and personal communication.

THE SIMILAR SYMPTOM PANDEMIC PHENOMENON

This paper is not so much a presentation of facts as it is a recording of observations. For years now I have been noticing that if I get a case of right shoulder pain or right hip pain, I will soon have a number of very similar cases. The side of the body may vary but the neuromuscular and musculo-skeletal involvement is almost the same.

We have all been exposed to the contagion aspect of the germ theory but that certainly does not seen to apply in these cases. If I have one sacro-illiac slip with weak sartoris and gracillis, I will have five or six within a two or three day period. If, as it was last week I have a patient complaining of pain in the left forth dorsal area radiating out under the scapula and down the arm, I will have five or six more soon after. Examination of these patients by x-rays and kinesiological methods reveals nearly identical problems, with minor variations. Remember we are talking about problems that seem to be almost purely musculoskeletal and yet they occur in pandemic episodes.

We must also remember that the same pandemic type occurance also happens in what seems to be functional type problems such as gall bladder attacks and infectious type problems such as sinusitis or gastroentoriris. The latter type problems have always been blamed on a "virus" of one sort or another and have

been accepted as such, but I wonder.

I have to believe that there is more involved in these problems than just a simple virus or anything similar. As is the case with the sacro-illiac slip, the only thing these people have in common is the resulting symptoms and diagnostic profile while the causes seem to be as varied as there are numbers of cases. I feel strongly that there is a common denomiator here somewhere.

Over the years I have questioned other doctors about this phenomenon and, no one has attached any significance to it. I believe the pandemic nature of the occurance of human ailments of all types has a common cause. Regardless of the germ theory, I believe that there has to be a common prexisting condition that allows only certain people to be affected by a particular type ailment. I believe this common prexisting condition must be present before these people can be affected by similar type ailments whether it be musculoskelectal, functional or infectious..

Over the years I have tried to find the common denominator by detailed questionare of patients, but to this date I have no positive answers. At present I am leaning toward the temerature, humidity, atmospheric pressure theory but it is far from conclusive.

Most papers presented to the I.C.A.K. are presented as solutions to problems, this one, I am sorry to say, will not be that way. I am presenting a problem which begs for a solution and in so doing I am challenging each and everyone who reads this paper to find the solution. I firmly believe that with the great unmatched diagnostic tools available in Applied Kinesiology, sooner or later someone will find the answer and when they do they will have found one of the great keys to human physiology. Good luck Doctors.

Delbert W. Evans

THE CONTACT REBOUND REFLEX PHENOMENON

As is the case in most discoveries the forerunner is an unsolved problem. In my case the problem was this.

I have been working with athletes for years, mostly in contact sports, and for years we have had the problem of early season injuries. The injuries we were concerned with were of the sprain and strain variety or those most associated with being, as they say, "In shape."

For years now most athletes have tried to stay "in shape" the year round but there was a time when this was not so. Of course in those early years, partly season injuries were much more common than they are now.

The problem persists tho even with the athletes reporting in shapefor the pre-season practices. Early contact and strenuous manurers still take and inordinate toll as compared to mid season activities of the same nature.

Our first attempt at solving the problem was to increase the quanity of running, weight lifting, and stretching exercises the athletes were doing in the off season. This helped a little but it was still far short of what we thought it ought to be.

Next we tried more flexabilty exercises and less weight lifting, then more weight lifting and less flexibility exercises but we were still not able to reduce those early season injuries to a satisfactory level. Finally a personnel experience brought the solution to light.

Contact Rebound Reflex Phenomenon/Page 2

Most of my life I have been involved in contact sports of one type or another nearly the year round. I had very few injuries of the strain or sprain variety except those involving extreme excesses of force such as kicking a cleat in the dirt while sliding into base. Then for several years, because of lack of time due to attending Kenesiology seminars and things of that nature, I dropped out of contact sports altogether.

The natural result of this inactivity was an accumulation of unsightly flab that was a constant source of embarassments. I decided it was time to get back in shape.

After a summer of swimming, running, water skiing and playing softball I was in pretty good shape. In the fall I started playing raquetball and this is what led to my discovery.

Raquetball is not a contact sport in the usual sense but when it is played vigorously there is a lot of contact with the walls, the floor and occasionally even an opponent. After a few months of playing the game I finally became proficient enough to be able to play vigorously and I had my first real contact with the wall. I have always been the type who loves contact. It was stimulating and invigorating and rarely caused soreness or aching later. This time it was different. I hit the wall fairly hard with my shoulder and I thought every joint in my body had come apart. The next day nearly every one of those joints were sore and aching also and this surprised me, I had never had that experience before. Jolts of that magnatude had never bothered me when I was in as good a shape as I was then.

I continued to play raquetball and hit the walls, the floor and an occasional opponent, and I began to notice that I was experiencing less soreness and aching even tho the amount and the magnitude of the contact was increasing. In trying to find the answer to that I deduced that maybe I was just learning to anticipate the contact better and was better prepared to withstand the jolt when it came. This seemed like a satisfactory explanation for awhile but soon after words I began to play basketball in an adult recreation league. As most everyone knows basketball is no longer a non-contact sport, especially the way it is played in the adult recreation league. Now I was being hit from all angles and at totally unexpected times. It was impossible to anticipate the contact, still I was not experiencing the sorness or aching of the earlier contacts. There had to be a reason.

After much reading and searching I could find nothing in the way of reflexes that seemed to apply. Again a personal experience helped me solve the problem. Some years ago I was in an auto accident, fortunatly I had my seat belt on my abdomen, "It's holding, it's holding, it's holding. The pressure only lasted an instant but in that instant my subconcious mind was able to repeat those two words three times. Other experiences of this kind have impressed me with speed with which the subconcious can react.

By putting these two experiences together I came to a conclusion about what was happeingin in contact reflex.

Since the athletes were in fine shape physically when the early contact started it could not be a lack of physical strength that caused the injuries. There had to be a reflex mechanism involved.

I came to the conclusion that the only type of reflex that would be fast enough to enable the body to react to protect itself from unexpected contact would have to be from the subconcious. This reflex seemed to be a conditioned reflex in as much as it seemed to increase in proficiency with use and decrease or fade with disuse. The conditioned reflex aspect of this reflex also ruled out a simple spinal cord reflex since that is not a learned type reflex. Because of the speed of the reflex it is impossible to measure it in anyway so we have had to accept the imperical evidence of experience for proof of its existance.

To gain this evidence we made one change in the past and preseason training of the athletes we were working with these athletes included football players, basketball players, raquet-ball players and hockey players. We had these athletes continue their contact along with the regular running and weight lifting that they had always done. We had them falling, bumping into walss, bumping each other, running inot sandbalgs and anthing elsc they would continue to provide the body with the jolting contact that was apart of their sprot. The result was a dramatic decrease in the early season injuries that had plaqued us for so long.

At this time I don not know the neurological pathways of this reflex or whether the receptors which instigate it are the

ligament, tendon, muscle, facia or the skin but we are working on it.

For all of you who are working with athletes who are in contact sports or who anticipate being involved in a contact sport remember to get that contact reflex in shape along with the rest of the body. Just as in any exercise, start with light contact and build gradually in magnitude until you reach the level you will experience in the activity involved.

Remember, to really be "in shape" the contact reflex must be in shape also.

Delbert W. Evans

USE OF CHAKRA POINTS IN THERAPEUTIC KINESIOLOGY

Joen Fagan, Ph.D.

Abstract. Touching the body points associated with the top four chakras increases the accuracy of response to psychological questions, using the Therapeutic Kinesiology procedure. In addition, each of the chakra points mediates different kinds of information and is touched differently. The way in which this was discovered, that of asking the body about its own processes and how to tap them, suggests the usefulness of the procedure as a meta-information system.

Diamond (1979) advocates touching the thymus point to increase the accuracy of responses to physical stressors. The illustrations in his book suggest that he has subjects lightly touch the thymus point with the tips of their middle three fingers. During the process of exploring and developing the Therapeutic Kinesiology procedure (Fagan, 1980), touching the thymus point seemed to increase the accuracy of the muscle response. It occured to the writer to use the "Yes-No" questioning process (Fagan, 1980) to ask, "Does touching this place (thymus) increase the accuracy of answers to questions?" On receiving a "Yes" response, other questions were then asked, including the best way to touch the point, the best kinds of questions to ask, and whether there were other body points. The results are shown below.

Location	Touch	Information
Thymus point	tips of all five fingers	Personal history, current problems, physical problems, emotional and psychological information
Base of throat	middle three fingers placed in apex with third finger at apex	Psychic and spiritual questions, such as past lives, negative entities, objects with bad vibrations
Forehead, 1" above brow	tip of index finger	Predictions, general information or abstract questions
Anterior fontenel	tip of index finger	Life purpose and goals

The above points have been confirmed on about fifty subjects with only a few very minor variations. Additional questioning has not located any other points. The first two points have been explored extensively by the writer, although she has no illusions that the exploration process is complete. The forehead point may be useful in obtaining information that may generalize beyond the case at hand, and researchers are encouraged to experiment with this. The predictive aspect of the forehead point should be used with caution and seems not to work in any situation that would involve personal gain. It is hypothesized that the use of the chakra points may tap into information available from the etheric body.

An additional finding is that in situations where external muscle testing is awkward or impossible, an internal "Yes-No" system can be used. "Yes-No" responses have been used within chiropractic by finger touching and leg length changes. However, Bandler and Grinder (1979) suggest another procedure. After relaxing the body, the subject asks the body for an internal sensation or movement that will signal "Yes," then asks for this to be intensified as a confirmation, then asks for a "No." Responses vary widely between subjects and appear idiosyncratic, but often the "Yes" response is in the direction of increased body mobilization for energy and the "No" indication represents lessened energy. In using the internal responses it is not necessary to touch chakra points.

This process suggests a continuum of body, emotional, interpersonal, informational, and spiritual informational circuits, each with similar but differing procedural approaches, making potentially available a vast amount of valuable information.

References

Bandler, R., & Grinder, J. (J. Stevens, Ed.), Frogs into Princes. Moab, Utah: Real People Press, 1979.

Diamond, J. Behavioral kinesiology. New York: Harper & Row, 1979.

Fagan, J. Therapeutic kinesiology. Collected papers of the I.C.A K., December, 1980.

MERIDIAN BALANCING AND THE BACH FLOWER REMEDIES

Joen Fagan, Ph.D.

Abstract. Six psychology graduage students were given several tests to assess meridian imbalances on both physical and psychological levels, and the Bach Flower Remedies were administered to assess their ability to strengthen meridians. Many of the results were inconclusive or inconsistent, but there does appear to be a clear relationship between the Bach remedies, Goodheart's "Now-Then" technique, and Franks' hand test.

Six graduate students in psychology who had had considerable experience with both AK and TK were given the following tests in the order indicated:

1. A questionnaire sheet containing four questions related to each of the Bach Flower Remedy (BFR) personality descriptions. A copy of this test is appended. It was derived from one devised by Dr. Paul White as published in Borrmann (1979). A few questions were rewritten and others added so that the scores for each remedy would be comparable.

2. Each subject, using TK procedures for obtaining a "Yes-No" answer using an IM (Fagan, 1980) was asked the following questions: (1) Is your _____ meridian being affected by any current emotional or psychological problems? (2) Is your _____ meridian being affected by any long-standing or deep psychological problem? Each of the 12 meridians was asked in turn for (1), then for (2).

3. Each subject was tested for meridian imbalance using pulse points, these being confirmed by alarm point testing.

4. Each subject, using the method described in his paper and amplified at the May, 1980, ICAK meeting by Franks (1980) was tested for energy blockages using the back of the hands on the back and front of the body. Any points weakening an IM were identified by negation of weakness upon tapping the alarm point.

5. The BFR, combined in groups of 4 or 5 alphabetically, were sniffed by subjects to ascertain which strengthened the meridians located by the pulse point (3 above) or Franks points (4 above). Individual remedy bottles were then checked.

Findings

1. Subjects, in response to the questionnaire, obtained scores of between 0 and 13 on the individual BFR descriptions, with a median around 4 and considerable scatter.

2. In response to TK questions, subjects indicated between three and six meridians being currently affected by emotional problems, and between 4 and 7 affected by long-standing problems. There was considerable overlap between the two lists, ranging from about 50% to 85%.

3. The meridians identified by pulse point ranged from 1 to 4, but showed no relationship to the TK identified meridians.

4. The meridians identified by the Franks technique showed almost no relationship with the meridians identified by the pulse point technique, nor to the TK-identified meridians.

5. The BFR which strengthened the Franks points, showed no relationship to the scores on the questionnaire. For example, if a subject strengthened on 4 remedies, his scores on the test would be 0, 2, 4, and 12, indicating a correlation near zero. <u>However, the same Bach remedies, usually between 3 and 5, strengthened both the pulse point and Franks meridians</u>.

Discussion and Additional Findings

The results given above confirm the relationship between the BFR and the meridian system, but shed no light on psychological factors. In thinking over

the data, the writer hypothesized that there might be a relationship between the Franks hand technique and Goodheart's Now-Then technique (Goodheart, 1980). The six subjects were retested with both procedures and did show a 100% relationship. The BFR also strengthened the weak Now-Then meridians and also negated the related Luo points. However, subjects who had 2 or more positive Now-Then meridians showed little overlap on the BFR's that were corrective. For example, a typical subject showed the following meridian imbalances, and BFR responses (with scores on the BFR Questionnaire shown in parentheses):

Meridian	Bach Remedies (S's Range = 0-9; Mdn = 3)
Lung	Olive (0), Elm (1), Gorse (0), Willow (0)
Bladder	Olive (0), Elm (1), Crabapple (1)
Spleen	Olive (0), Mimulus (4), Honeysuckle (5), Vine (9), Beech (5)

with the Franks and Goodheart procedures.

An additional eight subjects were tested. One showed no meridian imbalance, and seven showed identical Franks and Now-Then responses.

Tentative Conclusions

1. The Franks technique and Goodheart's Now-Then technique are both picking up identical otherwise hidden meridian blockages. The Now-Then procedure is easier and quicker to administer, since the Franks involves some body contortion.

2. Since 13 of 14 subjects did show meridian imbalance which was not reflected on pulse points (and since the writer has had excellent results in clearing up recalcitrant symptoms in a number of patients with the Now-Then procedure) it is suggested that this should be checked routinely with patients.

3. It would be of value to do a study comparing the efficiency of the BFR and the tapping of Luo points in clearing Now-Then meridians. (With five patients,

clearing the Now-Then meridian has taken persistant stimulation of the Luo points over a considerable period of time.)

4. The lack of relationship between the BFR Questionnaire scores and the actual BFR obtained by negating the imbalanced meridians suggests that the Questionnaire, and the diagnostic procedure used by Bach practitioners (Chancellor, 1971) may be inefficient except with extreme or very clear-cut cases, and direct muscle testing is much preferred.

5. The lack of psychological and physical correlation between the TK and AK approach to meridian assessment suggests the need for additional research from different directions.

References

Borrmann, W. R., Comprehensive guide to nutrition. Chicago: New Horizons Publishing Corp., 1979.

Chancellor, P. M., Handbook of the Bach Flower Remedies. New Canaan, Conn.: Keats Pub., 1971. (See especially Chapter 1)

Fagan, J. Therapeutic kinesiology. Collected papers of the I.C.A.K., December, 1980.

Franks, T. The sphenoid and other common findings. Collected papers of the I.C.A.K., May 1980. See especially page 240.

Goodheart, G. I.C.A.K. Research Tapy 59, 1980.

1. Do quarrels and arguments distress you?
2. Do you tend to conceal your fears from others?
3. Are you fond of exactness, order and discipline?
4. Are you quiet and kind?
5. Do you doubt your own ability?
6. Do you think you are on the verge of a nervous breakdown?
7. Do you tend to make the same mistakes over and over?
8. Do you feel that no one appreciates you?
9. Do you daydream often?
10. Do you feel unclean mentally or physically?
11. Do you at times feel overwhelmed by the responsibilities of your work?
12. Do you suffer from deep depressions?
13. Have you lost heart and suffer from hopelessness and despair?
14. Do you talk a lot?
15. Do you ever suffer from jealousy?
16. Do you have regrets about the past?
17. Do you feel more tired getting up in the morning than when you go to bed?
18. Do you sometimes become impatient with people who are slow?
19. Do you lack self confidence?
20. Do you blush easily?

21. Does gloom or depression ever descend on you like a black cloud without any reason?
22. Do you struggle in the face of difficulty and never give up hope?
23. Have you had a long illness that has sapped your vitality?
24. Are you never really content with your achievements?
25. Do you worry excessively about your family members?
26. Do you ever suffer from extreme terror?
27. Do you have strong opinions about religion or politics?
28. Do you suffer from indecision?
29. Have you had any disappointments, sad news or a bad fright lately?
30. Do you feel you have reached the limit of your endurance?
31. Do you force yourself to do things beyond your physical strength?
32. Are you confident of your abilities?
33. Have you decided to take a step forward in life and drastically change any habits?
34. When you are ill, do you prefer to be alone and undisturbed?
35. Do you have persistent unwanted thoughts?
36. Do you feel that life is passing you by?
37. Are yo resigned to life?
38. Do you think your prayers are unanswered and your efforts unrewarded?
39. Will you go to great lengths to avoid an argument?
40. Do you ever wake up in a cold panic, with a sense of disaster?

41. Do you find it hard to understand or make allowances for people?
42. Do you overtax yourself when other people need help?
43. Do you often follow other people's advice because you distrust your own judgement?
44. Do you fear you will lose control and do something dreadful?
45. Do you make repeated mistakes becuase of inattention or indifference?
46. Do you want to keep your loved ones close and help direct their lives?
47. Do you feel you withdraw in your own world when faced with an unpleasant task?
48. Do you have a lot of skin problems?
49. Do you sometimes feel you are not equal to your job, although you know you are qualified?
50. Are you easily discouraged when things go wrong?
51. Do you have a long standing illness that just doesn't seem to get any better?
52. Are you concerned about your ailments and like to discuss them?
53. Are you often angry with people?
54. Do you often think about pleasant memories of years gone by?
55. Do you feel mentally and physically tired?

56. Do you eat, speak and move quickly?
57. Do you feel inferior to other people?
58. Do you sometimes brood over the possibility of an illness?
59. Do you ever have a melancholia or gloom that seems to cover you like a blanket and leave in a day or two for no reason at all?
60. Do you constantly try to improve conditions?

61. Do you suffer from weariness and a lack of zest?
62. Do you blame yourself for not doing better?
63. Do you fear that something might happen to people whom you care for?
64. Do you often have nightmares?
65. Do you ~~have high ideals?~~ dislike superficiality?
66. Do you lack the ability to make up your mind?
67. Have you had a severe shock in you past life (death of someone close, accident?)
68. Do you suffer from extreme mental anguish?
69. Do you have strong opinions?
70. Do people see you as bossy?
71. Have other people clearly misguided you at times?
72. Are you generally quiet and self-contained?
73. Do you wake up in the night and can't get back to sleep because of persistent thoughts that won't go away?
74. Have you tried many things, but nothing seems to bring you happiness?
75. Do you feel you have to put up with the conditions in life that are bothering you?
76. Do you think that fate has singled you out unjustly, because you have not found happiness?
77. Does it seem that pills or alcohol help when you feel very bad?
78. Do you tend to conceal your fears from others?
79. Do you have high ideals?
80. Do others impose upon you?

81. Do you feel you often do foolish things that you know better than to do?
82. Do you feel desperate?
83. Does it seem hard to learn from experience?
84. Do you feel that you are sacrificing yourself for you loved ones?
85. Do you think the future holds more happiness than the present?
86. Do you get absorbed by or very concerned and fussy about details?
87. Do you sometimes feel that if you fail, it would bring about hardship on others?
88. Do you usually know what is causing your depression and despondency?
89. Has an inherited condition condemned you to a lifetime of suffering?
90. Do you dislike being alone?
91. When hurt or insulted by someone, do you think of ways to get even?
92. Would you like to relive your life?
93. Does it often seem that the demands of everyday life are just too much?
94. Do you prefer to work alone so you can go at your own pace and not be slowed down by others?
95. Do you not try new things because you feel you will fail?
96. Do you have fears that you would like to overcome?
97. Do you sometimes lose interest in everyday activities?
98. Are you reliable and dependable?
99. Does daily life seem like hard work?
100. Do you blame yourself for things that go wrong?

101. Are you an anxious person?
102. Have you had any emergencies recently?
103. Is self discipline important to you?
104. Do you experience extremes of joy and sadness?
105. Is it hard to let others console you?
106. Do you feel your very soul is suffering destruction?

107. Are you sure that you have found answers that would be valuable for others?
108. Do you find it hard to let other people make their own mistakes when you know how to help?
109. Can other people talk you out of your own ideas about what is best?
110. Are you usually capable and confident?
111. Do you have problems with concentrating?
112. Are you undecided as to what you want to do with your life?
113. Are you weary and lack vitality?
114. Do you resent others good fortune when you feel they have not worked as hard as you have?
115. Do you believe its much better to appear cheerful then burden others with your cares?
116. Does it sometimes seem that something terrible may be about to happen?
117. Do you get irritable and intolerant when people don't do their best?
118. Do you often do more than your share?
119. Even though you often get advice from others do things still seem not to work out?
120. Do you fear impulses or thoughts that could make you do wrong?
121. Does it seem other people learn about life easier and quicker than you?
122. Do you spend a lot of time caring for and protecting those you love?
123. Does it seem that you don't have a great deal of energy or interest in life?
124. Is there one thing that you keep being concerned about which seems essential to change?
125. Are a lot of people dependent upon your decisions?
126. Do you get very discouraged when there are delays or hinderances?
127. Do you feel it is useless to try anymore?
128. Do you seek out other people to be with and feel best when with someone?
129. Do others often seem to disregard your wishes or not care about you?
130. Do you like to tell others about things that have happened to you in the past?
131. Does it feel that you need more strength to get through life?
132. Are you a hard worker with high standards?
133. Do you often feel that you can't succeed, so why try?
134. Are you a nervous, shy person?
135. Do you find it difficult to "cover up" and not show it when you're depressed?
136. Do you get impatient with yourself if illness keeps you from doing something?
137. Does it seem like pleasure doesn't often come?
138. Do you work very hard to do well enough?
139. Do you think the world is getting more and more dangerous?
140. Have things ever seemed completely hopeless?
141. Is being healthy and strong worth living strictly with respect to many of the popular pleasures?
142. Do your moods change quickly?
143. When grieving, do you prefer to be alone?
144. Have you ever used or thought that the words "anguished", "despairing" and "hopeless" apply to you?
145. Do you enjoy arguing and trying to convince people who have different opinions or beliefs?
146. Are you a good person to have around in emergencies?
147. Would you like to start a new way of life?
148. Do you enjoy being alone?
149. Are there certain thoughts, worries, ideas you just can't get out of your mind?
150. Would you like to really accomplish something in life?
151. Does life seem monotonous?
152. Do things which you have enjoyed in the past seem less enjoyable now?

1.____	39.____	77.____	115.____	Ag
2.____	40.____	78.____	116.____	As
3.____	41.____	79.____	117.____	Be
4.____	42.____	80.____	118.____	Cen
5.____	43.____	81.____	119.____	Cer
6.____	44.____	82.____	120.____	Cher
7.____	45.____	83.____	121.____	Ches
8.____	46.____	84.____	122.____	Chi
9.____	47.____	85.____	123.____	Cl
10.____	48.____	86.____	124.____	Cr
11.____	49.____	87.____	125.____	El
12.____	50.____	88.____	126.____	Ge
13.____	51.____	89.____	127.____	Go
14.____	52.____	90.____	128.____	He
15.____	53.____	91.____	129.____	Hol
16.____	54.____	92.____	130.____	Hon
17.____	55.____	93.____	131.____	Hor
18.____	56.____	94.____	132.____	Im
19.____	57.____	95.____	133.____	La
20.____	58.____	96.____	134.____	Mim
21.____	59.____	97.____	135.____	Mu
22.____	60.____	98.____	136.____	Oa
23.____	61.____	99.____	137.____	Ol
24.____	62.____	100.____	138.____	Pi
25.____	63.____	101.____	139.____	Red
26	64.____	102.____	140.____	Roro
27.____	65.____	103.____	141.____	Rowa
28.____	66.____	104.____	142.____	Scl
29.____	67.____	105.____	143.____	St
30.____	68.____	106.____	144.____	Sw
31.____	69.____	107.____	145.____	Ver
32.____	70.____	108.____	146.____	Vi
33.____	71.____	109.____	147.____	Wal
34.____	72.____	110.____	148.____	Wat
35.____	73.____	111.____	149.____	Whi
36.____	74.____	112.____	150.____	Wilo
37.____	75.____	113.____	151.____	Wilr
38.____	76.____	114.____	152.____	Will

For each statement, mark (0) if you do not have the condition, (1) if you have the condition mildly, (2) if moderate and (3) if severe.

MAXILLARY - MANDIBLE FIXATION

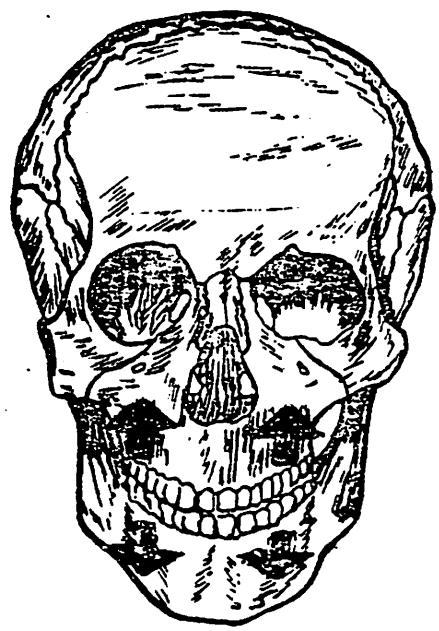
by Kenneth Feder, DC

Abstract: A micro-fixation has been found between the mandible and maxillary bone which may compromise the normal pumping of the cerebral spinal fluid.

Upon inspiration, the mandible moves inferior and posterior. The maxilla moves superior. If a micro-fixation exists such that the normal separation of the two bones can not move through their respiratory excursion, an interference with the normal cerebral spinal fluid flow may result.

Procedure

The maxillary and mandible bones may be challenged bilaterally by pressing up or superiorally with the thumb and index finger of one hand while pressing the mandible down or inferiorally with the thumb and index finger of the other hand (Figure 1).



Cranial Challenge and Correction

If the fixation exists, a strong indicator muscle will weaken. Find the phase of respiration that negates the challenge, which seems to be inspiration. The correction of the fault is made by pressing with force in the same direction which produced the challenge with the phase of respiration the negated challenge. The pressure applied should be approximately 4 to 5 pounds with 4 to 5 respirations.

Conclusion

A normalization of the cerebral spinal fluid is imperative for the proper functioning of the nervous system. I have found the correction of this fault a valuable aid in relieving severe headaches as well as a general approach to improving the functioning of the body.

CATEGORY II AND THE WALKING GAIT...A VALIDATION PAPER

H. WALLACE GUNN, SR., B.A., D.C.

ABSTRACT: This paper basically is written to validate the findings of Dr. Herbert C. Anderson, on his reported research presented in the Collected Papers at the ICAK meeting held during the summer meeting of 1978. (1)
It is also presented to report additional refinements we have made in applying Dr. Anderson's principles in our research and clinical application.

BACKGROUND: In our experience we have had patients with obivous low back problems which did not respond to routine AK therpay localization to the sacro-iliac joints. And it wasn't until Dr. Herb Anderson's paper that we found one of the answers to this type of condition. (I regret that we sometimes pass over these papers very lightly and do not give them the consideration and thought they deserve). I did not utilize this information for over a year after I read and saw it demonstrated. Then I finally had eyes that saw and ears that heard. What a difference it has made in helping to locate lesions that could have been passed over.....when we become busy we have a tendency to want to short-cut the procedure and do not always do first things first. I am of the opinion that many problems are not found and corrected simply because we are not doing first things first.

For example: Do you take it for granted that a patient can and does have the ability to therpay localize? If you take this for granted and do not first check the patient's ability to therpay localize.....you are missing many problems that you could help the patient with. Some patients can only therpay localize with palms up. Why? Some can only therpay localize with palms down. Why? Some patients neither way. Why? You can save yourself

much valuable time and with less effort on your part, as well as the patient's, if you first determine the patient's ability to therpay localize. This is one refinement most of us can do to improve our service. Listed below is the technic to check a patient's ability to therpay localize. (2)

1. IONIZATION: Have patient breath through his LEFT nostril, as the doctor holds the right side of the patient's nose closed. Have patient exhale through the RIGHT nostril, as the doctor holds the left side closed. Test your muscle indicator (Usually PMC). IF INDICATOR WEAKENS.... patient is low or deficient in positive ions....this indicates a need for calcium. And the patient will only therpay localize PALMS DOWN.

2. IONIZATION: Have patient breath through RIGHT nostril, as doctor holds patient's left nostril closed. Have patient exhale through LEFT nostril as the doctor holds patient's right nostril closed. Test indicator muscle. IF INDICATOR WEAKENS....patient is low or deficient in negative ions....this indicates a need for POTASSIUM and the patient will only therpay localize with PALMS UP.

3. IONIZATION: Patient may be low or deficient in both positive and negative ions and will not therpay localize at all. He needs both calicum and potassium. (About 1 out of every 100 patients).

WALKING GAIT TECHNIC:

After determing patient's ability to therpay localize, place patient supine. Then therpay localize one sacro-iliac joint and then the other. I usually use the Psoas muscle as an indicator, using the Psoas on the same side as the sacro-iliac joint being therpay localized. If this proves negative on testing the Psoas, then have the patient raise the opposite arm to the side you you are testing, about 30 degrees, and this places the patient in the true

walking position. Retest indicator with patient therpay localizing the sacro-iliac joint.....observe how many category two's you would have missed by not doing this.

RESULTS: For this paper we kept tract of three months all new patients. Each received our routine AK examination, which included a check for categories. 187 patients were examined. Of these 88 were positive for category two, without the walking gait technic. Applying the walking gait technic we found 115 category two's out of the 187 checked. Indicating that without the walking gait technic on the initial examination, we would have over-looked 27 category two's, or 1 out of every 4.....

CONCLUSIONS: Because of these facts and figures we now routinely place all patients in the walking gait position when we examine or check a patient before corecting a category two. This saves time and effort instead of testing first in one position and then in another.

ADDITIONAL OBSERVATIONS: My practice at this time is mainly geriatic and with patients in their 70's, 80's and some in their 90's, you have to be very careful with oseous adjustments. We have found very satisfactory results by balancing up the musclature involved and placing the patient on blocks and let the body do the corrective adjusting.

REFERENCES

(1) ICAK Collected Papers Summer meeting Detroit 1978 pages 5-7

(2) Advanced AK Seminar. Sheldon Deal/Wm. Heath Jan. 1978 Scottsdale, Ariz. Notes from Seminar.

Simplification of the Priority System

To Determine the Sequence of Spinal Correction

Presented by:

Thomas R. Hamilton, D. C.

Simplification of the Priority System to Determine the Sequence of Spinal Correction

Basic Premise - The priority system is based on Inhalation Assistance and "pinch or Melzack Wall Theory. This article is directed at simplifying the research work presented at the Detroit meeting by Dr. Alan Beardall and Dr. Michael Allen with special emphasis on the spine and pelvis.

This paper is presented by:

Dr. Tom Hamilton

Assisted by:

Dr. Karen Rexing

Dr. Robert Winchell

Margaret Fleming, R. N.

With the afore mentioned method, the staff has examined over a thousand patients and have found this to be the most complete and thorough analysis of the spine and pelvis.

The initial analysis is performed with the patient in a prone position on the table. Therapy localization to the pelvis for category I, II, III; the sacrum and coccyx; ilium and ischium for individual movement; and hip joints should be therapy localized individually. Upon discovery of a condition which meets the pre-requisites of the Inhalation Assistance and Melzack Wall, mark it, but do not correct the lesion at this time.

Secondly, check the cervical spine with therapy localization, especially the lateral atlas, occiput, and axis very closely. Continue to check the entire spine. We generally find an upper cervical condition existing jointly with a lumbar 4 or 5 or a pelvic condition.

On many occasions, we have found upper cervical conditions co-existing with lower lumbar or pelvic conditions which also strengthen with Inhalation Assistance and Melzack Wall. Therefore, we had both upper and lower spinal conditions co-existing and meeting the requirements for correction.

Next step is to determine the primary lesion: Tap for bone memory the upper cervical lesion and the co-existing pelvic lesion. The primary lesion will continue to test strong with Inhalation Assistance and pinching. The secondary lesion will not. Correct the primary lesion, and then re-check the secondary lesion. The secondary lesion will not always remain a lesion, but on occasion, the computer will kick out another problem which has been masking what initially was felt to be the secondary lesion. If, for example, the secondary lesion was a 5th lumbar and it will no longer test strong with Inhalation Assistance and pinch, then check the categories since they mask the 5th lumbar. When the categories are corrected many times the 5th lumbar will clear from the previous work.

References

1. Collected Papers of the Members of the International College Of Applied Kinesiology, "Body Priorities as Demonstrated by a Dental Splint" by: Sheldon Deal, D. C. May 1978 issue, pp. 65-71.

2. Collected Papers of the Members of the International College Of Applied Kinesiology, "Extra S pinal Bone Sequences" by Alan G. Beardall, D. C. May 1979 issue, pp. 23-34.

3. Collected Papers of the Members of the International College Of Applied Kinesiology, "The Cloacal Synchroniztion Technique", by Alan G. Beardall, D. C. Winter Issue, 1977.

4. Collected Papers of the Members of the International College Of Applied Kinesiology, "The Body Knows - Ask It" by Michael D. Allen, D. C. May 1979 issue, pp. 3-7.

The Body Therapy Localizes In

Three Separate Independant Units

Presented by:

Dr. Thomas R. Hamilton

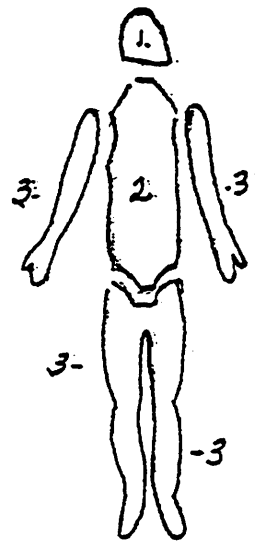
The Body Therapy Localizes in Three Separate Independant Units

This paper is based upon criteria as set forth in Dr. Sheldon Deal's paper in 1978, page 70 concerning body priorities. The criteria we have set forth for a primary lesion are: 1. It must be weak in the clear.

2. It must therapy localize (T. L.)
3. It must strengthen with inspiration assistance (I.A.)
4. It must remain strong with Mulzack Wall (Pinching) (M.W.)
5. It must remain strong with tapping (Tapping)

The concept that the body may operate in three separate units was reached following the fact that we found lesions in all three of the units which would fulfill all the requirements as set forth above.

We have found therapy localization to exist separately in each of these units:



Unit I Skull

Unit II Spine - including sacrum and coccyx - plus trunk and viscera

Unit III Extremities - ilium, ischi and pubis. The division line is the S. I. (sacroiliac joint)

The method we used in finding these to co-exist was testing everything and marking it without making any corrections. After we had totally outlined all of the conditions, subjecting them to our requirements, we tried to determine a starting point: For example: we have found inferior right occiput, 7th thoracic vertebrae and second metatarsal bone, all of which are weak in the clear by therapy localization. They strengthen with inspiration assistance and remain strong when pinched and would not weaken when tapped.

From the above research we concluded that it is possible for the body to fulfill all of our requirements in each of the separate units at the same time. But we have never found two lesions to exist within a unit who remain strong when subjected to our requirements.

When we find lesions to exist in all three of the units, we rapidly tap the three areas in question, have the patient inhale and subject him to Mulzack Wall. The lesion which remains strong is the primary lesion or our starting point. That is the first unit to be treated.

References

1. Collected Papers of the Members of the International College Of Applied Kinesiology, "Body Priorities as Demonstrated by a Dental Splint" by : Sheldon Deal, D. C. May 1978 issue, pp. 65-71.

2. Collected Papers of the Members of the International College Of Applied Kinesiology, "Extra Spinal Bone Sequences" by Alan G. Beardall, D. C. May 1979 issue, pp. 23-34.

3. Collected Papers of the Members of the International College Of Applied Kinesiology, "The Cloacal Synchroniztion Technique", by Alan G. Beardall, D. C. Winter Issue, 1977.

4. Collected Papers of the Members of the International College Of Applied Kinesiology, "The Body Knows - Ask It" by Michael D. Allen, D. C. May 1979 issue, pp. 3-7.

Acupuncture Masking Structural Conditions

Presented by:

Dr. Thomas R. Hamilton

Acupuncture Masking Structural Conditions

We have found that the masking of structural conditions by acupuncture problems is common. We have all seen patients who are essentially normal but are difficult to therapy localize. Yet, these same patients have demonstrated the symptoms and all the clinical manifestations of an existing lesion. Dr. Goodheart referred to this in his research tape # 42 side 2 when he was talking about the gate transmission of the therapy localization stimuli. He said the small fibers open the gate and the large fibers close the gate and that the substantia gelatinosa regulated this activity. In the patients that we have found who are essentially normal, we took the therapy localization a step further and therapy localized pulse points. When we found a positive therapy localization to a pulse, we would proceed to the alarm point which was hyper active. We then continued to the opposite side and treated the meridian connector. We have done this by inserting a needle at that point or by simply having the patient hold that connecting point or having the nurse hold the connecting point. It seems to have an effect of brightening up the picture. By holding the connecting point of the accupuncture meridian, it is then possible to go back and to tharapy localize many of the existing conditions which we suspected. As you know, the research that Dr. Goodheart was doing at that time was using R. N. A. and was talking about neurological chemical memory and neurological circuit memories. He was using ethyl chloride spray for a cold stimulus. I am of the opinion at this time that by simply holding the blocked acupuncture meridian, the acupuncture circuit opens the gate connector, allowing you to therapy localize the patient's conditions.

Page 2

There is a useful chart in the 1973 Research Manual on page 76 which outlines alarm points, organ and the meridian connectors. This is preceeded on page 72 by the observations of Dr. Alan Beardall when he discusses the stimulation of the appropriate connecting points, sometimes called "luo" points or "coupling points", which would release the block and allow the energy to flow balancing the circuit.

References

1. Goodheart, Dr. George J. "Research Tape # 42, Side 2

2. Goodheart, Dr. George J. Applied Kinesiology Workshop Procedure Manual, 1977 issue.

3. Goodheart, Dr. George J. Applied Kinesiology Workshop Procedure Manual, 1973 issue, pp. 72 - 76.

4. Perdlman, Dr. Robert, Collected Papers of the Mambers of the International College of Applied Kinesiology, 1980 Summer issue, pp. 399-400.

Dimethyl sulfoxide (DMSO) v.s. Muscle Weakness

Dr. Glen H. Hammer
Diplomate International College of Applied Kinesiology

ABSTRACT: Application of Dimethyl sulfoxide, hereinafter called DMSO, to the neurolymphatic areas of certain muscles may cause an increase in strength which increases dramatically after each additional application.

PROCEDURE:

I). Muscle test a patient using a well calibrated kinesiometer making certain to record accuratly the strength of each major muscle and noting cases in which due to pain, lack of mobility, etc. the test was unable to be performed.

II). Apply a heavy coat of DMSO to the lymphatic point of the subject muscle.

III). Retest the subject muscle and again record the strength using the kinesiometer.

IV). Repeat the above procedures on subsequent visits until total strengthening has been achieved.

INTRODUCTION:

Being interested in all of the public outcry pertaining to the chemical DMSO I wondered if there was any benefit obtained besides the highly acclaimed relief of pain. Along with the help of a Veterinarian in my town (DMSO is illegal in Georgia except for veterinarian use) who assisted in the obtaining and application of the product, we investigated the affects on muscle strength by applying it topically to the neuro-lymphatic areas, neurovascular areas, nerve levels and muscles themselves.

RESULTS:

In our study the patient was not told that DMSO was being applied to the various areas, however the distinctive odor and taste that most of the patients commented on made a true blind study impossible. They were definitly aware that a "topical anesthetic" was not being used in most cases. It is interesting to note that out of the eighteen (18) patients used in the study only one remarked about any feeling out of the ordinary and that being a "prickly feeling" over the Gluteus Medius area. The stastical results obtained showed that there was a definite change in many of the cases (see chart attached), but nothing conclusive can be drawn at this time. One important step to be careful of if the reader attempts this study and that is to clean all body oil from the patient to insure proper absorption. We also noted that the cases in which we were unable to complete the original test were soon overcome using DMSO.

DMSO - Hammer, cont.

Below is charted the percent of increase of strength after six treatments of DMSO given over a two weak period. If a muscle was not judged weak at the beginning of treatment, it is marked by n/a. If no apparent change in strength was noted it is marked with 0.

PATIENT	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16	#17	#18
Teres Minor	50	n/a	25	n/a	30	15	25	n/a	n/a	20	60	n/a	30	n/a	n/a	50	20	25
Subscapularis	n/a	40	10	n/a	30	10	15	10	25	n/a	30	n/a	10	n/a	n/a	20	n/a	10
Deltoids	n/a	n/a	30	n/a	10	0	n/a	5	10	5	15	n/a	10	20	5	n/a	15	5
Ant. Serratus	n/a	n/a	n/a	n/a	5	0	n/a	20	15	40	n/a	n/a	n/a	15	15	0	n/a	20
Coracobrachialis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Diaphragm	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Pect. Maj. Clav.	30	n/a	n/a	n/a	60	25	40	10	n/a	0	15	30	45	60	n/a	5	15	n/a
Pect. Maj. Stern.	35	n/a	n/a	n/a	20	80	20	5	40	n/a	n/a	40	n/a	10	n/a	0	n/a	n/a
Rhomboids	n/a	n/a	5	n/a	30	15	n/a	0	20	n/a	0	n/a	15	n/a	n/a	n/a	n/a	n/a
Levator Scapulae	n/a	n/a	n/a	n/a	20	0	10	n/a	n/a	15	n/a	n/a	0	5	10	n/a	5	30
Lat. Dorsi	70	40	60	n/a	10	90	40	30	30	25	0	n/a	0	15	20	n/a	n/a	0
Triceps	30	10	20	n/a	5	20	10	40	5	10	n/a	n/a	5	n/a	10	20	10	0
Ant. Deltoid	n/a	n/a	n/a	15	n/a	10	5	n/a	n/a	n/a	0	20	n/a	0	15	5	15	n/a
Supraspinatus	n/a	80	20	20	n/a	30	40	20	15	20	10	n/a	0	n/a	20	15	20	5
Trapezius	n/a	20	n/a	10	15	120	n/a	5	20	5	40	0	n/a	n/a	n/a	5	30	10
Upper Trapezius	n/a	25	n/a	n/a	n/a	70	5	n/a	0	0	n/a	10	15	25	10	n/a	n/a	n/a
Abdominals	40	n/a	n/a	n/a	35	10	5	n/a	40	15	n/a	10	20	30	n/a	0	n/a	15
Neck Muscles	75	60	15	40	80	20	10	15	n/a	n/a	0	n/a	0	0	5	25	15	15
Fascia Lata	60	n/a	10	n/a	n/a	40	n/a	10	15	5	10	5	40	0	n/a	0	n/a	n/a
Psoas	50	10	n/a	15	n/a	15	0	15	5	n/a	5	15	20	15	5	n/a	0	n/a
Gluteus Medius	20	n/a	40	0	n/a	15	25	40	0	20	n/a	0	15	5	10	15	0	0
Adductors	n/a	n/a	25	0	n/a	10	10	5	n/a	5	n/a	0	30	5	10	25	n/a	0
Piriformis	n/a	n/a	30	10	n/a	20	15	50	30	n/a	0	n/a	15	5	15	5	n/a	n/a
Sartorius	70	40	15	60	20	25	n/a	5	0	n/a	15	35	25	60	20	n/a	0	20
Popliteus	n/a	n/a	5	n/a	n/a	n/a	0	15	0	25	n/a	n/a	0	5	20	25	n/a	n/a
Quadriceps	n/a	15	n/a	n/a	n/a	70	20	n/a	n/a	0	15	n/a	n/a	10	10	n/a	10	15
Peroneus	n/a	30	n/a	n/a	n/a	10	5	0	n/a	n/a	15	0	n/a	15	10	n/a	n/a	25
Ant. Tibial	n/a	10	n/a	25	n/a	0	0	15	5	n/a	0	5	n/a	10	5	n/a	n/a	15
Teres Major	30	5	n/a	n/a	10	0	n/a	10	40	60	n/a	n/a	n/a	80	40	n/a	10	n/a
Gluteus Maximus	n/a	n/a	20	n/a	n/a	5	80	5	n/a	0	15	n/a	0	15	25	55	60	5
Hamstrings	n/a	30	15	n/a	25	40	n/a	0	15	n/a	0	5	15	10	5	40	n/a	0
Gracilis	n/a	n/a	n/a	40	0	10	5	40	0	n/a	10	25	50	20	10	0	n/a	10
Soleus	n/a	10	n/a	30	n/a	5	40	15	n/a	0	20	15	0	n/a	15	5	n/a	15
Sacrospinalis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Gastrocnemius	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Although many increases were noted, these may be due to the frequency of re-testing, or the education of the patient in the technique of muscle testing. OR, we have another very valuable piece of the puzzle.

THE SACRAL ROCK

Dr. Walter A. Beaumont III
Dr. Glen Hammer - Co-Author

ABSTRACT: It has been brought to my attention through extensive category III work ups with selected patients that residual pain from a "hot" disc still exists. With the technique of the "sacral rock" additional relaxing of the lumbar spine occurs.

PROCEDURE: 1. Muscle test and challenge the patient to discern a positive category III syndrome.

2. Do all work involved with this particular set up including traction of the area above and below the inflamed area with respirational phases of strengthening.

3. The sacral rock is done with the patient in a supine position. The patient is instructed to lace the fingers and lock them around both knees and pull them tightly to the chest.

4. It is important that the patient use only the muscles in the arm and totally relax the abdominal muscles as well as the low back muscles. Patient should breathe slow and easy.

5. At this point the doctor wraps his/her arms around the patient in suck a way that the patient's legs and feet are locked under the Doctor's chest and underarm (either side)

6. The Doctor should roll the patient up on one side just enough to get a fist under the S.I. joint of the patient. Then do the other side of the patient likewise.

7. At this time the patient is instructed to hold on to the knees keeping them tightly to the chest. Then the Doctor (using his fist as fulcrum points) "rocks" back and using the patient's feet as a lever, actually lifts the patient off the table. A slightly rocking motion is initiated.

INTRODUCTION

Being that ninety-eight percent of all my patients with a category 111 involvement to sustain some degree of soft tissue injury, it has been found that the sacrospinalis muscles in the area maintain a strong tendency toward chronic contraction causing stiffness and pain in the area as well as slowing down of disc rehabilitation.

RESULTS

During our studies involving category 111 work and incorporating the sacral rock with this, when hypertonic or inflamed sacrospinalis is involved we have noted that rehabilitation time has markedly decreased as well as residual pain. In the case where severe acute inflamation is involved this techinique is much less painful than that of the muscle spindle cell technique.

Because of the proprioception device at the muscle-spindle the "sacral rock" does well in toning down muscles even in the upper back.

THE UPPER TRAPEZIUS - UPPER - MID CERVICAL SUBLUXATION COMPLEX AND IT'S RELATIONSHIP TO SHOULDER PAIN AND DYSFUNCTION.

by

CHRISTOPHER L. HARRISON, D.C.

In this treatise, the author shows how the trapezius muscle, especially the upper trapezius, when found in a hypotonic state can cause other primary muscles of the shoulder to become weak and consequently cause shoulder pain and dysfunction. The neurological relationships of the C-1, C-2, C-3, and C-4 vertebral segments are given in terms of causal effect and clinical correction of the hypotonic upper trapezius muscle.

It has been said frequently in the past by many competent clinicians that it is the really tough case that forces one to become a better clinician. Most of us who have been in practice for a few years or more would probably agree with this.

Over six months ago, a patient came to our office with a complaint of left shoulder pain and weakness. We promptly isolated the left Pectoralis Major Clavicular and the left Anterior Deltoideus as being the involved hypotonic muscles.

In my practice, we usually go to the spine first and make a thourough check for causative subluxations. We check the nerve root segments and then organ and meridian related segments to the hypotonic muscles and of course each of the lovett and SOT trapezius-occipital fiber line related segments and any other possibility that exists. If after this, we still have not cleared out the hypotonicity we then proceed to the Applied Kinesiological methods of origin and insertion, spindle cell, neurolymphatic, neurovascular, meridian therapy, nutrition, etc.

In this particular case, our vertebral adjusting would bring the Pectoralis Major Clavicular and the Anterior Deltoideus up to around a three or four on a scale of ten but would upon the next office visit diminish to a one or two. Our Applied Kinesiological efforts manifested about the same effect. In effect, we were not able to strengthen these muscles.

Normally, I don't take my work concerns home with me, but in this case, I found myself lying in bed at night pondering why we could not strengthen these apparently simple muscle weaknesses. I reviewed the neuro anatomy of the muscles as well as all of the Applied Kinesiological modalities and found that all of these procedures were performed correctly. We then wondered if the origins and insertions of the involved muscles were attached to

stable osseous structures. We therapy localized and challenged both the humerus and the clavicle and found both to be unstable. We adjusted the humerus and obtained a brief and slight increase of strength but no significant changes were noted. However, upon challenging the clavicle we noticed a tremendous increase in both the Pectoralis Major Clavicular and Anterior Deltoideus. We felt that we had located the answer to the problem but when the patient returned to the office the muscles were once again found to be in a weakened state. The obvious question to be answered at this point was what was causing the clavicle instability and the resultant Pectoralis Major Clavicular and Anterior Deltoit weakness. At that point the big light went on and the upper trapezius came to mind. We immediately tested the upper trapezius, found it to be weak and therapy localized the spine and found upper cervical subluxations at C-2 and mid cervical subluxations at C-3 and C-4. After challenge and correction, the upper trapezius was a solid ten, the clavicle was extremely stable and both the Pectoralis Major Clavicular and Anterior Deltoideus were tens. Since that correction was made we have had to re-correct the area only once in the six months that have elapsed since.

NEUROLOGICAL-CHIROPRACTIC RATIONALE

The Upper Trapezius receives innervation from two basic sources:

1. Spinal Accessory Nerve
2. Branches of the ventral primary divisions of the third and fourth cervical nerves.

1. The Spinal Accessory receives its spinal source from the first five or six cervical nerves. This would involve intervertebral foramina from occiput to C-6. Please note the diagram #2.

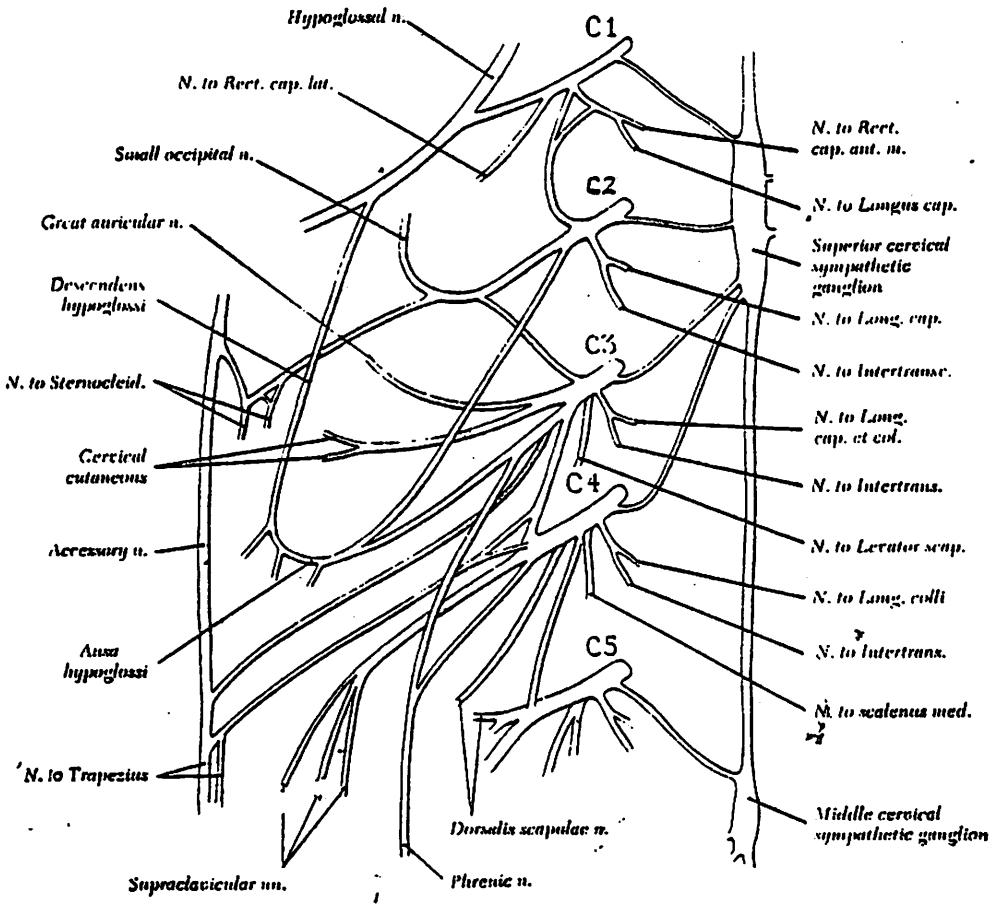
2. The third and fourth ventral primary cervical nerves exit from the intervertebral foramina between C-2 and C-3 and between C-3 and C-4.

Since correcting the above mentioned patient, we have noticed several Upper Trapezius weaknesses causing clavicle and Pectoralis Major Clavicular, Anterior Deltoid weaknesses and have noticed that the majority of subluxations that were causative to the Upper Trapezius hypotonicity have been located at C-1 thru C-4.

SUMMARY

The Trapezius muscle is an important muscle when considering stability of the shoulder joint. The Upper Trapezius can directly affect the shoulder joint and it can indirectly affect the shoulder joint by its hypotonicity and resultant clavicular instability thus creating hypotonicity of muscles that attach themselves to the clavicle, in this case, namely, the Pectoralis Major Clavicular and the Anterior Deltoideus.

It has been observed through clinical experience that the upper four cervical vertebra most frequently are the site of spinal subluxation that are causative to the Upper Trapezius weakness.



Reproduction granted through courtesy of Lea and Febiger, Gray's Anatomy 29th edition Editor Charles M. Goss.

CHRISTOPHER L. HARRISON, D.C.
PALO ALTO, CALIFORNIA
JULY 1980

THE NOSE AS IT RELATES TO THE TMJ

BY

KARL J. HAWKINS JR., D.C.

ABSTRACT: This paper shows the ramifications of the nose, especially as it pertains to the TMJ.

CASE HISTORY: I had a female patient, age 43, whose main complaint was fatigue and eye pain. Not until I corrected and balanced the TMJ did she experience freedom from her complaints.

I saw her about every six weeks for two reasons:

1. She didn't need care much more often than that.
2. It took about 7 hours to drive to my office.

The TMJ correction would last several weeks and I didn't find it necessary to recommend a splint at that point. However, after so many months of repeated correction I did recommend that we consider a splint. It was a mystery to me as to why the TMJ would hold for a month or more and then re-occur after that length of time. Certainly among the many things George has taught us is the one point that if you correct, truly correct the problem, it will not re-occur unless it is traumatized or some such thing. So with mixed feelings I approached the possibility of a splint.

On one particular visit the patient asked my opinion about a possibility of surgery on her nose, inasmuch as it was slightly crooked. I looked at her nose and the thought occurred to me that vertebrae move and I had adjusted noses before with dramatic response so I decided to adjust her nose and see what would happen. It was interesting to note that this was just a week after George had introduced to me, over the phone inasmuch as I would not be in Hawaii in 1979, the new work he had discovered relative to the mid-brain. At this time I gave it no thought and proceeded with a structural evaluation of the nose. Observation visually showed the nose just jutting off to the right so I challenged the nose at the naries as I would a segment of the vertebral column and found it responded from right to left, so I proceeded to adjust it from right to left. By adjustment I simply applied pressure on inspriation and after 5 or 6 pressures I checked and it was without strain based upon our experience with the vertebral challenge.

One month later the patient returned and some of her old symptoms were re-occurring, as was the custom when she needed her TMJ corrected. To my amazement I found no involvement of the TMJ but rather, I found an upper cervical atlas involvement. I corrected the atlas according to the findings and I also checked and corrected the nose in the same manner as I had done before recognizing that there had been a shifting and a straightening of the nose. After one more correction approximately one month later, the nose and the TMJ maintained their balance. I have not had to touch the nose or her TMJ since.

With the awareness of this rather phenomenal change I have since checked and corrected several noses with similar response. In some cases I found the nasal correction abolished the need to correct the C-7 as related to the mid-brain and Georges' newest discovery. In many I simply corrected the nose because it was crooked and to my surprise after just two or three corrections the nose stayed straight.

SUMMATION:

1. Obviously the nose relates to some cases of TMJ disorder.
2. The nose can be moved and balanced and phenomenal changes do result from this.
3. I would say in all cases of TMJ evaluation make sure you check the nose.

TMJ AND THE SEQUENCE OF ITS CORRECTION

BY

KARL J. HAWKINS JR., D.C.

ABSTRACT: This paper shows the importance of correcting the TMJ in proper sequence.

CASE HISTORY: I had a female patient, age 53, and she had problems with headaches, dizziness, fatigue and, in particular, pain and discomfort with her left knee. The above symptoms were responding to care through the things I found involved with satisfactory rates of recovery. One particular time I was checking the patient and she was still complaining of knee discomfort but showed how she was able to move her knee much easier with less stiffness and pain as compared to the first visit.

Inasmuch as she had had previous correction and involvement of the ileocecal as well as the TMJ I had her therapy localize the ileocecal and the knee and she was able to move the knee freely without pain. Instinctively I considered the involvement of the TMJ and had her therapy localize the ileocecal, which was positive, and therapy localize the TMJ simultaneously. In so doing, this negated the ileocecal. From this I assumed that the TMJ was the primary problem and I corrected the right TMJ, that is, I balanced the external pterygoid and masseter and buccinator in the opening and closing positions. This correction abolished the ileocecal and gave her complete freedom and no pain in her left knee.

At this point let the record show that she had traumatized the popliteus in her left knee and that this was the initial correction at first and it gave reduction to her pain.

After correcting the right TMJ I corrected the left TMJ and the patient remarked that the pain and discomfort came back to her knee almost immediately. I therapy localized and discovered it was necessary to correct the right TMJ again.

TMJ AND THE SEQUENCE OF ITS CORRECTION

KARL J. HAWKINS JR., D.C.

PAGE 2

CONCLUSION: From this discovery and experience I came to realize that the sequence of correction was most important relative to the TMJ.

The above case history and others since that time have indicated to me to correct the TMJ in proper sequence, which is to start with the left and finish with the right. I have not found any that reacted in the opposite manner to date.

RATIONALE: In my opinion this might relate to the fact that the right TMJ is governed basically by the left dominant brain and possibly this is the reason why we should finish with the right one and start with the left.

NOTE: Another factor in the spindle cell mechanism relative to the buccinator and masseter is the patient should bite down as you perform the spindle cell. It has proven the difference of success and failure.

BUOYANCY AS A DIAGNOSTIC AID AND ALSO AS A THERAPEUTIC PROCEDURE

By Hannes L. Hendrickson, B.Ch.E., P. E.,D. C.

ABSTRACT: By immersing an obese patient up to their waist or neck in water, it is possible, by taking advantage of the buoyant lifting force of the water, to alleviate in some instances, low back pains or other problems. Thus this buoyant process can be used as a diagnostic aid and also as a therapeutic procedure.

INTRODUCTION: Numerous tests and signs ha e been developed over the years to diagnose problems of the body. Multiple therapies have also been developed. The buoyance idea was developed accidently in the course of treatment of an obese patient with a protruding abdomen. A very brief outline of the patient's history and examination is presented here as follows:

Entrance complaints: Persistent pains in lower back when standing or walking which are relieved upon lying down or sitting in a very comfortable reclining chair. These pains developed when walking from his home to the office (one minute away). Pains were also present in his left calf. The patient is also a diabetic.

Examination: Age 63, Height 5'-6 3/4", Circumference about small of back and umbilicus 45", X-Ray shows sacrum base makes an angle of 51 degrees with the horizontal (see Figure 1), Weakness of the following muscles: piriformis (bilateral), fascia lata (bilateral), neck flexors (bilateral), TMJ and Pulse points negative, Liver 3 gait test positive on left

Treatment: AK was used throughout with acuaids placed over night for persistent piriformis on the left.

Buoyance Idea; During the course of the treatment the patient reported that he went clamming with his grandson. The water was up to his waist during this clamming and the patient reported that he felt absolutely no pain in his back despite the fact that he was in the water for more than an hour.

The treatments continued and it was found that using pantothenic acid (250 mg) daily for a week and thereafter once every other day brought the piriformis under control. The symptoms abated.

CONCLUSIONS: 1. No search of the literature was done on buoyancy and its effects on the body. However, the information should be of benefit to all concerned.

2. The buoyancy test can thus be applied to women with heavy breasts or anyone who has observed that they develope symptoms upon standing or walking.

3. Because of the uplifting action of the water, therapy can be developed for particular conditions.

4. This procedure does not obviate the need for a complete examination.

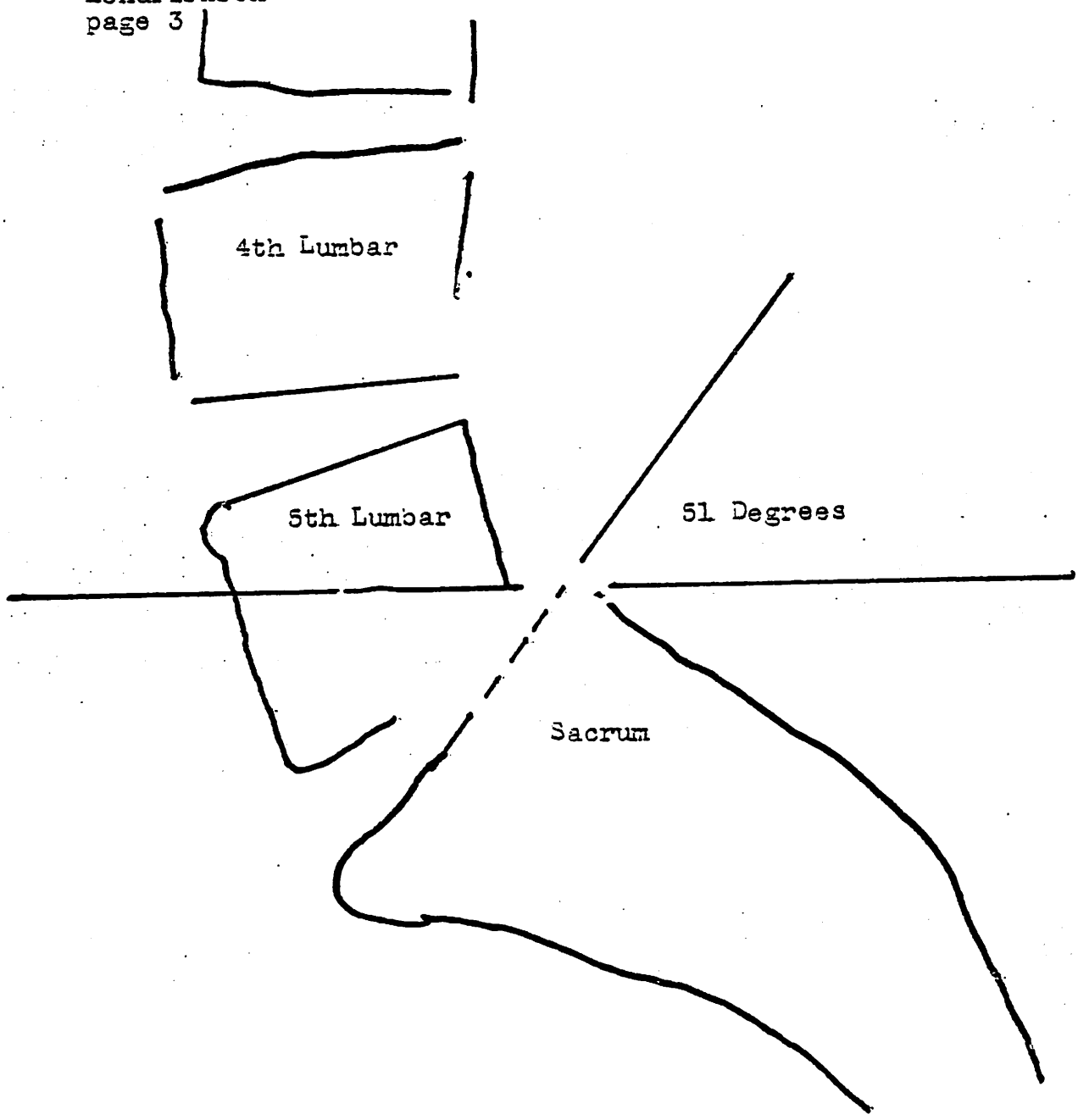


FIGURE 1-Tracing from lateral view of x-ray

AUTISTIC ?

James R. Lent, D. C.

ABSTRACT: This is an account of the progress of a case of questionable autism.

A year ago a challanging case was brought to me. The parents were earnestly seeking help for their three year old daughter, Ann.

Ann had previously been diagnosed at a University Hospital as autistic, retarded, and dislectic. She appeared as a slightly structurally imbalanced ambulatory child with a rather large head and some muscular incoordination. Emotionally there was almost continual uncontrolled screaming.

Upon closer observation it was apparent that there was no occular movement, and the slightly dilated pupils showed no response to light. Her vision was quite questionable since she bumped into and stumbled over things. She showed no response to people or sounds. It was impossible to get her attention.

When left standing alone, she would rock sideways from one foot to the other with her head tilted back as though she was looking at the ceiling, all the while crying out loudly.

She frequently suffered bouts of uncontrolled screaming, and seemed to indicate at these times that she did not know where she was, or whether her father or mother was holding her. It was as though she was alone in the world.

Even surrogate testing of this highly disturbed child was very difficult.

However, it was determined that every cranial suture was involved.

The distance this family had to travel from out of state limited the frequency of visits to once a month.

Initial treatment was confined to the cranial faults and emotional neurovascular points. The family was instructed to use cross crawling at home, and the Finegold diet was also recommended.

By the third visit some occular movement was noted, yet pupillary response to light was not seen until the fourth visit. At this point the pattern of cranial faults began changing. With the change it became easier to employ surrogate testing. Correction of neurolymphatic points and spinal faults did not bring about as violent an objection as noted on previous visits.

Each succeeding month the mother indicated that they were now aware of the progressive gradual improvements, both functional and emotional.

However, the most startling event was on the eighth visit when Ann picked up a magazine in the waiting room, sat on the floor, placed the magazine in the proper position and turned one page at a time, making unintelligible, but controlled, and softly uttered comments on various pages. The uncontrolled screaming was gone.

The mother then told me that on the way home, after the previous visit, there was a dramatic change noticable. For the first time, Ann had sat on her lap, and while looking out of the window had made intelligable comments

about things they passed along the highway. After they arrived home Ann did ask for milk, while standing in front of the refrigerator. Later, she would occasionally pick up something that she dropped.

Now, twelve months have elapsed, and the child is much more responsive and will allow me to do more without objection. Occasionally she will immediately respond when spoken to, but usually there is some delay. Improvement is progressive. Visual activity is greatly improved but it seems there is peripheral loss almost to the point of tunnel vision. She now shows an awareness of people around her.

Within this child's history, it is interesting to note that she apparently was perfectly normal until after she received an injection in the pediatritian's office before she was two years of age. The nature, or purpose, of the injection was not known.

I do not feel that the University diagnosis could have been correct, considering the obvious changes in Ann in one year.

The entire treatment of this case was based upon Applied Kinesiology. I feel that any other method would have been a matter of hit or miss, rather than positive application of specific treatment, to proveably alter positive findings.

The pleasure of being involved in changes such as these make me more appreciative of the practice of Applied Kinesiology.

THERAPY LOCALISATION AND THE CATEGORY TWO

by

Richard C. MELDENER D.C.

ABSTRACT : Category Two should always be Therapy Localized weight bearing .

Unilateral Therapy Localization (T.L.) to a single sacro-iliac (S.I.) articulation is the screening test I have exclusively been relying upon for determination of the De Jarnette Category Two fault .

When T.L. was found positive I use to look into the usual clinical signs described by De JARNETTE and GOODHEART for confirmation of the diagnosis :

Pain at :
- the mastoid
- First rib head
- the upper Inguinal Fossa : on the
- the medial knee : short leg side
- the lower Inguinal Fossa . on the
- the lateral knee : long leg side

But when T.L. was negative I used not to investigate any futtherand simply rule out the possible Category Two fault .

The number of Category Two fault I was finding was minimal as compared to the large number of Category One I was familiar to evaluate .

I have been , as you have been very pleased with Category Two treatment.

When the patient has a Category Two fault , when we succeed to find it , when we succeed to treat it , there is a good chance we are then in the direction to succeed to help this patient .

But sometimes , the patient has a Category Two fault and we don't find it and we don't treat it and this is a major fault and the patient is not responding as expected .

With these ideas in mind I decided to investigate a number of patients which failed to respond to treatment and I decided to try to corrolate the presence of S.I. therapy localization with the other Category Two signs previously discussed .
I soon made the observation that :

- Every Category Two patient presentsmost of the clinical signs described by DE JARNETTE and GOODHEART .
- Most of Category Two patients do not Therapy Localize to one S.I. articulation with one hand alone , using either side of either hand ,when examined in the prone position .

My conclusion at that point of investigation was that I Was previously failing to diagnose Category Two cases since I was relying totally upon Therapy Localization alone as a screening test .

I then decided to look into the anatomy of the S.I. articulation and was extremely surprised to realise that the auricular surface of the S.I. articulation we are all familliar with was sitting in a plane parallel to the gravity line.
Why did the Good Lord had designed such an articulation with such a spacial orientation which apparently seems to make it so vulnerable to gravity .
There has to be some reason for it .

In my knowledge and understanding the S.I. articulation has a minimum of three functions :

I - Spinal column support with the Weight Bearing boot mecanism
II - Sacral Wobble motion with the Primary Respiratory mecanism
III - Pelvic dilatation during parturition

The shape and orientation of the S.I. articulation is probably the best compromise responding to these three essential requirements for life .

However the S.I. articulation is parallel to the gravity line and consequently is more vulnerable to gravity and stress.

Could it be reasonable to assume that the S.I. articulation is the most vulnerable articulation to gravity ?

With this concept in mind , I started to examine patients placing them in different positions in relation to gravityand having them Therapy Localize for Category Two .

My observations over some IOO patients were as follow:

PATIENT'S POSITION	QUALITY OF THE THERAPY LOCALIZATION TO THE S.I. ARTICULATION
Prone	Effective if the fault is severe
Supine	Effective if the fault is severe
Supine in Walking Gate Position	Some more effective than supine or prone
Standing	Effective in some subclinical Category Two faults
Standing in Walking Gate Position	Some more effective than standing feet together
Sitting	Effective in almost every Category Two fault
Hand and Knee dog position	Effective in almost every Category Two fault

CONCLUSION : Weightbearing Therapy Localization has been previously discussed in Applied Kinesiology literature and I believe it should always be used in difficult problem cases .

However I presently strongly believe that Category Two should not follow that routine .

Category Two should not be Therapy Localized weight bearing in problem cases , it should be Therapy Localized weight bearing every time and all the time .

I have myself found that the sitting and the hands and knees dog positions are the two positions in which gravity traverse the sacro-iliac articulations in a direction allowing the best reliable Therapy Localization to the Category Two S.I. articulation .

.....

At this point it is my opinion that Category Two is one of the very most common major fault which we have so often been failing to diagnose because of failure to Therapy Localize it weight bearing.

.....

A THEORETICAL EXTRAPOLATION OF THE LIGAMENT INTERLINK LESION

Even though man walks on two limbs, a careful analysis of the gait of humans indicates he REALLY walks on four, because there is reciprocal arm movement on a contralateral basis if the man is allowed to walk with the arms swinging freely. This contralateral leg and arm movement ..... remains a unique feature of man's biped stance.

It seems reasonable, therefore, since ligaments are relatively a-vascular, that both the nerve and blood supply of the joints and ligaments would share a reciprocal contralateral relationship via the spinal cord reflex.[I]

This discovery by Goodheart is now common in Applied Kinesiology procedure. It is especially effective in extremity problems, particularly in the area of sports. The total commitment of an thlete requires the continual performance of normally infrequent actions with increased frequency, duration and intensity. In the treatment and care of world class athletes we need great precision and specificity. This principle has led me to the following hypothetical extrapolation of the ligament interlink lesion.

Discussion

If we examine the sport of canoeing we can obtain the necessary information to illustrate the ligament interlink.

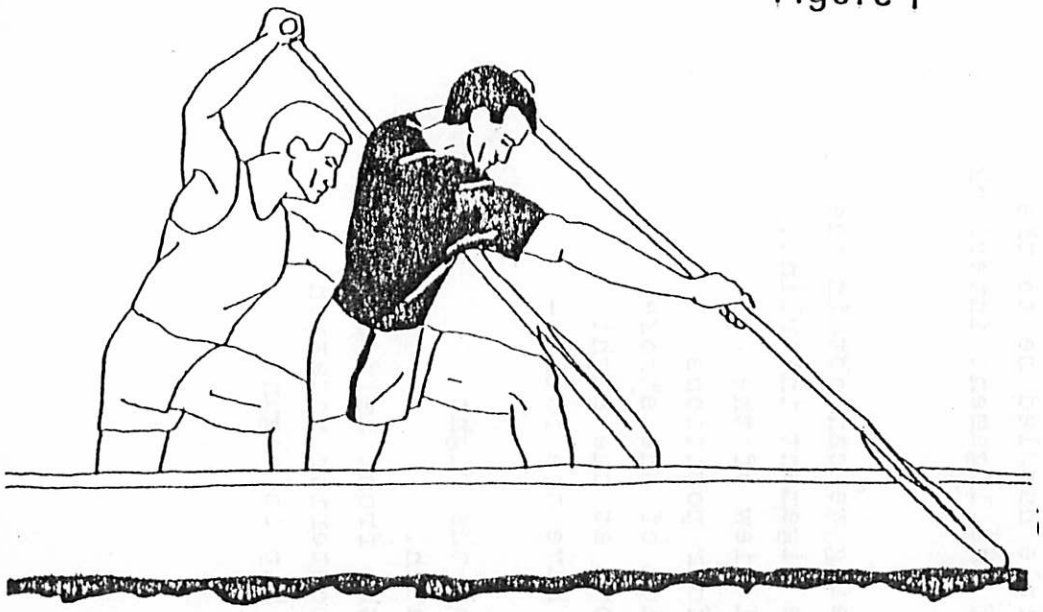
Figure # 1 illustrates a lateral view of the Canadian Pairs event (C2) with four positions of the stroke. Tracing the action of the stroke or bow position athlete (dark top) at the right shoulder and right hip joint we have the following motions occurring:

Position 1 - anterior rotation of the right shoulder and right hip at the catch.

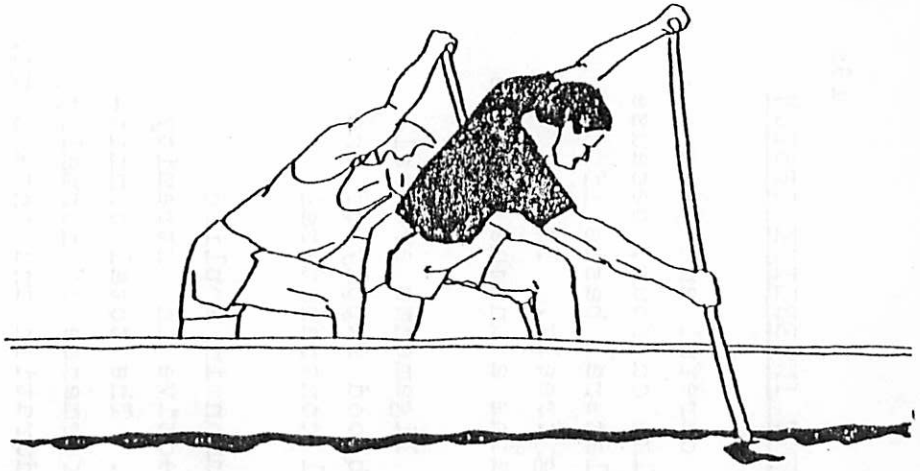
Position 2 - the pull phase in the front half of the stroke where the action of posterior rotation of the right shoulder and right hip is begun.

Figure 1

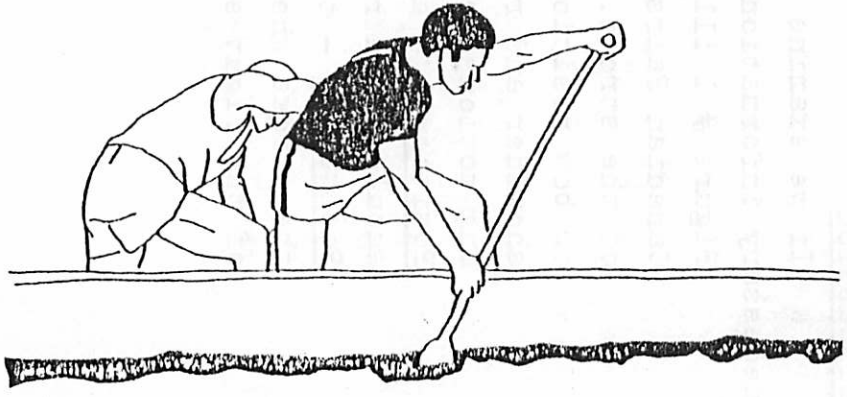
Position 1



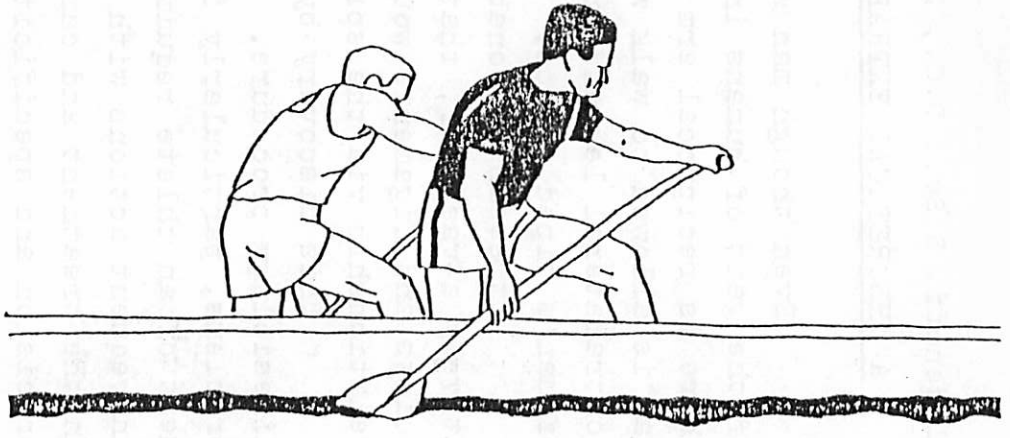
Position 2



Position 3



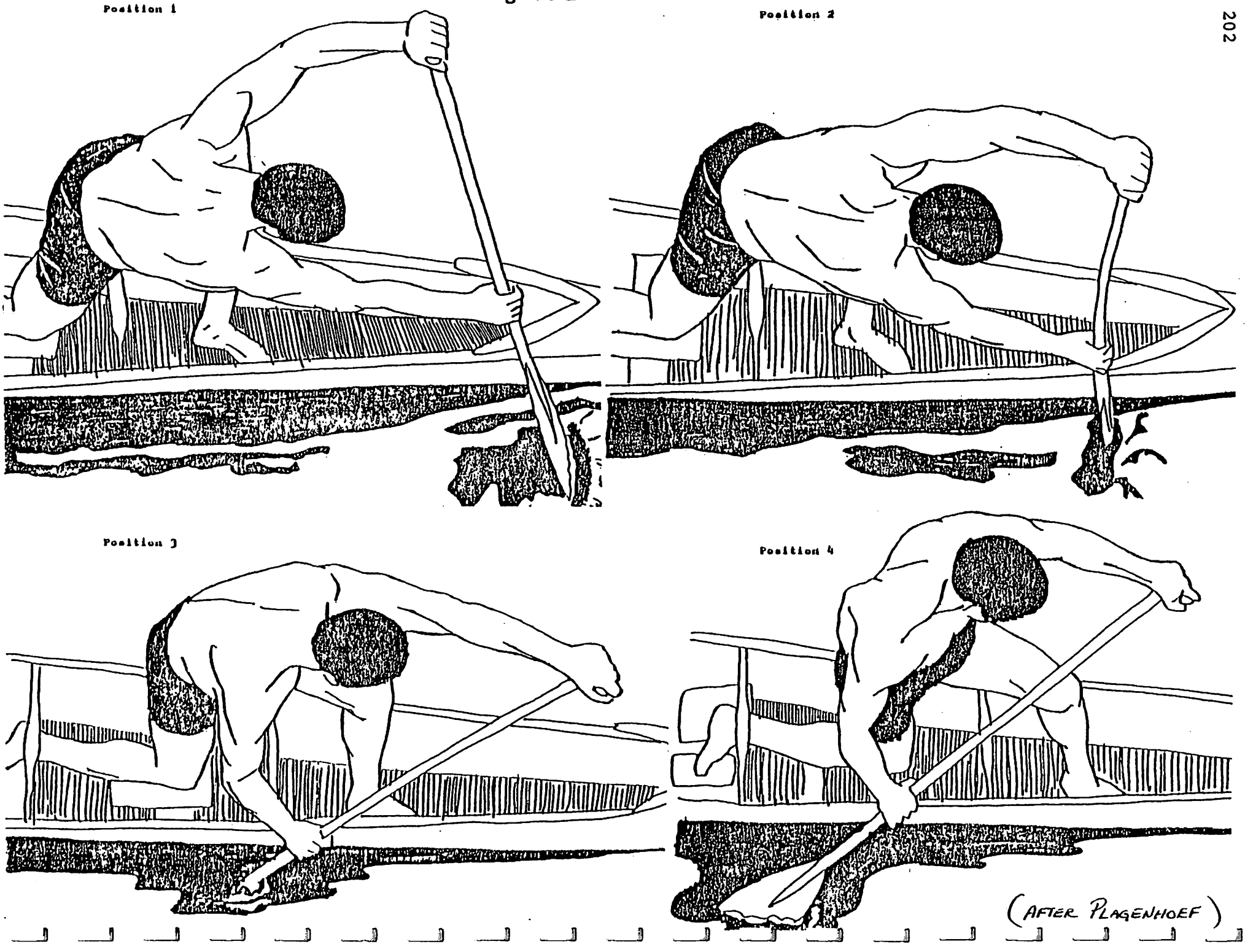
Position 4



(AFTER PLAGENHOEF)

Position 3 - the pull phase in the back half of the stroke with continuation of the posterior rotation from position 3 to position 4, the posterior rotation of the shoulder continues with the hip remaining stationary in general.
Position 4 - this portion of the stroke, the remaining shoulder motion to the upright recovery position is performed by the erector spinae group of muscles.
In figure # 2 there is a superior view of the 4 positions of figure # 1. Here it is evident that the anterior to posterior motion of the right shoulder and right hip are simultaneous. In order for this to occur it seems reasonable that the posterior ligamentous structures must have proper communication for proper function. Equally, the anterior rotation which would occur from position 4 returning to position 1, there must be proper communication between the anterior ligament structures. As Dr. Goodheart has said repeatedly, the action of walking backwards is an ipsilateral motion which is done infrequently, but nevertheless may still occur. Here we have an example where a world class athlete will be performing this action from 2 to 4 hours a day, 6 days a week. This is the contralateral-ipsilateral ligament interlink.
Goodheart has also presented the ipsilateral-contralateral ligament interlink.[3] This involves, for example, the right anterior shoulder ligaments.
The Kayak single (K1) event is illustrated laterally in figure 3 and from the superior in figure 4. Tracing the action of the shoulder motion we have

Figure 2

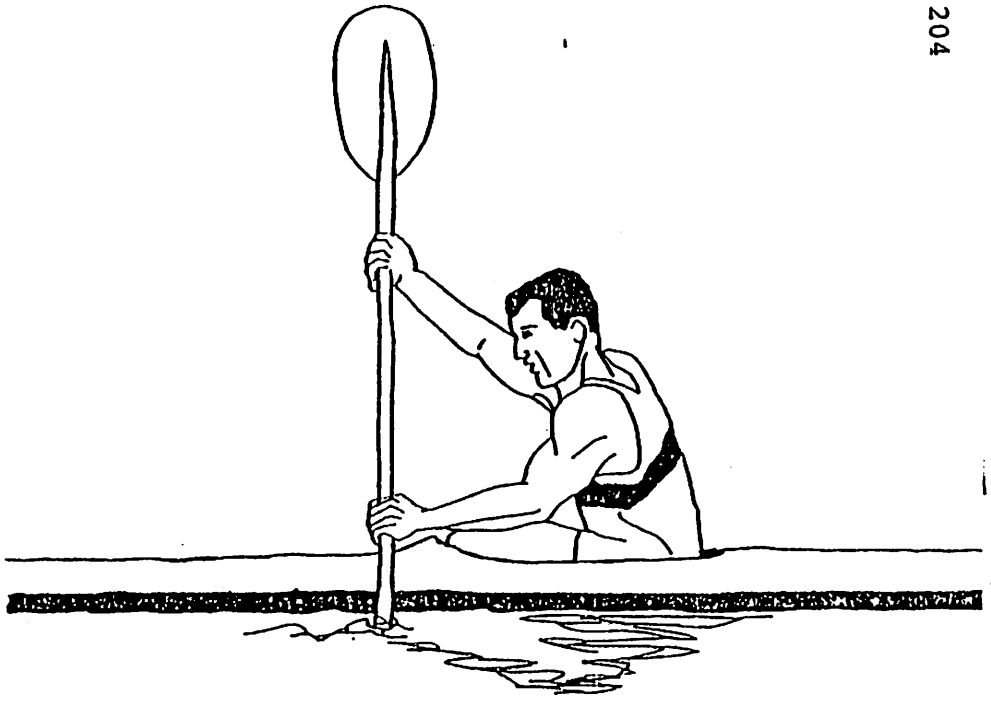

Position 1
Position 2
Position 3
Position 4
(AFTER PLAGENHOEF)

the following occurring:
Figure 3 - Position 1 - the catch, there is anterior rotation or the left shoulder and relative posterior rotation of the right shoulder. The action from position 1 through to position 4 is a pulling action of the left posterior shoulder and a pushing action of the right anterior shoulder.
It is important to note that the resulting changes in force for both the push and pull were recorded on an oscilloscope. (figure 5) Plagenhoef found that the pull hand generated between 40 - 45 lbs. force and the push hand between 15 - 20 lbs. He also noted that the faster the boat speed, the greater the pull force and the less the push force. 2
The ligament interlink at work in the Kayak positions must be contra-arthro anterior to posterior. For example, the left anterior shoulder ligaments and the right posterior shoulder ligaments. Again, this action is repeated ad infinitum by world class athletes and is part of their chosen sport.
Figure # 6 illustrates the position a downhill skier would be in when manoeuvering a gate. In general there is a swivel action that occurs where the right and left leg parallel each other. In this figure the action of the left lateral collateral ligament and the right medial collateral ligament of the knees must be the same. Here again we have the contra-arthro contra-ligament working together.
The interesting thing to note here is that the action of the medial knee ligament and lateral knee ligament is fundamentally the opposite.

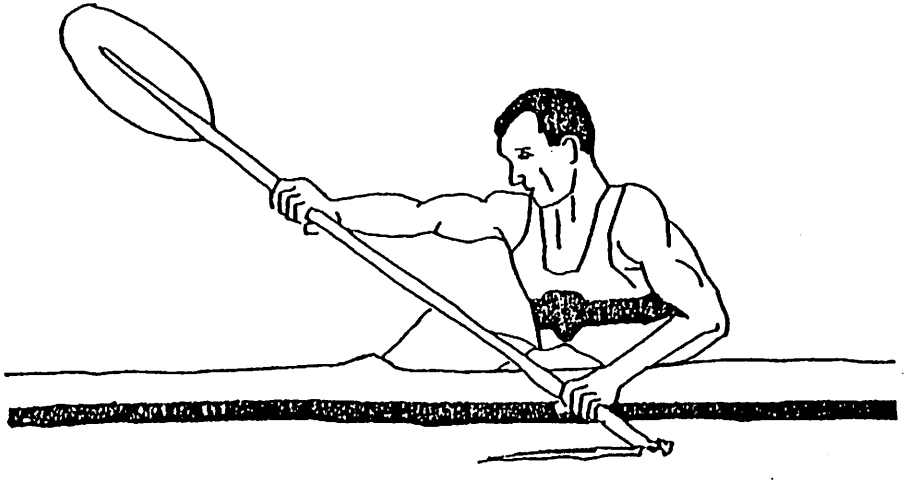
POSITION 1

Figure 3

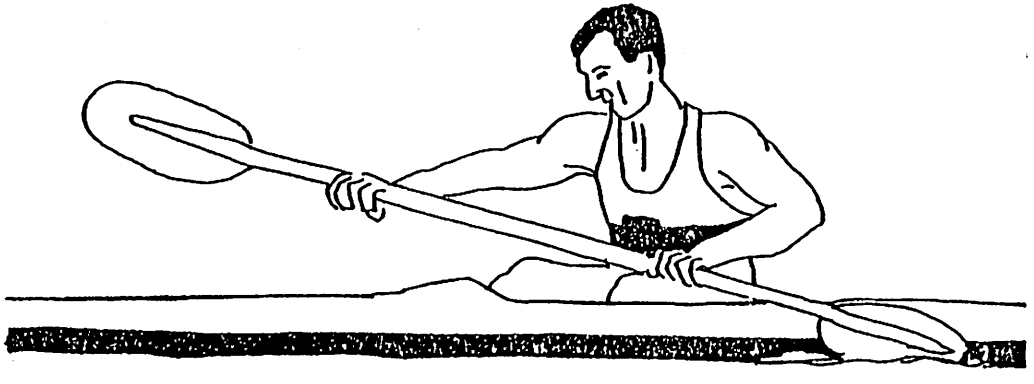
POSITION 2



POSITION 3



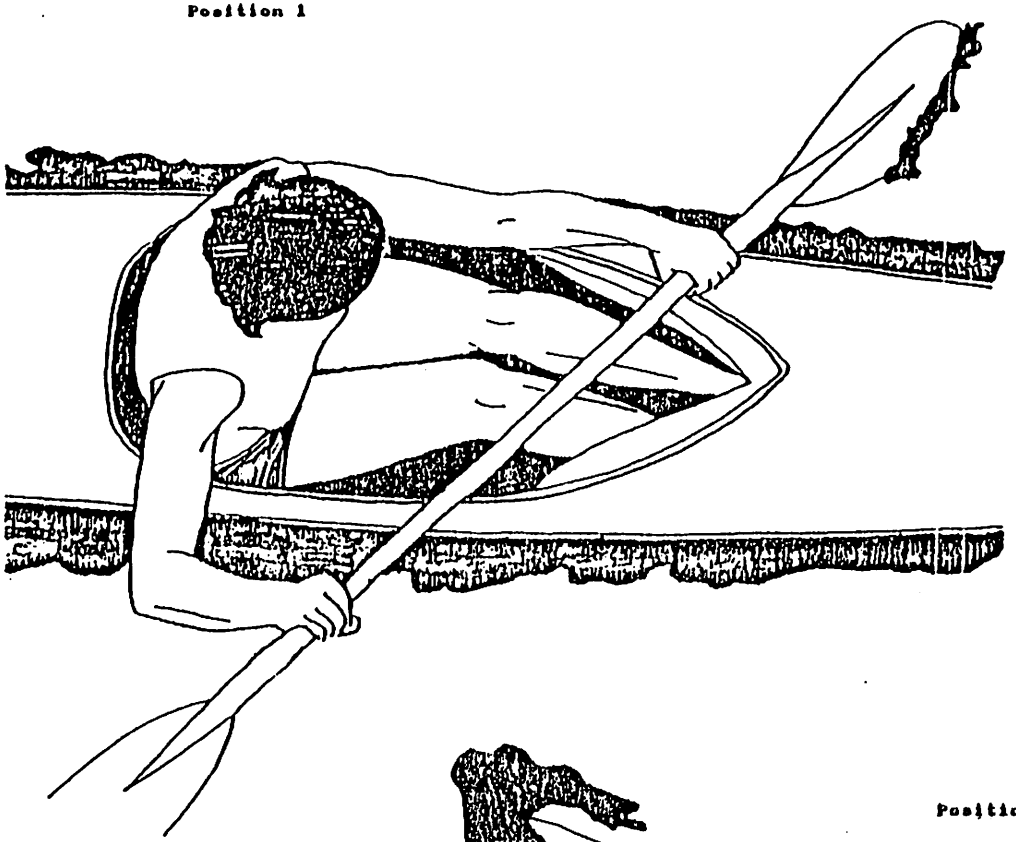
POSITION 4



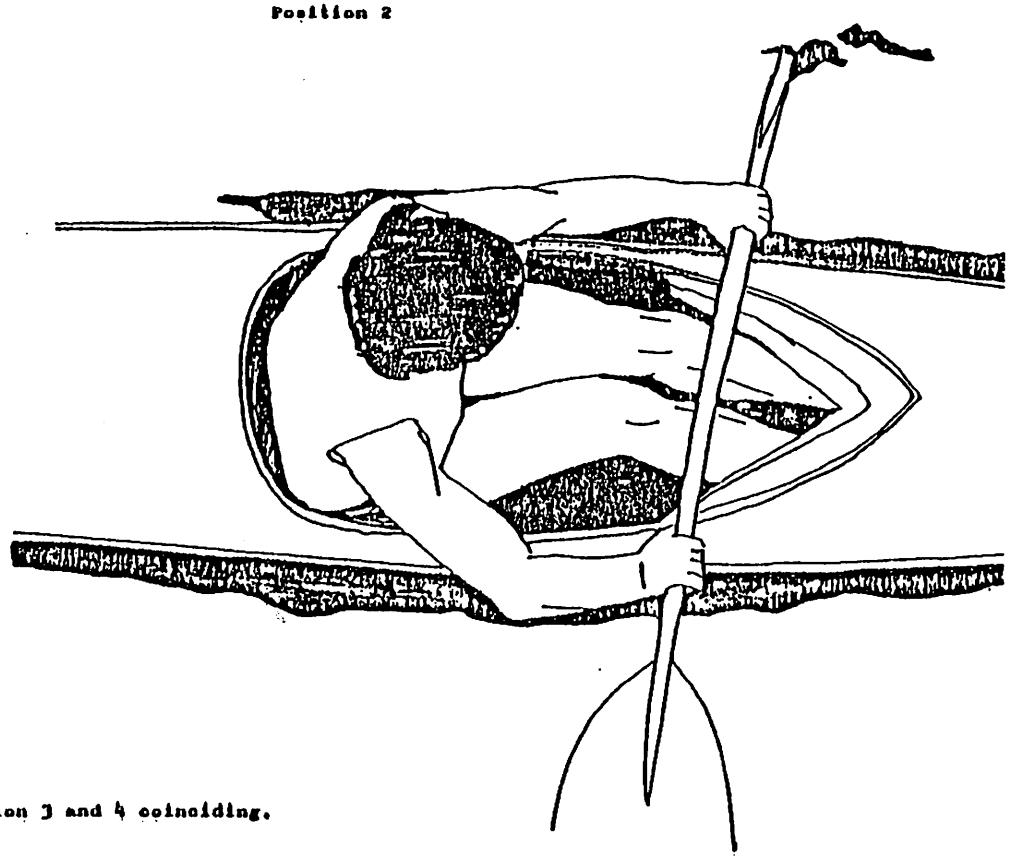
(AFTER PLAGENHOEF)

Figure 4

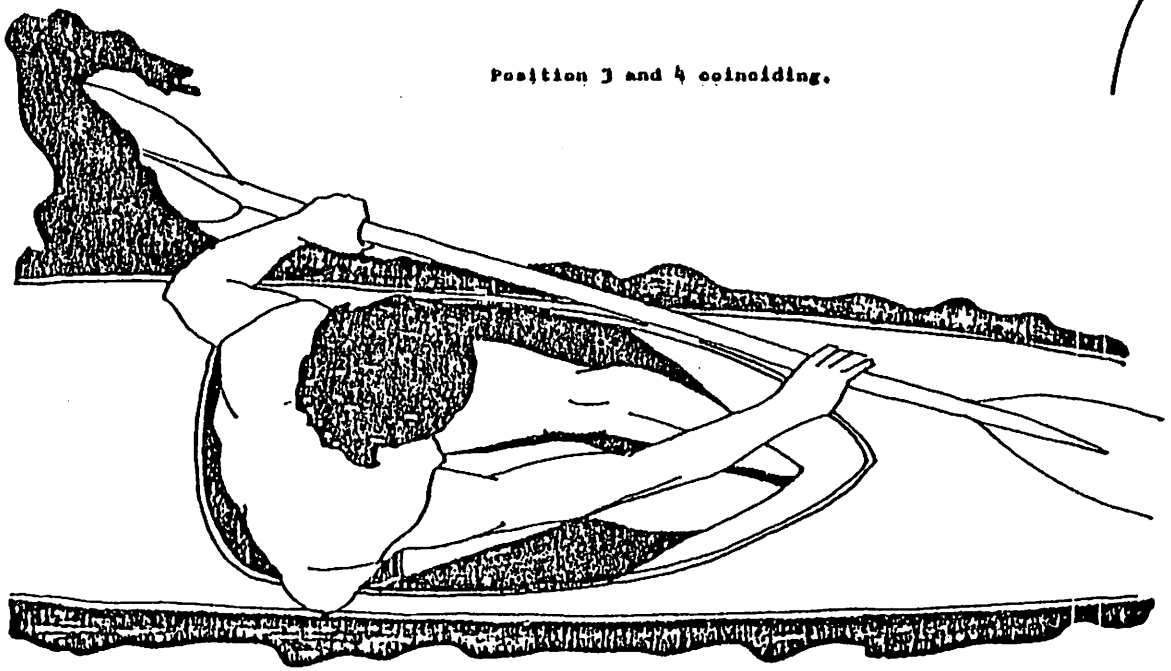
Position 1



Position 2



Position 3 and 4 coinciding.



(AFTER RAGENHOEF)

KAYAK - HAND PRESSURE

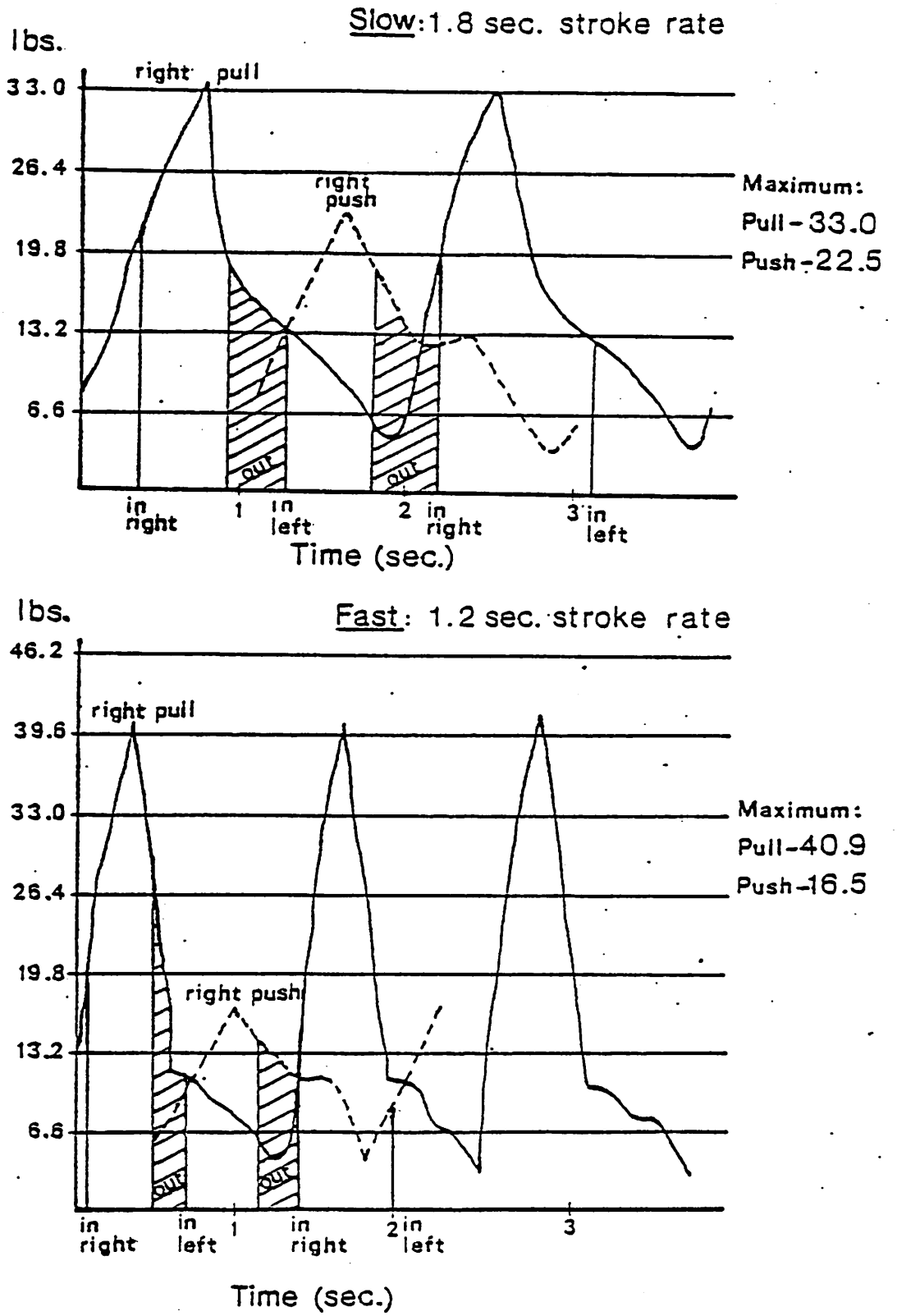


FIGURE 5

(AFTER PLAGENHOEF)

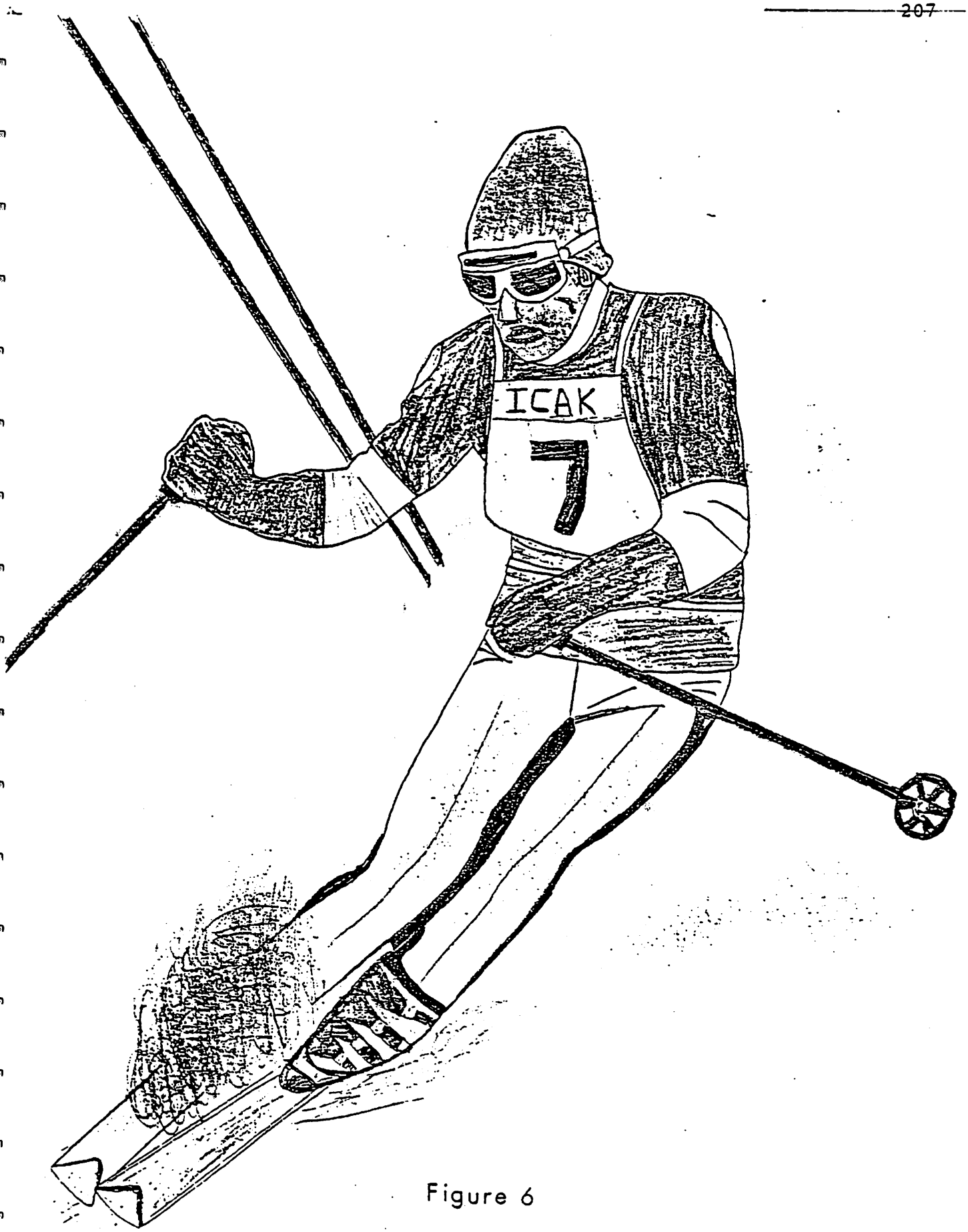


Figure 6

Once again proper communication must exist for efficient function. This example is an ipsiarthro-contraligament interlink.

Case History

A female canoeist was selected, who 2 years previously had had a frozen left shoulder. Treatment in the usual AK procedure produced a complete range of shoulder motion, however residual pain did remain to the point where it interrupted her canoeing career. Two years later, having undergone physiotherapy, Ultrasound, TNS, etc., cortisone injection was recommended. At this point the athlete returned to our office. The residual pain had remained unchanged and she had not trained in the Kayak since.

The first treatment consisted of balancing the shoulder musculature, which provided some improvement. Her next visit, it occurred to me to examine for ligament interlink because I had not done this in her previous care.

Therapy localization to the left shoulder and right hip (using opposite hands) was negative. Therapy localization of the left shoulder and the left hip was negative. Therapy localization of left shoulder (with left hand) and right shoulder (with right hand) was negative. Therapy localization of the right and left shoulders using the opposite hand was negative.

Recalling the biomechanics of canoeing as briefly described previously, it occurred to me that there must be contra-arthro - contraligament and ipsiarthro-contraligament lesion. Therapy localization was then attempted in the following manner:

1) Therapy localization of anterior left shoulder with right hand and posterior right shoulder with left hand. This produced a marked weakness upon testing a previously strong muscle. Correction to the right posterior shoulder ligaments produced a marked reduction in the palpable amount of pain in the left shoulder.
2) Therapy localization of anterior left shoulder with the left hand and the posterior left shoulder

with the right hand. Again, this produced a marked weakness of a previously strong indicator muscle. Correction to the left posterior shoulder ligaments further reduced the amount of palpable pain to the point where it was difficult to elicit.

Further investigation is being conducted to substantiate the hypothesis of the contra-artho contraligament and the ipsiarthro-contraligament interlink lesions. It is hoped that this presentation will stimulate the highly specific and minute attention that is necessary in the field of sports analysis and proper athletic care.

BIBLIOGRAPHY

1. Goodheart, G. J.; Applied Kinesiology 1978
Workshop Procedure Manual; 14 ed. p. 28

2. Plagenhoef, S.; The Biomechanical Analysis of Olympic
Platwater Kayaking and Canoeing.
Unpublished manuscript.

3. Goodheart, G. J.; presented at session 10 of 100 hour
AK syllabus, Detroit, Michigan. July 19/20, 1980.

AN EFFECTIVE USE OF LAY LECTURING AFFECTING THE MENTAL SIDE OF THE TRIANGLE

Jerold I. Morantz, D.C.

Abstract: A combination of the influence of John Thie, D.C. speaking in 1973 at the National College of Chiropractic on lay lecturing; Anatomy of an Illness by Norman Cousins; How to Choose a Good Doctor by George D. LeMaitre, M.D. and my own personal experimentation with lay lectures over the past six years has brought together, for me, the most effective component in dealing with the mental side of the triange, "A good doctor/patient relationship".

Being a firm believer in practice building and practice management, the first seminar I attended advocated lay lecturing in order to increase patient referrals. Having a strong background in Applied Kinesiology at that time, I saw ways to transpose the theory of lay lecturing with the flavor of Applied Kinesiology to enable the viewers and listeners to realize that this is the story which I care to tell.

It is now time to realize that the word "doctor" means teacher. We can no longer expect patients to accept the physician's authority on totally blind faith.

In discussing partnership between the physician and the patient in search of a cure, in Anatomy of an Illness Norman Cousins quotes Professor Eli Ginzberg, "No improvement in the health care system will be effective unless the citizen assumes responsibility for his own well-being. There are substantial potential gains to be made in linking the individual citizen to the health system through more sophisticated education." [1]

In general, up until now, the patient's responsibility has been limited to the practice of wiser lifestyles i.e., giving up smoking, watching one's weight, being more active physically or driving more slowly. Cousins has a broader view of the patient/physician interplay. The responsibility of the patient goes beyond the practice of healthy ways of life, when possible it includes sharing with the physician the responsibility of the choice and application of therapy.[2]

Cousins is of the opinion that very few patients have the capability, at present, to take an active role in selecting what treatment would be best for them.[3] This is primarily due to the patient's lack of knowledge.

Having utilized lay lectures for the past six years as an adjunct to patient communication in a high volume practice, the most important benefit can be seen in the patient's very next visit to the office,

especially that patient who has not responded up to your expectations. Their comments regarding their health are usually "much better", a definite change in attitude as well as their physical health.

James P. Issacs, M.D. discusses catecholamine levels with respects to bahavorial changes, physiology changes causing, for instance, a person's blood pressure to be at differing levels with different people. Emotional states have long been known to affect the secretion of certain hormones, for example, those of the thyroid and adrenal glands. It has been recently discovered that the brain and the pituitary gland contain a heretofore unknown class of hormones which are chemically related and which go by the collective name of endorphins. The physiological activity of some endorphins presents great similarity to that of morphine, heroin and other opiate substances which relieve pain, not only by acting on the mechanisms of pain itself, but also by inhibiting the emotional response to pain and therefore suffering. It is certainly not too farfetched to assume that, as in the case of other hormones, mental attitudes can affect the secretion of endorphins and thereby the patient's perception of disease.[4]

Having questioned patients on "why" their sudden improvement after the exposure to a lay lecture, they remark that they now understand more about our form of health care, that they are pleased to be informed and to know that the "Doctor really cares". In the book How to Choose a Good Doctor, by George D. LeMaitre, M.D. an entire

chapter is devoted to "The Most Important Sign of a Good Doctor - - He Cares About You as a Person".[5]

The following benefits are certain to become a reality with a good lay lecture for your patients:

a) Through the interplay of the three sides of the triangle, pain is reduced, chemistry is balanced and posture changes.

b) Decreases many unnecessary questions asked in the treatment room.

c) The old concepts of chiropractic care and the musulo-skeletal connections are broadened to include all viseral and endocrine disorders.

d) Much more enthusiastic patients.

e) To enable the patient to see the doctor as a more complete, caring person rather than a "white coat" moving from room to room.

f) Enables the doctor to build his own self esteem and personal image which in the long run will benefit the patient.

g) Increases patient knowledge and education of health care and broadens their knowledge of the scope of Applied Kinesiology.

h) And a most important benefit to us all, makes our patients, health care consumers, aware of the differences between the

"trick happy" bastardizing amateurs and a wholistically minded practioner using Applied Kinesiology.

Summary: At present, I do not feel that we use the mental side of the triange to the maximum benefit available to us. With what is already known through Applied Kinesiology as to the importance in treating the whole person and not just a part, it seems we should not deny our patients the added benefits which can be seen through lay lecturing.

[1] Cousins, Norman. Anatomy of an Illness. New York: W.W. Norton and Company, Inc., 1979. p. 22

[2] Ibid. p. 22

[3] Ibid. p. 22

[4] Ibid. p. 20

[5] LeMaitre, George D., M.D. How to Choose a Good Doctor. Andover, Mass.: Andover Publishing Company, 1979. P. 29 and 30.

- ATTITUDINAL NEUROLOGY -

Some Thoughts in re: Chiropractic, Applied Kinesiology & Holism

Clarke C. Odden, D.C.

"How are we to understand this life?" asks the initiate.
"All things are interconnected" replies the sage, "and interpenetrate each other as one."

Taoist Chinese writings

++++++++++++++++

It is perhaps unnecessary to comment extensively on the concept of holism as it seems every person or group involved in the healing arts has a separate idea thereof. I should surmise that this paper will reflect only one person's opinion and as such is only meant to proffer some perspective and some varying approaches and definitions to this subject. Finally I might suggest that as the life of an individual is in his BODY/MIND - Spiritual consciousness, that we are all, ultimately involved in the practice of holism whether or not our outward life shows it.

CHIROPRACTIC: a well known discipline within the major healing arts which has, more so than any other profession, advanced the idea that the competency and functionality of the spinal organism (principally, but not exclusively human) are determined by the integrity, physical alignment and efficiency of the structure. This is further modified by the premise that the overriding and principally dominant active directional system of this organism is its nervous system. It is this system which to a degree greater than any other determines that integrity and efficiency, particularly in an intimate relationship with the musculoskeletal structure. The musculoskeletal structure in its capacity to express misalignment and register or apply direct or indirect stress on the nervous system plays also a great role in determining the overall long-term health of the individual.

It may be stated for purposes of this presentation that chiropractic is not considered to be, per se, the adjustment, regardless of how that adjustment is delivered. Chiropractic is rather, a principle

of health inherent within the human system. This principle rests primarily upon the "inherent recuperative abilities" of the body (a euphemism to avoid saying "the healing power within") and is a true scientific principle which, with continuing research will be shown scientifically as such.
The point of this paper is not to do so, however, but rather to show some mental meeting ground for true holism. Holistic thought about health was extant in chiropractic thought before such was the fad and will be a viable concept for us and our patients long after such has ceased to be the catch-word of the day. This will happen in the same fashion that within chiropractic the principles and advanced practice of acupuncture have been nourished and applied although not always called by that name.

APPLIED KINESIOLOGY: a highly specialized development within the chiropractic field, capable of more efficiently and accurately demonstrating the activities of the chiropractic priciple (nervosism) through the various energy systems comprising whole body/mind function. This is accomplished by effectively utilizing the synchronous activity of alteration in standard muscle test responses and the qualitative loading and unloading of neuromotor, neurosensory and neurovegetative peripheral response centers on the body. All this developed and performed within the principal boundaries of the chiropractic discipline until recent years when other professionals, acknowledging the marvelous capabilities of A-K have begun to explore the field for use in their areas of expertise.
I fully agree with the statement by Dr. Peter Kfoury in the July-August Chiropractic Economics (page 30) "... AK is perhaps one of the greatest discoveries of the century. If a Chiropractor had not discovered it. I'm sure a Nobel prize would have been awarded. Proper use of AK gives valuable information that is difficult or impossible to obtain otherwise." The efficacy of AK can only continue to increase as the years proceed with the caliber of personal and organizational involvement and recognition of the vital and unique contribution of AK to the healing arts.
The contributions of AK to the teaching of the healing arts, esp ecially chiropractic, have only been begun. It offers a way

to both immediately and in retrospect, evaluate the efficiency and success of any technic or substance on a specific circuit within the nervous system and will also help us to learn more and more about the activity of the nervous system in many exciting ways. It will add so much to our functional knowledge of the body, build capabilities of evaluating both orthodox and unorthodox types of treatment as applicable to all three main areas of its triangular symbol.

As some of the original thought behind Chiropractic was indeed metaphysically based, so does AK present- for those who choose to see it and use it- a unifying philosophy and an overview of true holism which will be discussed in the next section of this paper.

HOLISM: A new (?) concept in the healing arts!! An "unheralded pronouncement" in the never-ending innovation-slogan consciousness of the western world- to paraphrase some of the statements which have been made in the last few years. Most of these statements have been made, however, by people who have been unaware of the emphasis which chiropractic has been trying to get across to its patients for the past 85 years in one way or the other. HOLISM- a word coined in the 1920's by Jan Smuts, has not been openly used by chiropractic to advance itself, but the concept of a balanced, integrated health of the whole person has been a major tenet of chiropractic philosophy since its inception. Although I think it obvious that organized medicine is changing some of its attitudes (some voluntarily, others by public pressure) it is still primarily lip service that is paid to the idea of whole person health- and high level wellness. Malcolm Todd, M.D., President of the A.M.A. in 1975, speaking to the annual meeting of the Association for Holistic Health in San Diego, stated- "Since the late fifties and sixties a goal of the A.M.A. has been a program of integrating body, mind and spirit in the treatment of the whole patient. This was part of our program of medicine and religion. And considerable progress has taken place." I think it rather obviously a political statement made to appease his audience, many of whom <u>were</u> true innovators in various health fields including medicine.

Holistic health and the holistic practice of chiropractic have been deemed by various chiropractic writers as both the salvation and the crucifixion of our profession. The term has, in recent times been applied to every separate profession, every pseudo-professional and many commercial ventures seeking to use this catch-phrase to attract more clients, customers, advocates and patients. Holism, by general definition has been considered to be scientific, UN-scientific, too general, too specific, misleading, inapplicable and dangerous- depending on who you care to read or listen to. Some people and professionals, have considered a holistic practice to be one in which a huge building is staffed with one or more of every kind of specialist of every medical of non-medical, orthodox or unorthodox segment of the healing arts and then to have the poor patient gone over by the lot of them in an effort to find out absolutely everythign that is, was, could be or must be wrong with him. This view leaves us in nearly the same position we are now, ex cept that it is more ineffective and unwieldy a situation. It also gives us the same position with regard to the doctor, et al, taking full responsibility for doing the healing of the patient. In this scheme of things the patient still is not given any responsibility for his own health or for what is done to him. He turns his life over to someone else. I have even read mention of this type of set-up being organized into a government agency. I think we can all surmise from their past degree of effectiveness and efficiency how well that would operate by any government staff.

On the other side of this coin is the solo practitioner who may feel that it is his responsibility to be able to practice as the be-all and end-all of all health practitioners. He feels he should be the final and most accurate of all with regard to any question that may be asked of him by a patient or non-patient whether it is within his field or not. Although a doctor or other health professional who seeks to become unusually knowledgeable in areas outside his own emphasis is to be commended, this is a sure fire was to frustration and difficulty.

All this and much more which is unsaid brings me to the final portion of this epic.

I would not presume to have all the answers for the questions about this subject. The many creative minds that are working to introduce holism to the masses will take care of this subject within the bounds of their own consciousness. Again, it is obvious that there is more than one way available to us to manifest a holistic life.

I will, however, be presumptuous enough to perhaps remind myself and others who may listen to these ramblings, of some ideas which we may have forgotten about temporarily. I would also suggest that we in chiropractic think more clearly about how our profession and AK in particular fit into the holistic paradigm with the other healing arts.

I would remind myself firstly of the development of chiropractic as being an improved and more efficient means of serving people in their times of well-being and dis-ease. This is true even more in these times than in the early days, partly because of the many breakdowns in the traditionalmedical paradigm. Chiropractic embodied, through a physical method, a new way of helping people to health, mentally, physically and chemically.

I would remind myself that there was a spiritual background to the development of chiropractic which tried to incorporate ideas of the self-healing, intelligent, integrated system of the body that was self-perpetuating with just a little help from the outside- help that was not in any way harmful, or dangerous, as the practice of medicine both was and is.

I would remind myself that chiropractic's views of the individuals health situation was, at the same time

1. rationalistic- it has always tried to develop a systematic and reproducible body of knowledge and practice
2. empirical- it used what got results and asked why later, basing its knowledge on observation and multiple trials. I might add that this method is coming more and more into favor with some researchers.
3. holistic- it considered the truly healthy person a balanced, mentally, spiritually, physically

and chemically efficient and competent organism and tried not to isolate one part of the body from other parts, but worked to harmonize the function in the entire body. Even though unexpressed as such I believe that the founders and pioneers intuitively knew that the body functioned synergistically and that the whole was always greater than the sum of its parts.

Applied Kinesiology has added immensely to the dimensions of these ideas and the demonstrations of their usefulness, practicality and has attested to the accuracy built into the body. It is making use of ideas involving the interconnectedness of all function to the individual cellular memory and the attitudinal set of both doctor and patient as a factor in the healing process. These things and many others are being done in a way not known or done before AK. It has given many of our colleagues a new appreciation of their work and the wonders of body/mind function. Others may feel threatened by this knowledge, but these minds are usually the inflexibles.

Finally, I would suggest that we consider the concept of holism.

Is it perhaps more a way of thinking about yourself and your patients than a specific way of practicing?

Is it perhaps more embodied in an attitude that helps people get well and fulfill their needs, regardless of whether thehelp comes directly from you or from someone in another field.

Is it perhaps approaching health from the standpoint of helping your patients to manage their health on a long-term basis of well-being, rather than on a short term basis of treating symptoms of questionable importance.

Is it perhaps helping people through structural, nutritional and attitudinal means to reach an enhanced level of function and to help them to maintain that state of health.

Is it perhaps, because of the laws of consciousness, a means which each of us has chosen to find our own fulfillment through the understanding of a concept and the practical application of that concept to serve others and to free ourselves and them.

There is, in my opinion, no single system of treatment or practice that is, on its own, totally holistic. Holism is not a thing!!

Holism is an individual attitude and completes itself within the individual through his own thoughts, feelings, actions and attitudes as they contribute to well-being and fuller living. In the I CHING, Chinese book of wisdom, it states- "a man is as those things which he allows to nurture him and according to those things to which he exposes his heart." There is a lesson here for us.

Perhaps the true meaning of holistic is being aware of the divinity within man, ourselves as well as our patients and being willing to both allow and to help that divinity to express to the fullest in each and every person.

We have, in our healing hands a "rainbow of healing abilities" and opportunities to share with our world. We have- or rather, we are privileged to have, in our expanding knowledge of chiropractic and Applied Kinesiology and the consciousness movement, the greatest tools available for helping ourselves and others to a healthful enlightenment and self-actualization.

Now is the greatest time in history to put them to use for the benefit of mankind.

++++++++++++

PRELIMINARY DATA COLLECTION FOR BLOOD PRESSURE STUDY

Clarke C. Odden, D.C.

ABSTRACT: As a beginning investigation into the premise suggested by Dr. John Campbell in the I.C.A.K. Collected Papers- Winter 1977 and the subsequent paper in Summer 1980 by Dr. John Hughes on THERAPY LOCALIZATION AND BLOOD PRESSURE, seventeen patients chosen at random in one day were tested. Only testing of the right and left brachial test points was done as described by Campbell. Suggestions for further continued study include:
1. The brachial T.L. point is valid.
2. May be valid for other than blood pressure.
3. Tends to indicate both high and low blood pressure.

No mechanism is yet suggested for its action at the T.L. point.

As this is a preliminary collection of a limited population of patients the data only will be presented at this time with suggestions for possible validation design of a more comprehensive nature.

METHOD:

1. Patient postural blood pressure (seated and standing) was taken prior to seeing doctor and without informing doctor of results.
2. Prior to adjustment, doctor tested patient response to the brachial test point with standard testing of psoas and/or piriformis muscle.
3. Post-adjustment postural blood pressure readings were taken by C.A. upon patient leaving dressing room.

Chart of results of combined tests on following page.

* ✓ = OK.

PRELIMINARY DATA COLLECTION – T.L. & BLOOD PRESSURE.

CLARKE C. ODDEN, DC

PATIENT INITIALS	AGE	PRE-ADJUSTMENT STD. B.P.	PRE-ADJUSTMENT STDG. B.P.	BRACHIAL T.L. * R.	BRACHIAL T.L. * L.	POST-ADJUSTMENT STD. B.P.	POST-ADJUSTMENT STDG. B.P.	REMARKS.
J.C.	43.	90/68	100/70	✓	✓	92/68	92/68	Very small, energetic woman
C.Z.	53	150/96	152/90	✓	✓	138/86	138/98	
A.A.	70	136/64	128/64	✓	✓	116/58	116/64	
W.S.	37	102/74	102/84	✓	✓	96/80	110/90	
A.H.	71	144/60	138/60	✓	+	128/58	122/60	History of H.B.P. supposedly controlled by adrenal insuff.
B.C.	64	128/78	120/68	✓	✓	150/80	140/84	Pain from cervical disk
L.B.	24	122/66	128/72	–	–	120/60	112/60	
K.W.	29	98/58	100/62	–	–	98/70	100/70	
L.S.	48	100/70	94/70	✓	✓	106/72	106/80	
R.O.	47	90/60	110/60	–	–	2nd reading – patient in a hurry.		
W.H.	45	128/88	116/80	?	+	110/80	104/80	Masked by insomnia & anxiety.
S.C.	33	80/58	94/62	–	–	74/60	84/70	
R.P.	75	110/54	100/54	+	–	110/48	110/70	Pulmonary congestion – possible CA or CHF.
D.P.	61	140/76	134/76	–	–	128/80	132/82	
S.M.	36	104/84	110/86	✓	✓	104/80	104/80	
Z.S.	35	132/80	140/92	✓	✓	134/76	138/90	Medically diagnosed "borderline H.B.P." – Overweight 40#
L.K.	34	110/80	120/90	–	–	126/84	126/90	
E.S.	44	114/70	114/70	–	–	108/70	118/78	

Because of the wide age variance and the excessive variability of other parameters allowed herein (inadequately controlled design) there are only a few areas of potential interest and future study.

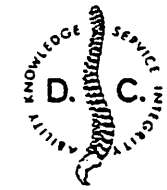
1. In each case where a positive T.L. was elicited, a persistent Ragland test was present both pre and post adjustment.

2. In the case of A.H. with previously recorded, but unremembered history of H.B.P. the T.L. demonstrated only on one arm with repeated testing. A.H. has been under prescriptive medication for several years for this condition.

3. In the other medically diagnosed case of "borderline H.B.P." , Z.S. did not demonstrate a positive T.L. . She is now on a weight control program with me and has lost seven pounds in the last week.

4. In R.P. a persistent Ragland test was positive in this situation of possible CA and evident Low blood pressure.

It is intended that this data will begin a continuing study of the validity of the T.L. points proposed by Dr. Campbell. This should ultimately correlate adrenal status, other major symptoms and health factors and the follow through of treatment with effective monitoring by the T.L. points as well as the efficacy of the second hand spinal T.L. abolishing. The validation of this one system would represent a terrific advantage in the treatment and monitoring of blood pressure cases and efficiency of therapies.



EXAMINATION AND TREATMENT OF THE KNEE

by Jose A. Rodriguez, M.S., D.C.

ABSTRACT: This paper reviews the procedures used by kinesiologists in evaluation and treatment of the painful knee.

INTRODUCTION

Managing painful knee problems can be either very rewarding or most frustrating. Through proper history taking and thorough kinesiological examination, it should be relatively easy to isolate and correct the cause of the problem. However, the chiropractor must first have a sure grasp of the major conditions that could be present -- infectious, traumatic, or degenerative.

Knee problems can tax the resources of even the most astute kinesiologists. With proper examination procedures, the successful management of most knee problems is within the grasp of chiropractors who may only have a working knowledge of applied kinesiology.

HISTORY

Pain, the most common symptom of knee problems, must be accurately defined. Determine whether the pain is constant or intermittent, related to weight bearing, associated with certain motions, or present during rest.

Next, find out if there is any buckling, that is, actual collapse of the knee on forced weight bearing. Often patients will comment that the knee feels as if it were about to give way. Stiffness

should be differentiated from locking. Locking is a mechanical block to the normal motion of the knee. Check for swelling and question the patient as to clicks coming from the knee during the acts of flexion or extension.

As Dr. Goodheart has so often suggested, a complete history taking may give you the clues necessary for managing a case successfully. The patient's age will help to rule out certain conditions while making others more probable. Swelling which occurs immediately after trauma is usually indicative of tissue tear.(1) Swelling which occurs hours after the trauma may indicate inflammatory effusion.(2) Tenderness below the femoral condyles may indicate meniscus involvement.(3) Tenderness over the collateral ligaments medially or laterally could be indicative of local ligament damage. Tenderness of the tibiofibular articulation could suggest articular damage. A strain will cause pain on muscular contraction.(4) A sprain will exhibit pain on joint motion. The following chart may be very suggestive:

SYMPTOM	SUGGESTS
Constant pain	Inflammation, infection, fracture
Intermittent pain	Mechanical dysfunction, subluxation
Pain on weight bearing	Subluxation, fracture
Pain at rest	Inflammation, infection
Stiffness	Inflammation
Buckling	Knee subluxation, quadriceps weakness
Locking	Knee subluxation (loose body, torn meniscus)
Swelling	Inflammation, infection, trauma
Clicks during motion	Normal but subluxated knee

EXAMINATION

Postural analysis will frequently give an indication of the muscles at fault. Following are some well-known examples:

SARTORIUS - GRACILIS — give medial knee support. Their weakness may cause a knock-knee appearance, or genu valgus.

TENSOR FASCIA LATA - GLUTEUS MAXIMUS — give lateral stability to the knee. The postural indication of this weakness is a bow leg, or genu varus position.

QUADRICEPS — weakness becomes evident after climbing stairs. There may be a hyperextension of the knee when standing.

GASTROCNEMIUS — weakness causes a compensatory hyperextension of the knee.

SOLEUS — weakness can cause an entire forward lean of the body.

After postural evaluation, observe the patient's gait for further clues of muscular involvement. Then proceed to the kinesiological examination which should include careful examination of the following muscles:

GASTROCNEMIUS — weakness may cause hyperextension of the knee and plantar flexion.

SOLEUS — weakness may cause flexion of the knee with dorso-flexion of the ankle. There may be a tendency to buckling and subluxation of the tibia or fibula.

SARTORIUS - GRACILIS — weakness of any of these can result in a QUADRICEPS posteriorly rotated ilium as well as an unstable and painful knee.

QUADRICEPS — a hypertonic quadriceps will cause the patella to shift superiorly, producing stress on the patellar tendon, commonly called patellar tendonitis. This may also cause hamstring weakness and a forward shift of the body's weight, placing stress on the anterior foot and predisposing the patient to shin splints.(5) The procedure for treatment of the hypertonic quadriceps has been well described by Drs. Goodheart, Perry, and Thie.

POPLITEUS — is the posterior stabilizer of the knee and is tremendously important to knee function and stability.

TENSOR FASCIA LATA — gives lateral support, stability and affects the iliotibial band which inserts primarily below the knee and helps maintain the position of the tibia.

POSTERIOR TIBIALIS — fascia contraction of this muscle will predispose the patient to tibialis myofascitis or shin splints.(6)

Remember, muscles give support and stability to the knee, while ligaments limit knee motion. In any knee injury it is wise to examine all the muscles associated with the knee, in the clear, for hypertonicity, and after stretching, for fascial involvement.

RADIOLOGICAL EXAMINATION:

If the preceding examinations are not revealing enough, then I would suggest that the radiological examination include the anterior-posterior view, lateral view, intercondylar view, and patellar view. I suggest these views be taken in the weight-bearing position whenever possible.

LABORATORY TESTS:

If arthritis is suspected, the laboratory tests should include uric acid, alkaline phosphatase, calcium, phosphorous, antinuclear antibody, latex fixation, sedimentation rate, and CBC.

ORTHOPEDIC EXAMINATION:

Although a good kinesiological examination will usually rule out the need for it, an orthopedic examination may become necessary for insurance purposes. Let's review some of the most common orthopedic procedures:

1. Examine the dorsalis pedis and posterior tibialis for circulatory or neurologic involvements.
2. Look for signs of trauma, swelling, and quadriceps atrophy and measure the range of motion.
3. Check for stability of collateral ligaments by securing the patient's lower leg and palpating the ligament as stress is applied to the joint.
4. Test for medial collateral instability by applying a valgus strain to the fully extended knee and also at 15 degree flexion. The purpose of testing in both full extension and 15 degrees of flexion is that flexing the knees releases the posterior capsule and the screw home mechanism, which, if not released, will give a false-negative result.

5. Lateral stability should be checked by applying a varus stress, again in both full extension and at 15 degree flexion.
6. To test the cruciates, keep the patient in a supine position and flex the knee to about 60 degrees. Next, secure the foot by sitting on it; make sure the quadriceps and hamstrings are relaxed. Pull the tibia forward to see if there is anterior slide and push it back to see if there is posterior slide. A modification of this test involves the rotation of the foot. If you rotate the foot medially in this position, you tighten the medial capsule and release the lateral capsule. Thus, if there is weakness in the medial capsule, as you will see with antero-medial instability, the knee will slide in external rotation of the tibia and not in internal rotation. This test is called the Slocum test.
7. Tenderness, a common feature of subluxation of the patella, as well as chomdromalacia, can be elicited by moving the patella from one side to the other. Because passive lateral movement of the patella may cause a feeling of nausea, the patient will try to protect against this motion. This defense against movement is called the apprehension sign.
8. Flexion rotation of McMurray — the so-called McMurray sign — is an indication of probable tear in the medial meniscus, most likely in its posterior half. It can be tested only when the knee can be flexed past 90 degrees.

(7)

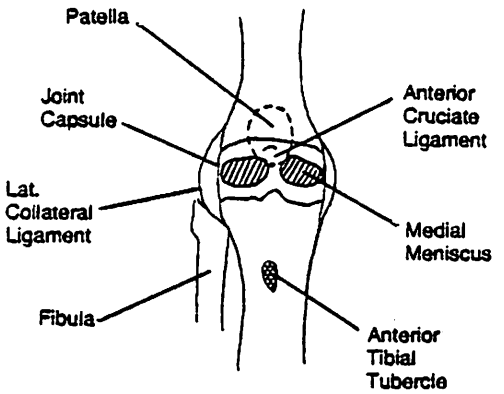
9. The Apley compression or grinding test is performed with the patient prone on the adjusting table with one leg flexed 90 degrees.

Gently kneel on the back of his thigh to stabilize it while leaning hard on his heel to compress the medial and lateral menisci between the tibia and the femur. Then rotate the tibia internally and externally on the femur as you maintain firm compression. If this maneuver elicits pain, there is probably meniscal damage. Ask patient to describe location of pain as accurately as possible. Pain on the medial side indicates a damaged medial meniscus; pain on the lateral side suggests a lateral meniscus tear.(8)

10. Distraction test helps to distinguish between meniscal and ligamentous knee problems. The test should follow the Apley test in logical progression. Patient remains in the same position and stabilized as described in the Apley compression test. Apply traction to the leg while rotating the tibia internally and externally on the femur. This maneuver reduces pressure on the meniscus and puts strain upon the lateral and medial ligamentous structures. If the ligaments are damaged, the patient will complain of pain; if the meniscus alone is torn, the test should not be painful.(9)

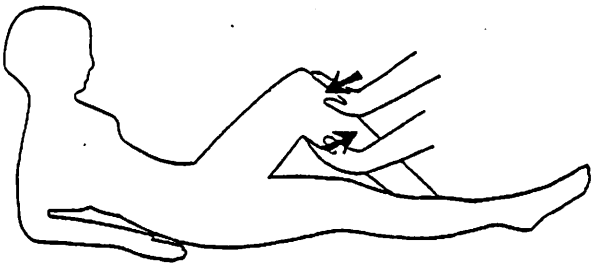
These procedures will allow a quick and efficient examination of the knee, and are by no means an exhaustive account of the anatomical or examination procedures which may be utilized by the chiropractor.

Knee Examination
Page 8



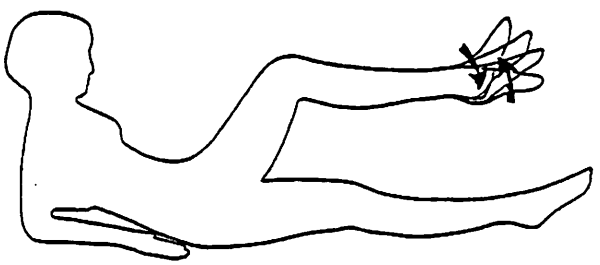
AP Right Knee

1. Push posterior.
2. Pull anterior.
3. Check for click or excessive motion.

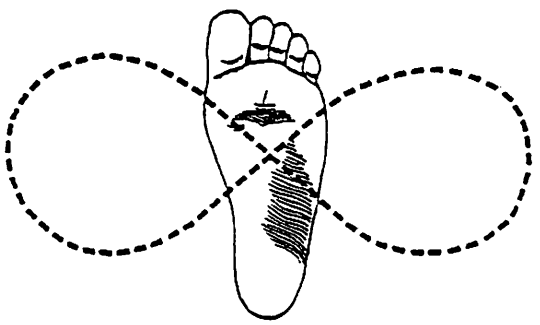


Drawer's Sign

1. Rotate medial and extend.
2. Rotate lateral and extend.
3. Postive sign = painful click.



McMurray's Test



1. Work through figure eight motion.
2. Feel knee for grinding or excessive lateral motion.

Figure Eight Motion

TREATMENT

The purpose of treatment is to relieve pain, restore normal motion, correct all pertinent weaknesses and mechanical deviations, and avoid unnecessary joint stress by providing support and stabilization. This can be very successfully accomplished by the simple application of the conservative procedures of applied kinesiology.

Almost immediate relief of pain can be obtained by direct ice massage and cold packs to the knee. This will help decongest and decrease localized edema, effusion and inflammation of the subcutaneous tissue. Clinically, ice therapy will help decrease hypertonicity and will thus facilitate knee motion. It will also help anesthetize the area prior to the application of deep pressure to the origin and insertion of the involved muscles. Heat may be introduced in the post-acute stage of treatment along with prolonged neurovascular and neurolymphatic reflexes. This will enhance circulation and nutrition to the affected tissues and will improve the permanency of the kinesiological procedure.

To restore the knee to normal motion, pelvic faults, foot imbalances, and femur head subluxations must be corrected. Every weak muscle must be strengthened and each intervetebral foramen factor associated with the weakened muscle should be individually therapy localized or challenged to eliminate all the hidden factors. Hypertonic muscles must be isolated and sedated. Reactive leg muscles should be balanced and muscles with fascial involvements must be stretched out.

Determine direction of joint correction by challenging, and adjust in direction of strength. Pelvis, femur, tibia, fibula, patella, ankle and foot must be corrected to avoid recurrent knee problems and to provide knee stabilization. The Schultz taping method, or a good elastic support, will be very beneficial. Properly executed exercise will aid recovery and stimulate patient cooperation.

A torn cruciate ligament may require surgical intervention; however, most meniscus injuries can be successfully managed with kinesiological procedures. The rectangularity of the cartilagenous space can be restored by muscle balancing, particularly of the popliteus, and knee manipulation.(10)

CONCLUSION

The complexity of the knee mandates thorough examination and treatment. All possible causes of joint dearrangement must be sought and corrected to provide joint stability, full range of motion and total relief. Applied kinesiology should be the treatment of choice in the management of knee problems because it provides the most holistic of all approaches.

REFERENCES

1. Prior, J.A., and Silberstein, J.S.: Physical Diagnosis, 5th ed., 1977, pp 440-443.

2. Ibid.

3. Ibid.

4. Basic Chiropractic Procedural Manual, 2nd ed., American Chiropractic Association, 1977.

5. Perry, L., and Thie, J.: Collected Papers of ICAK 1977;"Knee Stress Syndrome", pp 344-351.

6. Bandy, J.: Collected Papers of ICAK, Summer 1978; "Posterior Shin Splints", pp 9-13.

7. Testa, M.: Modern Medicine; Vol.47 No.8, pp 24-32.

8. Hoppenfeld, S.: Physical Examination of Spine and Extremities, Appleton-Century-Crofts, New York.

9. Ibid.

10. Goodheart, George J., D.C., Digest of Chiropractic Economics, July/August 1971, "Knee Joint Problems".

OTHER SOURCES

1. Houg, Cole and Bradford: Osteopathic Medicine, McGraw-Hill, 1969.

2. Greenfield, G.B.: Radiology of Bone Disease, 2nd ed., J.B. Lippincott Company.

3. Walther, D.: Applied Kinesiology, The Advanced Approach in Chiropractic, privately published, Pueblo, Colorado, 1976.

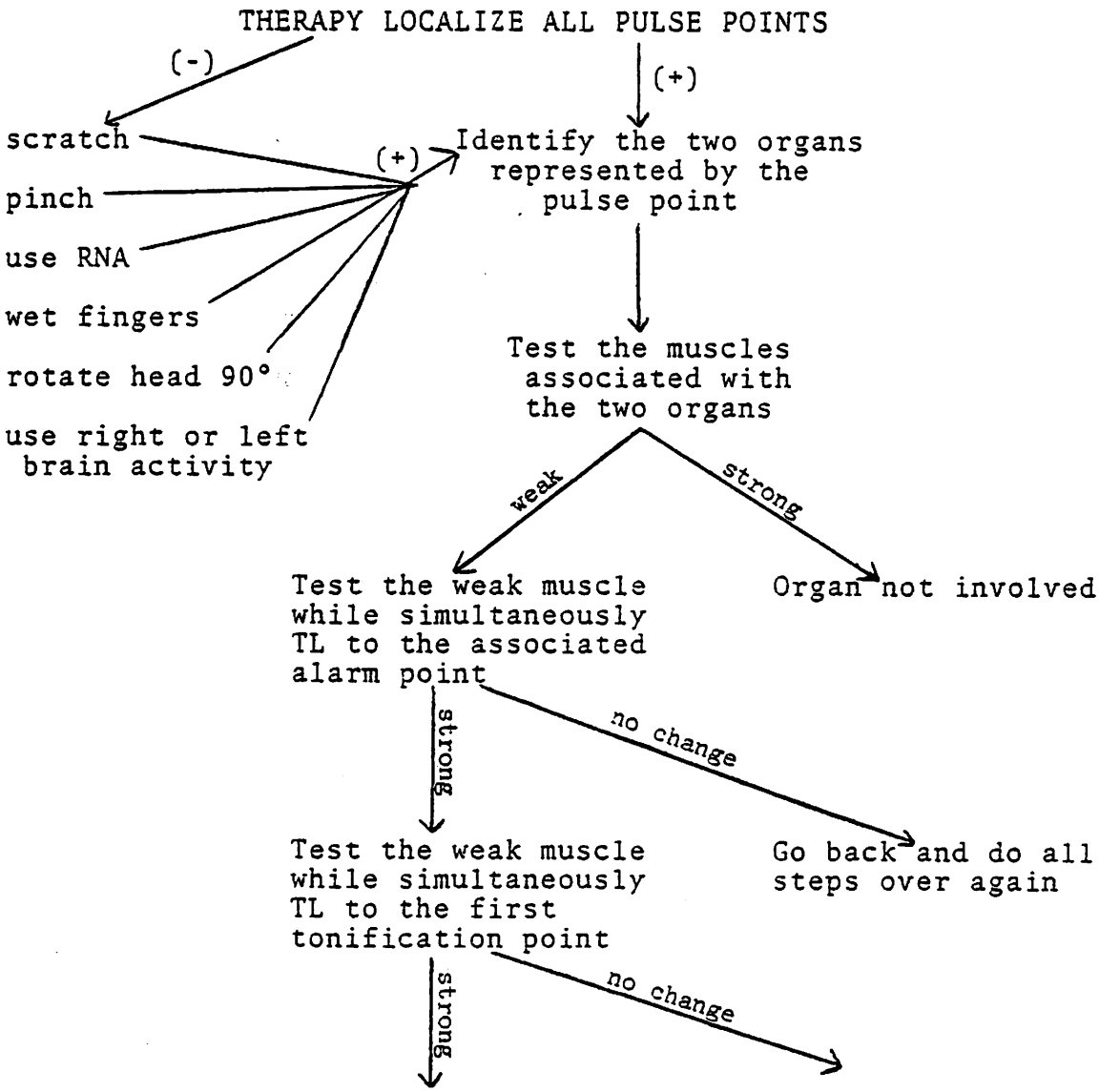
4. Cooper, V.H.: ACA Journal of Chiropractic, "Examination of the Knee", September 1979.

5. Gray's Anatomy, 44th ed., pp 333-336.

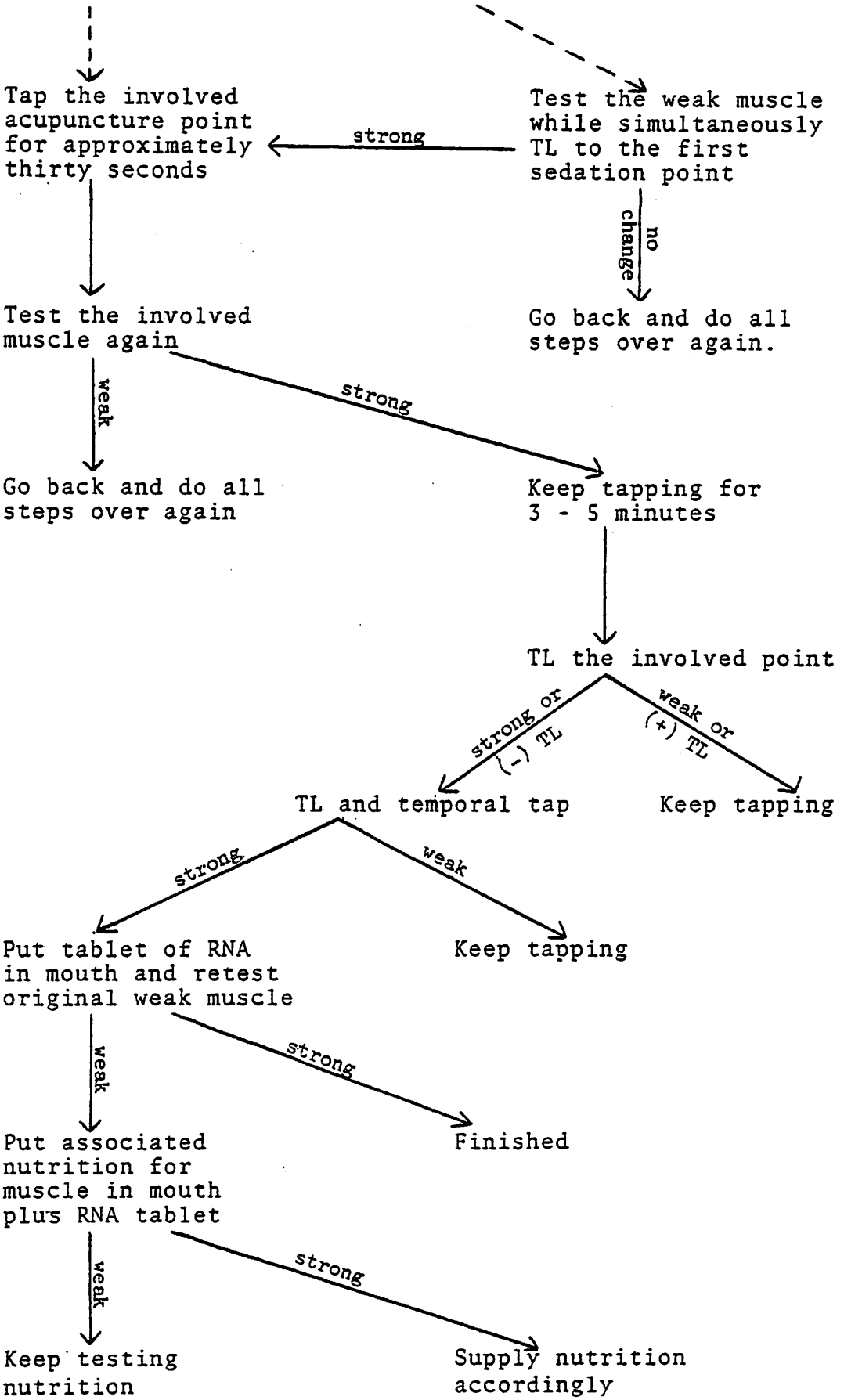
MELZACK - WALL PAIN CONTROL FLOW CHART

Dale K. Sandvall, D.C.

Abstract: Correct applied kinesiological procedures are essential to obtaining maximum clinical results. This flow chart is to be used as an aid to the practitioner to assure that the correct steps are followed.



Melzack - Wall Pain Control...Sandvall
Page 2



References

Goodheart, George J., Applied Kinesiology 1977 Research Manual, privately published, Detroit, 1977.

Goodheart, George J., Applied Kinesiology 1978 Research Manual, privately published, Detroit, 1978.

Goodheart, George J., Lecture notes, April 1978.

INTRODUCTION OF APPLIED KINESIOLOGY IN JAPAN

Walter H. Schmitt, Jr., D.C.

ABSTRACT: A paper on the fundamentals of AK, as presented to a Japanese group this past June is presented.

Applied Kinesiology was presented to an interdisciplinary group in Tokyo, Japan, on June 7-8, 1980. This was the first exposure to these Japanese doctors of the fundamental principles of applied kinesiology. This paper gives the basis for the lecture which we presented, and it was translated into Japanese by Kenzo Kase, D.C. for distribution at this seminar, at which about 130 doctors were in attendance. The entire lecture was done through an interpreter (Dr. Kase). Included in the presentation was a discussion of the common clinical syndromes of stress-related illness. This was an attempt to give the audience something clinical around which to develop the individual techniques presented.

It is hoped that this oversimplified approach to the basics in AK will aid others in developing future overseas programs to such groups, where the language barrier is a problem and the simplest approach turns out to be the best.

APPLIED KINESIOLOGY-

The Research of Dr. George J. Goodheart

The fundamental premise of Applied Kinesiology is that muscle spasm, muscle hypertonicity, and muscle tightness do not exist as a primary entity, but rather almost all muscle spasticity, hypertonicity, tightness is secondary to antagonistic muscle weakness. This weakness is not due to atrophy or pathology. The muscle weakness we see is due to neurological inhibition of the muscle. Every time one muscle contracts or is facilitated neurologically, its antagonist must relax and becomes inhibited or turned off neurologically. Every time a muscle relaxes or becomes neurologically inhibited, its antagonist must contract and become neurologically facilitated.

It is like a mast on a sail boat with 2 guy wires: If one guy wire is loosened, the mast will sway to the opposite side and it will appear that the normal guy wire has tightened, when actually, the problem is with the loosened guy wire. Tightening up the loose guy wire brings the mast back to its normal, original position and automatically normalizes the other guy wire which seemed too tight.

The same thing is true of muscles. Muscles move bones. Muscle weakness causes muscle imbalance and dysfunction occurs. By directing the proper treatment toward the weak muscle, we correct the muscle imbalance and normalize function. The dysfunction may be a recurring subluxation of the spine or pelvis, it may be limited range of motion, it may be pain, it may be visceral disease. In applied kinesiology, we always look for weak muscles, and try to find out what is causing the weakness. The source of weakness is the patient's primary problem.

5 FACTORS OF THE INTERVERTEBRAL FORAMEN

In Applied Kinesiology we talk about the model of the 5 factors of the intervertebral foramen that can be involved whenever there is a subluxation. In the intervertebral foramen

there exists:

1. a nerve
2. a lymphatic vessel
3. blood vessels
4. an acupuncture meridian connector (we will not discuss at this session)
5. cerbrospinal fluid circulation which relates to cranial bone movement and dural tension (we will not discuss at this session)

A 6th factor which is important to the function of the body is nutrition.

Whenever there is a spinal problem, one or more of the above 6 factors will become involved. Each of these is associated with a specific muscle weakness pattern. That is how we have come to an understanding of muscle imbalance coming from a chiropractic background.

Each muscle has a relationship with each of the above 6 factors. Each muscle is also related with a specific organ. A problem with an organ will cause its associated muscle to become weak. The muscle can also be weak if its associated organ is healthy. That is, the muscle itself could be injured, or the muscle could be weak due to a subluxation or other structural problem. Or the muscle could be weak due to a nutritional need of the patient.

Each of the above 6 factors can cause muscle weakness. We will talk about 4 of them:

1.) Nerve: a.) subluxation or fixation of the spine or pelvis
b.) irritation or injury to the nerve endings in the muscle itself-particularly the golgi tendon organ and muscle spindle.

2.) Lymphatic vessel: each muscle and its related organ have a neurolymphatic reflex which is the same for both of them.

3.) Blood vessels: each muscle and its associated organ have a neurovascular reflex which is the same for both of them.

4.) Nutrition: each muscle is related to a need for certain

nutrients. The nervous system is like an electrical switchboard with different circuit breakers on each line. If there is a problem somewhere along the line, one or more of these circuit breakers will "short-circuit" resulting in dysfunction and also "short circuiting" a specific muscle causing it to test weak. Muscle testing and Applied Kinesiology are really diagnostic tools which communicate directly with the nervous system and allow it to "speak" to the doctor through the "body language" of muscle weakness.

THERAPY LOCALIZATION

Therapy localization is a tool for diagnosing exactly which circuit breaker is short-circuited causing a muscle to test weak. It involves placing the patient's hand or hands on an area which might be part of the problem. If the muscle being tested changes strength when the hands are placed on an area of the body, it means something is wrong in that area of the body. Therapy localization is positive when either a weak muscle becomes strong or a strong muscle becomes weak when the hands are placed on an area of involvement. The change in muscle strength will last as long as the patient's hands remain on the involved area.

To discover what is making a weak muscle weak, the doctor places the patient's hand or hands on suspected areas of involvement.

1.) The spine where possible subluxations may be present
2.) The attachments (origin and insertion) of the muscle
3.) The neurolymphatic reflex
4.) The neurovascular reflex

After the proper correction is made, the muscle will test strong. Therapy localization to the treated area will not cause a change in the muscle strength unless the correction was not complete. Therapy localization to other involved areas will cause the muscle, which is now strong, to become weak again. When all of the involved areas are treated, the

muscle will remain strong permanently. (Note that we are not able to discuss all of the possible factors in this session.)

TREATMENT OF THE ORIGIN AND INSERTION OF A MUSCLE

The origin and insertion of a muscle become irritated due to traumatic injury. The trauma may be from a single accident or it may be due to repeated irritation such as occupational or postural. A few of the fibers in the attachments of the muscle tear away or micro-avulse from the bone. To treat this micro-avulsion, the doctor uses a hard, heavy, rotational pressure over the attachments of the muscle to the bone. It is usually painful to the patient, but the results are dramatic and long-lasting, especially in athletic type injuries.

TREATMENT OF THE NEUROLYMPHATIC REFLEXES

Most of the neurolymphatic reflexes are located in the intercostal spaces on the anterior body and in the interspinous-transverse space on the posterior body(see figure 3-4) each muscle has a specific neurolymphatic reflex. The neurolymphatic reflex for an organ is the same as its associated muscle.

Treat the neurolymphatic reflex with firm rotational pressure on both the anterior and posterior areas. 15 seconds is usually enough. Retest the muscle and therapy localize the reflex after treatment to assure correction.

TREATMENT OF THE NEUROVASCULAR REFLEXES

Most of the neurovascular reflexes are located on the head.(See chart in figure 3-5) Each muscle and its associated organ have the same specific neurovascular reflex. Treat the neurovascular reflexes by holding a light, tugging contact on the skin. Do not use deep pressure. Hold the neurovascular reflex until a pulsation is felt in the doctor's fingertips.

Sometimes a pulsation will be felt after several minutes or not at all. Retest the muscle and therapy localize the neurovascular reflex after treatment to assure correction.

VERTEBRAL CHALLENGE TECHNIQUE TO IDENTIFY SUBLUXATIONS

When the spine or pelvis is subluxated, it will therapy localize with one finger to the involved segment. To identify the listing of the subluxation we use the vertebral challenge technique. The challenge technique will cause a change in muscle strength only if the vertebra being challenged is subluxated.

Challenging involves moving the subluxated vertebra through its normal ranges of motion. There is a "rebound phenomenon" which causes the vertebra to bounce back opposite to the direction of your pressure as soon as the pressure is released. (See figures 1A-E & 2A-E). The vertebra rebounds or bounces back even farther out of place when you release your challenge pressure in the direction that the adjustment should be made. Therfore, you must adjust the vertebra in the direction of pushing and releasing that causes muscle weakness.

You can see that we adjust the subluxation as we have learned. Challenging the vertebra has the exact opposite effect on the vertebra as does adjusting it. Pushing and releasing in the same direction as we need to thrust will cause muscle weakness. Therefore, you can see how a very slow adjustment could make a patient even worse.

After the proper adjustment has been made and the subluxation has been corrected, challenging the vertebra through all of its ranges of motion will have no effect on muscle strength. This verifies correction.

NUTRITIONAL TESTING AND ALLERGY TESTING

To test for a nutritional need, we find a weak muscle, and have the patient chew or suck on the nutrient we wish to test. If the muscle becomes strong after the patient has

tasted it for 5-10 seconds, then the patient needs more of that substance in his diet. If a substance is bad for a patient, for example, a toxic dose of a vitamin or drug, or a food that he is allergic to, tasting that substance in the mouth will not strengthen the weak muscle. In fact, a substance which is toxic to a patient will cause a strong muscle to become weak. See figure 7 for specific muscle - nutrient relationships.

TRIAD OF HEALTH

In Applied Kinesiology, we look at health as an equilateral triangle. The base of the triangle is structure. One side is body chemistry. The other side is the patient's psychology. (See figure 6). Any problem in one side of the triangle will have an effect on the other two sides. In treating a patient holistically, it is important to take all three sides of the health triangle into consideration. Using Applied Kinesiology, we are able to evaluate each side of the patient's health triangle individually. We can also see how each side of the triangle is related to the other 2 sides.

STRESS, FUNCTIONAL HYPOADRENIA, AND APPLIED KINESIOLOGY

A good example of how we apply the fundamentals of Applied Kinesiology in a holistic (structural, chemical, psychological) evaluation of a patient is in the case of stress. The diagnosis and treatment of stress-related illness makes good use of the fundamentals of Applied Kineseology which we have discussed.

The major anti-stress organs in the body are the adrenal glands. The adrenal glands are like the body's reserve tank. Whenever the patient is under stress, the adrenal glands are supposed to respond. That is their purpose.

There are 4 categories of stress:

1.) Physical stress- examples: too much work
not enough sleep
overtraining in an athelete

2.) Chemical Stress- examples: poor diet with excess sugar and refined carbohydrates
hormonal imbalances, especially in women
environmental pollutants

3.) Thermal Stress- example: overheating the body
getting chilled

4.) Emotional Stress- example: family problems(death, divorce, etc.)
worrying
studying too hard

Patients under prolonged stress from one or more of the above categories go through a process called the "General Adaptation Syndrome." This pattern of adaptation to stress has been researched for many years by Hans Selye, M.D. and his associates in North America. They found that patient's adrenal glands go through 3 stages during prolonged and severe stress:

Stage 1: Alarm Reaction- the adrenal glands work hard in response to stress. This is called functional hyperadrenia. Near the end of this stage, the adrenal glands get worn out and begin to function less. We call this functional hypoadrenia.

Stage 2: Resistance Stage- the adrenal glands begin to grow stronger in order to better tolerate the stress. This is a functional hyper-adrenia again

Stage 3: Exhaustion- the severe and prolonged stress is so great that it overwhelms the adrenals in the resistance stage. Now the patient will certainly become sick, if he is not already sick from the previous 2 stages. This is severe functional hypoadrenia.

These 3 stages may take months or even years to be completed. But in our offices, we see 50% to 85% of new patients who are suffering from the exhaustion stage of functional hypoadrenia. There are many different symptoms caused by a functional hypoadrenia. For example: fatigue, dizziness or light-headedness when standing up; eyes sensitive to light. Functional hypoadrenia is the major aggravating factor in many other illnesses: low back pain, knee pain, asthma and bronchitis, hemorrhoids, allergies, menstrual disorders, recurring infections, psychotic disorders, and many more. Improving adrenal function in these patients is usually necessary before any of their symptoms will change significantly. It is the reason why so many of these problems are of recurring nature.

The one factor that all of the above diseases and symptoms have in common is weakness of the adrenal glands. The muscles which are related to the adrenal glands are (primarily) the sartorius and the gracilis. The sartorius or the gracilis are always weak in the exhaustion stage of stress-related illness. Therefore, the one muscle testing factor which all of the above diseases have in common is a weakness of the sartorius and gracilis muscles.

We will approach the diagnosis and treatment of stress-related functional hypoadrenia from a holistic (structural, chemical, psychological) point of view using muscle testing and Applied Kineseology as our guide.

STRUCTURE: The most common structural problem in functional hypoadrenia is a sacroiliac subluxation, particularly a posterior innominate on the side of sartorius and gracilis weakness. The second most common structural fault is a knee problem where the tibia rotates laterally on the femur. These 2 subluxations are due to the weakness of the sartorius and gracilis. The sartorius and gracilis are weak due to the functional hypoadrenia. In other words, the adrenal problem must be corrected before either of these two subluxations will stay corrected.

We use therapy localization to identify which factors are involved and treat them as we have previously discussed.

We must check for and correct the following structural factors Sacroiliac subluxation (posterior innominate), knee subluxation, T-9 subluxation (spinal level for adrenal glands), adrenal gland neurolymphatic reflex, adrenal gland neurovascular reflex, origin and insertion of the sartorius and gracilis.

CHEMICAL: We test the sartorius or gracilis and see which nutrients cause these muscles to become strong when they are tasted by the patient. The nutrients we test are: Vitamin C, riboflavin, niacin, and adrenal tissue nutritional extracts. After we have strengthened the sartorius and gracilis we test for possible toxic substances by placing them in the mouth and observing for weakness of the sartorius and gracilis. The most common toxic substances in hypoadrenia patients are sugar and other refined carbohydrates. We add more of the helpful substances to the patient's diet. We restrict the toxic substances from the patient's diet.

PSYCHOLOGICAL: We test for emotional or psychological stress by testing the sartorius and gracilis after we have strenghtened them. We also test both pectoralis major, clavicular muscles.

We ask the patient to close his eyes and think about a problem which is bothering him now or, about a problem which bothered him in the past. He must not speak about the problem. If emotional stress is involved the patient will show rapid eye movements under the closed eyelids when he is thinking about the problem. When these rapid eye movements appear, retest the sartorius, gracilis, and pectoralis major, clavicular muscles. They will now be weak. This demonstrates the effect of the psychological side of the patient on his health.

This pattern may be corrected. There will be positive therapy localization to both neurovascular reflexes for the pectoralis major, clavicular muscles. These neurovascular points are found on the middle of the forehead, directly over each eye. Hold these reflex points with a light, tugging contact. Hold the points until a pulsation is felt in the doctor's fingertips. This sometimes takes several minutes in a very emotionally stressed patient. After pulsation

is felt by the doctor the patient is instructed to think the same thoughts as he did previously. If the contacts have been held long enough, there will be no weakening of the muscles.

This treatment corrects the effect of the patient's psychology on the rest of the body. He may still require other psychological treatment. We always recommend for the patient to hold these neurovascular reflexes each night before he goes to sleep. This keeps the reflexes from "short-circuiting" again if the emotional stress continues.

SUMMARY

Applied Kinesiology and muscle testing allow the doctor to diagnose and treat a patient holistically. The doctor can identify exactly what factors are making his patient sick by muscle testing, therapy localization, nutritional and toxicity testing, and emotional thought patterns. The doctor can make the specific corrections his patient needs and observe how all of the holistic factors work together. The body speaks to the doctor through the muscles. The doctor can understand the body's language by using muscle testing and Applied Kinesiology. When the doctor gives the proper treatment, the body says "Thank you" by healing itself. amd the patient's health improves.

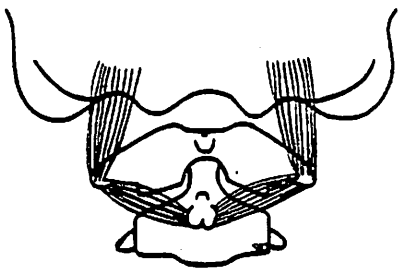


Fig. 1-A

Semi-schematic drawing of upper cervical region with representative intrinsic muscles (obliquus capitus superior and inferior). No subluxation present. Normal intrinsic muscle balance.

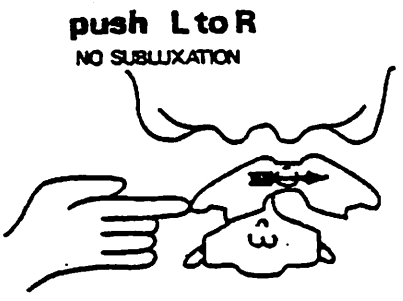


Fig. 1-B

Pressure applied to non-subluxated atlas from left to right. Sensory feedback from normal intrinsic muscles informs nervous system of atlas position within normal range of motion. No change in peripheral muscle strength.

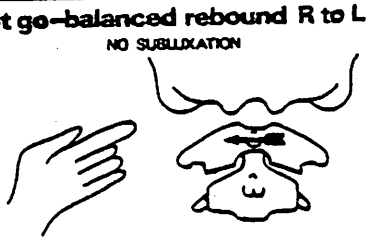


Fig. 1-C

L to R pressure released. Normal intrinsic muscles "rebound" atlas to original, normal position. No change in peripheral muscle strength.

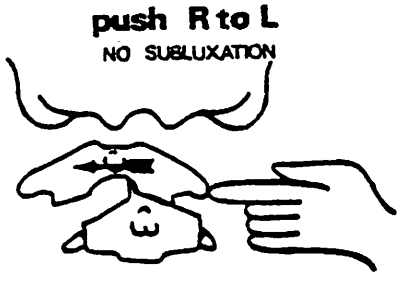


Fig. 1-D

Pressure applied to non-subluxated atlas from right to left. Sensory feedback from normal intrinsic muscles informs nervous system of atlas position within normal ranges of motion. No change in periperal muscle strength.

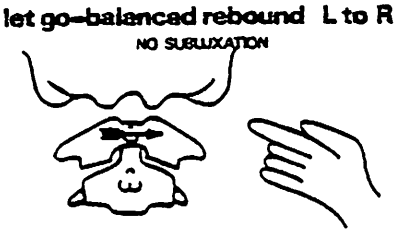
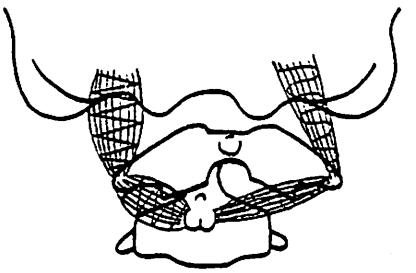


Fig. 1-E

R to L pressure released. Normal intrinsic muscles "rebound" atlas to original, normal position. No change in peripheral muscle strength.



Right Lateral Atlas Subluxation

FIG. 2-A

Semischematic drawing of upper cervical region with representative intrinsic muscles (obliquus capitus superior and inferior). Intrinsic muscle imbalance — left obliquus capitus muscles hypertonic (facilitated) and right obliquus capitus muscles hypotonic (inhibited) — allows right lateral atlas subluxation. (Atlas rotation would also be present.)

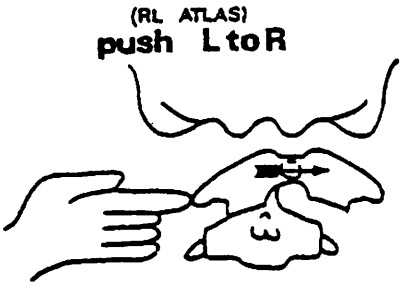


Fig. 2-B

Pressure applied to RL (ASR) atlas from left to right, exaggerating the subluxation. Any indicator muscle will test weak (inhibited.).

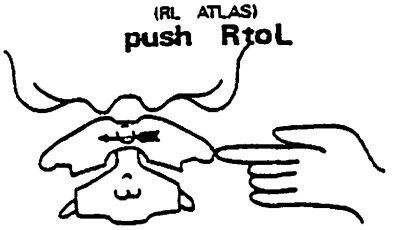


FIG. 2-D

Pressure applied to RL (ASR) atlas from right to left, holding it in its normal, homeostatic position. Indicator muscle will test strong. (NOTE — A thrust in this direction will make permanent correction.)

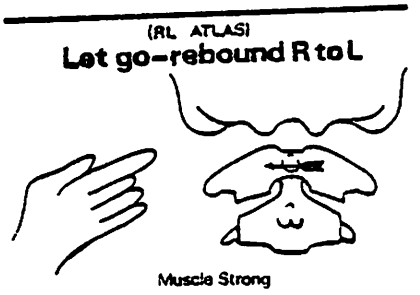


Fig. 2-C

L to R pressure released. Imbalanced muscles cause an over-rebound of the atlas past the subluxated (Fig. 2-A) position to its normal, homeostatic position for up to 30 seconds. Indicator muscle will test strong.

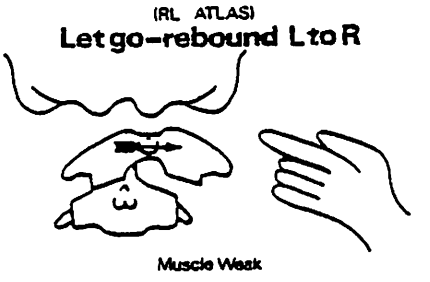


Fig. 2-E

R to L pressure released. Imbalanced intrinsic muscles cause an over-rebound of the atlas past the subluxated (Fig. 2-A) positon farther into subluxation. After 5-30 seconds the atlas will resume the subluxated (Fig. 2-A) position. In the meantime, any indicator muscle will test weak.

FIGURE 3

NEUROLYMPHATIC (NL) AND NEUROVASCULAR (NV) REFLEXES

MUSCLE	ORGAN	NL	NV
Abdominals-Transverse	Duodenum	1	8
Rectus	Duodenum	2	8
Adductors	Climacteric	3	12
Coracobrachialis	Lungs	4	3
Deltoid	Lungs	5	3
Diaphragm		6	10
Gluteus Maximus	Prostate/Broad ligament	7	12
Gluteus Medius & Minimus	Uterus/Seminal vessicles	8	9
Gracilis	Adrenals	9	11
Hamstrings	Rectum	10	10
Infraspinatous	Thymus	11	
Intrinsic spinal muscles (K-27)		12	
Jaw Muscles	Clicking Jaw	13	4
Latissimus Dorsi	Pancreas	14	7
Levator Angula Scapulae		15	3
Neck Flexors and Extensors	Sinuses	16	4
Pectoralis Major-clavicular	Gastric	17	1
-sternal	Liver & Bladder	18	2
Peroneus Longus & Brevis	Bladder	19	1
Piriformis	Uterus/Seminal vessicles	20	9
Popliteus	Gall Bladder duct	21	
Psoas Major	Kidney	22	13
Quadratus Lumborum	Appendix	23	9
Quadriceps Femoris	Small Intestine	24	9
Rhomboids		25	1
Sacrospinalis	Cystitis	26	1
Sartorius	Adrenals	27	11
Serratus Anticus	Lungs	28	3
Subscapularis	Heart	29	3
Supraspinatous	Brain fag	30	3
Tensor Fasciae femoris	Colon	31	9
Teres Minor	Thyroid	32	6
Tibialis Anticus	Urethra	33	1
Trapezius-Middle & Lower	Spleen	34	10
-Upper	Eye,Ear	35	5
Wrist Extensors	I-C Valve		

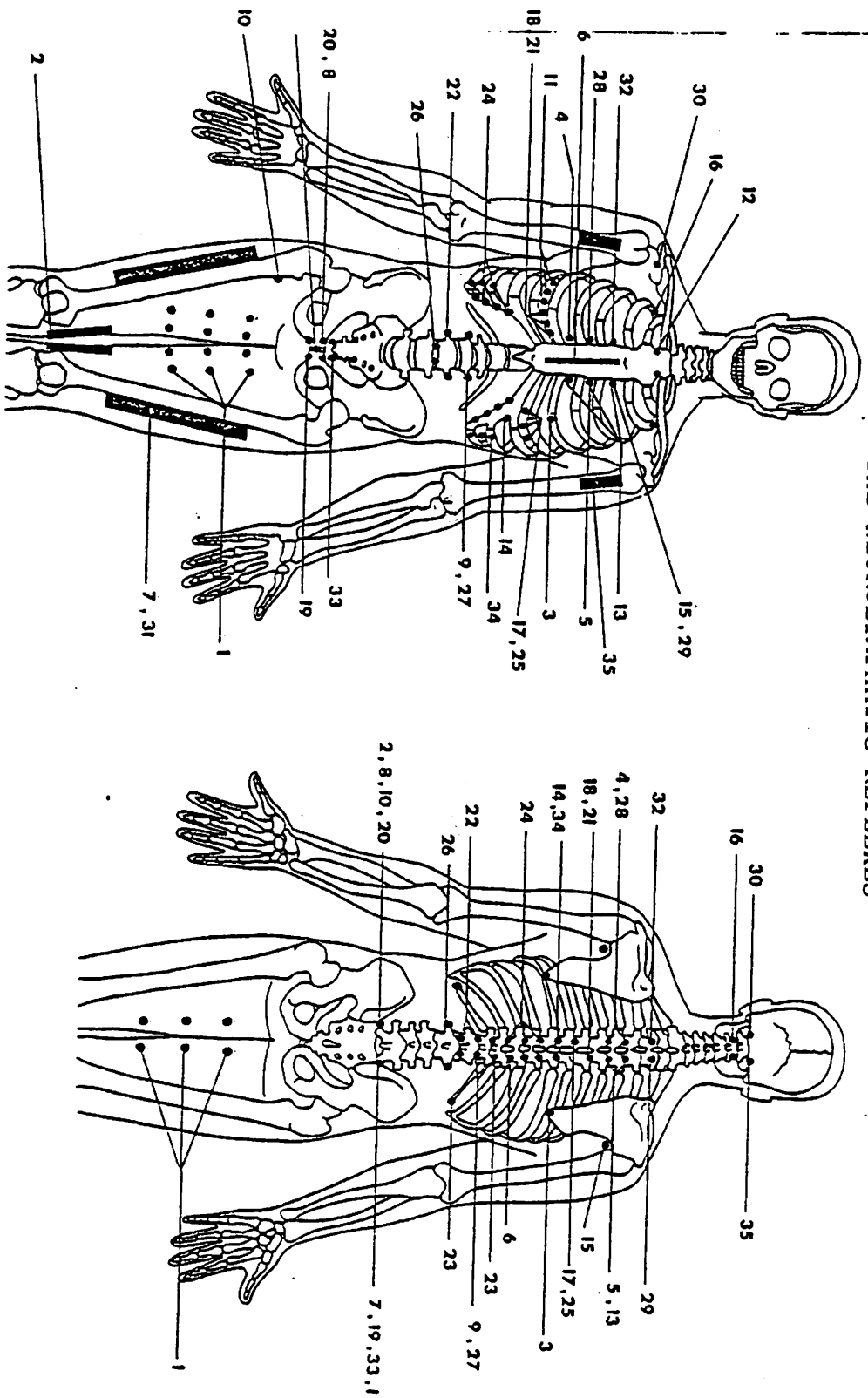


FIGURE 4

THE NEUROLYMPHATIC REFLEXES

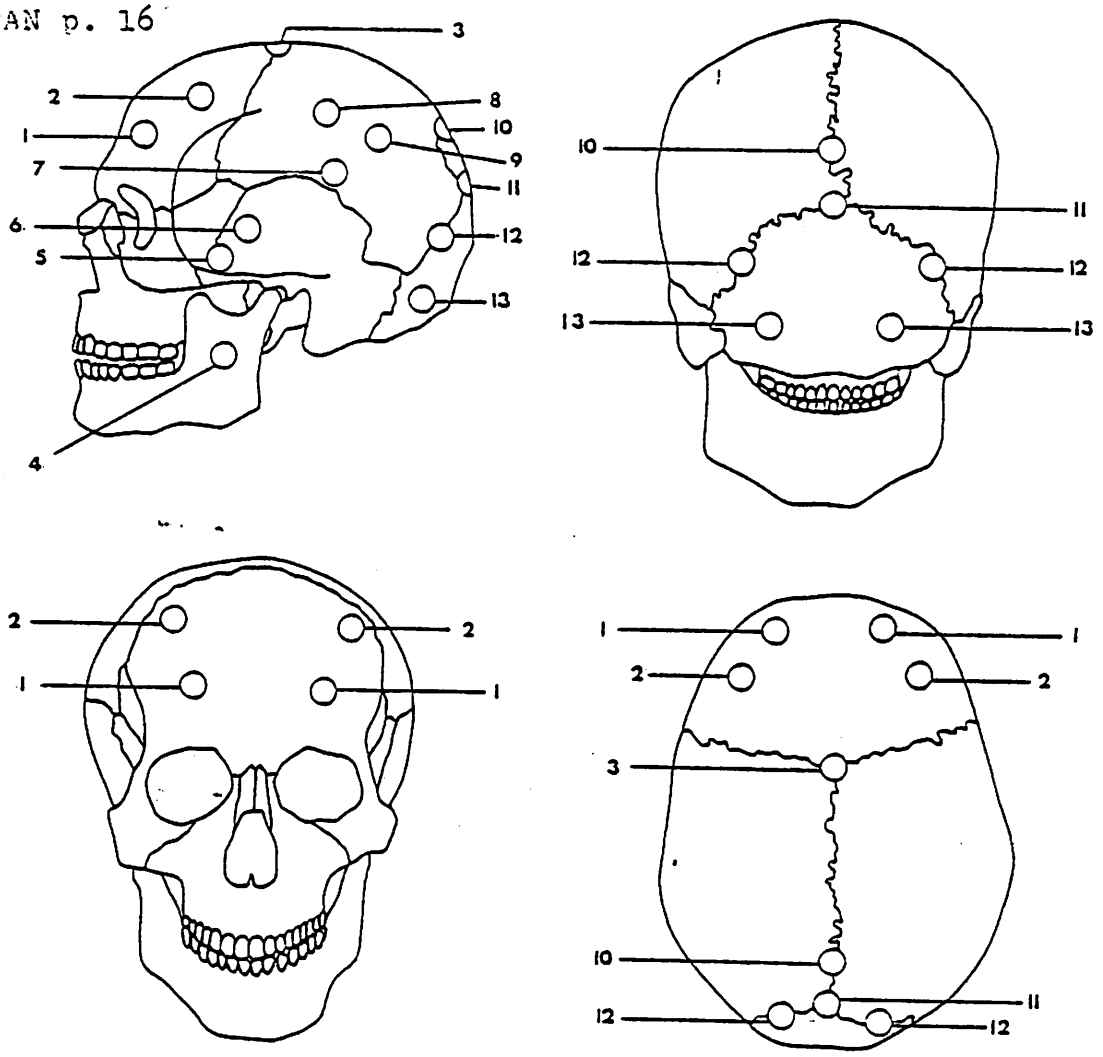
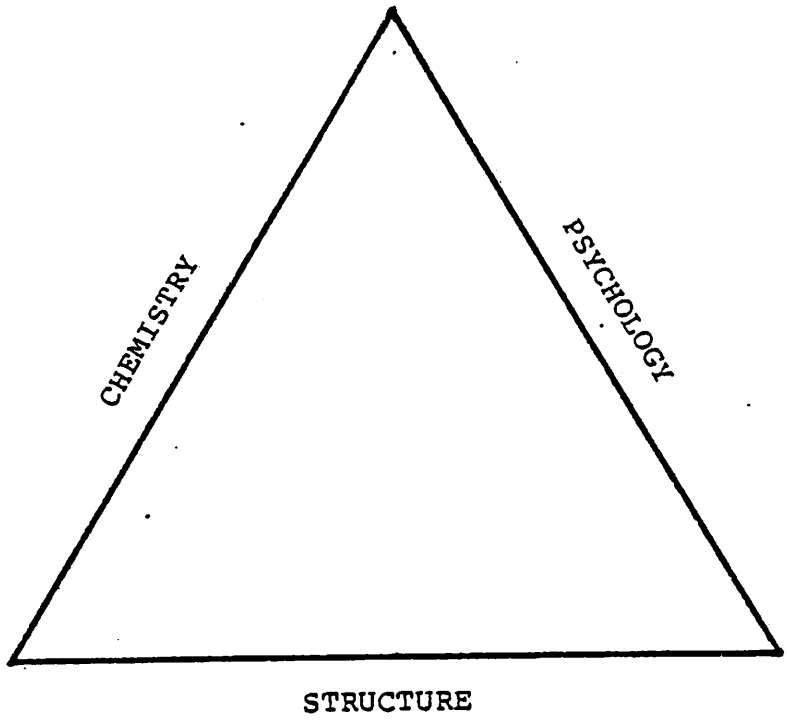


FIGURE 5

THE NEUROVASCULAR REFLEXES

FIGURE 6
THE TRIAD OF HEALTH



A patient's health is viewed as an equilateral triangle with each side (structure, chemistry, and psychology) in intimate contact with the other two sides, and each side being affected by, and having an effect on the other two sides.

FIGURE 7

SPECIFIC MUSCLE-NUTRIENT RELATIONSHIPS

MUSCLE	NUTRIENTS
Abdominals	Vit. E; Duodenal tissue
Adductors	Vit. E; Ovary, Uterus, Orchic tissues
Corachobrachialis	Vit. C; Lung tissue
Deltoid	Vit. C; Lung tissue
Gluteus Maximus	Vit. E; Ovary, Uterus, Orchic, Prostate
Gluteus Medius & Minimus	same as Gluteus Maximus
Gracilis	Adrenal tissue
Hamstrings	Vit. E
Infraspinatus	Thymus tissue
Latissimus Dorsi	Pancreatic enzymes;Vits. A, F, Betaine
Neck Flexors & Extensors	Niacin; Iodine; Vit B-6 (Pyridoxine)
Pectoralis Major-clavicular	Vit. B; Vit. G; Hydrochloric acid (both weak
-sternal	Vit. A; Bile Salts; Liver tissue
Peroneus muscles	Vit. B; Vits. A,C,&P
Piriformis	same as Gluteus Maximus
Popliteus	Bile Salts; Vits. A,F, Betaine
Psoas	Vit. A; Vit. E; Kidney tissue
Quadriceps Femoris	Vit. D; Duodenal tissue
Sacrospinalis	Vits. A,C,&P
Sartorius	Adrenal tissue
Serratus Anterior	Vit. C; Lung tissue
Subscapularis	Heart tissue; Vit. G; Vit. E.
Supraspinatus	Brain tissue
Tensor Fascia Lata	Acidophilic substances for bowel flora
Tensor Fascia Lata-bilateral	Iron
Teres Minor	Iodine; Thyroid tissue
Teres Major	Alkaline Ash Minerals (Potassium)
Tibialis Anterior	Vit. B; Vits. A,C,&P
Trapezius, lower and middle	Vit.C; Spleen tissue
Trapezius, upper	Calcium, Vit. F; Vit. G
Triceps Brachii	Pancreas tissue; Pancreatic enzymes
Any muscle-shortened fascia	Vit. B-12

Richard H. Schroeder , D.C.
2535 N. Fresno St.
Fresno Ca. 93703
October]976

ROCKER BONE CRANIAL FAULTS

And Pelvic and ankle lovett brothers

Abstract : Occipital-atlas micro-cord - pressure during neck rotation or lateral bending or antero-posterior motion.
A_P Rocker Bone discovered by Dr Goodheart]976

Test any muscle with patient's head and neck straight. Then fully rotated one side then the other.
Then test with head neck tilted side ways. One side, then other.
Then test with head rocked chin down and then chin up.
Note which position or positions produce weak muscle test.

] st lovett brother is sacral-5 th lumbar, where rotation, lateral tilt or flexion- extension position will coincide with occipital atlas faults discovered in] st part.
2 nd lovett brother - Tarsal- tibial junction-- where rotation,tilt or flex-extension will also match.

MAJOR FAULT NEGATES TEST WEAKNESS ON INSPIRATION . And correction of major fault corrects others.
When rotation rocker bone exists all muscles perform less or poorly while head , pelvis or ankle is rotated. But we found, if fault exists even while head- neck is straight, one of the anterior deloid has poor performance and will return to normal when correction is made.

Whenlateral tilt of the head or pelvis or ankle is positioned any or all

muscles perform poorly (if fault exists) and even with the head - neck straight we find unilateral latissmus wekness. Which returns to normal when correction is made.

When A-P rocker bone exists, any and all muscles perform poorly- when head , pelvis or ankle is flexed or extended.. And when fault exists even with straight positioning, bilateral weakness of the anterior tibial is noted, which corrects on fixing rocker bone fault.

CORRECTION PROCEDURE

For rotation falt, head-neck major. Have patient resist head rotation during inspiration, twice on each side.

pelvic major. Have patient resist lumbar roll on inspiration, twice on each side.

Ankle major. Have patient resist ankle turning during inspiration, twice on each side.

For tilt fault, head-neck major . Have patient resist lateral pressure during inspiration, twice on each side.

Pelvic major, Have patient resist quadratus lumborum test during inspiration, twice on eah side.

Ankle major. Have patient resist lateral ankle motion, during inspiration, twice on eah side.

A-P rocker bone fault, head-neck major. Have patient resist forward and backward head motion effort on inspiration, twice each direction.

Pelvic fault major. Have patient resist to lower back flexion and extension on inspiration, twice each direction.

ALL PREVIOUS REACTIONS AND WEAKNESSES SHOULD NOW BE GONE...

Rocker Bone — Schroeder

Lasting power- excellent . Seems to last as long as person doesn't hit head. I'm sure this is where the expression came from, " I hit my head so hard , I nearly knocked my head off. " They actually did by a millimeter or so .

SPECIAL BENEFICAL AFTER EFFECTS

People who awaken in the morning feeling wiped out, or just as tired, no energy to go to work .--- But after being up for 10 to 20 minutes felt better and went to work.. I believe the rocker- bone fault sleeping position produced the symptoms , which never showed up again after it's total correction..

Hang-over , after party fatique , the morning after effect, also have rected properly.. The feeling of the head not belonging to the body, is commonly expressed by those with a hang-over.

I believe we have the cure and prevention of hang-over with this correction . Hope you test it, and use it on any and all. For total service care.

Hic

Richard H. Schroeder, D.C.
2535 N. Fresno St.
Fresno, Ca. 93703
October 1979

LIST OF NEW MUSCLE TEST S

Must be demonstrated

Ilio-psoas minor	60° elevation
Iliacus	90° elevation
Gluteus medius ant	elevated 5-10°
Gluteus medius post	lower than horizontal by 5-10°
Gluteus minimus	leg hyper-lateral,
3 different quadriceps	turning lower leg & foot in for lateral, leg & foot out for medial, straight for central.
3 different adductors	
Magnus	foot rotated out
Longus	foot straight
Brevis	rotated in
Oblique internal abdominal	leg raise but also lateral
Gracilis	1st part of sartorius test
Sartorius	pressure lateral side of Knee
Brachial's	biceps position except hand pronated
Brachio radialis	biceps position thumb up
Flexor carpi radialis	flexed hand pressure on thumb side to extend
Flexor carpi ulnaris	press on little finger side

2

List — Schroeder

Pectoralis clavicular minor---------- same as PMC but with arm lateral full

Subclavian ---------- with arm elevated along side of head, palm out

Infraspinatus ---------- Teres minor type test but with arm along side of head

Different angles of pectoralis sternal ---------- several angles from different points of origin

Splenius capitius ---------- hyper-extension

Splenius cervicis ---------- moderate extension

Short ham ---------- full or hyper-flexion

Pectoralis minor ---------- arm flexed extended forward

Transnerse abd ----------pect stern with opposite hip raised

Pectineus ----------
leg lateral full , pull further.

Obturator externus ---------- supine- leg flexed, down to side of table, press in prone- raise thigh, hold knee, press in

Short biceps ---------- arm fully flexed

Short triceps ----------arm fullyextended

Sacro-spinalis ----------same as tensor , but with leg across other one

Richard H. Schroeder, D.C.
2535 N. Fresno St.
Fresno, Ca. 93703
October 1979

PRESENTED TO I.C.A.K.

SEPARATION OF THE VERTICAL OCCIPITAL SUTURE (S-Vo-S)

Abstract: "New Cranial Work" Appears to clear out or correct:

1. Cervical hyper-extension muscle (Splenuis Capitis)
2. Thigh-leg hyper-flexion muscle (short head of the biceps femoris)

References

Page 125 Gray's

Behind foramen magnum is the median nuchal line ending above at the external occipital protuberance. (Figure 147)

Page 125 Gray's

Opisthion-posterior center point of occipital at foramen magnum margin. Basion is anterior point.

Page 161 Gray's

The planum muchale of the squama is occified from two centers, which appear about the seventh week of fetal life and soon unite to form a single piece. (Proves to be wrong. RHS)

Each of the lateral parts begins to ossify from a single center during the eighth week of fetal life.

Page 162 Gray's

Between the eighteenth and twenty-fifth years the occipital and sphenoid become united forming a single bone. (Wrong-Since spheno-basilar flexion-extension is proven with our cranial adjustment at any age.)

2

Reference -- Schroeder S-VO-S

Page 394 Gray's Splenius Cervicis Actions

The splenii of the two sides, acting together, draw the head directly backward, assisting the trapezins and semispinalis capitis; acting separately, they draw the head to one side, and slightly rotate it, turning the face to the same side. They also assist in supporting the head in the erect position.

Page 502 Gray's Biceps Femoris

Short head, arises from the lateral lips of the linea aspera, between the addrictor magnus and vastus laterals, extending up almost as high as the insertion of the glutens maximus; from the lateral prolongation of the linea aspera to within 5CM of the lateral condyle; and from the lateral intermuscular septum. Fibers of long and short join in an aponeurosis which gradually contract into a tendon which is inserted into the lateral side of the head of the fibula and by a small slip into the lateral condyle of the tibia.

Test challenge mid line (suture) of occiput

Test challenge pushing it together

Test challenge pulling it apart

Usual finding is weakness of that muscle on mid line and pulling apart challenge. Then the splenius cervicis is tested. Prone position, patient raises head moderate degree of extension. If condition related to splenius cervicis are normal, it will test normal. Then a fuller extension or hyper-extension of the cervical spine (splenius capitis) is tested and will be found (new phrase) non performing, instead of weakness. Still unexplainable you will find no performance of the splenius cervicis.

3

Schroeder S-VD-S

It appears the performance of the splenius cervicis depends on performance of the splenius capitis when hyper-extension is tested.

P.S. The upper part of occipital suture near posterior fontanell when separated during inspiration cycle effects correction of this weakness.

(I believe when we thought we were testing the splenius capitis we were testing the splenius cervicis. Moderate extension of the cervical spine is performed by the splenius cervicis while hyper-extension is accomplished by the splenius capitis.)

Before Correction Suture Fault-

Test hamstrings at right (90°) angle. Should test strong if all things are corrected pertaining to it. Now hyper-flex leg on thigh with heel as near buttock as possible. You will find poor or no performance of this muscle which we believe is the short head of the biceps femoris.

Surprisingly you'll find no or very poor performance of the rest of hamstrings.

Again it appears the performance of the hamstring depends on the performance of the short head of the biceps femoris.

P.S. Correction of the lower part of the closed vertical occipital suture by separation restores all of those situations to normal.

Adding this cranial technique has improved many neck and or lower back conditions.

I now have a list of 38 cranial adjustments at my disposal.

SOME DANGERS IN THE DEVELOPMENT OF NEW TECHNIQUES IN APPLIED KINESIOLOGY

by

Jason P. Schwartz, D.C.

ABSTRAGT:
The role of mental matrices in research and development of new techniques must be understood to ensure quality results.

DISCUSSION:

During the past several years while using Applied Kinesiological techniques, it has become obvious that there are two classifications into which the various techniques can be placed:

A - Class 1:

This classification is based on the principle of objective reproducibility. It works for anyone, anywhere, anytime, if the procedure is done correctly. Muscle-organ relationships, therapy localization[1] are just two examples of this type, among hundreds.

The basis upon which these techniques operate is discussed in Walther's text[1], Dr. Goodheart's workshop manuals[2], and Stoner's text[3].

This classification of techniques is the basis upon which Applied Kinesiology has been founded, has grown, and has been accepted.

B - Class 2

These techniques operate upon the principle of mental matrices. You program in the guidelines of the technique through powerful mental images. This principle is at work in Van Rump's Directional Non Force Technique. Even Dr. De Jarnett mentions briefly 'asking the body questions mentally.'[4]

Every successful sales person or business person knows the power of thoughts or mental matrices. Goal setting is taught at all sales and practice-building seminars. Write down on Sunday how many cars you are going to sell this week and know you will do it.

These techniques will sell cars and fill offices, but they have no place in the development of new techniques in Applied Kinesiology.

Thoughts are things and powerful forces. If we believe, for instance, that point "X" on the body is the therapy localization area for a high triglyceride level, then it will be so. Every patient we see who therapy localizes to point "X" will have high triglycerides. We made the matrix and it will operate as we have structured it.

You ask, what is wrong with that? Point "X" is working only because of the mental matrices we have established.

Instead, if you think you have found such a point (X) to screen for high triglycerides, ask ten doctors to therapy localize point "X" on fifty of their patients. Do not tell the doctors what point "X" signifies. After the findings are in, go over the blood chemistries and see how well point "X" correlates with high triglycerides.

Do you see the difference?

There are many doctors who have developed techniques which could not stand up to this type of scrutiny. Often these techniques become tangential to Applied Kinesiology. The founders may even become resentful because the majority of Applied Kinesiologists have not adopted their techniques. These techniques work for them and anyone else to whom it has been explained or taught to. In other words, adopt their mental matrices and it will work for you too.

CONCLUSION:

There is an imperative need to move out of the subjective, "it works for me in my office," type of research and technique to the more objective, it works for anyone, anywhere, anytime, even if they do not know what they are looking for.

There must be an understanding of the powerful mental matrices that we all make and use. Using these mental molds as a methodology to develop new techniques in Applied Kinesiology brings with it certain dangers. The old saying, "if it works, use it" will not fit now.

We must be able to have it stand the challenge of objectivity.

REFERENCES

1. Walther, David S., Applied Kinesiology - The Advanced Approach in Chiropractic, Systems DC, Pueblo, Colorado, 1976

2. Goodheart, George, Applied Kinesiology Workshop Manuals, Detroit, Michigan, Privately Published, 1976-1979

3. Stone, Fred, The Eclectic Approach to Chiropractic, Las Vegas, Nevada, F.L.S. Publishing Co., 1975

4. DeJarnett, Major Bertrand, Sacro Occipital Technic, Nebraska City, Nebraska, 1975-1979

BIBLIOGRAPHY

1. Walther, David S., Applied Kinesiology - The Advanced Approach in Chiropractic, Systems DC, Pueblo, Colorado, 1976

2. Goodheart, George, Applied Kinesiology Workshop Manuals, Detroit, Michigan, Privately Published, 1976-1979

3. Stone, Fred, The Eclectic Approach to Chiropractic, Las Vegas, Nevada, F.L.S. Publishing Co., 1975

4. DeJarnett, Major Bertrand, Sacro Occipital Technic, Nebraska City, Nebraska, 1975-1979

5. Collected Papers of the Members of the International College of Applied Kinesiology, New Life Publishing Co., 1001 N. Swan, Tucson, AZ 85711, 1975-1980

6. Twitchell, Paul, The Flute of God, Illuminated Way Press P.O. Box 2449, Menlo Park, CA 94025, 1977

THE UNDERSTANDING OF THE GLABELLA FAULT

By Paul T. Sprieser, B.S., D.C.

Abstract: The exploration of the glabella fault, its causes, identification, and its corrections.

My study was carried out because of my curiosity of the respiratory challenge of the glabella fault. As you know, the glabella fault can be respiratory challenged by inspiring through the mouth.

Its' causes seem to be blows to the skull. The amount of force required did not necessarily equate with the patient remembering an incident in which it took place.

I found the presence of the cranial fault was almost always found in athletes who were in contact sports where the skull might receive some trauma regularly (ie. football, wrestling). I have never found participants in either of these two sports that did not have this fault.

The importance of this fact, in my mind, was the increased chance of injury if this player was traumatized while taking an oral inspiration. His or her chances of injury were probably increased from 35 to 60 percent due to the muscular weakness that occurs while orally inspiring.

Part of my information came from my studies of the T.M.J. dysfunction an observation. When I corrected the retraction phase of this dysfunction (temporalis muscle) it always seem to correct the glabella fault with no cranial correction required.

Methods Of Identification And Correction: Patients that had both T.M.J. dysfuction and a glabella fault were tested. The number of cases in this study were fifty.

1. Muscle used was the tensor fascia lata.
2. T.M.J. examined by T.L. to the joint while jaw was placed in varous position of motion (open-closed-right and left lateralization- retraction-protrusion).

Methods Of Identification And Correction:

3. Glabella fault was found by T.L. to the glabella with one hand while the other hand was placed on the external occipital protuberance.
4. Respiratory challenge of an oral inspiration was used to verify the presence of the glabella fault. Upon inspiration a strong indicator muscle would weaken.
5. Osseous challenge of pressure on the glabella and coincident pressure on the external occipital protuberance with both hands pressing toward each other will cause a weak indicator muscle to become strong.
6. Spindle cell technique on the belly of the muscle was used on the therapy localization positive side pressing the spindle together to correct and pulling apart to reproduce the original findings.
7. Patient was then asked to take a deep breath through the nose to re-check glabella fault to rule out the deep inspiration was causing the muscular weakness.
8. Patient was then asked to just open mouth to rule out that opening the mouth did not cause a test muscle to weaken.
9. Patient was finally asked to place teeth together without biting and take a deep breath through the teeth. At this point, the indicator muscle was tested. In all cases no weakness was noted.
10. Another factor was to prove that the positive respiratory challange of this fault was opening the mouth and inspiration either oral or nasal. This fact was checked by having the patient who show the fault present by all the above mentioned means do one more screening test. This was done by opening the mouth and covering the mouth with the hand and inspiring through the nose, which caused a positive weakening of the test muscle. Patient was first checked to make sure that placing the hand over the mouth did not cause a positive therapy localization.

Methods To Check Causes (Trauma):

Another observation I have been more aware of is that many of my T.M.J. patient who originally were negative to the presence of a glabella fault both to respiratory challenge and therapy localization; these same patients showed its presence when the T.M.J. was active and had retraction as one factor on one or both sides present. These patients did not have any trauma that effected the head region.

It has been mentioned that the glabella fault was also due to trauma to the skull. Its presence was most often found in football palyers, and wrestlers. This seems to indicate that the force most likely would be an oblique A to P or P to A towards the sphenobasilary junction.

I tested this though by having football and hockey helmets worn by the athletes. By using a moderate concussive force in the region of the anterior or posterior fontanels.

1. Patient was again tested before to make sure no glabella fault nor T.M.J. retraction involvement were present.
2. The concussive force was applied through the helmet. The the presence of the glabella fault was then found by respiratory challange and therapy localization.

Findings: Fifty cases consisting of 17 female and 33 males with both components of this study present. The first is the presence of the glabella fault and T.M.J. involvement at the time of the intial examination.

1. All cases that had T.M.J. with retraction T.L. positive (temporalis muscle) were treated with spindle cell technique to the involved muscle. This corrected the glabella fault in every case without any osseous correction.
2. When spindle cell was reversed (pulled apart) and the patient was rechecked the glabella fault was found to return.
3. Correction of any other phase of T.M.J. muscular dysfunction (reactivity) did not correct the glabella fault.
4. After the force was applied all tested parties showed the presence of the glabella fault and a retraction T.M.J. dysfunction present.

Findings:

5. Other lines of concussive force were tried from directly on top of the foramen magnum and direct at the squamous suture at the region of the temporal-parietal bones none of which seem to produce the T.M.J. dysfunction nor the glabella fault.

Conclusion:

1. The glabella fault was caused by the imbalance of the temporalis muscle either unilaterally or bilaterally.
2. The imbalance of the temporalis causes the condyle of the mandible to be drawn upward and psoterior into the fossa causing a decrease of the anterior to posterior size of the sull and a increase of the lateral dimension.
3. The respiratory challange was not oral inspiration, but rather the opening the mouth and inspiration that produced the weakness.
4. Glabella fault could be corrected by just rebalancing the spindle of the involved side of the temporalis msucle. This is a similar observation of Dr. Goodheart had with the jammed saggital suture being released with the spindle technique on the temporoparietalis muscle and its effect on the galea aponeurotica. This was done instead of pulling the suture apart.
5. That a concussive force in the region ofthe anterior or posterior fontanels could cause the imbalance in the temporalis muscle and cause a glabella fault.

Discussion:

The glabella fault was actually a cranial fault that was identified by weakness of a strong indicator muscle weakening on oral inspiration. In actuality was a fault that occured when the mouth is open and a inspiration is taken either orally or nasally.

The observation, that when a T.M.J. dysfunction was present and had retraction of the jaw therapy localization positive (temporalis muscle). That when this was corrected it (the spindle of the temopralis muscle) it corrected the glabella fault.

Discussion:

This would mean that the reactive or positive muscle side was drawing the head of the mandible condyle up and back into the fossa locking the cranial movement into flexion at the sphenobasilar junction. This would cause the A to P dimension in a shortened position and the lateral dimension increased.

That when the spindle is treated on the involved temporalis this would allow for the return of the normal cranial respiratory movement and a more central position of the condyle in the fossa.

The mechanism of the positive respiratory challange that I believe causes the above mentioned phenomena of weakening a strong muscle on oral or nasal inspiration are the following:

1. On inspiration we cause flexion at the sphenobasilar junction and decrease on A to P measurements and a increase of lateral cranial dimensions.

2. On opening the mouth we activated two muscles the external pterygoideas and the diagastricus. If we study the origin and incertion we see that the external pyerygoid originates from the upper head from the infratemporal surface of the greater wing of the sphenoid. Lower head from the lateral surface of neck of mandibular condyle and capsule of mandibular joint.

2b. Digastricus origin posterior belly from mastoid notch of temporal bone; anterior belly from digastric fossa of mandible. Incertion both bellies by an intermediate muscle tendon which passes through incertion of stylohyoid muscle and is attached to side of body and greater cornu of hyoid bone by a fibrous loop.

3. Temporalis origin from the floor of temporal fossa and temporal fascia. Insertion the anerior border of coronoid process and anterior border of ramus of mandible.

Activation of the external pterygoid and the diagastricus causes additional flexion at the sphenobasilary junction. Imbalance of of the temporalis causes a locking of the sutural movements causing the cranial vault to be held in a decreased A to P dimension and a increased lateral dimension. All three of the above mentioned muscular factors and inspiration cause an overload at the sphenobasilary junction and a temporary C.S.F. flow change and the muscular weakness that is seen.

Bibilography:

1. Goodhear G.J., D.C.-Applied Kinesiology Work Shop Procedures Manual, 1977, 1978, 1979, 12, 13, 14 Editions, Private Publication.

2. Gray Arthur C., M.D. Anatomy Of The Human Body, Lea & Feibger Phil. 1965.

3. Kendall Henry, Dendall Florence, Wadsworth Gladys- Muscle Testing and Function, Second Edition, Williams & Wilkins Co. Publisher, Baltimore, Md. 1976.

4. Walther David, S. D.C., Applied Kinesiology-The Advanced Approach in Chiorpractic-Private Publication Second Ed. 1976

5. Warfel John, H., PhD. The Head, Neck And Trunk Muscles and Motor Points, Lea & Febiger, Publisher, Phil Pa. Forth Edition 1976.

A PROFILE OF THE T.M.J. PATIENT

By Paul T. Sprieser, B.S., D.C.

Abstract: The profile of the T.M.J. patient. A clinical look at the physical, structural, psychological aspects of patients with T.M.J. dysfunction.

My study consisted of fifty three patients with fefinite T.M.J. dysfunction symptoms. The distribution was fifty female, three male in this study.

The symptoms patterns varied, but the most common common complaints were headaches, jaw clicking, neck pain, shoulder pain and stiffness, sinus symptoms, dizziness, fatigue, ear aches, general stiffness, eye problems, low back pain. Out of this list of symptoms the most commonly occuring and universily found are: headaches, neck and shoulder stiffness and pain, facial pain.

The most predominant physical characteristic of the T.M.J. patient, and this must be based on the women in the study, because only three men were in the study.

1. Most of the woman were taller then average with an average hight of 5 Ft. 5 In. tall.

2. Age-The ages of these patient varied from twenty to fifty. The following is the break down by age 50-to-59(8), 40-to-49(25), 30-to-39(17), 20-to-29(3).

3. Weight-Most of the group were from average weight to thinner then average for their height. A high percentage were very thin.

4. Almost all could be classified into the ectomorphic or mesomorphic categories.

5. Personality-On a personality basis most were outgoing and friendly, and might appear to be very "happy-go-lucky" type of persons. However, on closer investigation, this is the face the patient will show to the public. Close observation showed a very intense person that holds his or her emotions in check.

6. Ethnic bacground-There is also an ethnic or national basis for the T.M.J. syndrome, with the greatest occurance found in persons from the (not necessarily in this order) English-Irish-Scotch-German and Scandinavian.

Conclusion:

There is a definite picture or profile that we can see, that will help us spot the T.M.J. patient perhaps even before we take the patients history.

SELF TESTING

By: John F. Thie, D.C.

ABSTRACT

A technique is presented on self-balancing showing that it is possible, by using the neurovascular points on the forehead, that the patient can become a surrogate for the doctor.

If an inhibited muscle is present in the doctor and not the patient, it can be shown on the patient by the doctor holding his/her neurovascular points while testing the patient.

If the muscle inhibition is present in the patient and not the doctor, the muscle on the patient will then show a facilitation while the doctor holds his own frontal eminences (the neurovascular points for the Pectoralis Major Clavicular/ emotion holding points).

INTRODUCTION

Two problems have faced the applied kinesiologist for a long time:

1. The doctor being a surrogate for the patient and having his muscle inhibition or strengths, showing up during the examination. This then, does not reveal the patients' true condition.

2. Many doctors do not have access to competent persons and are treating patients when they themselves are out of balance.

When I was discussing these problems with Gordon Stokes, Training Director for the Touch for Health Foundation, he said he knew of a way that he could balance himself using a class member as his own surrogate. He said he discovered this technique while explaining muscle testing to a class and found a weak muscle and then while re-testing the muscle to show the class, he accidently placed his hand on the frontal eminences while testing the student. The muscle was no longer inhibited. Because that surprised him, he took his hand off his forehead and the students muscle was returned to its original inhibited condition.

He and I further developed the technique and tested it until it could be incorporated into a self-testing method.

I decided to see if this was transferable to others and set up the program to research this at the 5th Annual Meeting of the Touch for Health Foundation at the University of San Diego, in June 1980. The instructions given at this meeting are attached in APPENDIX A. The form used to record the results is APPENDIX B.

The people participating are all experienced persons in using muscle testing. Many are certified Touch for Health instructors.

In addition to giving out the forms. I gave a demonstration of the technique and read over the form with the group. No supervision was given while each person did the testing, as the experiment was done over 5 days during the morning balancing sessions before the speakers' lectures.

RESULTS:

Eight-five different people participated in the test.

70 who did the test found at least one muscle inhibited on themselves, using the patient as a surrogate, which was not inhibited after utilizing the applied kinesiology basic techniques.

15 (17%) did not find any of the 14 test muscles weak on the surrogate when holding the frontal eminences.

6 (7%) found no inhibition on the fourteen test muscles on either the patient or themselves.

CONCLUSION:

This method seems to be worth further testing for usefulness in solving the two problems presented.

The doctor can balance him/herself prior to seeing the patient, even if no other qualified person is available. In cases where the doctor is not sure if he is transferring his own strength or weakness to the patient, this may be a way of checking on the validity of the test.

I will be happy to hear from others who are using Applied Kinesiology and will try this experiment on themselves and communicate the results to me.

John F. Thie, D.C.
1192 N. Lake Avenue
Pasadena, CA 91104

APPENDIX A

INSTRUCTIONS FOR SELF BALANCING USING SURROGATE PRINCIPLE EXPERIMENT

1. Ask your partner who you will balance to rate themselves a number 10, on how they presently feel. After you finish, you will again ask them to rate themselves. If they feel exactly the same the number will remain 10. If they feel better the number will be lower than 10 to a possible 0, which would mean they could feel no better. If they feel worse, they would rate themselves higher than 10 up to 20, which would be the worst they could possibly feel.

2. You now take an assessment of yourself and rate yourself with the same method.

3. Ask the question "Is there any reason I cannot test your muscles?"

4. Make the statement that if they feel at any time that the testing is not helpful or is hurting them too much and they cannot stand it without being concerned with it being harmful to themselves, tell them to say stop and you will immediately stop as you want them to be completely in charge of themselves and in control of the process.

5. Test the fourteen (14) indicator muscles for the fourteen (14) meridians. Write down the results using the following symbols
   (.) for the muscle being normal and locking strong
   (R) Indicating a weakness or inhibition of the muscle on the right
   (L) Indicating a weakness or inhibition of the muscle on the left
   (B) If the muscles were weak or inhibited on both sides
   (P) If there was pain caused by the test, which would be an indicator of that meridian being out of balance also.

6. Now you will retest the same fourteen (14) muscles, but this time using only one hand on the partner and with your other hand hold your own frontal eminence (neurovascular point 11). Write down the results. These results will indicate your own condition according to the observations we have made thus far. The muscles that remain weak when you are holding your frontal eminences indicate the muscles that are weak in common in both you and your partner. The muscles that remain strong are muscles that you have strong in common. The muscles that are weak that were not weak before indicate your own weaknesses that are not the same as your partner. Using the same symbols as in 5, mark your strong and weak muscles down in Column C - my own weaknesses.

7. Using only the basic class method of starting with the first muscle weakness you found on yourself, balance the energy flow by using first the Neurolymphatic massage point (NL), then challenge. If positive use the Neurovascular point (NV), rechallenge and if positive use the Meridian (M) tracing method, challenge. If positive challenge use the Origin/Insertion (O/I) technique and challenge. If positive challenge, use the acupuncture holding points. Place the following numbers in the box to indicate what was done to bring about a balance. 1 - NL; negative challenge; 2 - NL, NV, negative challenge; 3 - NL, NV, M, negative challenge; 4 - NL, NV, M, O/I, negative challenge; 5 - NL, NV, M, O/I, Acu. HP; 6 - failed to get strengthening response.

8. Check all muscles related to the meridian that the indicator muscle was related. Using the same technic of placing a (.) in the box under the balancing line indicating that no weakness was found. This will require you to go back to step (5), testing your partner in the usual TFH method and then step (6), for yourself.

   Remember that you are using the balancing technics on yourself and having your partner be the surrogate for you so the partner would be placing their hand on the challenge point on themselves, while you have your hand on your frontal eminences, while using the other hand for the test. The points that you cannot reach yourself, imagine that you are reaching them and doing what you would be doing if you could reach them and having that feeling that it would create if you were reaching them. This experiment is not the only way that this could be done, but for our observations to be more meaningful, we would like everyone who is participating in these observations to be doing them the same way.

9. Go to the next muscle that was indicated weak on you and retest the muscle. Do the appropriate technics the same as in steps (7) and (8). If the muscle is no longer an indicator, that is that it is not strong to test while you are holding your neurovascular point (11), put a (0) in the balancing column, indicating that no technic was used and it was strong on testing following the balancing of the previous muscle.

10. Now you, the TFH trained person, are balanced and in the most appropriate place to re-rate yourself. So, do so and put it down. Under 10 - you feel better; 10 - you feel exactly the same; over 10 you feel less good.

11. Now balance your partner using the usual TFH technics, putting down the technics used to balance as in step (7).

12. Ask your partner to rate themselves and write that down.

13. Write down any comments on this procedure and any additional observations.

SELF BALANCING DATA SHEET

DATE: _____

MY NAME _____ PARTNER'S NAME _____

RATING: Before _____ After _____ RATING: Before _____ After _____

INDICATOR MUSCLES

		PARTNER TECH. USED		MYSELF TECH. USED						PARTNER TECH. USED		MYSELF TECH. USED						
		A	B	C	D	E	F	G	H	A	B	C	D	E	F	G	H	
1. SUPRASPINATUS/Central	33																	
2. TERES MAJOR/Governing	35																	
3. PECT. MAJOR CLAVICULAR	37																	LEVATOR SCAPULAI
/Stomach																		NECK MUSCLES
																		BRACHIORADIALIS
4. LATISSIMUS DORSI/Spleen	45																	TRAPEZIUS
																		TRICEPS
																		OPP. POLL. LONGUS
5. SUBSCAPULARIS/Heart	53																	
6. QUADRICEPS/Sm. Intestine	55																	ABDOMINALS
7. ANTERIOR TIBIALS /Bladder	59																	SACROSPINALIS
																		PERONEUS
8. PSOAS/Kidney	65																	UPPER TRAPEZIUS
																		ILIACUS
9. GLUTEUS MEDIUS/Circ-Sex	71																	ADDUCTORS
																		PIRIFORMIS
																		GLUTEUS MAXIMUS
10. TERES MINOR/Triple Warmer	79																	SARTORIUS
																		GRACILIS
																		SOLEUS
																		GASTROCNEMIUS
11. ANTERIOR DELTOID/Gall Bladder	89																	POPLITEUS
12. PECT. MAJOR STERNAL/Liver	93																	RHOMBOIDS
13. DELTOIDS /Lung	97																	CORACOBRACHIALIS
																		ANTERIOR SERRATUS
																		DIAPHRAGM
14. FASCIA LATA/Lg. Intestine	105																	HAMSTRINGS
																		QUAD LUMBORUM

CODES TO BE USED

(.) No weakness found

If weak:

R - Right

L - Left

B - Both

P - Pain found on test

TECHNIC CODES USED

0 - Retest found strong

1 - NL only

2 - NL, NV

3 - NL, NV, M

4 - NL, NV, M, O/I

5 - NL, NV, M, O/I,

6 - Muscle failed to respond

ADVANCES IN APPLIED KINESIOLOGY

Table of Contents

Submitted to the I.C.A.K. on
August 10, 1980 for further
testing by Daniel P. Towle

I would like to thank my Mentors for their patient guiding help, my group of proofers and all those that kindly submitted to the experiments now enclosed in this paper. It is to you that this paper is dedicated.

D.T.

Energy Systems

In the Applied Kinesiology Manual, Dr. D. Walther relates this fascinating piece of information:[1] "Shafica Karagulla, a psychiatrist and neuro-anatomist, has been a pioneer in her evaluation of individuals who have higher sense perception. Many of the individuals Karagulla has studied can see energy fields around people. Quoting Karagulla: 'It is the other things that Diana 'sees' which continue to fascinate me. She observes a 'vital or energy body or field' which sub-stands the dense physical body, interpenetrating it like a sparkling web of light beams. This web of light frequencies is in constant movement and apparently looks somewhat like the lines of light on a television screen when a picture is not in focus. This energy body extends in and through the dense physical body and for an inch or two beyond the body and is a replica of the physical body. She insists that any disturbance in the physical structure itself is preceded and later accompanied by disturbances in this energy body or field. Within this energy body or pattern of frequencies she observes 8 major vortices of force and many smaller vortices. As she describes it, energy moves in and out of these vortices which look like spiral cones. Seven of these major vortices are directly related to any pathology in the physical body in their general area . . .

"Five of these macro-vortices are located in a line along the spine. There is one at the base of the spine, one approximately midway between the pubic bone and the navel, one at the navel, one at the level of the midsternum near the heart area and one near the larynx or adams apple. There is another

macro-vertex on the left side of the body in the area of the spleen and pancreas. This one does not seem to be connected with the spinal pattern of vortices. There are two other macro-vortices, one approximately where the eyebrows meet, and one at the top of the head. There is a ninth smaller vortex at the back of the head in the vicinity of the medulla oblongata."

The description given above and the results obtained using the information presented in this paper clearly suggest that what Applied Kinesiology can treat is, in fact, the energy body. If the disturbances can be corrected early enough, then the physical manifestation of the problem will not occur. If it has occurred, then the situation will be corrected most quickly and efficiently by first treating the energy body. Once the energy body has been properly treated, the physical body will again reflect its characteristic vital forces and return to a healthy state.

Scientific advances in the field of observing and understanding the energy body took leaps forward with the work of many researchers, most notably the Kirlians. They found that it is possible to photograph the bioplasmic (energy body) fields that surrounds all plants, animals and humans. In an article written by Kirlians, this bioplasmic field is described as "electrons and ions of the discharge flux in motion . . . This electronic structure is not constant, since it depends on the condition of the organism . . . (and) by studying the geometric shapes, their spectra, and the dynamics of their development, it is apparently possible to judge

the biological (including pathological) state of an organism."[2]

Dr. Inyushin, another Russian researcher, has written: "The bioluminescence visible in the Kirlian pictures is caused by the bioplasm, not the electrical state of the organism . . . This bioplasm is not a chaotic system; it has specific spatial organizations." He states that this includes ionized electrons, photons and other particles which are capable of being environmentally influenced by such things as thunderstorms, different colors of light, or highly charged atmosphere disturbances.[3]

The bioplasmic field and the specific locations of its generation are what the psychic "sees" when viewing an active human being. The energy produced by man, who is an electromagnetic, biomagnectic animal, is similar to the energy found in a magnet. In addition, it is technologically feasible to photograph bioplasmic fields, and also to note the color changes in them. Dr. Thelma Moss, from the UCLA Neuropsychiatric Institute has found that all natural healers can control these biomagnetic waves. Their control extends even to the point of changing colors by utilizing different energy wave lengths to suit the needs of their patients! This paper proposes methods to move, eliminate, balance or vary human energies, which can result in better health for our patients, and an improved understanding of the human body.

Centering

Centering will be the general term used in this discussion for the proper disposition of the bodily bioplasmic fields. Dr. Sheldon Deal, of the Swan Clinic of Chiropractic and Naturopathic Medicine, presented a seminar in Chicago where he des-

cribed the cloacal response. Physically it entails two sets of muscles which are constantly interacting, those in the pelvis and those in the head/neck region. There are three sets of reflexes associated with these muscles. They are the vestigal sex reflex, the tonic righting reflex, and the tonic labyrinthine reflex. Dr. Goodheart relates these to the "automatic pilot" of the body, since they are responsible for maintaining homeostatic head (more specifically, the eyes and balance mechanisms) position with respect to the pelvis.

These reflexes can be therapy localized with any strong indicator muscle (SIM) at the supraorbital notch (righting reflex), pubic symphysis (vestigal sex reflex) in the anterior division, and the mastoid (labyrinthine reflex), sacroilliac junction (vestigal sex reflex) in the posterior division. All of the pelvic points are found approximately 2 inches, either right or left, from the midline of the body. Once found with therapy localization (TL), they can be corrected physically by determining the direction of motion that causes weakness with the phase of respiration of strength. This can be done unilaterally or bilaterally. A moments reflection will reveal that there are 8 cloacals, 4 anterior and 4 posterior. In the anterior division, two will run vertically. They course from the right supraorbital notch (SON) to the right pubic symphysis, and from the left SON to the left pubic symphysis. The two remaining are crossed and run from the right SON to the left pubic symphysis (PS), and from the left SON to the right PS. The same is true for the posterior division, except that the TL points are located in the mastoid and at the sacrailliac junction.

Dr. Deal related a sequence of muscle tests, which can be used to determine which of these reflexes are out of order. They are quite similar to the gait testing mechanisms, and indeed are intimately related to it.

The anterior division can be tested by using contralateral forward arm and leg on each side. The supine patient flexes the hip, keeping the knee extended, and at the same time the shoulder is flexed with the elbow extended. The doctor directs his line of force to approximate the arm and leg, This should also be done ipsilaterally to both sides giving a total of 4 tests anterior. This yields information in the following manner. If the right arm-left leg combination were weak, this would indicate the right side of the righting reflex and the left side of the vestigal sex reflex were not functioning normally. These disorders will <u>always</u> be paired in this fashion.

The posterior division is tested similarly. The important difference is that the doctor will pull the two limbs apart, instead of approximating them. If the left labyrinthine reflex and the left vestigal sex reflex were not operating efficiently, one would expect to see the left arm - left leg combination, when tested, to show weakness. There is no direct interaction between these two divisions, hence there is no reason to check the posterior cloacals against the anterior cloacals.

Dr. Deal also presented a quick screening method to determine whether a patient is uncentered. Anything that shocks the body, such as a gentle slap to the leg, in conjunction with a SIM going weak, is sufficient to demonstrate a misalignment of the cloacals, If a SIM remained strong, it would show that the nervous integration of the body was efficient enough to react

to, and compensate for, the shock applied to the body quicker than it could be tested for. Obviously, the body's integration would be slower if the energy fields were not aligned properly, thus showing a SIM going weak results.

Dr. Deal's method of repairing the cloacals is to find the pair of cloacals which are not functioning normally. Using a two finger contact at each point, the doctor maintains contact until a synchronized pulse point is felt in both sets of fingers. The procedure is similar to that utilized when a neurovascular point is repaired. This method is often slower than the physical adjustment, but is more effective and will hold better, again because the treatment was to the bioplasmic field and not just the body. In other words, the doctor can be considered a "jumper cable", pulling the field back into alignment.

Actually the bioplasmic field is not a straight line from the head to the pelvis. It is a twisting coil which winds down the body making contacts at several points. The contact points are the frontal orbital protberances, symphysis menti, sternal notch, xiphoid process, umbilicus and the pubic symphysis. Superimposed on Goodhearts pre- and post-ganglionic points,[1] a correlation can be made between systems. If the centering has been done correctly, no pre- or post-ganglionic problems will remain. Also, centering will automatically unswitch all patients. This phenomenon occurs due to the restoration of correct distribution of the nervous flow to all parts of the body.

In a series of private communications,[5] a new sequence of tests were developed for the same reflexes. Instead of challenging the body with a light slap, another quick screening

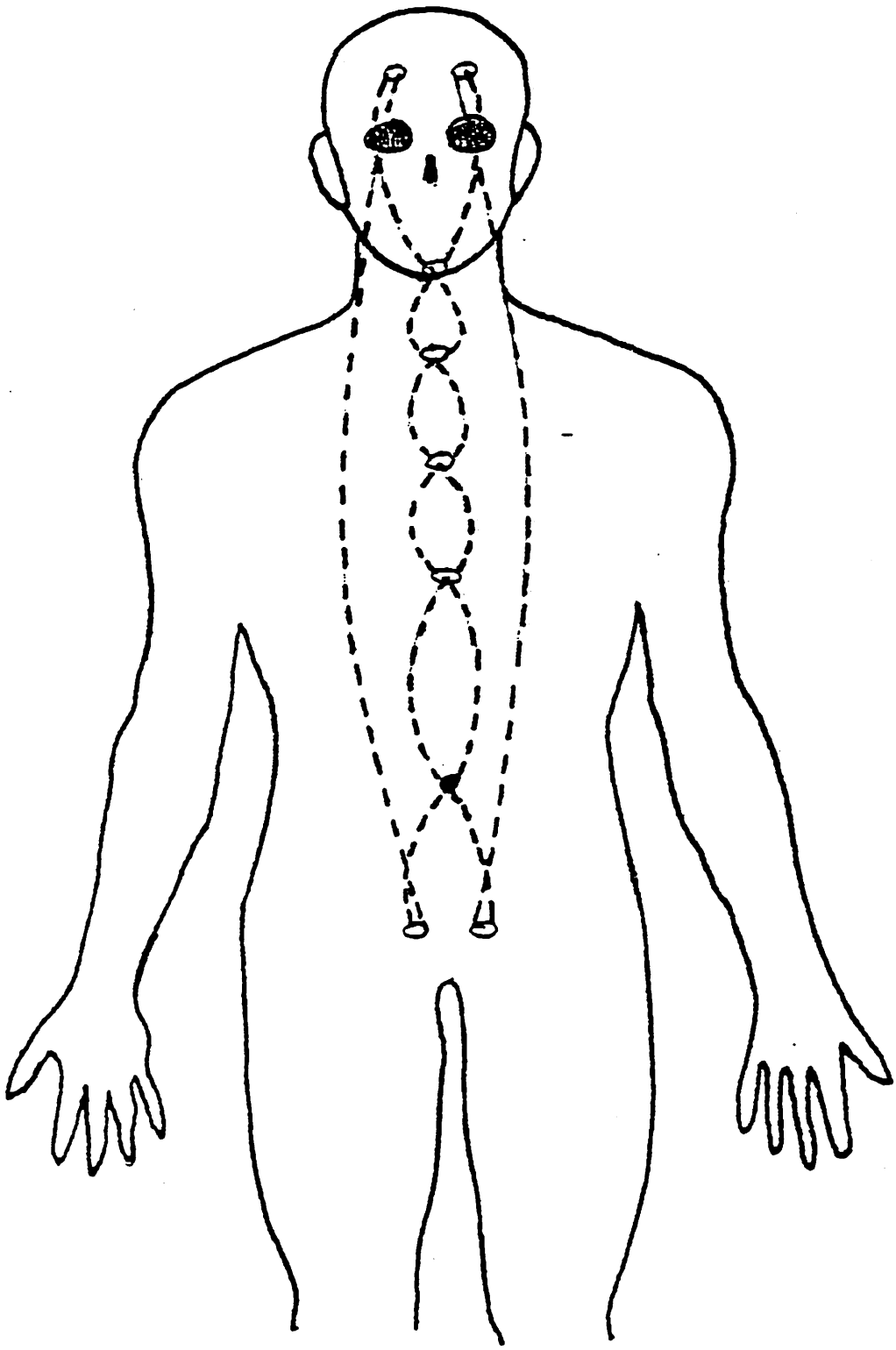
DIAGRAMMATIC FRONTAL VIEW OF THE CLOACALS

POSTERIOR

1) mastoids
2) level of C-5
3) level of T-2
4) level of T-10
5) level of L-4
6) SI joints

ANTERIOR

1) frontal protuberances
2) symphysis menti
3) sternal notch
4) xiphoid precess
5) umbilicus
6) pubic symphysis



method can be utilized. Three fingers are used in a 1-2-3 drumming motion on the patients forehead, directly between the two eyebrows. If the patient is uncentered, any SIM will be weak. Using an occular locking mechanism, an uncentered patient can be quickly diagnosed as to which cloacals are misaligned. The patient is instructed to look down to the feet using eye movement only. If a SIM becomes weak, then one or more of the cloacals in the anterior division are involved. If the patient looks up to the top of his head, and a SIM goes weak, cloacals of the posterior division are not functioning normally. Casting the eyes left or right will yield information concerning the perspective side.

Once the affected side and division are known, the patient places two fingers on the SON of the involved side while maintaining handedness (i.e. left hand to left SON contact). Next, have the patient look to the left while testing a SIM. If it remains strong, then have the patient look right, again using only the eyes and not the head. If a SIM goes weak, then the left righting reflex and the right vestigal sex reflex are misaligned. The finger contact used "ties into" the cloacal while the eye movements determine which part of the pelvis is affected. The same test can be used by having the patient touch two fingers to the mastoid and looking right or left to determine which of the posterior divisions are involved.

Taking an uncentered patient, for example, if a SIM of a patient remains strong as he casts his eyes to the left, it would indicate that the four cloacals originating from the head (2 from the SON and 2 from the mastoid) on the left side were in order. The next test has the patient look right, re-

sulting in a SIM going weak. This indicates that one or more cloacals are affected on the right side. If the patient then looks up and a SIM goes weak, the posterior division is also involved, Have the patient place two fingers on the right mastoid and look to the left (SIM remains strong), then to the right. Weakness of the SIM as the patient looks right indicates the cloacal of interest is the right mastoid to the right SI junction. Having the patient TL the SON on the right side will yield the same type of information for the anterior division. Recheck by testing for centering. Experience shows the anterior cloacals to be more important and more commonly out of order. It should be noted that no harm can be done if you accidently "overcenter" someone by using unnecessary points.

Initially, when someone is centered for the first time, the centering will not hold very long. The body resets the cloacals back to their original condition, since it is accustomed to this orientation. A small stimulus, such as fasting or fatigue, could be sufficient to cause the cloacals to uncenter. Normally, the longer a patient remains centered, the more difficult it is to uncenter him. It may be necessary to center some patients twice while in your office and several times a week there after. You will notice, for example, 7 cloacals out when your patient walks in. If you recheck before he leaves, you may treat 3 of them again. This can be treated in the office and the patient can be taught to center himself. Have the patient do this 2 to 3 times daily for awhile. Next time in your office, you can check again.

As previously mentioned, the longer a person is centered, the more difficult it is to be uncentered. However, severe trauma, extreme emotional upset, or certain physical stimulus can change

this. Using X-rays will not only uncenter all 8 cloacals totally, but you probably will not find a strong muscle left anywhere. In a case like this, centering will undo a lot of the damage to the body, and it will restore strength to the muscles. Hence, X-rays should be used very sparingly since the damage to the bioplasmic field is rather severe. In addition, if left uncorrected, this condition can lead to many harmful physical effects later on.

The primary advantages to centering all of your patients is that: a) they will all be unswitched without needing them to cross crawl extensively, b) as Dr. Goodheart noted with the pre- and post-ganglionics, certain corrections will hold better, and c) later you can precenter them, a process that will be explained in depth later, which involves the master cloacals. The precentering has been successfully used to eliminate some neurological damage due to trauma or birth defects, such as dyslexia and schizophrenia (with nutritional help).

It should be noted that it is possible for a person to be uncentered and <u>not</u> switched simultaneously; however, if they are switched, then they must be uncentered.

Dr. Deal had suggested to us that with the centering other factors should be checked also. One was the hyoid, which, if out of line, could be corrected using origin-insertion and golgi tendon organ work on the muscles of the hyoid. Another factor to consider was the gait mechanism. Ordinarily, a sequence of contralateral muscle tests are used to determine if the gait is not functioning normally.

A quick screening method for gait is to have the patient lie prone. Using the hamstring muscles, take a two finger contact

at the anterior aspect of the heel, directly in line with an imaginary line dropped from the center of both malleoli. Apply 4 to 7 Kg. of pressure and test the SIM. If weak, then one or more of the gait mechanisms are involved. Instead of tracking down which gait is abnormal, 15 to 20 seconds rubbing of this same test point with 10 to 15 Kg. of pressure will clear all of the gaits on the involved side.

Many times this point will appear as a trigger point and should be treated accordingly until it is cleared out. The trigger point is one of the manifestations of an energy block to an area as it appears on the physical body. Often it may be useful to instruct patients to rub this point 2 to 3 seconds before putting shoes on and when taking them off. This will reinforce the correction, often eliminating the general fatigue a patient feels after walking/standing for an extended period of time. This is always a good thing to recommend to runners.

Often there is a hidden cranial fault present, which will not show up in a general screening for cranial faults. Dr. Goodheart recommends[4] having the patient dorsiflex one foot and plantar flex the other foot. With a SIM going weak, a sphenobasilar flexion or extension fault is indicated. He also states that if left uncorrected, this fault will interfere with the effective correction of stress receptors. Personal experience has shown that gait and hidden cranial faults can screen some, or all, categories, fixations, and other cranial faults until they are repaired.

Precentering

Precentering was the term adopted for the correct alignment of the master cloacals, which are found only in the head region. Of the several dozen of these that have been discovered, there are 6-8 very predominant ones which will be emphasized. Some of these were discovered and related in a series of private communications[5], and were later expanded on as the need arose. They were found to be vital for the overall centering mechanisms of the body and in many cases the patient must be precentered before being successfully centered.

The general screening mechanism is again related to the occular locking mechanism. Have the patient move his eyes so that they are looking up to the top of his head. The doctor taps the forehead 3 or 4 times and then checks any SIM. If weakness ensues, then the patient has one or more of the master cloacals misaligned. It should be noted that in many cases a patient will not test positive for the need of centering. This indicates that either the person is centered or that his centering problem is buried under the need for precentering. A person can be centered and not precentered simultaneously, therefore, a check for precentering must initially accompany the test for centering.

Once a person is precentered, the procedure should not need to be repeated. It would take an extreme trauma to the head region to disrupt the energy pattern flow. When a person is initially precentered, whether he is centered or not at the time, he will become uncentered. This always involves at least one anterior cloacal (acute) and possibly several others, either anterior or posterior. These can be repaired immediately, yielding a patient that is as fully "centered" as we know it.

Precentering is a more difficult process than centering, since the energy polarities vary from person to person, and they vary from point to point on the head. Therfore, each set or points has to be tested individually. The correcting procedure requires the proper polarity of the points and this is most easily accomplished by: 1) have the patient TL the points in question using the thumb (neutral contact) and the index finger of the left hand (negative contact, see acupuncture section for a full explanation). The SIM remains strong. 2) have the patient switch the index finger with the middle finger (now a positive contact) and recheck the muscle. If the SIM is weak, then this master cloacal can be corrected by having the doctor take positive contacts on the two points. In this case, using the middle finger of the left hand and the index finger of the right hand on the other side. This contact is held until the pulse is felt in the manner of correcting a neurovascular point.

If the muscle remained strong on both of these tests, then those points are in the clear and can be bypassed. The entire precentering procedure should be done following the priority sequence of the body (see section on priorities).

There is also a nutritional component that can be checked and seems to be always indicated if five or more of the master cloacals are misaligned. Have the patient bilaterally TL the temples and check any SIM. If weak, this shows the need for Neurotrophin (Standard Process Labs). This combination has proven valuable in eliminating dyslesia, lack of coordination, and can remove some resistance to other corrections that are being done on the patient.

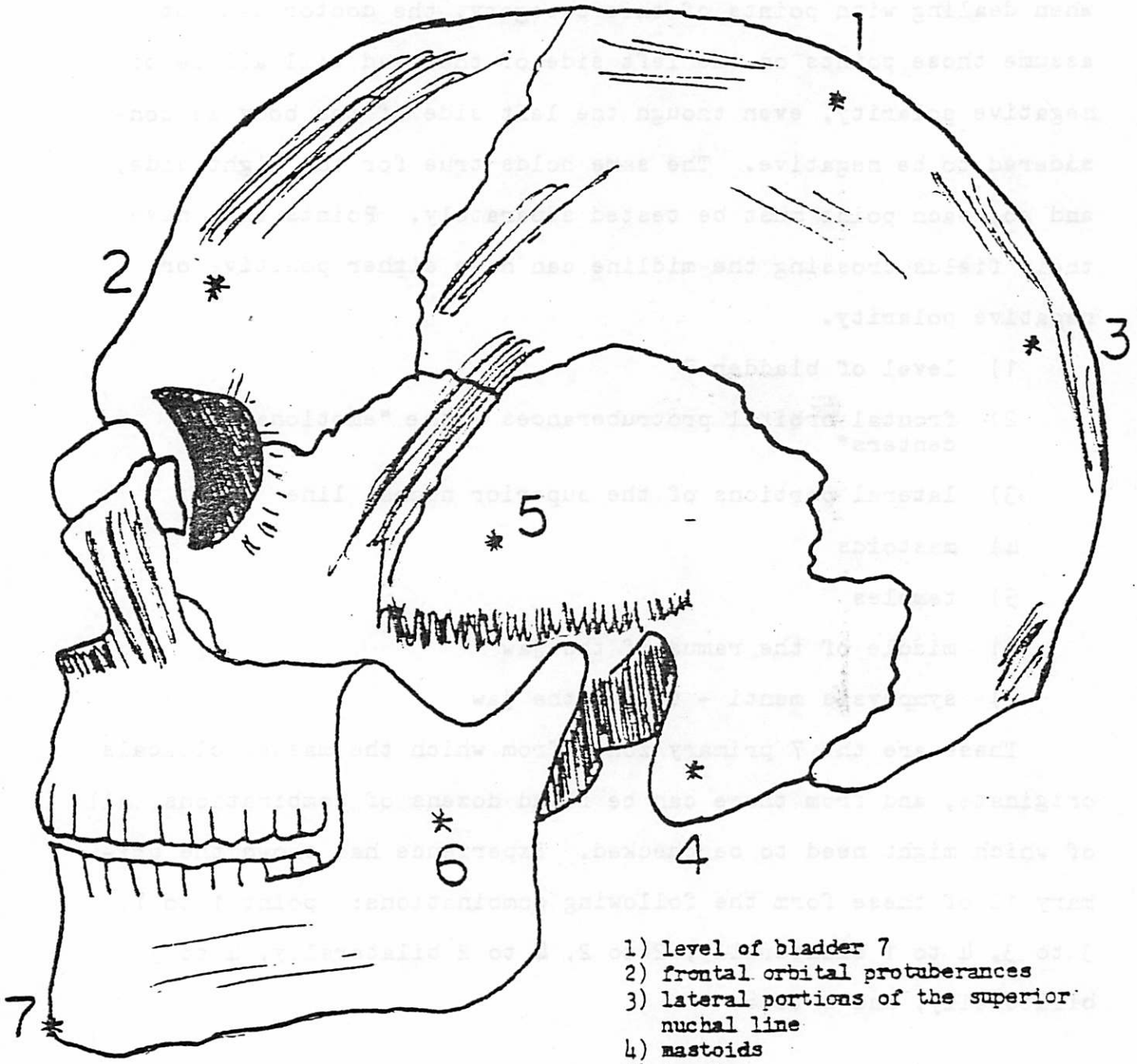
A list of the major points follows and these can also be

on the charts. If both points are located on the same one side of the head, experience shows that the same two will be misaligned on the other side and they will always be of opposite polarity. When dealing with points of this category, the doctor can not assume those points on the left side of the head will all be of negative polarity, even though the left side of the body is considered to be negative. The same holds true for the right side, and so, each point must be tested separately. Points that have their fields crossing the midline can have either positive or negative polarity.

1) level of bladder 7
2) frontal orbital protruberances - the "emotional centers"
3) lateral portions of the superior nuchal line
4) mastoids
5) temples
6) middle of the ramus of the jaw
7) symphysis menti - tip of the jaw

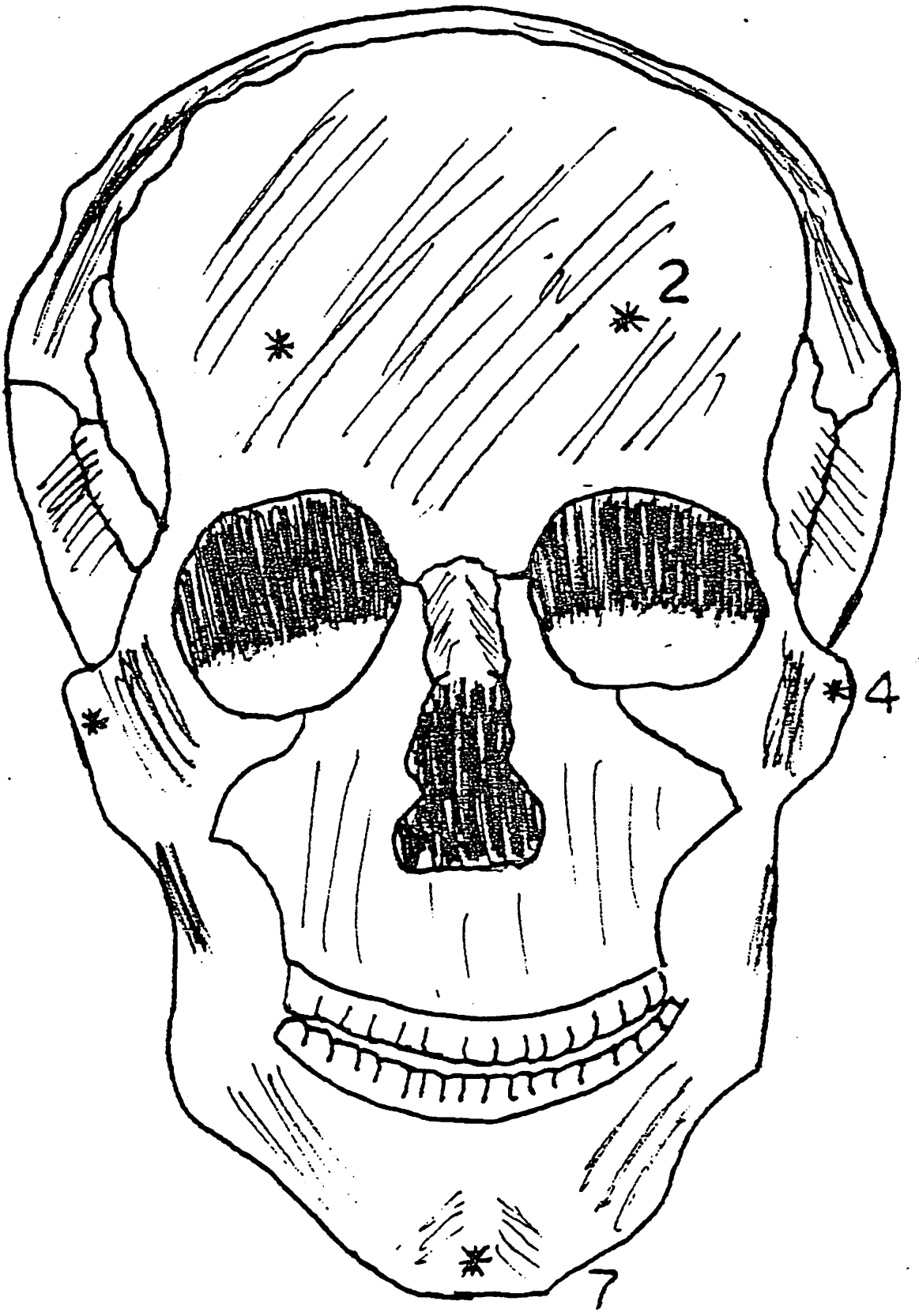
These are the 7 primary zones from which the master cloacals originate, and from these can be found dozens of combinations, all of which might need to be checked. Experience has shown the primary 10 of these form the following combinations: point 1 to 1, 3 to 3, 4 to 1 bilaterally, 2 to 2, 4 to 2 bilaterally, 4 to 3 bilaterally, and 6 to 6.

DIAGRAMMATIC LATERAL VIEW OF THE MASTER CLOACALS

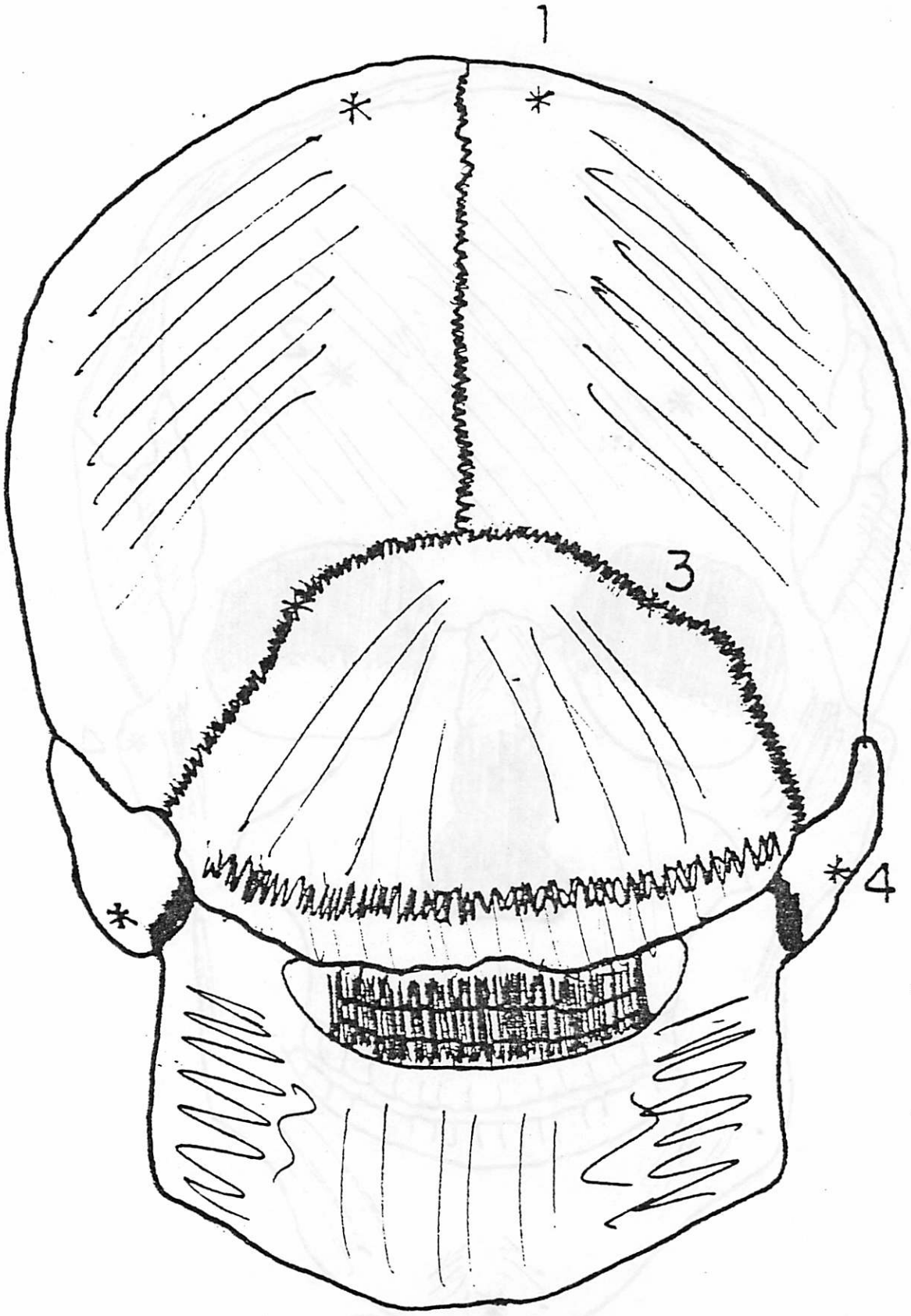


1) level of bladder 7
2) frontal orbital protuberances
3) lateral portions of the superior nuchal line
4) mastoids
5) temples
6) center of the ramus of the jaw
7) symphysis menti

DIAGRAMMATIC FRONTAL VIEW OF THE MASTER CLOACALS



DIAGRAMMATIC POSTERIOR VIEW OF THE MASTER CLOACALS



Acupuncture Therapy

Since we are constantly dealing with energy, the acupuncture systems must be considered as playing a very large part in patient health and welfare. Dr. Felix Mann, founder of the Medical Acupuncture Society in Great Britian, gives this comparison: "From the point of view of Western medicine, disease ensues when the biochemical processes of the body are disturbed. If, for example, there is a deficiency of potassium, the body chemistry is altered and the patient has, among other symptoms, little energy. The energy can not be measured directly; only its secondary effect in reducing muscular activity can be measured.

The Oriental doctor considers energy as something primary and 'real', whose deficiency (or excess) causes disease. The Occidental doctors think the chemistry of the body, which only secondarily effects energy, is primary. Textbooks of physiology do not mention the conception of biological energy as something primary."[6] While these two points of view appear to be contradictory, they are in reality looking at life from two very different points of view.

As with every kind of energy we know of, for every positive charge, there is a negative charge to balance it. For every north pole in existance, there must be an equivalent south pole generated. For every yin there is a yang. One can not exist without the other. This same concept also holds true for the human body, half of it is positive and the other half is negative. The dividing line lies down the midline of the body with a narrow neutral zone between them. The size of this neutral zone varies on each person, but whether they are right or left handed, the right side is always positive and the left negative.

The polarities of the hands and fingers are unique and require a special note. Moving down the right arm to the palm or surface of the hand, it is found to be positive as is the right index finger. The dorsum of the hand, however, is negative, as is the right middle finger. The fingers continue to alternate polarities, the right ring finger being positive and the little finger being negative. The thumb is considered to be completely neutral. The left hand is the exact opposite. Since the polarities of the fingers do alternate, it can readily be seen why, in most cases, that the TL is with two fingers.

Magnetic properties of the body have been proven scientifically[7], and can easily be demonstrated kinesiologically with a magnet. The north pole is negative and the south pole is positive, and the appropriate muscle tests will indicate this. This is very important in meridian therapy, since each person stores either positive or negative energy in their meridians. Also, the doctor must know the polarity of a meridian if he intends to open or close it. In addition, the energy stored within the cloacals have the opposite polarity, thus maintaining the charge balance of the body.

The test for any meridian abnormalities, over or under, involves having the patient place two fingers on the umbilicus and checking a SIM. If weak, have the patient use one finger at a time. The finger (polarity) that causes weakness in the SIM will be the polarity of the meridains involved. For example, if the SIM goes weak when applying the right middle finger, the polarity of all the meridians is negative. The number of affected meridians can be ascertained by tapping the umbilicus, once for each

meridian involved. For example, two taps would show two meridians unbalanced, they could either be both over, or one over and one under. The tap test simply indicates how many meridians are involved, not what condition they are in.

If we have a patient with two unbalanced meridians, by using the finger of appropriate polarity and checking the six sets of pulse points with a SIM, we can determine which meridians are over. If you apply two fingers of the same polarity to the pulse points, you can determine which meridians are under.

Under meridians can not exist without a corresponding over meridian. Thus, if the appropriate corrections are made, knowing which one is under is af academic interest, since it will be restored to balance with the energy from the over meridian. It should be noted that over meridians can exist by themselves, and are indeed the major source of problems that you will encounter.

The meridians that are over can be clarified by having the patient TL to the appropriate alarm points. Again, under meridians can be tested by having the patient take a double TL, using two fingers of identical polarity, to the alarm point. Once the over meridians are known, they can be opened and the excess energy removed or used to balance the under meridians. The known meridian relationships are listed below.

LU - SI	K - SP
Cx - SI	LV - ST
H - TH	B - GB
LI - TH	CV - GV

If one meridian is over, it will occur alone, or be involved with its paired meridian, which would appear under.

The meridians can be opened by running them backwards (high # to low #) using the finger of appropriate polarity. The tracing finger should contact the body or be within an inch of it. This must be done bilaterally when possible. This "unzipping" motion need only be done with the over meridians, if an under meridian is associated with it, it is automatically taken care of.

With the meridian open, have the patient TL to CV-24, if a SIM goes weak, then there is too much energy in the meridian. Conception vessel-24 is the point that would be stimulated to remove this excess energy. If a SIM remains strong, have the patient TL to the pubic symphysis (CV-2), this is the balancing point. Stimulation here will balance intra- and inter-meridianally, therefore taking care of the under meridians. If the previously SIM is weak at CV-2, then balancing and removing the excess energy is necessary. Excess energy must still be removed, even during the balancing process, since there will invariably be a greater surplus of energy available than is needed to restore the under meridian to normal function.

The best way to "tap" (remove excess energy) a meridian is for the doctor to rub (3 - 5 Kg pressure) CV-24. If a great deal of energy is present, the doctor will notice an odd sensation which may be described as a "creeping paralysis" moving up his arm as he acts to ground out the excess energy. Having the patient rub this point will accomplish nothing, since the patient just completes a circuit and the energy is withheld in the system. When the doctor notices this feeling in his arm beginning to abate, the meridian is "tapped out". If in doubt, have the patient relocalize to

CV-24 and check a SIM. Certain meridians need to be closed after "tapping" them, others close automatically when the surplus energy is eliminated. They are:

OPEN and CLOSE		OPEN only	
Cx	SP	LU	LI
H	ST	SI	B
K	GB	TH	LV

The balancing process can be accomplished by opening the meridians as stated above, then have the patient take a double TL to the pubic symphysis just off the center line to each side. The patient rubs these two points vigorously while the doctor rubs CV-24 until he feels the meridian is drained. This is the procedure for a bilaterally over meridian which is the only kind that will appear when the umbilicus is localized. A unilateral meridian would be best treated using the stimulation or sedation points on the involved side. It is important to remember that a patient should always be checked for switching first. This is done because switching will cause a unilaterally affected meridian to appear on the opposite side. In addition, the meridian must be run in the opposite direction (low # to high #) to be opened when switching is present. Switching will not affect the polarity of the meridian however.

The two center line meridians, the conception vessel and the governing vessel are very unique and do not follow the aforementioned relationships. Therefore these techniques should <u>not</u> be utilized to treat them.

There is a limit as to the number of meridians that should be treated at any given time. This is, of course, dependant on the patients constitution. A suggested guideline for most patients is

to treat three meridians/day with a three day waiting period between treatments. If time allows, a more complete treatment of the meridian can be used:

1) tap and balance the meridian - leave it open

2) check the alarm point for the overs, if a SIM becomes weak then treat the connecting point.

3) treat the tonification point

4) treat the auricular points if necessary

5) check the associated points for subluxations

6) close the meridian if necessary

The previously mentioned tapping and/or balancing proceedure is a short term treatment that will alleviate the patient's immediate symptoms and will restabilize a meridian which was previously overloaded. This "short treatment" doesn't do the whole job, and the full treatment should be taken care of as soon as possible.

Whenever the acupuncture meridians are "tapped" in this fashion, the energy will quickly shift from a region of high concentration to a lower one, in this case, the doctor. Therefore, care should be taken to thoroughly wash your hands after using this technique. In effect, this simple act will "ground out" the doctor by washing the excess energy down the drain. If a little time is taken to let the water run over your wrists and hands, the majority of the excess energy will be efficiently removed from your system.

Each person has a certain resevoir for excess energy which is filled very quickly by the patients energy as he is "tapped out". This results in the doctor carrying too much energy within himself. In order to maintain these large amounts of energy safely in the

doctors body, he must expend his own energy. Therefore, if the excess energy is not quickly eliminated, it can cause extreme fatique due to the energy drain on the doctor. It is possible to increase this resevoir however, and therefore tolerance to this kind of uncontrolled energy will also increase. It simply takes time and practise in the beginning. Some practitioners will probably find it much easier if they only treat one patient in this fashion per day. Gradually the doctor will increase his tolerance until he can treat as many patients as he likes with no ill effects to himself.

Clinically this therapy can be applied to many common problems and will aid in the treatments of others. For example, a hiatal hernia is always caused by an excess of energy in the SI meridian. If this meridian is "tapped" and balanced properly, the hernia will correct itself with no manual techniques used. Diaphragm problems are easily linked to excess energy in the lung meridian, but on some occasions, the standard means of correction may be required. However, applying both acupuncture and the manual techniques results in a more effective treatment. Constipation is related to the LI meridian, as well as the ICV. Edemas frequently respond to treatments of the Cx-Sex meridian, often with a dramatic clearing of the swelling. Whenever there is a sprain or excessive strain in a limited region, there could be an unbalanced Cx-Sex meridian. If left untreated, this could cause related muscle weakness. In case of flu or colds, or swollen glands (including tonsils), many people have problems with the Spleen-Pancreas meridian. Treating these meridians won't cure these self-limiting diseases, but does seem to improve healing time with reestablishment of energy flow to a

primary immunologic center.

When galvinism is used on a patient, great care should be taken to check his meridians after the galvinism treatment. Passing a current through the body often does much harm to the bioplasmic field. This damage can appear as weakness of the muscles on the side galvinism was applied to. In addition, uncentering the patient or the overloading of several meridians may result. If possible, galvinism should be avoided. This allows the body to heal according to its own pace, which when properly treated with the five factors, usually is very rapid. It seems unreasonable to cause excessive [illegible] stress on the whole system in the name of speeding the healing time in a limited region.

Included in table one are the correlations between the muscles, organ systems, meridians, neurolymphatic points, and the specific acupuncture points related to the NL points. Each of the NL points can be treated identically to an under accupuncture point. In addition, organ systems can be stimulated or sedated by using all of the accupuncture points listed within a system.

A general screening method for determining problems relating to [illegible] stimulation or sedation of the meridians has evolved from the alarm points. Have the patient TL to the umbilicus and to the alarm point for the governing vessel. If a SIM becomes weak, then there exists one or more meridians which must be stimulated or sedated. To determine the number of meridians affected, have the patient maintain the TL on the umbilicus while the doctor taps the alarm point for the governing vessel. The number of taps that causes a SIM to weaken indicates how many meridians must be stimulated or sedated.

The specific meridian involved can be ascertained by having the patient TL to the umbilicus and to the alarm point of the meridian in question. If a SIM becomes weak, then that meridian should be treated after further testing to determine whether the stimulation or sedation point should be used. The general screen can then be repeated as necessary.

Occasionally an entire meridian must be cleared out point by point, as compared to the gross technique already described using tapping and balancing techniques. This has been very useful in pain control across joints that still present pain after all the sublux-ations and ligament interlink problems have been dealt with. What appears to happen is the acu-energy pools at certain points in the meridian. These pools are very painful and can manifest as trigger points, but even if they don't, these "pools" of energy are able to disrupt normal musculo-skeletal functions in a limited area. To test for this, have the patient TL to the umbilicus and to the stimulation point of the meridian running across the joint involved. For example, check the lung meridian for the shoulder. Once the meridian is known start at the distal end of the extremity and vigorously rub each point moving proximally up the limb. Certain points are liable to be extremely tender for the patient. If pain persists in the joint, check the other meridians at that joint, as well as rechecking the ligament interlink for any previously hidden problems.

TABLE 1

Related Muscles	ML Locations[8]	ACU	Meridian
ADRENALS			
Sartorius	2" S. and 1" L. to the umbilicus	S-24	Cx-Sex
	11 - 12 D near lamina	B-19	
Gracilis	2" S. and 1" L. to the umbilicus	S-24	Cx-Sex
	11 - 12 D near the lamina	B-19	
Post. Tibialis	2" S. and 1" L. to the umbilicus	S-24	Cx-Sex
	11 - 12 D near the lamina	B-19	
Gastrocnemius	2" S. and 1" L. to the umbilicus	S-24	Cx-Sex
	11 - 12 D near the lamina	B-19	
Soleus	2" S. and 1" L. to the umbilicus	S-24	Cx-Sex
	11 - 12 D near the lamina	B-19	
Points related to the adrenals: S-24, B-19			
KIDNEY			
Quadriceps	8 - 11 costochondral junction	GB-24	SI
	8 - 11 Dorsal	B-20	
Psoas-Iliacus	1" S. and 1" L. to the umbilicus	S-25	Kidney
	12D and L1 between the SP and TP	none	
Points related to the kidneys: GB-24, B-20, S-25			
SPLEEN			
Flexor Hallicus Longus	Inferior to the symphysis pubis	CV-1	Cx-Sex
	Between 5L and the PSIS	B-25	
Flexor Hallicus Brevis	Inferior to the symphysis pubis	CV-1	Cx-Sex
	Between 5L and the PSIS	B-25	
Middle Traps	7-8 ICS, 2" parasternally on left	S-19	Spleen
	7-8 D near the lamina	GV-9	
Lower Traps	7-8 ICS, 2" parasternally on left	S-19	Spleen
	7-8 D near the lamina	GV-9	
Points related to the spleen: CV-1, B-25, S-19, GV-9			
PANCREAS			
Triceps	7-8 ICS, 2" parasternally on left	S-19	Spleen
	7-8 D near the lamina	GV-9	

Lat. Dorsi	7-8 ICS, 2" parasternally on the left 7-8 D near the lamina	S-19 GV-19	Spleen
Anconeus	7-8 ICS, 2" parasternally on the left 7-8 D near the lamina	S-19 GV-19	Spleen

Points related to the pancreas: S-19, GV-19

THYROID

Teres Minor	2-3 ICS, parasternally 2 D lamina	K-26 B-13	TH
Infraspinatus	2-3 ICS, parasternally 2 D lamina	K-26 B-13	TH

Points related to the thyroid: K-26, B-13

LIVER

Pect. Major Sternal	5-6 ICS on the right 5-6 D lamina	S-18 B-16	Liver
Pect. Minor	5-6 ICS on the right 5-6 D lamina	S-18 B-16	Cx-Sex
Subclavius	5-6 ICS on the right 5-6 D lamina	S-18 B-16	Cx-Sex

Points related to the liver: S-18, B-16

DUODENUM

Abdominals	Upper 1/3 anteromedial thigh PSIS	SP-11 B-48	SI

Points related to the duodenum: SP-11, B-48

BLADDER

Sacrospinalis	S. pubis or L. umbilicus TP of L2	S-26 and/or S-30 B-22	Bladder
Peroneus Longus	Inf. ramus of pubes SP of L5 and sacrum	between CV 1-2 B-31	Bladder
Peroneus Brevis	Inf. ramus of pubes SP of L5 and sacrum	between CV 1-2 B-31	Bladder

Peroneus Tertius	Inf. ramus of pubes	between CV 1-2	Bladder
	SP of L5 and PSIS	B-31	
Ant. Tibialis	3/4" above symphysis pubis	S-29	Bladder
	Upper border of L2	between B 21-22	
Biceps	2-3 ICS, 3" parasternally	S-15	ST
	C2 lamina	GV-25	

Points related to the bladder: S-26, S-30, B-22, B-31, S-29, S-15, GV-25 between B 21-22, between CV 1-2

GALL BLADDER

Popliteus	5-6 ICS on the right	S-18	GB
	5-6 D on the right lamina	GV-10	

Points related to the gall bladder: S-18, GV-10

EYE & EAR

Upper Traps	3" of anterior upper arm	LU-3	Kidney
	Arch of atlas to lateral mass	GB-12	

Points related to the eye and ear: LU-3, GB-12

HEART

Subscapularis	2-3 ICS	K-26	Heart
	2-3 D	B-13	

LUNGS

Diaphragm	Length of the sternum	K 22-27	LU
	Lateral to 10D on the left	B-19	
All Deltoids	3-4 ICS parasternally	K-23	LU
	3-4 D on the lamina	B-14	
Coracobrachialis	3-4 ICS parasternally	K-23	LU
	3-4 D on the lamina	B-14	
Serratus Ant.	3-4 ICS parasternally	K-23	LU
	3-4 D on the lamina	B-14	

Points related to the lungs: K-22 through 27, B-19, B-14

STOMACH

Pect. Major Clav.	6-7 ICS on the left	none	ST
	6-7 D on the lamina	GV-9	

Brachioradialis	Over the pect. minor	LU-1	ST
	Origin of the supraspinatus	SI-12	
Pronator Teres	Behind areola	S-18	ST
	Below inferior angle of scapula	B-41	

Points related to the stomach: GV-9, LU-1, SI-12, B-41, S-18

BRAIN

Supraspinatus	Below coracoid	S-20	CV
	TP of the atlas	T-16	

Points related to the brain: S-20, T-16

SPINE

Teres Major	2-3 ICS, 2½" parasternally	K-26	GV
	2-3 D on the lamina	between GV 12-13	

Points related to the spine: K-26, between GV 12-13

COLON

TFL	Anterolateral thigh	SP-31	LI
	Triangle of 2L, 4L, illiac crest	B-46	
Levator Scapula	----------	----	ST
	C7 - T1, 1" from the TP	SI-15	
Supinator	6-7 ICS, 1" parasternally	none	Cx-Sex
	6-7 D on the left lamina	GV-9	
Opponens Pollicis	Inferior to symphysis pubis	between CV 1-2	Cx-Sex
	Between 5L and PSIS	B-25	

Points related to the colon: SP-31, B-46, SI-15, GV-9, B-25, between CV 1-2

TMJ

TMJ	1-2-3-4 ICS	S-12-13-14	ST
	2-3-4 D at the lamina	GV-12-13	

Points related to the TMJ: S-12-13-14, GV-12-13

SINUSES

Neck Flexors	1-2 ICS, 3½" parasternally	S-13	ST
	2C lamina	GV-25	

Neck Extensors	1-2 ICS, 3½" parasternally	S-13	ST
	2C lamina	GV-25	

Points related to the sinuses: S-13, GV-25

RECTUM

Hamstrings	Lesser trochanter of the femur between	S-30-31	LI
	Upper SI joint by PSIS	B-25	

Points related to the rectum: S-30-31, B-25

APPENDIX

Quadratus Lumborum	Upper border of the 12th rib	LU-13	LI
	IMD lamina	B-20	

Points related to the appendix: LU-13, B-20

PROSTRATE - UTERUS - SEMINAL VESSICLES - CLIMATERIC

Gluteus Maximus	Anterolateral thigh	GB-31	Cx-Sex
	Between 5L and PSIS	B-25	
Gluteus Medius and Minimus	Upper symphysis pubis	S-30	Cx-Sex
	Between 5L and PSIS	B-25	
Piriformis	Symphysis pubis	S-30	Cx-Sex
	Between 5L and PSIS	B-25	
Adductors	Behind areola	S-18	Cx-Sex
	Below inferior angle of scapula	B-41	

Points related to the reproductive organs: GB-31, B-25, S-30, S-18, B-41

THYMUS

Infraspinatus	2-3 ICS, parasternally	K-26	TH
	2D lamina	B-13	

Points related to the thymus: K-26, B-13

OTHER

Pronator Quadratus	none
Opponens Digiti Minimi	none

Priority

Priority, a method of determining what sequence is the most effective in correcting structural or bioplasmic field problems, is a technique practiced by Dr. Deal. Clinically, it has been found that often just the compensations are treated, while the real problem remains undiscovered. This results in either a recurring set of symptoms, or a variation in previous symptomotology, as energy is channeled to new locations. When the underlying cause is removed, all of the compensations clear spontaneously with no further adjustments necessary.

The test follows this sequence:

1) using any SIM, challenge the system in question, the indication will be weak.

2) have the patient inspire and hold his breath, recheck the challenge and the previously week indicator. If the muscle is still weak, then it should not be corrected. If inspiration strengthens the muscle, then (3).

3) with the patient still holding his breath, apply a small pinch or similar stimulus, usually on the extremity being tested and recheck the previously SIM. If the SIM became weak, then this is not the most important problem the body has, or it is being corrected out of the bodies own sequence. If the muscle remains strong then there is a priority problem at that site.

This could be analogous to the acupuncture system, which says that chi energy is taken into the body via the lungs and is pumped by the diaphragm. If the body is bringing in energy on inspiration, then part of it is going to the site of priority. Thus, less external force is required to insure the cor-

rection. The priority system automatically precludes all expiration corrections in preference to inspirationally assisted ones. This check also insures that the underlying problems are really being corrected and not accidently overlooked as the doctor treats compensations.

In a test group, the general sequence of priority problems appeared to be: centering, gait, foot subluxations, pelvic problems, cranial faults and fixations. Occassionally, two or three problems will show priority simultaneously. These are usually in the categories and cranial faults. In a case such as this, a secondary priority check can be used to establish which problem supercedes the others. The same sequence is followed as before, except that the left temporal-sphenoid line is tapped counter-clockwise after the pinch challenge. This will eliminate the lesser priority problems and will show which problem should be treated first. The doctor then moves on to find the problem which has the next highest level of priority.

If two or more problems showed secondary priority simultaneously, then a test for tertiary priority involves:

a) counter-clockwise T-S line tapping on left

b) tap the umbilicus several times

c) check the SIM, all while the patient maintains the inspired breath. After the correction, again move to the next highest level of priority. This can be rather time consuming, since a patient in this situation will be so critical, that whatever is done will benefit him. As a general rule, a patient treated in the priority sequence will maintain better than 90% of their adjustments. The priority system doesn't seem to be of any use nutritionally, but when used on muscle systems the

priority sequence NL, NV, then stress reception, is realized.

It has been found that when too many problems are treated in a short period of time, whether following priority or not, the patient becomes overloaded with the energy released by the corrections. As a result, the patient will demonstrate extreme exhaustion for no apparent reason. In addition, the patiant may become unaccountably edgy. This edginess usually procedes the exhaustion stage by a short period of time.

The way to determine whether a patient is overloaded is to challenge or TL the point to be corrected and tap the left temporal-sphenoid line counterclockwise two or three times. If a previously weak indicator remains weak, this suggests that the correction being questioned will overload the body. This is very important in the high energy corrections such as centering, precentering, acupuncture meridians and cranial faults. Each of these utilizes a large amount of energy to maintain the compensations for the problems, especially if they are chronic.

It is possible to change this threshold if absolutely necessary. Some of the excess energy can be removed, via CV-24, by having the doctor vigorously rubbing this point. This again is due to the flow of energy from high to low concentration. In this case the doctor acts as a ground for the excess energy. The body has the ability to convert acupuncture energy into that used for the cloacals and vice versa. Therefore, CV-24 can be used to "tap" the energy from the acupuncture system. This will also lower the energy in the cloacal system as the excess energy is converted to acu-energy needed to maintain the balance. This can be done before, or after, a correction is made, but is only temporary if the patients body has a difficult time handling the corrections.

Occassionally, patients with many chronic problems will have all of them corrected easily and will never become overloaded. However, there is no noticeable correlation present to this observation.

If a patient is overloaded badly, then recommend that they return home and take a long, hot bath. This follows the same principle as the doctor washing the excess energy down the drain following the administration of the acupuncture therapy. Then, if possible, have the patient eat a 'heavy' meal. This is useful since there is a large amount of energy consumed in digestion. Also, this will guarentee that any depleted energy stores in the body will be later normalized.

BIBLIOGRAPHY

1) Applied Kinesiology: The Advanced Approach to Chiropractic, Dr. D.S. Walther, 1976; Systems DC, Pueblo, Colo., p. 275.

2) J. of Scientific and Applied Photography, 1961, 6: 397-403.

3) The Probability of the Impossible, Dr. T. Moss, 1974, The New American Library, Inc., New York, N.Y., p. 35.

4) Applied Kinesiology, p. 277.

5) Private Communications with Robert Eberle and Jeffrey Fedorko.

6) Acupuncture: The Ancient Chinese Art of Healing and How It Works Scientifically, Dr. F. Mann, M.B., 1971; Random House, Inc., New York, p. 232.

7) The Rainbow In Your Hands, Albert Roy Davis and Walter C. Rowls, Jr., 1979; Exposition Press, Hicksville, N.Y.

8) Neurolymphatic Points from the Applied Kinesiology Manual.

LIVER AS RELATED TO NUTRITION

By

Paul A. White, D.C.

ABSTRACT:

The purpose of this paper is to present a nutritional understanding of the liver related to specific vitamins, enzymes, and trace elements.

INTRODUCTION:

The human organism is a highly integrated mechanism whose optimum maintenance or even survival depends on the functioning of many different organs, tissues and cells. Many of these organs must be capable of variation in function and of compensation for physiologic and disease changes. Therefore, it is somewhat unrealistic to isolate one organ and study only its biochemistry. Therefore, when the liver is being discussed many interrelations with the liver are known or inferred. For example, the term " HEPATIC COMA" Means the abnormal brain response associated with liver failure. The disease state hepatolenticular degeneration denotes a brain and liver interrelationship: while the hepatorenal syndrome suggests a relation with the kidneys.

In discussing the liver, we would ultimately like to understand it in this interrelated sense. According to the Merck Manual there is no one test to determine total liver function; there are many. Because it is impractical and at times detrimental to

the patient, only the obvious function tests are taken. The common test utilized in evaluating the liver are total protein, albumin, globulin, A/G ratio, total bilirubin, SGO-T, LDH, and Alkaline Phosphatase.

There are still wide gaps that exist in understanding this marvelous organ and the large amount that is understood is not combined into one authoritative monograph.

The liver is the main chemical mill in which compounds are burned, altered, broken down, synthesized or excreted. In addition, the liver plays the role of modifier to many systems. For example: if too much pressuor amine (an organic compound derived from ammonia) is circulating, the liver will oxydize it. It continually reduces the level of free circulating hormones, particularly the steroids. It also provides compounds to be used for further synthesis by other tissues. for example: It supplies creatine for muscle creatinephosphate, or 5 hydroxytryptophan for brain serotonin. This is the reason that L-tryptophan (tryptoplex) works so well for insomnia. If it does not, it is probably because the liver is not functioning properly.

The liver is interposed on an important barrier between the PORTAL BLOOD and its many harmful organisms and other organs.

for example: The rapid intravenous injection of ammonium salts will lead to a high level of blood ammonia, convulsions and death.

The liver does not have the time to get this out of the peripheral circulation. However, when ingested orally and it enters the portal blood which flows through the liver directly, allowing the removal and preventing the ammonia from entering the peripheral blood in large amounts. This can be seen when oral ammmonium citrate is given to a patient before and after a PORTAL SHUNT or ANASTOMOSIS; on the bypass of the liver the patient quickly becomes saturated with ammonium in the peripheral circulation. The same would hold true for alcohol or other metabolic products if the liver were by-passed by a shunt.

APPLIED KINESIOLOGY AS RELATED TO THE LIVER

The pectoralis sternal muscle is the muscle that is associated with the liver on a organ, muscle relationship basis. This muscle originates on the sternum to 7th rib, cartilages of true ribs and aponeurosis of external oblique abdominal muscle and inserts into the bicipital groove of the humerus. This muscle is tested with the patient in a supine position, with the arm extented. The patient directs his forse toward his opposite anterior superior iliac spine, against the Doctors resistance. If this muscle is found to be weak, careful examination with the use of therapy localization of the five factor of the intervertebral foramen

are carried out; nerve, neurolympatic, neurovascular, acupuncture connector meridian, cerebral spinal fluid.

THE ROLE OF ENZYMES IN THE LIVER

Many of the chemical actions of the liver can be reproduced in a test tube but the reactions would be so slow that they would hardly be detectable. To speed up these reactions, catalysts or enzymes would be needed. Although there are some actions in the liver that may not be enzyme induced, they are enzyme controlled. Enzymes, when split, yield a smaller nonprotein COENZYME or PROSTHETIC GROUP. Many of these COENZYMES are made up of vitamins such as those of the B COMPLEX (nutri-beta) family. This would explain why heavy drinkers suffer from a vitamin B Complex diffiency.

The protein part of oxidative enzymes has the ability to act as a electron reservoir which can expand or contract, with the coenzyme functining as a valve or duct thru which the electrons flow. Inaddition to that, the nature of the coenzyme in certain OXIDATION REDUCTION REACTIONS determines the ability to give off or accept electrons.

In STARVATION the liver gets smaller because of protein loss in

this process many enzymes are reduced in their amount in the liver. It may well be that this loss of protein may really be enzymes and material for enzymes, and therefore, reflects A DIMINISHED CHEMICAL REACTIVE CAPACITY. The enzymes are amphoteric and in addition their activity is dependent upon the PH. In the liver their activity is limited to the pH of the liver cells, approximately 6.8. The increase or decrease in body PH could presumably raise or lower enzymatic activity and cause metabolic effects. In ACIDOSIS some enzymes may become inactive and others active. In vivo the exact effects of this are not known. However in a diabetic it can be demonstrated that in acidosis the blood PH is diminished and insulin sensitivity is decreased. Whereas return to a normal PH increases insulin sensitivity.

THE ENZYMATIC ACTIVITY MAY BE ENHANCED BY ASSURING THE PRESENCE OF TRACE ELEMENTS SUCH AS COPPER (Nutri-cu chelate), MAGNESIUM (Nutri-Mag chelate), IRON (Nutri-Fe chelate), MANGANESE (Nutri-Mang). Vitamin and trace mineral dificiency lower co-enzyme and enzyme activity.

CONTROL OF BLOOD CONSTITUENTS

The function of the liver is essentially that of regulation of

the individual constituents of the blood. There are only a few substances that the liver does not add or eliminate to or from the blood. Every tissue of the body is dependent on the liver for its nutritive content. It also removes a variety of noxious agents. The liver will remove any diffusible substance injected into the blood very rapidly. A rapid drop occurs within the first five minutes. One third of all cardiac blood output passes through the liver. The hepatic tissue is saturated with freshly oxygenated blood.

One factor in addition to the many others governed by the liver is the release of glucose into the bloodstream, essential for all vital functions particularly the brain. The endocrine system cooperates closely on the release or conversion of the stored insoluble starch, glycogen into the liquid blood sugar, glucose, ACTH from the pituitary stimulates the adrenal release of steroids. Thyroid and pancreatic function as well as the autonomic nervous systems interact to keep the gluocse level balanced. In the center of all this activity the liver is a most important and vital organ. Since the brain has a relatively high oxygen consumption, and since its major source of energy is glucose, hypoglycemia has an adverse effect on the brain. The most effected cerebral area is the cortical area. The manifestations of hypoglycemia are predominantly related to anoxia which tends to stimulate the

sympathetic nervous system and supress the parasympathetic nervous system. This, with all its ramifications produces a symptom pattern, so bazaar, that it, at times, masquerades as many different diseases.

CLINICAL CONSIDERATIONS

These patterns are generally classic and follow a progressive pattern if the initial cause is not remedied. The symptoms of liver disturbances are fairly obvious, such as poor fat metabolism, nausea, constipation and toxemia accompanied by visible veins on chest and abdomen, poor carbohydrate metabolism, deviations in the blood sugar pattern as well as water retention, hypercholesteremia and possible varicosities and hemorrhoids. However, many are more hidden such as possible kidney involvement because of poor protein supply to this organ, or the manifestations of such conditions as arthritis. Lipotrophic factors or fat metabolism is only one phase in liver dysfunction. Various hormones, carbohydrates, proteins and tissue factors must be taken into consideration. Clinical evaluations have shown that with a breakdown of these functions or even impairment are associated with| the presence of bile in the urine, decreased serum albumin, palpation, blood pressure problems, enlarged liver and spleen, indigestion, alcoholic stool, jaudice, leukocytosis

and many more.

Raw liver (Livaglan or Livaglan Chelate) has been known to work favorably in cases of pernicious anemia, diabetes and other liver problems when included in the diet. Its intrinsic factors seem to be supportive of all liver tissue and function. Raw liver is rich in the levels of protein, enzymes, B vitamins, minerals and other important factors that make its inclusion in the diet most beneficial.

Restoration of liver function is aided by the added administration of lipotropic factors (Leciplex); particularly choline (250 mg) and inositol (125mg)

B complex (Nutri-Beta), high levels of B1,2,3,6 and supported by pancreatic (Panglan) and liver substances (Livaglan).

Thyroid substance (Thyroidglan or Tri-Glan 42)or support may be indicated if metabolism is sluggish.

Live acidopholus (Nutri-Lacto) bacteria to support in case of constipation.

Vitamin C (C-500 C-1000 TR or C-1000) at higher levels, 500 to 1,000 mgs.

Adrenal support (Adrenoglan 80, 160 or Adrenoplex) may be indicated in cases of hypoglycemia.

Trace minerals (VM Trace) in rich amounts for enzyme production.

Pollen materials give a broad spectrum support.

DIET SHOULD CONTAIN; Many RAW vegetables and foods. Juiced if they cannot be tolerated otherwise.

References

Diseases of the Liver, Schiff, 2nd edition
Applied kinesiology The Advanced Approach In Chiropractic
by David S. Walther, D.C.
Human Biochemistry by Kleiner and Orten
Medical Physiology by Guyton

Mental and Elemental Nutrients by Carl C. Pfeiffer,

CO-FACTORS

by James R. McGlinn, D.C.

Abstract: Different parts of the body work with each other to perform certain functions and, sometimes for diagnosis, need to be tested as such. If two parts are factors in a specific function (i.e. stomach and small intestine in digestion), they should be tested together since that is how they function.

The human body is a truly remarkable entity. It can run marathon distances, create new life, and turn food into its own tissues. It consists of trillions of different parts working together for the good of the total organism.

I was watching someone parallel park his car and thought about the incredible amount of co-ordination taking place that we all take for granted. The driver first calculates whether the space is large enough to park in, lines the car up, watches the traffic, puts the car in reverse, turns the steering wheel, rechecks the traffic, and uses both clutch and accelerator in relation to the turning of the steering wheel. All of this is being done at the same time, and is constantly being re-evaluated and changed as the car moves into the parking space. Add to this the intricacies of muscle function that we all know and you cannot help but be in awe of the capabilities of the body. The point I'm making is not how wonderful the body is, but that all parts

act together--not one of them alone can park the car. They are all co-factors in the parking of the car.

Just as the musculo-skeletal system works together to perform a function so also do all systems act together within the body(respiratory and hormonal systems, G.I. tract, etc.). In Applied Kinesiology, we usually test one organ or muscle at a time. We therapy localize to the organs, i.e. the NL, NV, alarm, but we're not necessarily testing how the organs are functioning in relation to one another. Since they function together and communicate with each other, they should be tested with each other.

What happens when digestive disturbances continue even after all muscles and organs relating to this area are strengthed? Suppose the stomach and small intestine (or any other digestive organ) test strong indicating normal function, but due to some problem, possibly with inter-communication, they are performing out of synchronization with each other. It's like the wide receiver that cuts to the right and the quarterback that throws to the left. The pass pattern may be beautifully run and the pass beautifully thrown, but the ball falls incomplete because they did not function properly in relation to each other. The stomach and small intestine may be doing the right things, but if they are not properly co-ordinated there can be malfunctions within the digestive system. To measure the function of the two organs together you can test both organs simultaneously. This can be done

by therapy localizing NLs, NVs, etc. of both organs and testing a non-related muscle, or by testing a PMC or Quadriceps and therapy localizing to a small intestine or stomach reflex. Both the stomach and small intestine are important in digestion, but each cannot do it alone. They are co-factors in the process of digestion.

These concepts have been used before in AK. We have tested the large intestine with the lips and breasts in constipation, and the pituitary with other organs, especially the thyroid. No organ works alone, but only in conjunction with other organs and parts of the body can it accomplish anything beneficial to the body. The combinations you can use in testing the organs is virtually limitless, as all parts work with each other. Once you find a co-factor weakness, it can be treated by standard means. Usually one of the organs is more important to treat than the other--a fact which can be discovered by seeing which reflexes and nutrition counter the combined weakness.

It is important to remember that the human body works as a unit, and its parts sometimes need to be tested to determine how they are functioning as part of that unit. This paper has primarily dealt with the organs, but the muscles, too, work in combinations, and occasionally need to be tested as such. Gait testing is an example of co-factor or combined muscle testing. Living in Vermont, one sees a

number of problems relating to cutting and splitting wood. The Gluteus Maximus and Latissimus Dorsi are two muscles used extensively in splitting wood and at times a weakness will only show up when they are tested at the same time. They can be strong in the clear, but one or both weak when tested simultaneously. They, along with other muscles, are co-factors in splitting wood.

REFERENCES

Goodheart, George, D.C., monthly tape # 54.
Hanicke, Bert, D.C., years at Logan College of Chiropractic.
Ridler, Robert, D.C., 1973 seminar tape.
THE GP and the ENDOCRINE GLANDS, Louis L. Rubel, M.D., Decatur, Illinois, 1959.

Diagnosis and Treatment of Allergy using AK

by Anu de Monterice, M.D.

This paper discusses a way to test for an allergy problem by using two new acupuncture points for therapy localization, derived from Dr. Voll's work. A method of testing for specific allergens is described, followed by a description of treatment utilizing these points as indicators.

Dr. Reinhard Voll, an acupuncturist and physician from West Germany, has discovered new acupuncture points and channels which are of great importance in the preventive practice.[1.] Like the Conception Vessel, these channels are not called meridians since they are not known to have tonification and sedation points, connecting points, command points, etc. One of these channels is called the Allergy or Allergy Degeneration Vessel. Only the distal points of the Allergy Vessel have been mapped. They lie on the ulnar side of the dorsum of the middle finger.[1.2.]

Figure 1. shows three allergy points: AD 1, 2, 3. According to Dr. Voll, AD 1 relates to a) the skin of the lower portion of the body, including the lower extremities, and b) the organs in the abdomen and lower pelvis. It is also involved with sensitivities to chemical substances in the environment. AD 2 relates to a) the skin of the upper portion of the body, including the neck and the upper extremities, and b) the organs in the chest and neck. AD 3 relates to a) the skin of the head, and b) the organs in the head, the oral cavity, and the sinuses.[2.]

One year ago I began checking all new patients for therapy localization to these points. After several months, I stopped using AD 2, never having found it to therapy localize. It is possible that persistence would have established an indication for its use. Perhaps if I had tested more patients with asthma or rashes on the arms, I would have seen it therapy localize. In any case, I continued to use AD 1 and 3, finding these points to be very useful in diagnosis and

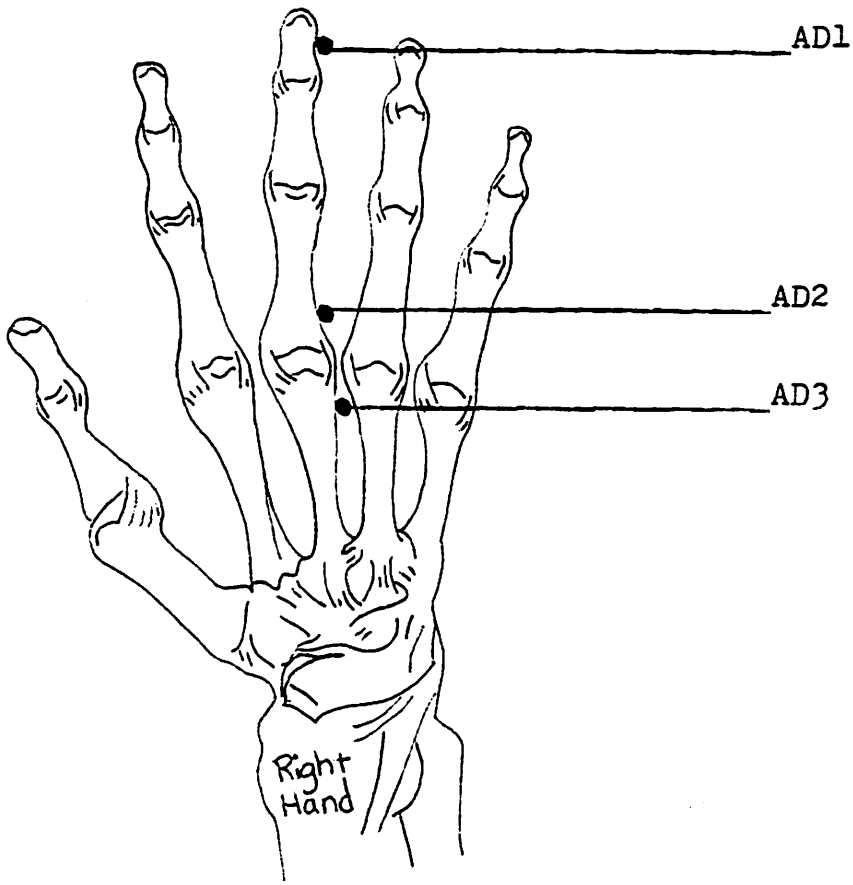


Figure 1.
Allergy Points as discovered by Dr. Voll

therapy.

AD 3 will therapy localize in cases of allergic headaches, allergic rhinitis and sinusitis, allergic conjunctivitis, allergic bronchitis, and cerebral allergy. AD 1 will therapy localize in cases of allergically-caused abdominal pain, gastroenteritis, cystitis, or any interference with organ function in the abdomen due to allergy. Pollen, mold, dust and dander allergies usually show up an AD 3. Foods, preservatives, coffee, sugar, and hydrocarbon allergies, when they cause nervous disorder, will usually show up on AD 3; if they cause digestive problems they may localize on AD 1. In any single case either or both points may therapy localize.*

In cases with current symptoms, one or both of these points will practically always therapy localize. In some cases RNA or choline or physostigmine may be needed to uncover the diagnosis.[3] This does not happen often. It occurs more frequently if the patient has intermittent symptoms and is not suffering at the time of the doctor visit. In occasional instances of intermittent symptoms neither point will therapy localize, even with these aids. In other words, if either allergy point therapy localizes, you can be sure the person has an allergy problem. But lack of this reaction does not necessarily rule out the problem.

In my work I have almost exclusively used the allergy points on the patient's right hand. I have not found using points on the left hand to add any more useful data.

TESTING SPECIFIC ALLERGENS

In Applied Kinesiology treatment of the underlying causes of a patient's allergic tendencies has been emphasized. These include hypoadrenia, hypoglycemia, and hypochlorhydria.[4] However, it is also important for

* These points may be therapy localized by the patient or the doctor; however, if the doctor does the localizing, he must be aware of the possibility of a false positive reading if he himself has an overt or latent allergy.

the patient to know specifically what he is allergic to, so he may avoid the allergen until his system is strong enough to handle it. Later in this paper we shall also describe a treatment based upon this knowledge. Now we shall describe how to test for specific allergens, using the described allergy points.

In a patient with suspected allergy, let's say that neither AD 1 or 3 therapy localizes. In that case, one may proceed as follows. First, place the suspected allergen in the patient's energy field.* Localize AD 1 and/or AD 3 and test a strong indicator muscle each time.

Now,in the case of allergy, a strong indicator muscle will often go weak when the allergenic substance is placed in the person's energy field, even without localizing the allergy points, especially if the Pectoralis major clavicular or Latissimus dorsi muscles are used. However, in a small but definite minority of cases, the patient will not test weak until AD 1 or 3 is localized. Thus use of these points will make your testing more accurate. This method is more sensitive than testing all 12 meridians.

In the testing, the allergen used may be the whole substance (e.g. an apple, a collection of dust from the patient's home, animal hair from a pet, food dyes purchased at the supermarket, etc.) or it may be the allergy extract or dried antigen, in a glass vial or plastic bottle.** One must be aware that if a commercial, sprayed apple is used, and the person tests allergic, he may be reacting to the pesticide on the peel and not to the apple itself. One must then either peel or wash the apple and retest.*** With sprayed oranges, the insecticide may penetrate the peel and contaminate the whole orange. Thus one must use an unsprayed orange, or the prepared extract or powder, to differentiate between sensitivity to pesticide from sensitivity to orange.

* For example, it may be placed in the hand or an the abdomen.

** These may be obtained from Hollister-Stier, the large allergy supply house with outlets in various states. The main office is in Spokane, Washington (Box 3145 T.A., Spokane, Wash.). Unless otherwise specified, all the allergy material mentioned in this paper may be obtained from this firm.

*** For washing I recommend either a very dilute solution of chlorox, or an organic cleanser such as "Heavenly Horsetail Natural Organic Herbal All-Purpose Cleanser".

The use of allergy points will show pesticide sensitivity when other means of testing may not.

Hydrocarbon sensitivity is an important entity and may cause a wide range of symptoms, including cerebral disturbances.[5] This allergy may be tested by using numerous substances, including 1) an extract of automobile exhaust* 2) synthetic ethyl alcohol 3) an indelible "magic marker" type pen 4) preservatives.** Another test for an important hydrocarbon is to have the patient take a whiff of gas from a gas stove, after blowing out the pilot light, then test. This "in the field" test may also bring on the patient's symptoms of which he is complaining.

Pollens are tested by using prepared extracts of specific pollens important in your area, including those from trees, grasses, and weeds. These may be purchased already prepared, or may be made by oneself.***

In testing for suspected items, mold may be gathered by the patient from his home, or a commercially prepared extract may be used. The best extract for mold testing is a mix of the mold family, named Dematiaceae. It should be emphasized that mold allergy can cause more than just an allergic rhinitis, but may cause various complaints, including disorders of the nervous system.[6] Dust sensitivity may also cause more symptoms than commonly thought.[7] In addition to house dust extracts, extracts made from mites are useful for testing (tiny house mites may be a factor in some dust allergies).

The doctor may feel that in testing specific allergens, substance in the patient's mouth, or perhaps having him inhale it as in the case of testing natural gas, is more accurate than merely placing the allergen in his energy field. I have not found this to be so. Considerations of time also militate against routine testing by having patients chew a bite of a particular food, or by putting a few drops of a dilution

* This is obtainable from Dr. Harris Hosen, 2649 Proctor St., Port Arthur, Texas 77640.

** An extract containing a mixture of preservatives and additives is also obtainable from Dr. Hosen.

*** The pollen bearing part of the plant may be put into a blender or juicer with water, strained, and mixed half and half with glycerin and put into a vial for testing.

of the antigenic extract on his tongue. For the patient then has to wash his mouth out, and the doctor may have to do some energy-restoring procedure to return the patient to a state where the next substance can be tested. One may perhaps wish to do this, especially in the skeptical patient, to confirm the diagnosis. But it is too unwieldy a procedure on the whole. Another major drawback is that testing in this manner may provoke a full-blown allergic reaction in the office.

Let us return to the case of our hypothetical patient. If on the initial testing, one of the allergy points therapy localized, then we know he has an allergic problem. Then to do the specific allergy testing, we need first to temporarily abolish this therapy localization. This can be done by stimulating the allergy point in the right ear. The patient will then show a temporary return of the therapy localization when the substance he is allergic to is placed in his energy field.

The auricular allergy point is pictured in the diagram in Walther's book.[4] However, its location is not on the rim of the helix, but on the underside of the fold of the helix.[8] It may be stimulated by electro-acupuncture (50 microamps, 10 Hertz), needle, pencil, or stem of a Q tip for a few seconds. Then recheck the therapy localization; it should be neutralized. Do not stimulate the allergy point too long or you may prevent the specific allergy from manifesting in your subsequent testing.

TREATMENT

In all allergies, correction of hypoadrenia and hypoglycemia is crucial. In food allergies, hypochlorhydria and/or pancreatic enzyme deficiency should also be corrected. Certain vitamins, especially Vitamin C, B6, niacinamide, and pantothenic acid need to be considered. The food-sensitive patient should avoid the foods he tests allergic to, for at least 3 months. Most allergies are not fixed, but will change. For someone with multiple food allergies, the 4-day rotational diet is prescribed.[9,10]

For mold allergies, the patient should try to reduce the amount of mold in and around the home. Bathrooms, closets, basements and all damp places should be checked. Basements may be painted with a mold-inhibiting paint. Indoor plants and dried flowers may contain mold and may have to be discarded or given away. Going away for a weekend and leaving out pans of formaldehyde in the house will kill mold. Of course, the house must be thoroughly aired upon return.