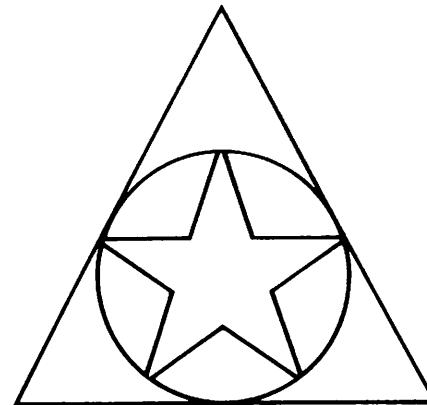


# Clinical Kinesiology

## Instruction Manual



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## **DEDICATION**

To those Doctors of Chiropractic  
and other healing professionals  
whose desire is to serve their  
patients.

## ACKNOWLEDGEMENTS

No book on Kinesiology would be complete without giving tribute to the founder, developer, and researcher of Applied Kinesiology, Dr. George Goodheart of Detroit, Michigan.

Special thanks to the artists, Greg Smith and Joel Ito.

Special consideration must be given to my wife, Sharon, and my five boys, Christopher, Timothy, Michael, Thomas and Matthew for their patience during the many hours of manual preparation.

I would like to thank the following: Dr. Rene' Espy for her unselfish dedication and support. She was responsible for editing and managing the production of the book. Dr. Burt Espy for his assistance in production and format.

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Cris Gilbert and J.J. Bond for their special assistance when needed.

## INTRODUCTION

The Instruction Manual of Clinical Kinesiology has a dual function:

1. To introduce the practitioners of the healing profession to the details and complexities of the Clinical Kinesiology workshop manuals.
2. To introduce the new and revolutionary hand modes.

Applied Kinesiology, an evolving aspect of the practice of Chiropractic, has been expanding and increasing in complexity since 1964 when Dr. George Goodheart, a Detroit chiropractor, discovered that muscles are dynamic tools that can provide a method of detecting aberrant body functions and are intimately related to structural dysfunction.

Clinical Kinesiology is the name I have chosen for this publication. This has been done to preserve the trademark and the originality of Dr. Goodheart's work. Clinical Kinesiology is at present not considered part of the accepted procedures adapted by the official organization of Applied Kinesiology, the International College of Applied Kinesiology (I.C.A.K.). Clinical Kinesiology is an outgrowth of my personal practice proven to be consistent and practical over a period of time within an Applied Kinesiological practice.

This Instruction Manual is not intended to replace any of the present Applied Kinesiology manuals. In fact, many of the concepts are an expansion of the knowledge gained from the authors listed below. Their works are a prerequisite to this work. The Instruction Manual will introduce five areas of significant contribution:

1. Bio-computer concepts.
2. An expansion of Dr. Hans Selye's concepts on the General Adaptive Syndrome.
3. Various clearing techniques.
4. Introduction to the new organic or bio-technological non-evasive diagnostic techniques of computer language.
5. Additional factors that affect muscles on a local computer basis.

Goodheart, George, D.C. Applied Kinesiology, Workshop Procedural Manuals, 542 Michigan Building, Detroit, Michigan 48226

Walther, David, D.C. Applied Kinesiology, The Advanced Approach to Chiropractic Systems D.C., 275 W. Abriendo, Pueblo, Colorado 81004

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# **Chapter I**

# **The Living Computer**

"The tabernacle that houses our spiritual essence is enveloped in our physical body which acts as a transmitter of external stimuli to bring the soul in touch with the physical body and the external environment. Through our sensory system, we become aware of the raw data that is around us."

Alan G. Beardall, D.C.

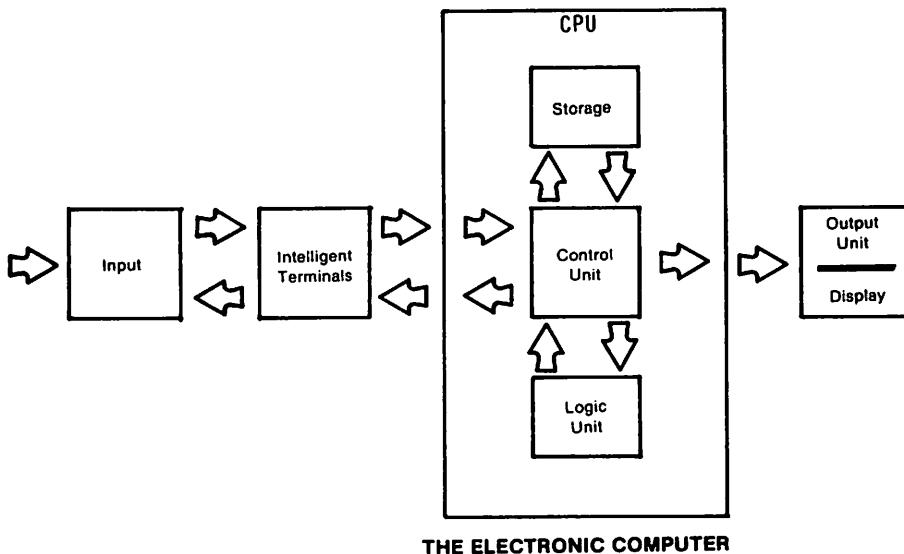
## THE LIVING COMPUTER

### The Electronic Computer

Our clinical observations at this time lead us to conclude that the body is a biological computer which has an extensive nervous system with processing capabilities similar to that of an electronic computer. To increase our understanding of this biological computer, let us first consider basic computer functions and terminology.

data is transformed into common codes so that the computer can determine whether it recognizes the information received.

Central processing is divided into three parts: The arithmetic or logic unit, the storage unit and the control unit. The arithmetic unit performs logical operations such as the comparison of two items of data. The storage unit stores the data while it is being processed.



THE ELECTRONIC COMPUTER

A computer can be defined as an "electronic machine for the purpose of high speed performance of logical operations for the processing of large masses of coded information."<sup>2</sup> In simpler terms it is "a device that accepts information, processes it and produces meaningful results."<sup>3</sup> The computer has three basic functions. They are input, central processing and output.

The input unit is the sensory system of the computer- it gathers raw data and breaks it down into small parts that can be handled simultaneously one item at a time.

The computer contains many intelligent terminals which detect and correct certain operator errors as well as capture and enter raw data. All data must be accurate and properly timed. Aberrant information results in the "garbage in--garbage out" phenomenon.

Information is next sent to the central processing unit (CPU) where all data is coordinated and controlled. Here raw

Whatever is passed on to storage is received in abstract symbolic terms and stored as general facts about the state of the environment. The capability of a computer to "remember" is one of its most essential aspects as it cannot function unless it can store instructions, facts and figures for retrieval when needed. Stored data remains there until it is called upon by the control unit. The control unit is the most vital for it directs overall functioning of the other units and controls the data flow between them. This unit contains the programmed instructions which must be written in the language of the computer. The central processing unit has a hierarchical arrangement with each level having a number of relatively independent processing elements each pursuing its own job and each trading information with levels above, below or laterally and with each other. Different aspects of problems are handled in different portions of functional sub-systems and are represented potentially at all major levels of the physical system.

1. Emphasis ours  
2. Computers in Action  
3. Ibid.

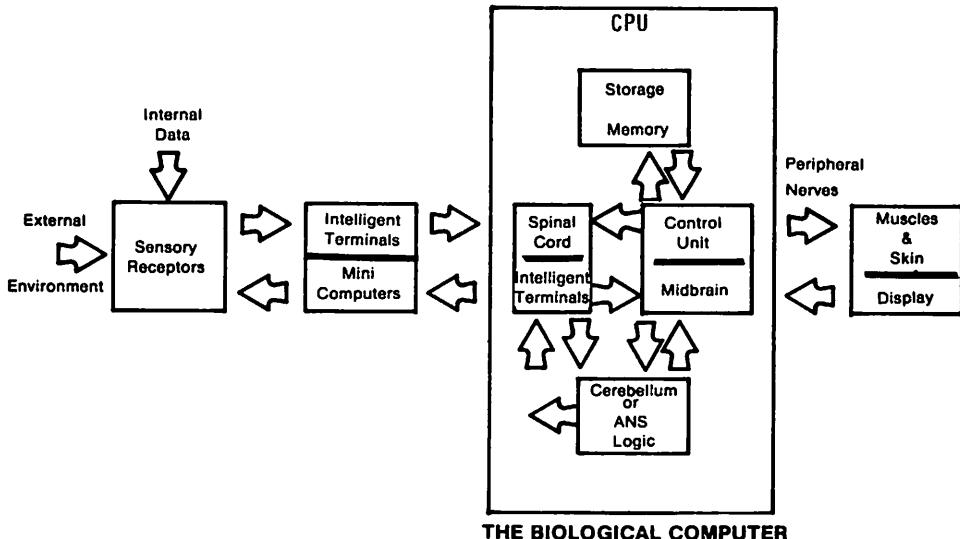
The output unit reports on information from storage and transmits the strategies to the display unit. This unit then reflects the desired actions and computations of the CPU.

In summary, a computer is involved in manipulation of large amounts of sensory data which is processed for input error, monitored, coordinated, controlled, compared, integrated, evaluated and reacted upon to produce adequate solutions to complex problems.

### The Biological Computer

With our understanding of the electronic computer, let us now compare these qualities with the biological computer.

collect internal data. Adequate irritation of these receptors is called the stimulus (sensory data) and must be reduced to neurological impulses so that the actual physical event can be translated and presented to the nervous system. These impulses are acted upon by intelligent terminals (synapses), and what can be called mini-computers, where the impulses are detected, corrected, acted upon or entered for processing at other levels of functioning. In essence, information collected by the sensory system must be directed to the proper areas for adequate processing and integration. Numerous intelligent terminals perform many important functions and simple actions are processed entirely at the level of the spinal cord from input to output. i.e.



The human body is a complex combination of different types of organs and tissues. These tissues are involved in a series of interreactions both with external and internal stimuli (raw data). This raw data is interfaced with and if necessary reacted upon. These reactions must reflect the "desired action" or will of the primary tissue involved with the problem. The reaction may result in modified behavior or motion, thus the statement "body language never lies."

The human body acts similar to a computer in that it has the same basic functions: input, central processing and output. The following discussion attempts to correlate these functions into a meaningful relationship.

Our input unit would be our sensory collection system viz. the eyes, ears, nose, taste, touch and also includes many other receptors within our bodies that

reflex arc. The brain may receive impulses from a simple reflex arc and may cause other systemic reactions (evaluation), i.e. eyes focus on an object, head turns toward the object, etc. The body then places all this information in storage for future reference. What was once a simple impulse can become a systemic reaction that may have many sites of storage or memory. (see diag. Reflex Arc).

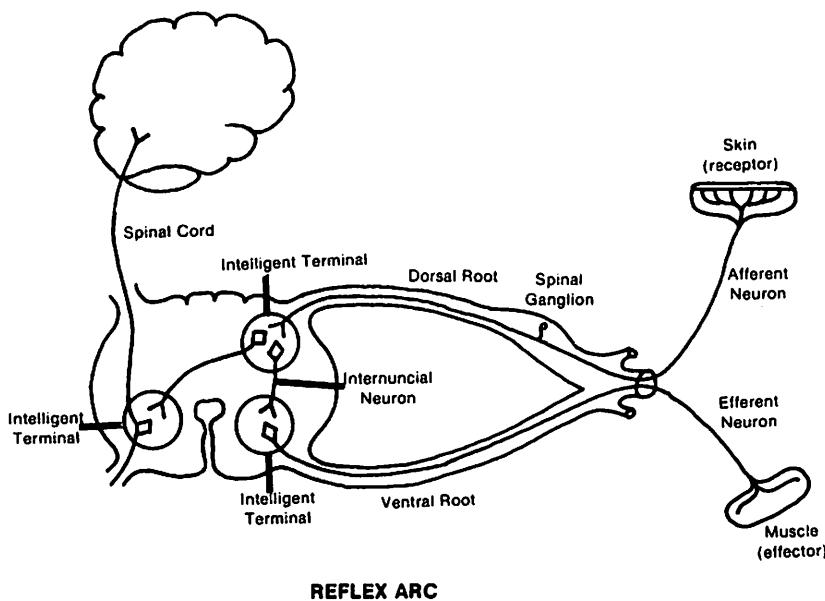
The CPU is made up of the nervous system and its divisions: A. Peripheral nerves, B. Spinal cord, C. Midbrain, D. Cerebellum and Cerebral tissues.

Once information that was sensory data is reduced to impulses traveling along the nerve, they are acknowledged, integrated, regrouped and prepared for evaluation and storage. "The specific area for storage or memory has not been located, however,

evidence suggests that it is incorporated into the structure wherever the stored information is to act."<sup>4</sup> This would lead us to believe that memory is distributed throughout the body.

Complex data must be reduced to decisions

internal environment. Massive data (input) from these areas must be processed, adapted to or reacted upon successfully. Information not received cannot be included in the CPU evaluation.



REFLEX ARC

in order to monitor heart rate, temperature, blood and tissue pH, nutritional needs, oxidation rates, thyroid function, muscle tone, spinal positioning and protection of injured or diseased tissue and organs, etc.

The output or display function concerns itself with presenting the processed information of the CPU in a meaningful form, for it must reflect the central processing unit's evaluation of the problem. This unit of the biological computer is the muscles and the skin of the body.

Abnormal muscle function under these circumstances takes on a new and meaningful perspective.

Muscle weakness must be evaluated and interpreted as potentially reflexing the CPU. Thus abnormal thyroid function can be efficiently displayed into the Teres Minor muscle and proper interpretation and treatment can result in resolution of both the thyroid and Teres Minor muscle aberration.

The goal of the organism is to survive a potentially dangerous external and

The complexity of the body necessitates an efficient organization. Apparently, it operates on at least four different levels, each being responsible for organizing and monitoring its particular area of functioning with some overlapping into other areas. We call these areas computers of different complexities. They are: 1. The cerebral computer, 2. The glandular or autonomic nervous system computer, 3. The spinal computer and, 4. The local computer.

The first or primary computer relates to cerebral activity. It is by far the most complex for it is capable of evaluation, integration and storage far beyond the other levels of function. The secondary computer is called the glandular computer. It regulates most automated functions as well as monitors the Endocrine system. Next, is the tertiary or spinal computer, which is responsible for communication, integration of information, and the chemistry of digestion. The local computer is the most rudimentary and is found in the motor point of each muscle and thought to be in other types of specific tissue. This functions as the display unit of the CPU. (see fig. Biocomputer).

## INTELLIGENT TERMINALS

The biocomputer contains many intelligent terminals which are a network of mini-computers or sub-systems in each of the four types of computers - primary, glandular, spinal and local. These terminals are responsible for capturing, correction and monitoring of input information, along with the entering of raw data to primary computers. These terminals also act as mediators between computers, as well as monitors of the cloacals, visual and labyrinthine mechanisms of posture. Information which represents an overload to a more primary computer may be inhibited or put on hold at this level, until this information can be processed successfully. These units are important.

## CENTER OF MAN

The bio-computer also has a center from which everything that occurs in the body must be focused. This center is the umbilicus, and has twelve areas that are arranged as a clock and are labeled as such. Any changes that occur in any of the computers must be processed through the center of man in order to allow proper integration.

## COMPUTER LOCATIONS IN THE BODY

Each computer has a primary site or physical representative area in the body. At this site, analysis of proper function of that computer may take place.

### K27

The primary physical location of the local computer (muscles) is an acupuncture point called K27. It is located at the junction of the 1st rib, clavicle and sternum. The kinetic representative of K27 is the two divisions of the muscle, Sternocleidomastoid. Thus head turning is tied to local computer function and K27 identification. The bones related to the local computer are the clavicles.

### HYOID

The primary physical location of the spinal computer is S9, and the hyoid bone. Its kinetic relationship is its primary muscles. They are listed as follows: 1. Anterior and Posterior belly of Digastricus, 2. Stylohyoid, 3. Mylohyoid, 4. Geniohyoid, 5. Sternohyoid, 6. Sternothyroid, 7. Thyrohyoid, 8. Omohyoid. Muscles that

are directly related to the computer (see 1-9 hyoid muscles) record or store all adaptive information. As display units of each computer, they reflect the status of that computer in time and space.

### TMJ

The primary physical location of the Endocrine computer is the temporal mandibular joint (TMJ) and associated tissues. The acupuncture point is S7. The muscles of the Endocrine computer are as follows: 1. Masseter, Superficial Division, 2. Masseter, Deep Division, 3. Pterygoid Internus Medialis, Sphenoid Division, 4. Pterygoid Internus (Medialis), Palatine Division, 5. Pterygoid Externus (Lateralis), Sphenoid Division, 6. Pterygoid Externus (Lateralis), Lower Division, 7. Temporalis, Parietal Division, 8. Temporalis, Occipital Division.

### EYE

The physical location of the primary computer is the eyes and its adjacent musculature. They are as follows: 1. Rectus Superior, 2. Rectus Medialis, 3. Rectus Inferior, 4. Rectus Superior Oblique, 5. Rectus Lateralis, 6. Rectus Inferior Oblique, 7. Trapezius, Upper Division. 8. Longus Capitus, 9. Semispinalis Capitus and possibly more. The bones of the cranium are to the primary computer what the vertebrae of the spine are to the spinal column. The acupuncture point of the primary computer is BI.

### TO REVIEW

Each computer represents a level of expression and processing. Each level is capable of input, processing and output. The hierarchy is set so that the most important decisions are made by computers which are capable of the greatest degree of related computation. Thus problems of an endocrine nature are handled by the Endocrine computer. Problems of a muscle level are processed at this level also. However, since a muscle is a display unit for the other computers, muscle aberration requires special attention.

### KINESIOLOGY

In 1964 Dr. George Goodheart discovered a new diagnostic test for body evaluation. It was called Applied Kinesiology and consisted of muscle testing to evaluate

the musculoskeletal status of the patient. Since 1964, the body of knowledge and application of Applied Kinesiology has grown to immense proportions.

Muscle testing is biological computer evaluation. If interpreted correctly, adequate insight into body signs, symptoms and language are easily processed into meaningful information.

#### ADAPTATION

In the early stages of disease clear relationships exist between muscles and organs. Thus every thyroid dysfunction demonstrated a weak Teres Minor. Every kidney dysfunction demonstrated a weak Psoas muscle, etc. These decisions are generally a reflection of the strategy of the Endocrine computer. Perhaps at this point in time, all elements necessary for healing of the kidney are not available. The stress in the kidney and Psoas muscle are too great and the organism is threatened. This forces the Endocrine computer into a decision or what may be called an adaptation. The adaptation means in a practical sense that the weight or burden is switched to another organ. In a successful adaptation, frequently the pain or discomfort leaves and the patient may feel better even though the kidney problem still exists. In this case, depending on other variables, the Psoas muscle may return to normal tone. Switched means exactly what it says--the burden is delegated to another organ or tissue. Generally this results in a hypertonic organ or muscle related to that organ. To be switched, as is often stated in Applied Kinesiology, indicates a successful adaptation. Kinetic diagnosis made in adaptive stages are less significant. This is why the switching technique treatment has become so important.

As a disease proceeds in time, generally speaking, the display spreads. The muscle system may show many muscle weaknesses, but many are effects of the adaptation rather than the cause.

With the above understanding, a new conceptualization of disease may be presented. Disease can be represented as:

1. Breakdown in communications.
2. Conflict in strategies between levels of functions or computers.
3. Circuit overload.
4. Circuit erosion.
5. Inadequate input for adequate resolution.
6. Inadequate transferring of information, nutritional deprivation, RNA, neurotransmitters, etc.
7. Priority of CPU not recognized by treating physicians.
8. Abnormal input from oral cavity, i.e. suppressive drugs, etc.
9. Computer processing at full capacity and therefore data is put on hold.
10. Compartmentalization of aberrant tissue.

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## **Chapter II**

# **The Adaptive Syndrome**

There is a principle which is a bar against all information, which is proof against all argument, and which cannot fail to keep a person in everlasting ignorance. This principle is . . . contempt prior to examination.

---William Paley, Eighteenth Century

## GENERAL ADAPTIVE SYNDROME

### History

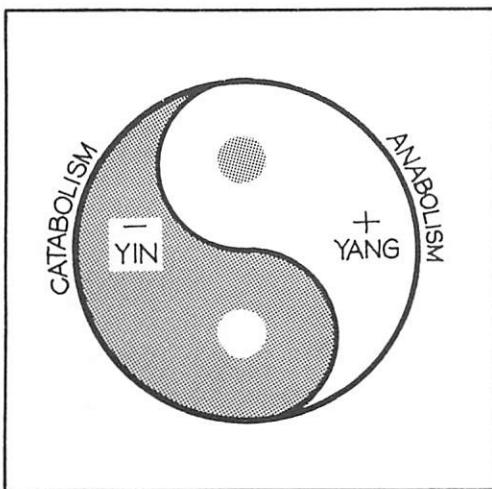
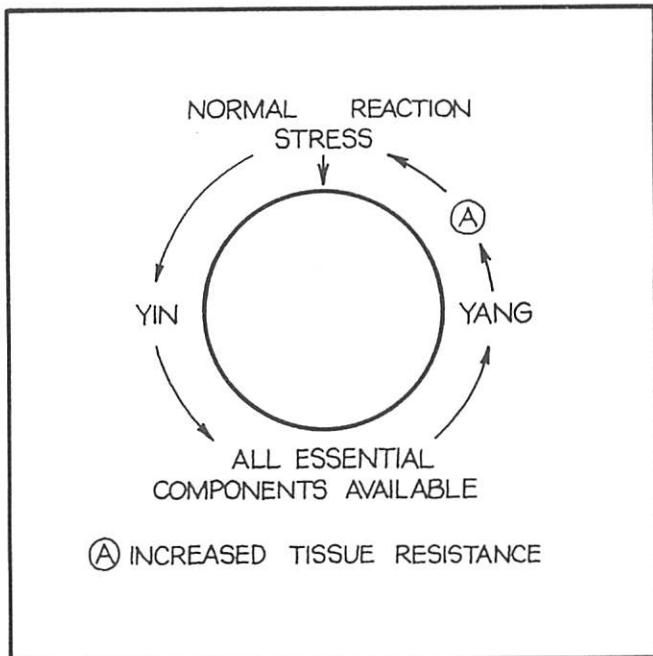
In the late 1940's and early 1950's Dr. Hans Selye, a noted Canadian Physician completed his research on stress and wrote "THE STRESS OF LIFE." This book discusses the "G.A.S." (General Adaptive Syndrome) and the L.A.S. (Local Adaptive Syndrome). The G.A.S. was divided into three phases: 1. Alarm 2. Resistive (adaptive) and 3. Exhaustive. These three phases describe the reaction of the body to stressors and have been called: 1. Shock phase 2. Counter shock phase 3. Resistance phase and 4. Exhaustive phase.

In Clinical Kinesiology there is a difference between resistive and adaptive states. Resistive refers to the ability of the inner mechanism of the cell or tissue to perform a task it was previously unable to achieve without major support from other tissues or organs. Adaptation is the failure of the inner mechanism of the cell to perform a task for it requires support from other tissues or organs. In the resistive stage, the cell does not borrow from the reserves of other tissues or organs.

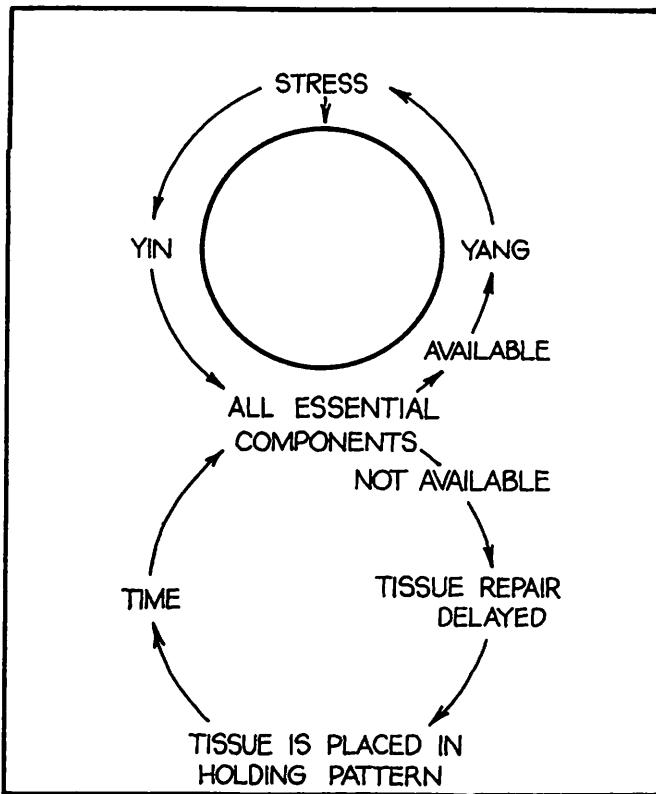
Normal cells are biphasic in nature. Their basic functions include: 1. Catabolism (Yin) 2. Anabolism (Yang).

Catabolism is defined as destructive metabolism of the cell while anabolism is defined as constructive metabolism of the cell.

Stress is defined by Selye as the "rate of wear and tear caused by life."



Stress is a normal part of our lives. It provides natural stimulation and perpetuates life. The diagram above demonstrated a normal healing cycle. As a result of exposure, the organism gains greater resistance and knowledge about itself and its environment.



Greater resistance is achieved by having all essential components of tissue repair available. If they are available tissue repair takes place and the cell survives. If these components are not available the tissue is placed in a holding pattern to allow time for all components to be made available. It is important to be aware of the essential components of repair. They are divided into two parts: 1. External and, 2. Internal Factors.

#### I. External Factors

##### A. Nutrition

1. Proteins - amino acids
2. Carbohydrates
3. Fats
4. Minerals
5. Vitamins

##### B. Electromagnetic Energy

We live in a sea of energy. Under normal circumstances we utilize energy from the sun, earth, moon, water, air, plants, etc.

C. Rest

D. Exercise

E. Absence of these negative external stressors, i.e.

1. Financial worries
2. Family problems
3. Bacteria, virus, parasites, etc.
4. Trauma
5. Overuse syndromes
6. Aberrant emotional patterns
7. External environment over-load - heat, cold, etc.

#### II. Internal Factors

- A. Blood supply
- B. Lymphatic drainage
- C. Minimum venous stasis
- D. Nerve supply
- E. Structural alignment
- F. Acupuncture energy - "Chi"
- G. Adequate hormone levels
- H. No interference from other systems:

1. Viscera
2. Other muscles
3. Glands
4. Mental State
5. Emotional state
6. Nervous system

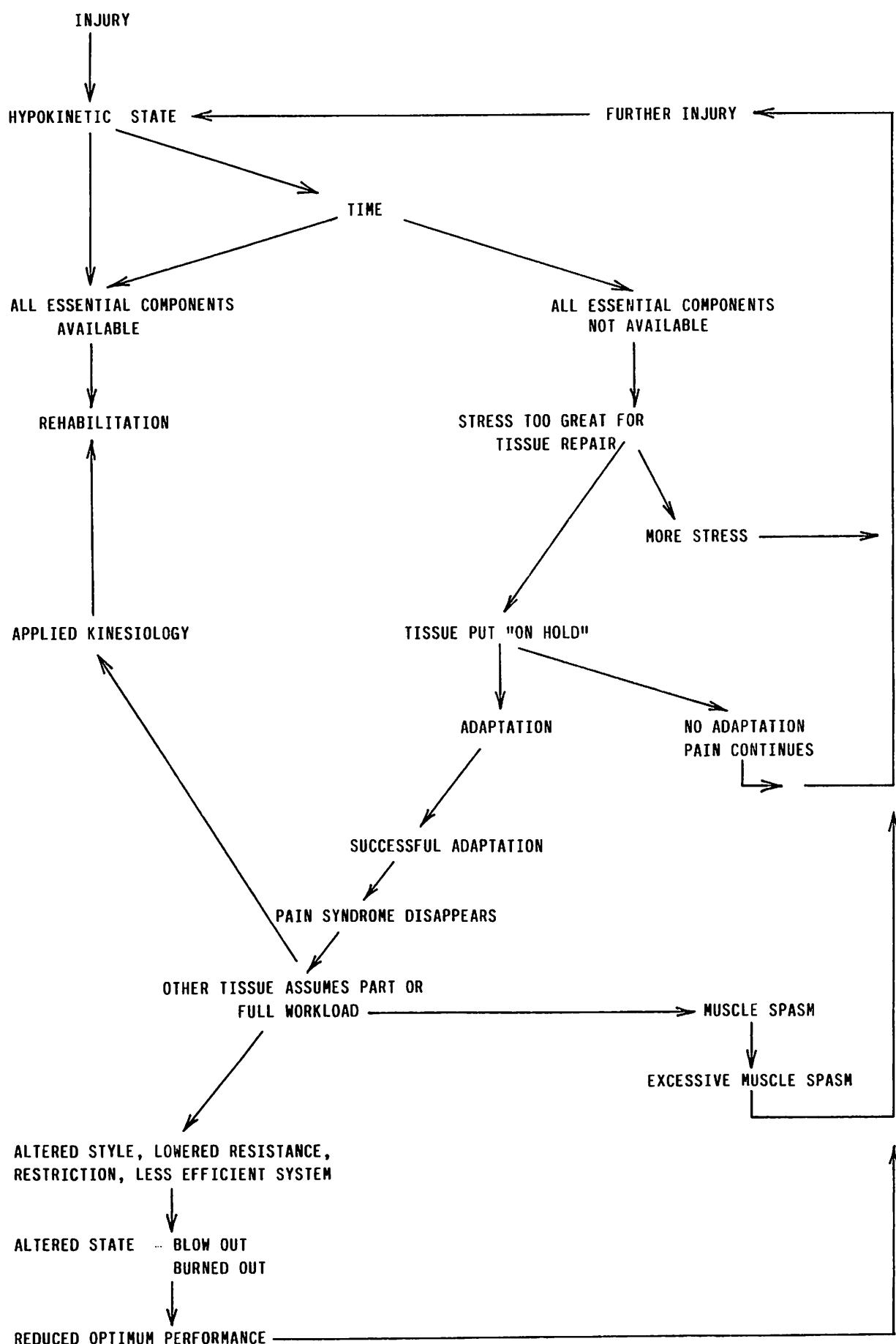
In order for tissue repair to take place all of these factors must be available in "sufficient" quantity in the tissues that are participating in healing.

The chart below describes the steps the body generally takes following an injury.

The injury that does not rehabilitate but undergoes a successful adaptation has the following problems:

1. Some other tissue has assumed at least part of its work load.
2. The related tissue has altered functions i.e. stiffness, spasm, hypokinesia, etc.
3. Somewhere in the organism there is a reduction in performance.
4. Diminishing of the reserve force and draining the organism of its positive strengths.
5. The organism as a whole is less efficient and restrictive.
6. Further injury potential.

## THE INJURY SYNDROME



The science of Clinical Kinesiology is dedicated to help the doctor accurately diagnose the conditions of the body and the factors that may be missing or interfering with the optimum healing process. If the Doctor intercedes at the right time, the healing process can be successfully guided and enhanced with increased resistance without a general adaptive syndrome.

When the day comes that all stress is maintained within the triphasic and biphasic stages of healing, we will live to the maximum of our physical vehicles in excellent health. With this basic understanding of the general injury cycle, we will now discuss its component parts.

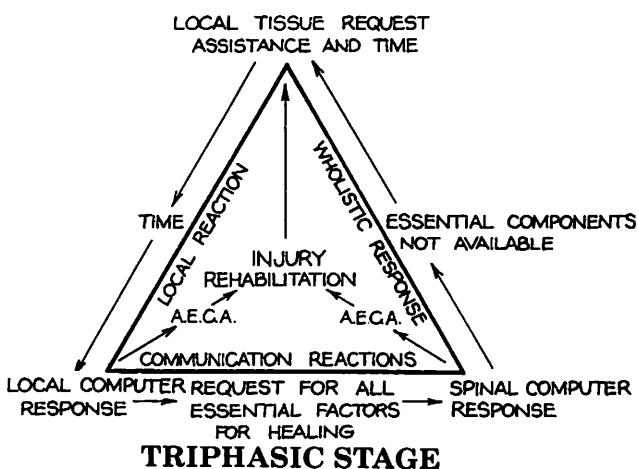
#### Excessive Stress Syndrome

When all essential elements are available healing of tissue is easy and relatively simple. Generally all that is needed is -Time!

The Triphasic Stage is resistive and not adaptive.

(From this point on, all essential components available will be abbreviated -A.E.C.A. and all essential components not available-A.E.C.N.A.).

Normal tissue is biphasic in nature. Tissue injured beyond its inherent capabilities cause it to become triphasic. The biphasic and triphasic stages do not appear to have:



1. Any positive T.L.
2. Any positive mode or produce any high frequency radiation as detected by the Toftness Radiation Detector. While the cells are not normal, they are under control and the tissue is organized.

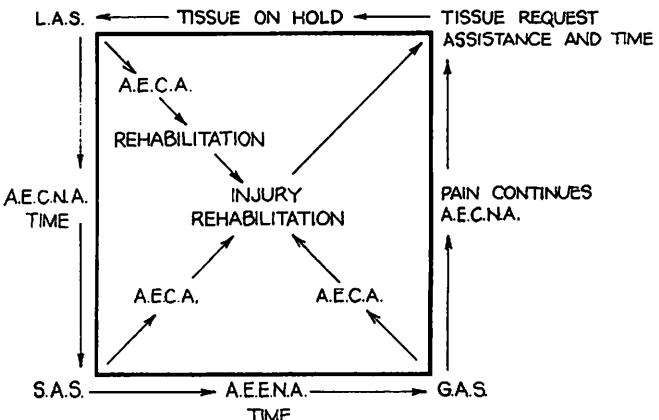
In the triphasic stage of healing the cells and local injured tissue need assistance for the repair process. Their messages are recorded in the local computer network and the AECA may be provided from that level. If not, the local computer requests assistance from a more sophisticated computer network, the Spinal Computer. This computer is in charge of digestion. The request for help is made and the nutrients and other necessary factors are made accessible. Pain is not normally part of this phase. It is characterized by slight tissue swelling, stiffness and muscle soreness. When discussing adaptation the following symbols will be used:

1. L.A.S. - Local Adaptive Syndrome
2. S.A.S. - Spinal Adaptive Syndrome
3. G.A.S. - Glandular Adaptive Syndrome
4. P.A.S. - Primary Adaptive Syndrome

These refer to the Local, Spinal, Glandular, and Primary Computers respectively.

When all the components are not available to resolve an injury, the injury takes on a new dimension called a holding pattern. This pattern is the "Acute Stage" of disease.

#### ACUTE STAGE OF DISEASE Holding pattern



#### ACUTE STAGE OF DISEASE

This is the first visible stage of disease. There is evidence of inflammation, tissue swelling, and sharp pain. This tissue will have a positive palmer T.L., respond to modes and express high frequency radiation as determined by the Toftness Radiation Detector. These tissues are A.E.C.N.A. or if they do have sufficient material it is in insufficient quantity for tissue healing. The tissue may be so damaged that more time is necessary to set the stage for healing. This is very common in bone fractures, ligament strains, cuts and bruises, etc.

Tissue requests are first handled by the Local and Mini-Computers (L.A.S. Local Adaptive Syndrome). If unable to handle rehabilitation, the problems are passed to the another level of hierarchy, the Spinal Computer. Here efforts are made to initiate rehabilitation. If this is not possible, requests are passed to the next hierarchy. In the acute stage of healing, the Glandular Computer is the highest level of decision making. It may decide to produce more hormones by accelerating specific organs and by supressing others. It has several options. If rehabilitation is not initiated within a reasonable period of time, the patient's CPU may accelerate the acute phase producing enough inflammatory reaction to complete the healing.

If rehabilitation occurs, the patient is taken out of the holding pattern and placed in the triphasic stage for its completion. Sometimes the stress on this particular system is so great that more reserves must be sought and the body then switches to the sub-acute stage of healing. This is the first real stage of biological adaptation and is more than a holding pattern. The C.P.U. must develop strategy and commit itself to a precise course of action resulting in a reduction of general energy, and a commitment of certain energies, hormones, glands, liver and adrenal action, etc, to protect the injured area being healed.

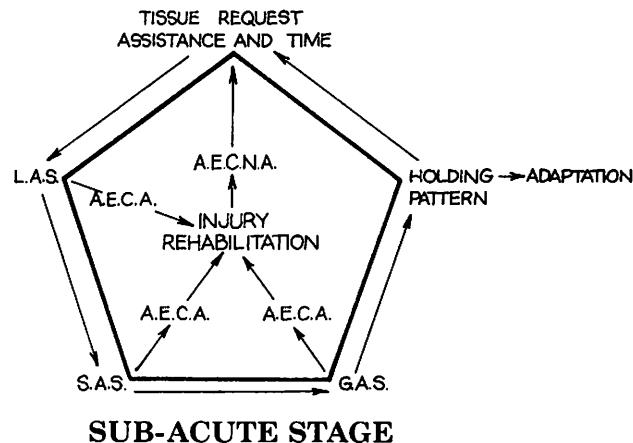
#### COMPARTMENTALIZATION OR SEGMENTATION

True adaptation takes place where the L.A.S. and S.A.S. are unable to deal with stress by adequate resistive action. The goal of the organism is to survive a hostile external and sometimes internal environment. A tubercular cyst is a good example of the C.P.U. moving from the acute to sub-acute and from the chronic to degenerative stages. In each step there is a loss of energy as the body attempts to share the stressor with other parts of the body. This accounts for

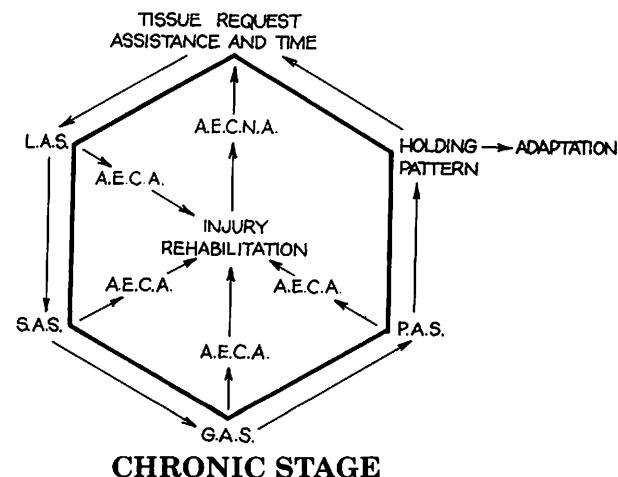
healthy organs in one part of the body while other parts are weak and prone to disease.

Once we recognize the system the body uses for adaptation, it is then necessary to find the number of steps the body has taken for adaptation. The deeper the problem, the less chance the body has to generate its own internal healing. Therefore it requires external support systems to return to normal function.

The sub-acute stage is transitional in nature. It is not a major holding area in disease patterns. The body sets its strategies better in the acute, chronic and degenerative stages. In this stage the Glandular Computer has committed itself and the Primary Computer is left with the adaptive decisions.



Chronic



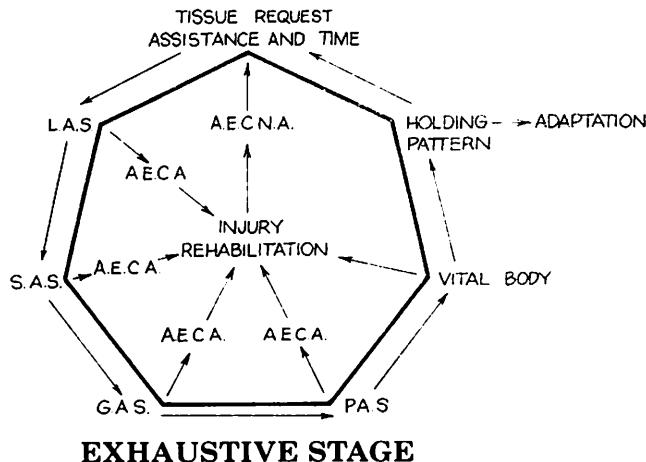
In the chronic phase sharp pains have disappeared because the body has undergone a successful adaptation. The patient complains of occasional dull aches, sensations, loss of energy and inability to perform certain physical feats. Remember that this adaptation can be very specific and does not necessarily mean that there is a gross shift in vitality. Most people are dealing with several problems in the chronic stage and a few in the degenerative stage by the time they are 50 years old.

The important thing to remember in chronic as well as the rest of the disease stages is that the patient is in a definite adaptive pattern. The muscle weakness and positive T.L. seen are most frequently an aberrant display of kinetic systems responding to overall strategy of the computer's C.P.U. Dorsum T.L. is positive in this stage.

The organism always seeks the most efficient way to maintain and prolong life. In some instances it may do this to the detriment of a local area or tissue. Its primary interest is in the survival of the organism as a whole. It must sacrifice some local functions in order to keep the organism surviving. It must also spread the stress of the disease and may develop specific patterns that are not necessarily to our liking.

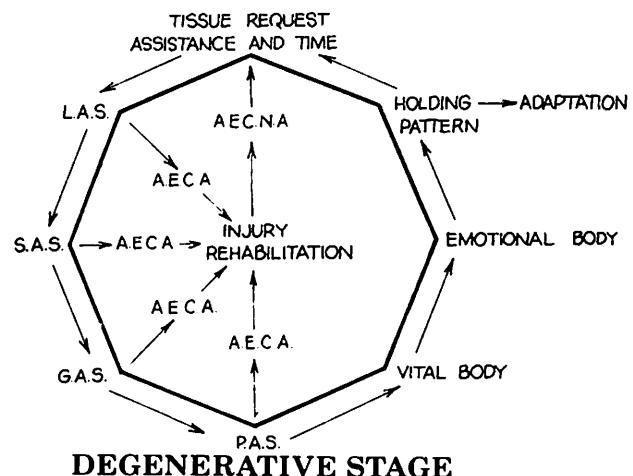
In the "Stress of Life", Dr. Selye talks about adaptive energy. This energy is the acupuncture system. We have found that aberrations in the cloacal mechanism, the gaits, and the group muscles are all physical evidence of the activation of adaptation. These mechanisms will be discussed in the chapter on clearing techniques.

#### Exhaustive Stage



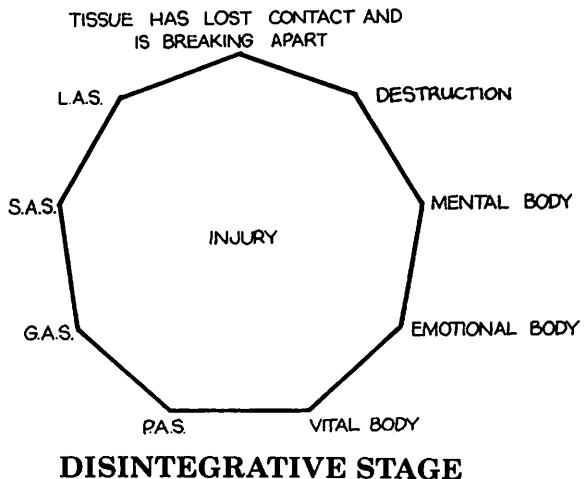
In this stage of the disease the tissue is exhausted and unable to maintain reasonable energy. The tissue is losing its polarity and does not appear to be able to recover with rest. This stage is transitional by nature and is not a stable position. There is less vitality and function than in the chronic stage, but it is not in a degenerative stage.

#### Degenerative Stage



At this stage of the disease rehabilitation is very questionable for most people. It will take a long time of consistent treatment to allow this area or tissue to regain its vitality. Cellular metabolism does not change over night. Under conscientious treatment the cells in certain tissues may start modifying and upgrading their function. This represents a drain of the vital and emotional bodies. In the degenerative stage the person can become very emotional for no apparent reason.

## Disintegrative Stage



Notice that the mental body is activated in this stage. The will of the soul is keeping the tissue from dying. There is no vitality in the tissue for it has degenerated and is now in its final stages ready for death. This may be a totally isolated area of the body and does not necessarily reflect the organism as a whole.

Dr. Selye has presented a general picture of adaptation. We have tried to expand these concepts to give precise steps that the individual organism develops while in moving through the disease process. The

treating physician is concerned about the priorities of the organism and how to help it solve these problems in a reasonable, rational and natural way if at all possible. In these later stages the organism may be helped best by surgical extraction of the disintegrating tissue.

The following thoughts should be kept in mind.

1. There is a significant difference between resistance and adaptation.
2. When stressors exceed resistive resources, the tissue undergoes specific stages of resistance and adaptation. They are as follows:
  - a. Biphasic
  - b. Triphasic
  - c. Acute
  - d. Sub-acute
  - e. Chronic
  - f. Exhaustive
  - g. Degenerative
  - h. Disintegrative

These stages may be compartmentalized and may not necessarily reflect the organism as a whole.

Our goal is to find ways to measure and increase our resistance without initiating the adaptive process. Adaptation should be a temporary state if the stressors are intense and prolonged. Adaptation leads to tissue exhaustion and death.

## **Chapter III**

# **Clearing Techniques**

The mere looking at externals is a  
matter for clowns, but the intuition  
of internals is a secret which belongs  
to physicians.

--Paracelsus

## COMPUTER CLEARING TECHNIQUES

### COMPUTER CLEAR OUT

Frequent observations by Applied Kinesiologists suggest that the number of muscle weaknesses in an area of complaint appears out of proportion to the number of organs actually involved. Certainly not all muscles are reflecting an organ dysfunction. In painful situations, numerous feedback systems and computer adaptations lead to a mass of overriding neurological output which results in multiple muscle aberrations.

In chronic degenerative conditions, the body spreads the stress to many areas (muscles, organs).

Basic challenges must be used so that the doctor can accurately determine if the CPU and each of the computers are functioning properly.

The most efficient entry point at this time is the use of the "Now" or Alarm Points of the acupuncture system. (see charts for Alarm Points).

The Chinese system of acupuncture states that Chi or energy, while being present in all meridians, concentrates its energy in a specific meridian for a two hour period. This wave of energy (wave crest) follows a predictable sequence and can be measured kinetically by therapy localizing the Now or Alarm Point of each respective meridian. The Alarm Point of the meridian, when in its horary period, should T.L. in the clear. The Now Point and the Alarm Point are considered the same.

#### Challenges for the Alarm Point

1. The Alarm Point should have a positive bilateral T.L. in the clear.
2. The Dr. should be able to elicit a positive T.L. as well as the patient.
3. The Alarm Point when T.L. should produce muscle weakness in all intact muscles in all four quadrants

and the neck.

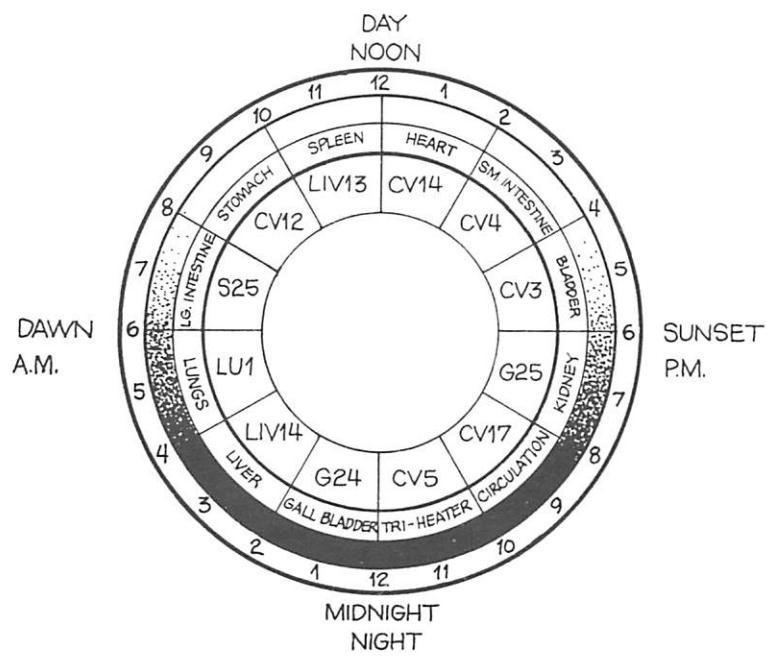
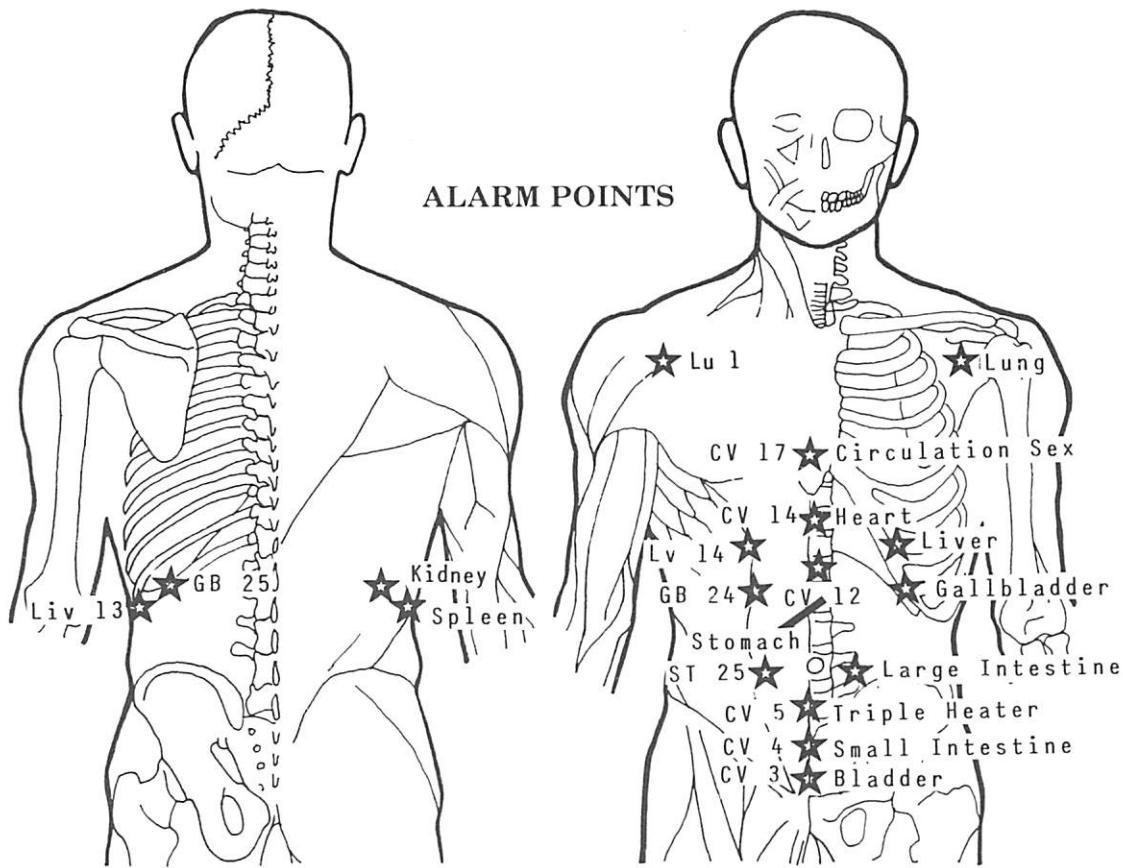
4. The Alarm Point should produce a positive two-point when the contralateral hand is placed over the ipsilateral hand while testing a lower extremity muscle.
5. The Alarm Point should have a positive T.L. with either hand in any quadrant of the body.
6. While maintaining a positive alarm point, the following areas should be negative with all five fingers: A. Umbilicus, B. Xiphoid, C. Lips, D. Nose.
7. The area of complaint should always two-point to the Alarm Point.

If any of the above are not positive or do not produce a positive two-point, the bio computer is considered in a stage of bio-adaptation and not operational for efficient diagnostic procedures. It is then considered positive for clearing techniques.

#### Clearing Techniques

There are five basic types of clearing techniques each symbolized by a specific finger:

- I- The thumb represents the computer clearing technique (C.C.T.).
- II- The index finger represents the mini-computers of the Local Computer.
- III- The middle finger represents the mini-computers of the Spinal Column.
- IV- The ring finger represents the mini-computers of the Glandular Computer.
- V- The little finger represents the mini-computers of the Primary Computer.



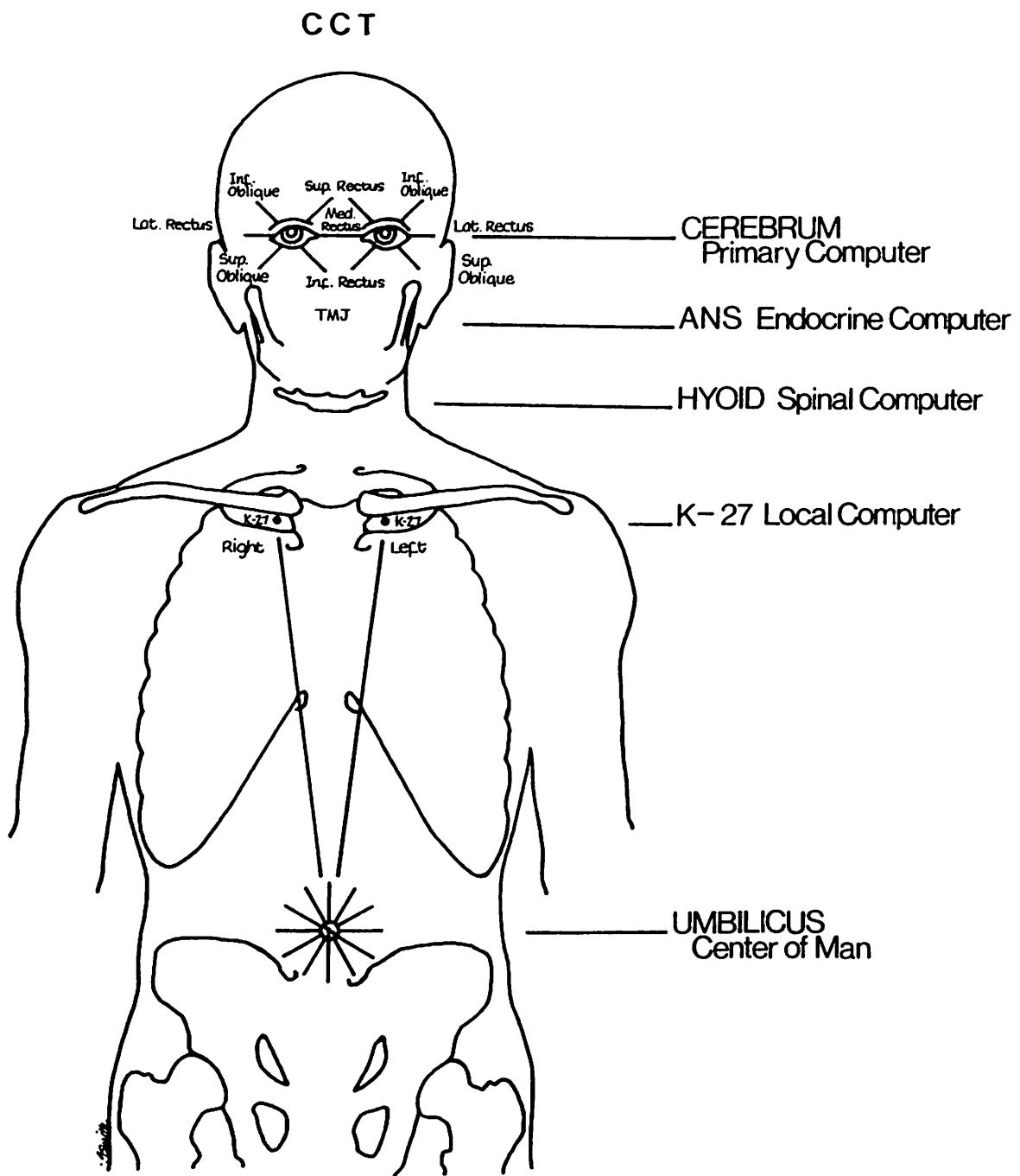
Note: The acupuncture points listed above are the Alarm or "Now Points" for their respective meridians. The above chart represents Daylight Saving Time. For Standard Time, move back one hour.

A) C.C.T. Computer Clearing Technique -  
Thumb

The C.C.T. is the most complex of all clearing techniques. It involves activation of all computers and represents a major shift in bio-adaptation. The C.C.T. is considered positive when any of the following areas has a positive two-point to the thumb.

1. Umbilicus, 2. Xiphoid, 3. Lips, 4. Nose.

1. If the thumb two-points, find a direction in the umbilicus and a neutral finger that also two-points to that muscle or muscle group. There are 12 possible directions to the umbilicus. (see CCT Chart).



2. Retest the muscle and confirm the direction of the umbilicus contact. Continue with the rest of the computer clear out.

3. Challenging the Local Computer - K27. Turn the head to the left and right and test. Find the positive two-point. If the direction of the umbilicus was 1-5, the K27 should be positive on the left with the head turned to the right. If the direction on the umbilicus was 7-11, the K27 should be positive on the right with the head turned to the left. Head turning to the opposite side of the positive K27 is activated by the Ipsilateral Sternocleidomastoid. Note your information and place the head in neutral again. If the direction of the umbilicus is 6 or 12, test each side of head turn to determine the correct position.

4. Challenging the Spinal Computer-Hyoid. The Spinal Computer adaptations are generally stored in the muscles of the Hyoid. The most frequent muscle involved is the Stylohyoid and is challenged primarily R-L or L-R. Record the positive two-point with the umbilicus. Put the Hyoid in neutral and proceed to the TMJ. The hyoid generally moves the same direction as head turn.

5. Challenging the Endocrine Computer-TMJ. The Endocrine Computer adaptations are stored in the muscles of the TMJ. They may be hypertonic or flaccid depending on the circumstances. Most adaptations appear in the Pterygoid Externus muscle activated by opening the jaw and moving it laterally. Find the TMJ position that has a positive two-point to the umbilicus contact. Place the TMJ in neutral and proceed to the eyes. The TMJ usually moves opposite to the hyoid on the same side as the umbilicus contact.

6. Challenging the Primary Computer-Eyes. The involved eye is usually found positive on the same side as the TMJ. Activate each of the eye muscle groups until a positive two-point to the umbilicus is found.

#### PROCEDURES FOR CORRECTION

- a. Hold the proper direction of the umbilicus.
- b. Turn the head opposite the side of the diagnosed K27.
- c. Place the patient's hand on the hyoid bone and push in the proper direction.
- d. Move the jaw to the diagnosed position.
- e. Activate the eye muscle of the patient in the proper position and hold all of the above.
- f. Hold the umbilicus direction and tap or rub the correct K27 and wait for harmonious pulsations. This should take 30 seconds to one minute or at the most 2 minutes.

#### B) Local Computer Clearing Technique - Index Finger

The local computer mini-computers are considered positive when the index finger two-points to any of the following areas: 1. Nose, 2. Lips, 3. Xiphoid, 4. Umbilicus.

#### Procedure for Clearing Local Computer

While maintaining contact with the involved areas above, find a positive directional two-point to the umbilicus and to one or more of the following areas:

1. Bilateral B10 located at the junction of the atlas and the axis 1 inch lateral to the spine.
2. Bilateral S13 located on the mid-clavicular line at the junction of the 2nd rib and clavicle.
3. Bilateral K11 located just superior to the pubis one inch lateral to the midline.
4. Bilateral B26 located at the junction of L5 and the sacrum just medial to the PSIS.

Once the diagnosis has been completed, hold the positive point with the umbilicus until a synchronal pulsation is felt.

### C) Spinal Computer Clearing Technique - Middle Finger

The spinal computer mini-computers are considered positive when the middle finger two-points to any of the following areas:

1. Nose 2. Lips 3. Xiphoid 4. Umbilicus

#### Procedure for Clearing Spinal Computer

While maintaining contact with the involved area above, find a positive directional two-point to the umbilicus and to one or more of the following areas:

1. Bilateral LI15 located at the junction of the humerus and the scapula.
2. Bilateral G30 located on the fascia just inferior to the greater trochanter.
3. Anterior Cloacals - see Anterior Cloacal Reflexes, this chapter.
4. Visual reflexes - see Visual Righting Reflexes, this chapter.

Once the diagnosis has been completed, hold the positive points with the umbilicus until a synchronal pulsation is felt.

### D) Glandular Computer Clearing Technique - Ring Finger

The glandular computer mini-computers are considered positive when the ring finger two-points to any of the following areas:

1. Nose 2. Lips 3. Xiphoid 4. Umbilicus

#### Procedure for Clearing Glandular Computer

The hand and foot gait reflexes are considered to be the mini-computers of the Glandular Computer. While maintaining contact with one of the 4

areas above, find a positive directional two-point to the umbilicus and to one or more of the gaits (see section on Gaits).

Once the diagnosis has been completed, hold those points with the umbilicus until a synchronal pulsation is felt.

### E) Primary Computer Clearing Technique - Little Finger

The primary computer mini-computers are considered to be positive when the little finger two-points to any of the following areas:

1. Nose 2. Lips 3. Xiphoid 4. Umbilicus

#### Procedure for Clearing Primary Computer

The entry acupuncture points are considered to be the mini-computers for the primary computer. These areas will be identified from medial to lateral, head to foot. While maintaining contact with one of the 4 areas above, find a positive directional two-point to the umbilicus and to one or more of the following areas.

##### Eye:

1. B 1 located on the medial aspect of the eye.
2. G 1 located on the lateral aspect of the eye.
3. S 1 located on the inferior aspect of the middle of the eye.

##### Chest:

4. L 1 located on the anterior aspect of the scapulo-humeral junction.
5. CX 1 located on the anterior and lateral aspect of the chest just lateral to the nipple at the 5th rib.
6. H 1 located in the axillary fascia at the junction of the scapula and the humerus.

##### Hand:

7. Si 1 located at the base of the cuticle of the little finger.
8. TW 1 located at the base of the cuticle of the ring finger.
9. Li 4 located at the junction of the proximal section of the 1st and 2nd metacarpals.

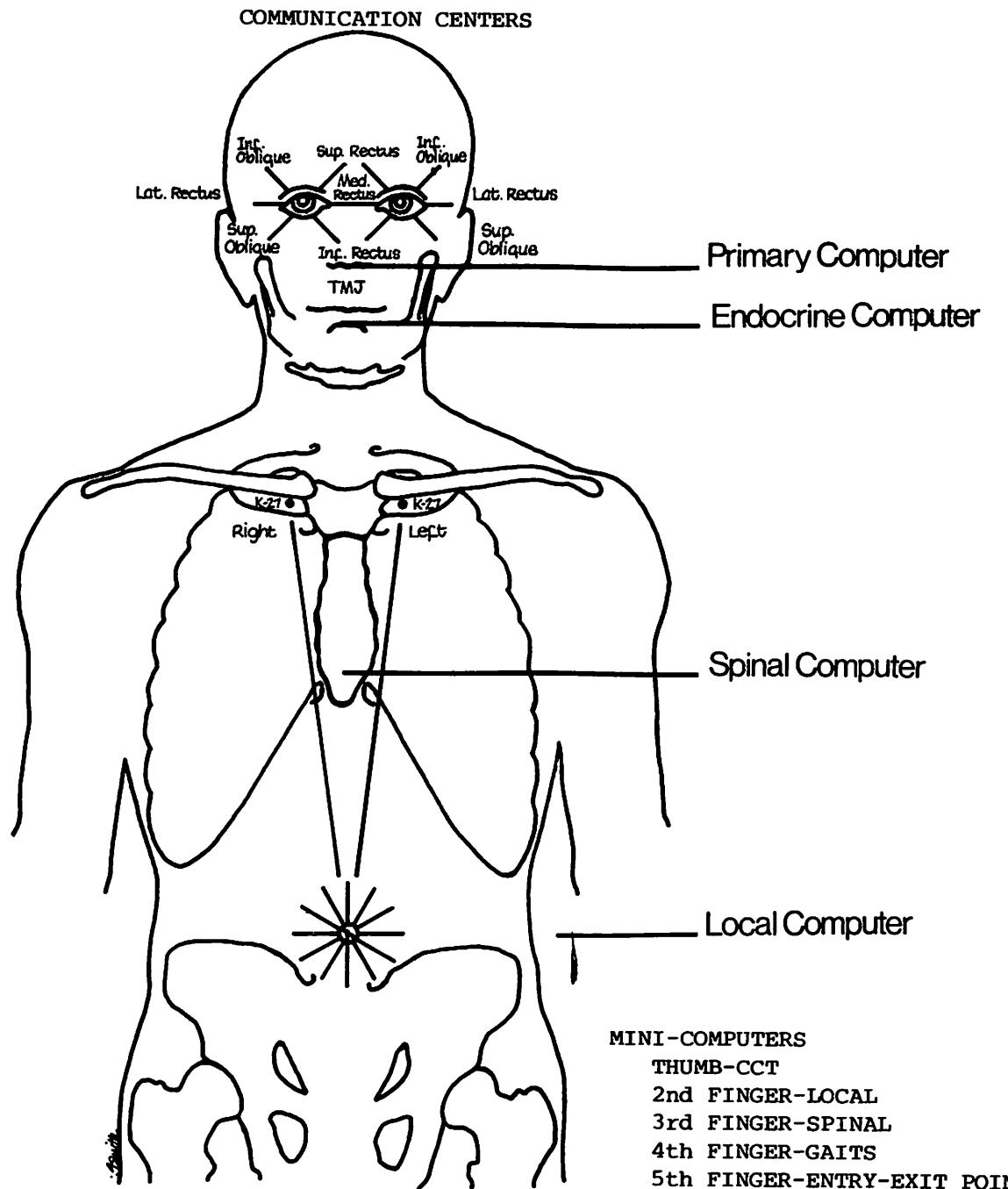
**Foot:**

10. SP 1 located at the base of the cuticle, medial aspect, of the big toe.
11. LV 1 located at the base of the cuticle at the lateral aspect of the big toe.
12. K 1 located at the mid-metatarsal plantar surface of the foot in line with the 3rd metatarsal.

Once the diagnosis has been completed,

hold the positive points with the umbilicus until a synchronal pulsation is felt.

Listed in this section under clearing techniques are gaits, cloacals, and group muscle testing. Our knowledge at this time indicates that a patient is clear when they have complied with those standards listed under challenges for the alarm point, and have normal gaits, cloacals and group muscle tests.



## GAIT TESTS

The gait mechanism and its application to Applied Kinesiology by muscle testing was introduced to the Chiropractic Profession by George Goodheart, D.C. in 1974. His original presentation consisted of four basic gait mechanisms which became known as the liver, spleen, stomach and gallbladder gaits. These gaits were named according to the acupuncture meridian which contained their respective active reflex. All were located on the foot.

Dual simultaneous muscle testing was a new concept in Applied Kinesiology. Prior to 1974 only single or isolated muscle testing had ever been used. Gait testing opened a new opportunity in exploration of body language.

### HISTORY

Dr. Goodheart's original gait tests covered four of the six meridians of the foot. Our personal research concluded in 1975 - 76 resulted in two additional gait tests - kidney and bladder. This investigation also suggested that the acupuncture point generally related to the gait mechanism was located on the distal aspect rather than the proximal aspect of the metatarsals. In 1978 further research resulted in the development of hand gait reflexes which were then coordinated with the foot gait reflexes. (see chart below).

GAIT	FOOT	CONTRALATERAL HAND
Bladder	B 65	L 10
Liver	LV 2	Li 3
Kidney	K 1	Si 3
Stomach	ST 44	H 8
Gallbladder	GB 43	CX 8
Spleen	SP 3	TW 3

### FUNCTIONS

The gait mechanism appears to be associated with the following:

- 1) General adaptation of the CPU.
- 2) Mobilization of the human body through time and space by coordinated contralateral muscular activity.
- 3) Neurological activity of the spinal cord.
- 4) Reflex activity of the Endocrine computer system.

We have found that clearing the gait mechanism is important in that it helps prevent "switching" or reversal of polarity fields. It is also helpful in preventing excessive fatigue from ordinary exertion such as walking, running, and jumping, etc. Problems with right/left coordination may also indicate the need for gait balancing.

All gait treatment points are located at the distal end of each of the metatarsals. Each of the gait muscle challenges will be demonstrated later in the chapter.

### DIAGNOSIS

Gait energy affects muscular coordination between the upper and lower contralateral extremities. Therefore, testing for gait imbalance involves testing a lower extremity muscle against a contralateral upper extremity muscle to determine if they are able to contract simultaneously. In a gait aberration one or both muscles will test weak when tested simultaneously, while the individual muscle will test strong.

Manual muscle testing (see next section) is by far the most efficient method of determining a positive gait aberration. General therapy localization is often used but not necessarily valid. The general clearing technique will usually point out the need for gait therapy. Disturbances in gait function are often detected by visual examination. These are then confirmed by manual muscle testing.

## SPECIFIC MUSCLE TESTS

All muscle tests are performed in a supine position. The large white arrows indicate the direction of test. The

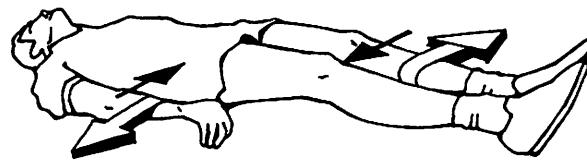
small black arrows indicate patient resistance.

**BLADDER GAIT (fig. 1) CONTRALATERAL HIP AND SHOULDER ADDUCTORS.** Adductor Longus (804) vs Contralateral Latissimus Dorsi (428).

Patient: Supine. Adduct ipsilateral femur. Internally rotate contralateral humerus keeping elbow extended and adduct

elbow to side of body.

Dr.: Contact ipsilateral knee and with contact at dorsal aspect of contralateral forearm, attempt to abduct arm and leg from side. The test may be performed by adducting the arm forcefully and testing the hip adductor.



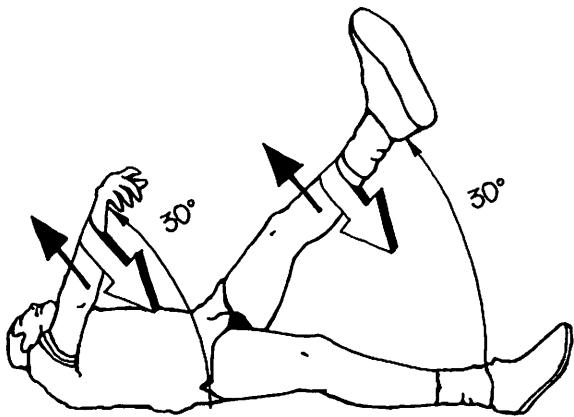
BLADDER GAIT - ADDUCTOR LONGUS VS LATISSIMUS DORSI

**LIVER GAIT (fig. 2): CONTRALATERAL HIP AND SHOULDER FLEXORS.** Rectus Femoris (796) vs Contralateral Anterior Deltoid (416).

Patient: Supine. Flex thigh 30 degrees from table keeping knee extended. Flex contralateral shoulder 30 degrees with slight internal rotation of humerus

keeping elbow extended.

DR.: With contact at anterior surface of ankle and second contact at dorsal surface of forearm, attempt to simultaneously extend arm and leg.



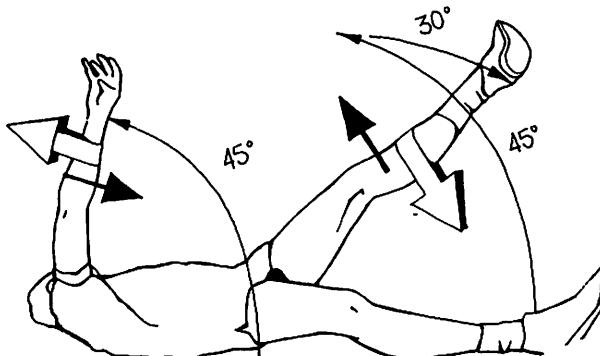
LIVER GAIT - RECTUS FEMORIS VS ANTERIOR DELTOID

KIDNEY GAIT (fig. 3): Psoas Major (724) vs Contralateral Pectoralis Major, Sternal Division (400).

Patient: Supine. Flex the ipsilateral femur 45 degrees with 30 degree abduction and full external rotation. Flex

contralateral humerus 45 degrees with full internal rotation.

Dr.: Contact ipsilateral medial malleolus and contralateral wrist and abduct arm and leg.



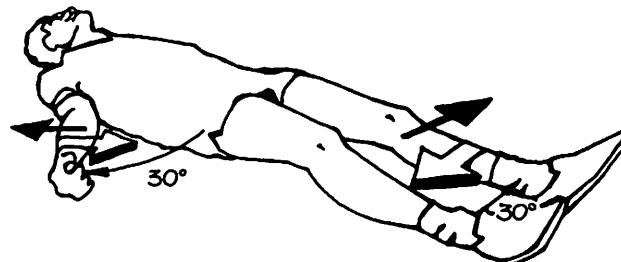
KIDNEY GAIT - PSOAS MAJOR VS PECTORALIS MAJOR, (STERNAL DIV.)

**STOMACH GAIT. CONTRALATERAL HIP AND SHOULDER ABDUCTORS.** Gluteus Medius (782) vs Supraspinatus (420).

Patient: Supine. Abduct ipsilateral femur 30 degrees from midline with no rotation (foot up). Abduct

contralateral arm 30 degrees keeping palm toward body.

Dr.: Contact contralateral malleolus and ipsilateral dorsal surface of forearm to adduct leg and arm simultaneously.



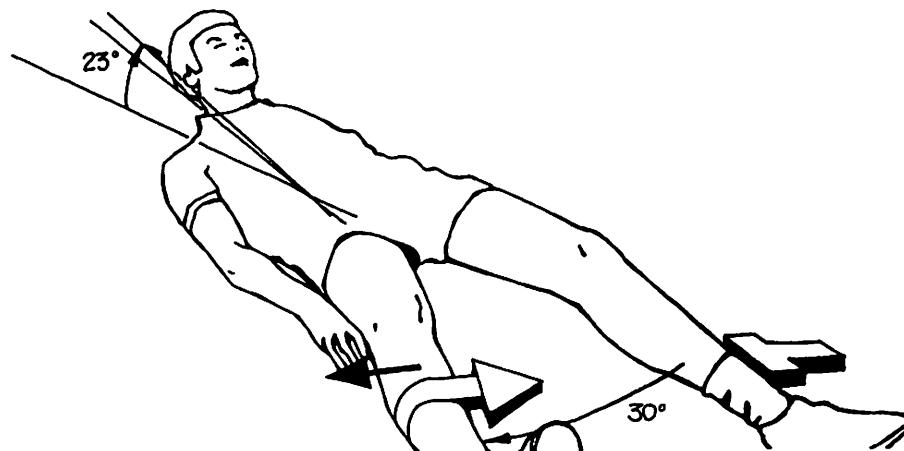
**STOMACH GAIT - GLUTEUS MEDIUS VS SUPRASPINATUS**

**GALLBLADDER GAIT (fig. 5): CONTRALATERAL HIP ABDUCTOR VS TRUNK FLEXORS.** Gluteus Medius, Middle Division (782) vs contralateral Rectus Abdominis.

Patient: Supine. Abduct ipsilateral femur 30 degrees with no rotation. Flex

trunk 23 degrees from horizontal plane to look at knees, (activate Abdominals).

Dr.: Stabilize contralateral ankle and with ipsilateral malleolus contact, adduct the leg.



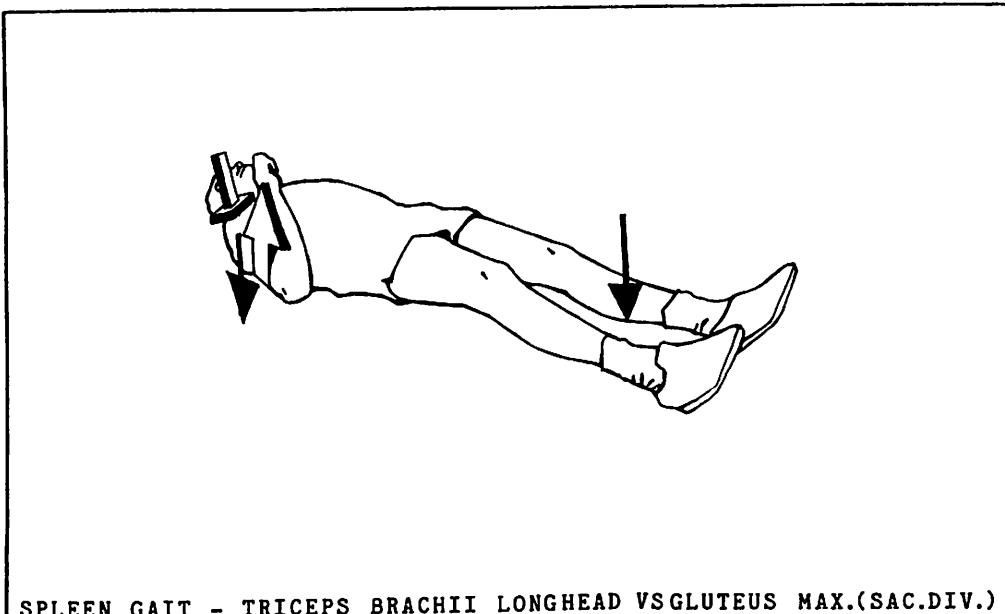
**GALLBLADDER GAIT - GLUTEUS MEDIUS VS RECTUS ABDOMINUS**

**SPLEEN GAIT (fig. 6): CONTRALATERAL HIP EXTENSORS VS SHOULDER EXTENSORS. Gluteus Maximus, Sacral Division (850) vs contralateral Triceps Brachii, Longhead (434).**

Patient: Supine. Raise ipsilateral leg from table keeping knee extended, and extend contralateral leg into table.

Extend ipsilateral arm into table.

Dr.: Brace anterior ipsilateral humerus and with distal humerus contact, flex arm. The test may be reversed by extending ipsilateral humerus and extending contralateral femur, while bracing ipsilateral leg.



#### DIAGNOSTIC PREPARATION FOR GAIT CORRECTION

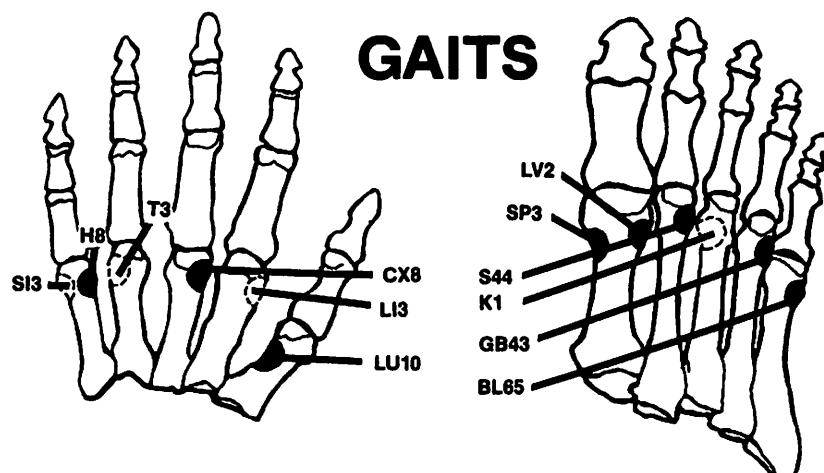
1. The gait reflex point should therapy localize (T.L.) in the clear.
2. The gait reflex should be a non-respiratory assisted lesion, (N.R.L.).
3. Use the gait test for verification.
4. If an N.R.L. gait reflex is not found:
  - a. Check the clearing technique procedures
  - b. Check for structural aberration
  - c. Check for nutritional imbalance
5. Following correction of other factors, recheck gait mechanism to

find N.R.L. lesion.

#### PROCEDURE FOR CORRECTION

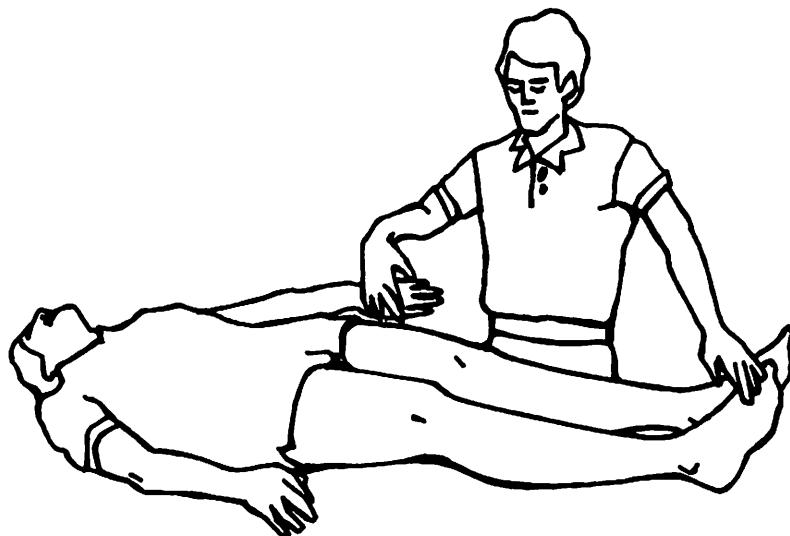
- 1) Correction consists of using synchronous pulsation technique between foot and contralateral hand reflex.
- 2) Have patient swallow frequently during pulsation technique.
- 3) Have patient rotate head first to the right and then to the left. Whichever position yields strength upon muscle testing (negates positive T.L. to gait point) is to be maintained during treatment. (See fig. below).

# GAITS



PALMAR ASPECT

DORSAL ASPECT



GAIT CORRECTION

## CLOACAL SYNCHRONIZATION REFLEX TECHNIQUE

In 1976 George Goodheart, D.C., introduced the cloacal mechanism to practicing Applied Kinesiologists and other professionals. His Research Tape No. 33 identifies the history and development of the cloacal reflexes (1-4). The tape also includes discussions of tonic neck reflexes, labyrinthine reflexes and visual righting reflexes. These reflexes are referred to as the "Cloacal Synchronization Technique."

### HISTORY

The therapeutic benefit of stimulating cloacal reflexes rests upon a solid foundation and has been used extensively in Chiropractic for over forty years. Hurley and Saunders' AQUARIAN AGE HEALING describes the use of a perianal contact. In the late 1940's and early 1950's Dr. Randolph Stone described the use of the perianal contact to correct polarity imbalances between the pelvis, neck and shoulders. Techniques such as Sacro - Occipital, Logan Basic and others have also used the perianal cloacal reflexes. However most of these procedures use only the posterior part of the reflex mechanism. There is also an anterior (perigenital) as well as a posterior (perianal) area of contact in humans, resulting from the fact that the perineum is divided into sexual (genito - urinary) functions and anal functions.

### PURPOSE

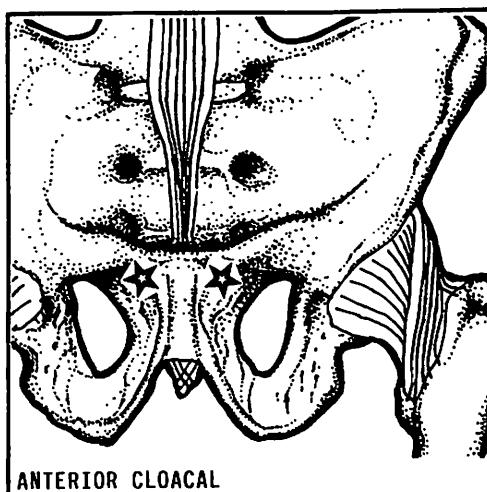
The cloacal mechanism, the labyrinthine reflexes and the visual righting reflexes have at least three functions: 1) A sexual centering device, 2) A postural balancing mechanism and 3) A system of biomechanical adaptation.

The body can be compared to a battery with opposite poles, the head and the pelvis, having electromagnetic energy flowing between them. Vibrant health is a result of the unimpaired flow of that energy. Using special Kinesiological muscle testing procedures, we can identify aberrations in this energy flow as well as detect improper coordination of these postural centers. These systems may not be disoriented in themselves, but

may lack coordination between each other.

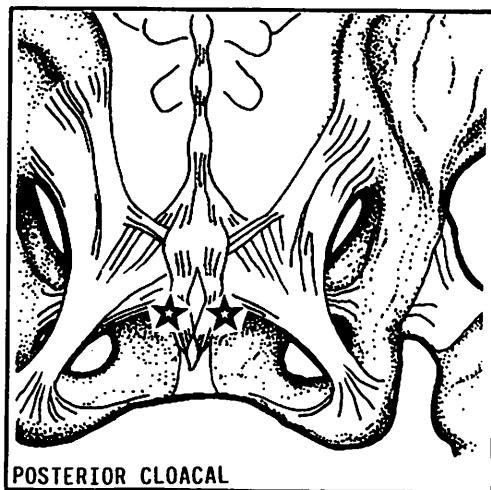
### LOCATION

The anterior cloacal area is exact and specific. It is located bilaterally on the anterior external surface of the superior ramus of the pubis, below the origin of Pectenueus, lateral to the origin of Adductor Longus along the superior border of Obturator Foramen. This is palpable as the area just lateral and inferior to the pubic tubercle.



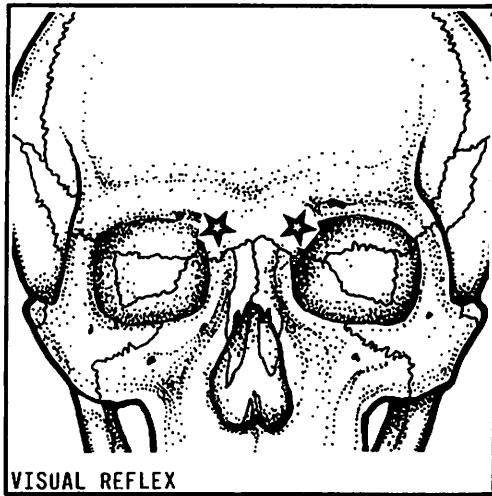
ANTERIOR CLOACAL

The posterior cloacal reflex is located bilaterally on the sacrotuberous ligament at its attachment to the 4th and 5th transverse tubercles of the sacrum and the lateral margins of the coccyx.



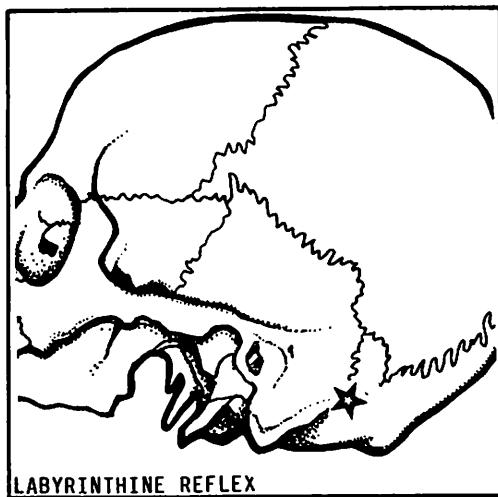
POSTERIOR CLOACAL

The visual righting reflexes are also exact and specific. They are bilateral and are located on the external surface of the frontal bone below the superciliary arch on the medial side of the supraorbital notch or foramen in the supraorbital margin. They are lateral to the attachment of the Orbicularis Oculi.



VISUAL REFLEX

The labyrinthine reflexes are located bilaterally on the mastoid portion of the temporal bone at the external surface of the mastoid notch or digastric fossa which serves as the attachment for the Digastricus. It is medial to the attachment of the Splenius Capitis and the Longissimus Capitis at the most superior section of that fossa.



LABYRINTHINE REFLEX

#### DIAGNOSIS

Our method of diagnosing aberrations of these centers in the past has been therapy localization of each of the postural areas, ie:, the cloacal reflexes anteriorly around the Obturator Foramen and posteriorly on the medial lower third

of the gluteal area. Specific muscle tests of these centers did not exist.

In 1976 and 1980 we devised specific tests for challenging the cloacal synchronization reflexes. These tests measure the coordination between one center and another.

#### MUSCLE CHALLENGES FOR CLOACALS

As muscle tone determines posture and the anterior and posterior cloacals, labyrinthine and visual righting reflexes are postural in nature, these reflexes must affect specific muscles or muscle groups. If these reflexes are not in proper working order, we should therefore be able to see corresponding muscle aberrations within the framework of the body. These are demonstrated by the following tests.

#### CLOACAL TESTS

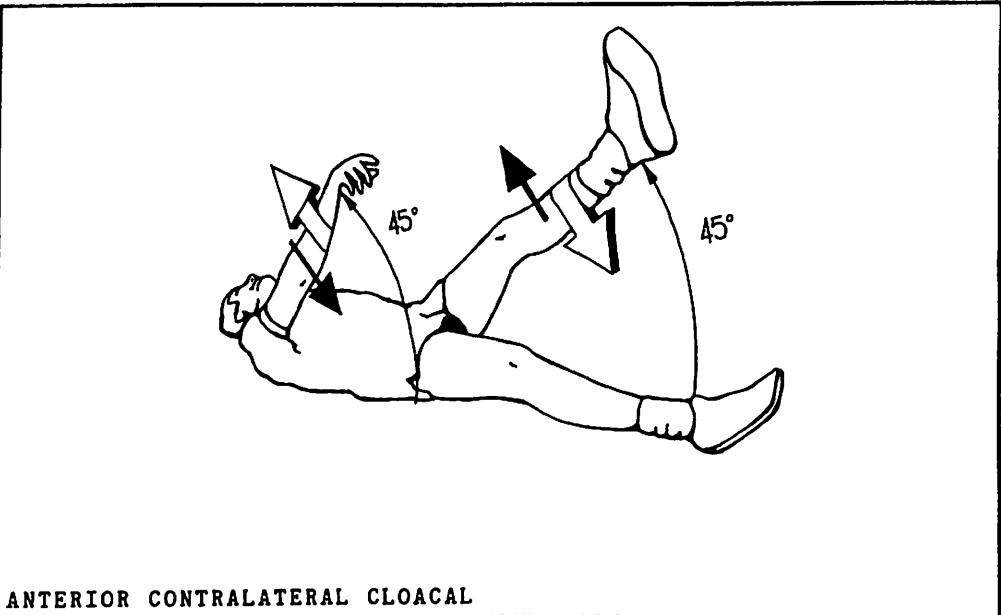
##### ANTERIOR CONTRALATERAL APPPOSITIONAL MOVEMENTS

Coordination from the anterior cloacal area to the opposite superciliary ridge controls the muscle groups that are involved in contralateral appositional movements. By testing these muscle groups we can gain significant information about the integrity and coordination of these two reflexes. If a breakdown in communication is suspected, or if it is desired to test the coordination from the right Obturator Foramen with the left visual reflex, it is tested in the following manner:

Patient: Supine. Flex the right leg 30 degrees and flex the left arm 30 degrees. The patient then extends the arm and flexes the contralateral hip in apposition.

Dr.: Attempts opposition of these muscle groups. If the systems are normal, there will be normal muscle tone. A similar test is given for the reflexes on the opposite side.

KEY: CONTRALATERAL APPPOSITIONAL MOVEMENTS ARE ANTERIOR CONTRALATERAL CLOACAL AND VISUAL IN NATURE.



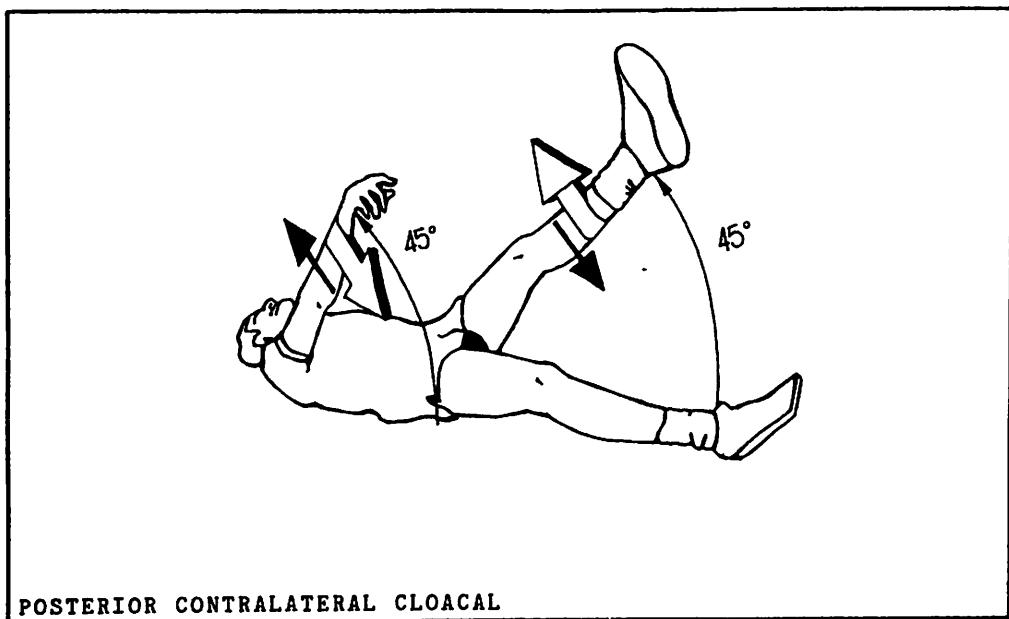
#### POSTERIOR CONTRALATERAL OPPOSITIONAL MOVEMENTS

The posterior cloacal centers, as they relate to the opposite labyrinthine centers are measured by the following muscle test:

Patient: Supine. Flex the ipsilateral leg and contralateral arm.

**Dr.:** Test for a contralateral, oppositional movement by pulling the opposite arm and leg together while the patient attempts oppositional movements. (Arm and leg apart).

**KEY:** CONTRALATERAL OPPOSITIONAL MOVEMENTS ARE POSTERIOR CONTRALATERAL CLOACAL AND LABYRINTHINE IN NATURE.



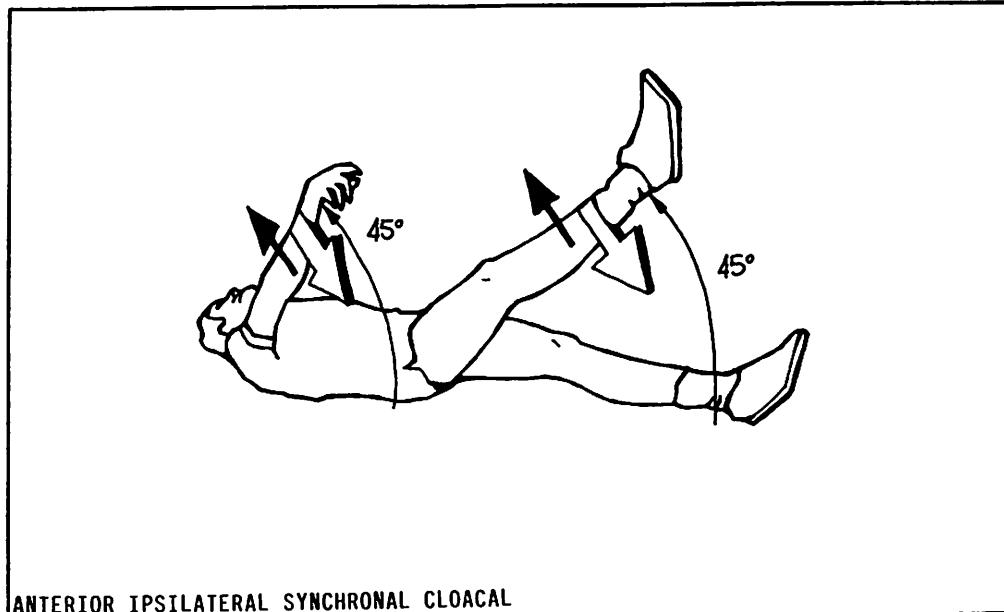
## ANTERIOR IPSILATERAL SYNCHRONAL MOVEMENTS

The muscle groups that are involved in the ipsilateral coordination between the anterior cloacal reflex and the anterior visual reflex on the same side are measured in the following manner:

Patient: Supine. Attempts ipsilateral simultaneous leg and arm flexion movements similar to those in a homolateral crawl.

Dr.: Extends the ipsilateral arm and leg (similar to liver gait only ipsilateral). Inadequate muscle tone indicates an interference in this energy flow ipsilaterally.

KEY: ANTERIOR IPSILATERAL SYNCHRONIZATION MOVEMENTS ARE IPSILATERAL CLOACAL AND VISUAL IN NATURE.



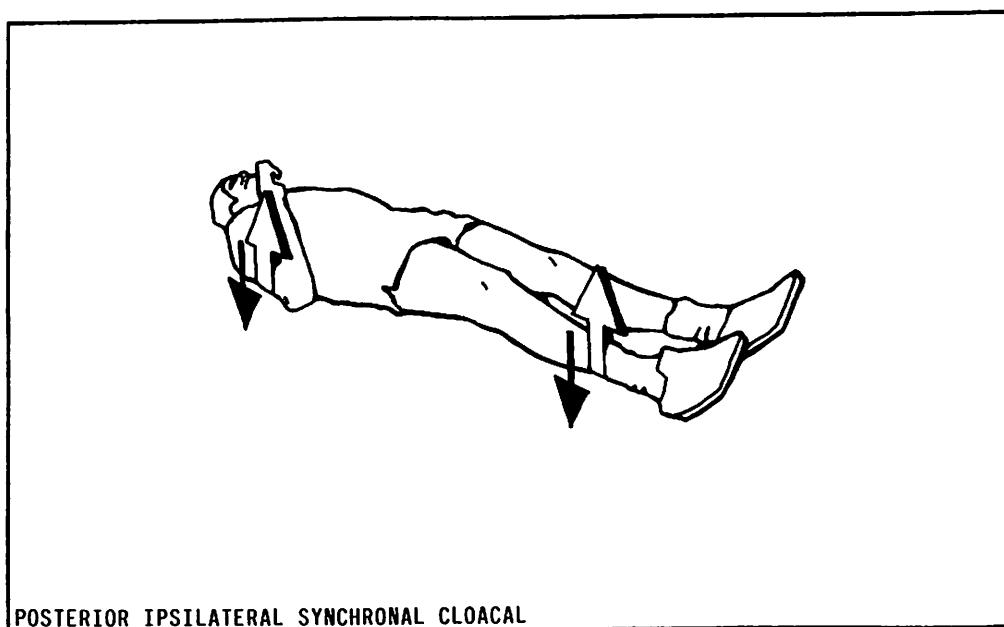
## IPSILATERAL POSTERIOR SYNCHRONAL MOVEMENTS

Posterior ipsilateral energy between the posterior cloacal reflex and the posterior labyrinthine reflex is measured by the following muscle test:

Patient: Supine. Extend ipsilateral arm and thigh.

Dr.: Attempt ipsilateral arm and thigh flexion.

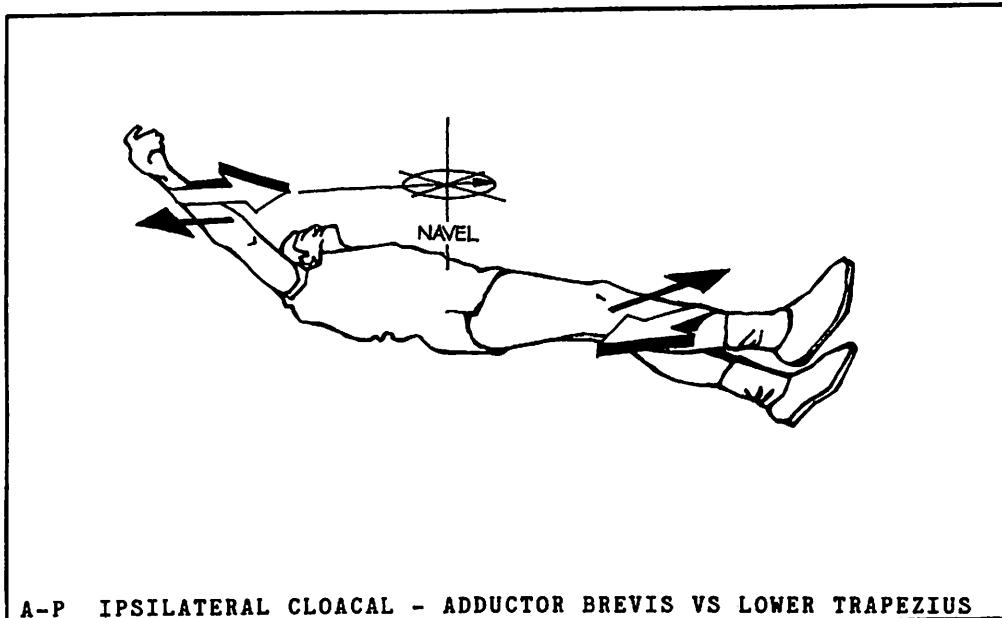
KEY: POSTERIOR IPSILATERAL SYNCHRONIZATION MOVEMENTS ARE IPSILATERAL CLOACAL AND LABYRINTHINE IN NATURE.



## ANTERIOR TO POSTERIOR IPSILATERAL CLOACAL SYNCHRONIZATION

The muscles that measure anterior cloacals vs labyrinthine centers on the same side are Ipsilateral Adductor Brevis

(808) vs Lower Trapezius (404). Test simultaneously or place one in a state of contraction while testing the other.



## POSTERIOR TO ANTERIOR IPSILATERAL CLOACAL SYNCHRONIZATION

The muscles that challenge posterior cloacal vs visual righting centers on the same side are Gluteus Minimus, Anterior Division (786) and Pectoralis Major,

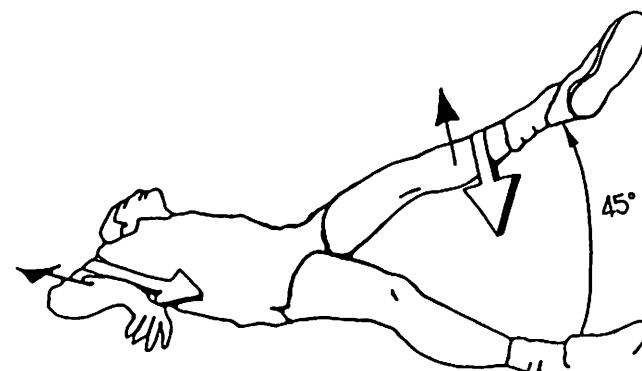
Clavicular Division (402). Test simultaneously or place one in a state of contraction while testing the other.



## ANTERIOR TO POSTERIOR CONTRALATERAL CLOACAL SYNCHRONIZATION

The muscles that challenge the anterior cloacals vs the labyrinthine center on the opposite side are Contralateral

Iliacus (710) vs Posterior Deltoid (474). Test simultaneously or place one in a state of contraction while testing the other.

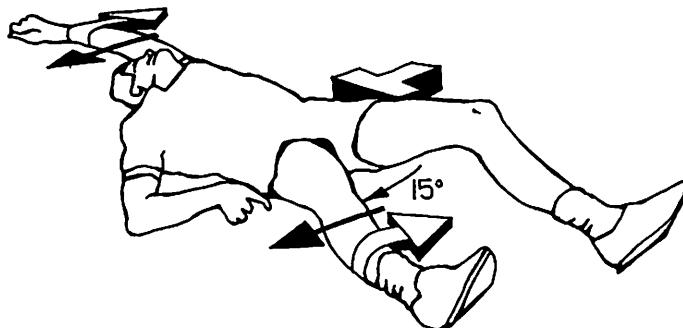


A - P CONTRALATERAL - ILIACUS VS POSTERIOR DELTOID

## POSTERIOR TO ANTERIOR CONTRALATERAL CLOACAL SYNCHRONIZATION

The muscles that challenge the posterior cloacal vs the visual righting centers on the opposite side are Gluteus Medius,

Middle Division (782) vs Subclavius (394). Test simultaneously or place one in a state of contraction while testing the other.

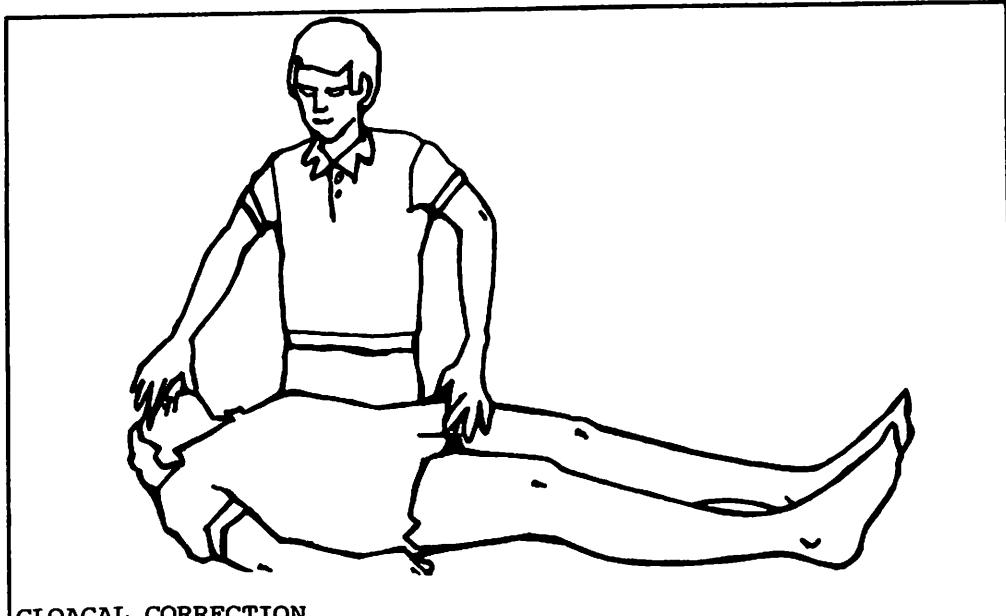


P - A CONTRALATERAL CLOACAL - GLUTEUS MEDIUS VS SUBCLAVIUS

## TREATMENT OF CLOACAL REFLEXES

The treatment that we have found to be most successful for stabilizing these reflexes is to use a double hand contact between the two areas that have been muscle challenged and found weak. For example, if there is a muscle weakness in the contralateral appositional movement, hold the anterior cloacal and

the opposite visual center reflex and wait for synchronous pulsation. We have found in patients with a significant energy loss, such as in MS and other exhaustive chronic disease, the energy levels are extremely poor, and may take two to three minutes to bring the energy into a simultaneous pulsation.



CLOACAL CORRECTION

## REFERENCES

- 1 Watkins, Ronald J., "Anthropology in Reflex Technic", N.C.A Journal, Aug. 1948.
- 2 Alexander, F. Mathess, RESURRECTION OF THE BODY, University Books, New York.
- 3 BIOLOGY TODAY, C.R.M. Books, Delmar, California.
- 4 O'Connel and Gardner, UNDERSTANDING THE SCIENTIFIC BASES OF MOVEMENT.
- 5 Stone, Randolph, THE WIRELESS ANATOMY OF MAN AND ITS FUNCTION, pp. 37 - 8, published by Dr. Randolph Stone, 7557 S. Merrill Ave., Chicago, Ill., March 1953.
- 6 Goodheart, George, RESEARCH TAPE NO. 33, CLOACAL SYNCHRONIZATION TECHNIC.
- 7 Beardall, Alan G., D.C. "ADDITIONAL GAIT TESTS", Collection of papers of the diplomates of ICAK, 2nd presentation, Fall 1976.

## GROUP MUSCLE TESTS

The utilization of muscles for testing purposes has exposed a new area of exploration in the health field. Health is an abundance of vitality which can be readily measured by muscle testing.

Individual or isolated muscle tests dominated the Applied Kinesiology practice until 1974 when Dr. George Goodheart introduced dual simultaneous contralateral muscle testing via the gaits. This concept of muscle testing was again emphasized with the cloacal muscle tests in 1976. In 1982 group muscle tests were demonstrated by Dr. Alan Beardall. Each of these tests provides a different type of challenge to the body systems.

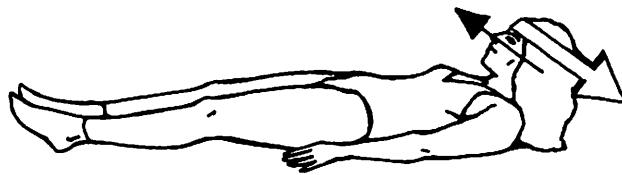
Gait testing is dual, simultaneous, contralateral and synchronous muscle testing with the exception of the kidney gait. Cloacal testing is dual, simultaneous, contralateral, ipsilateral, appositional, oppositional and synchronous muscle testing. Group muscle testing adds a different dimension, as it consists of dual, simultaneous, contralateral, homologous muscle testing. This means testing bilateral identical muscles simultaneously.

Listed and demonstrated below are the major muscle groups that we have used successfully.

### BILATERAL NECK FLEXORS.

Patient: Supine. Flex neck on trunk.

Dr.: Contact forehead to extend neck.

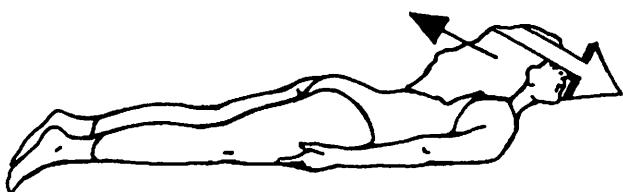


BILATERAL NECK FLEXORS

BILATERAL NECK EXTENSORS.

Patient: Prone. Extend neck on trunk.

Dr.: Contact occiput to flex neck on trunk.

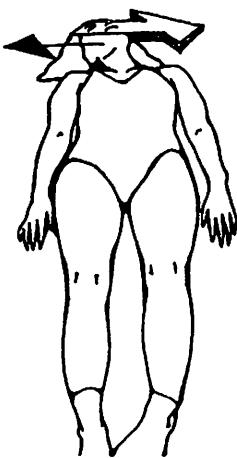


BILATERAL NECK EXTENSORS

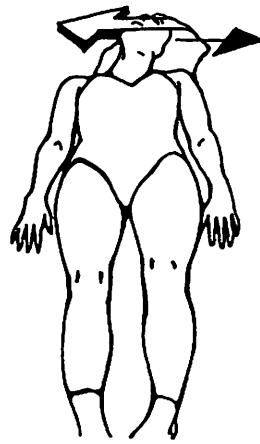
LATERAL NECK FLEXORS - RIGHT AND LEFT.

Patient: Supine. Laterally flex neck on trunk.

Dr.: Brace contralateral shoulder and contact ipsilateral temporal area to extend laterally flexed neck on trunk.



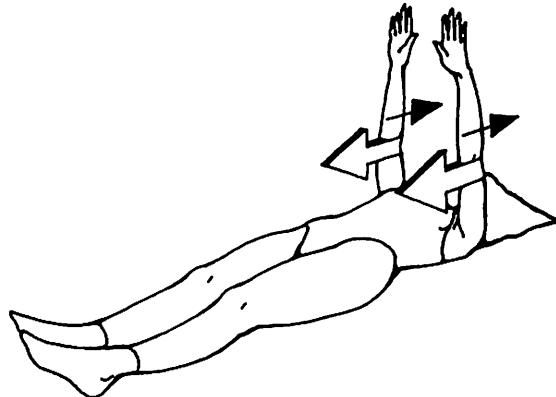
LATERAL NECK FLEXORS (RIGHT)



LATERAL NECK FLEXORS (LEFT)

BILATERAL ARM FLEXORS.

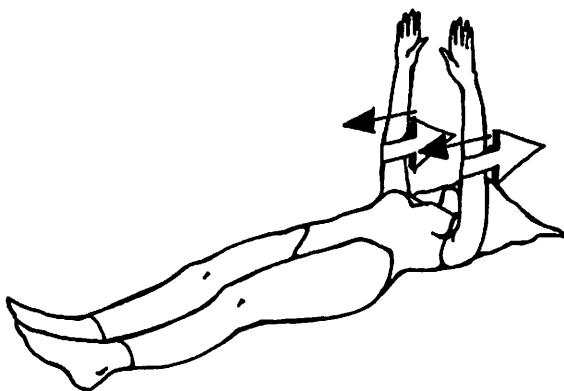
Patient: Supine. Flex bilateral arms 90 degrees. Dr.: Contact forearms and extend arms. This is commonly called the straight arm test.



BILATERAL ARM FLEXORS

BILATERAL ARM EXTENSOR.

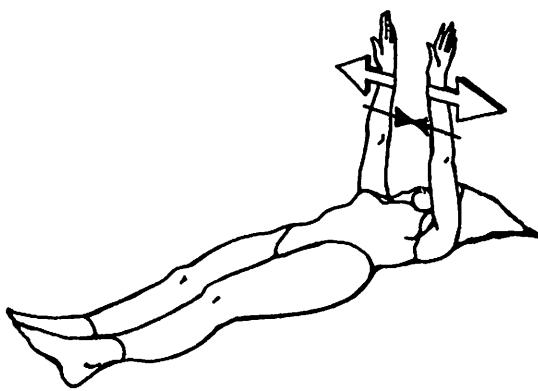
Patient: Supine. Flex arms 90 degrees. Dr.: Contact elbows to flex arms.  
Face palmer surfaces of hands toward feet.



BILATERAL ARM EXTENSORS

BILATERAL ARM ADDUCTORS.

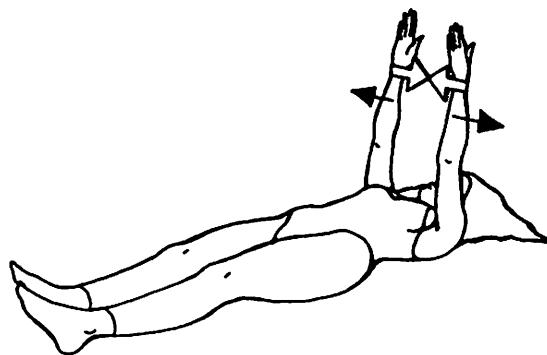
Patient: Supine. Flex arms 90 degrees Dr.: Contact forearms to abduct arms.  
with full internal rotation.



BILATERAL ARM ADDUCTORS

BILATERAL ARM ABDUCTOR.

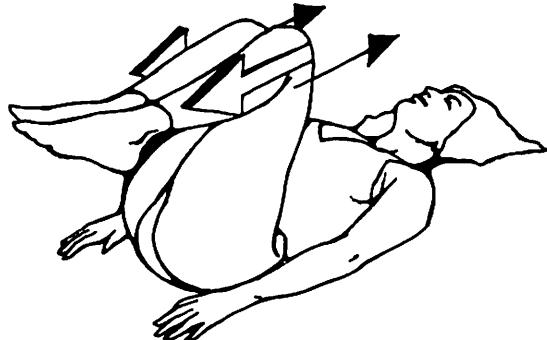
Patient: Supine. Flex arms 90 degrees. Dr.: Contact forearms to adduct the arms. Face palmer surface of hands toward each other.



BILATERAL ARM ABDUCTORS

BILATERAL PELVIC FLEXORS.

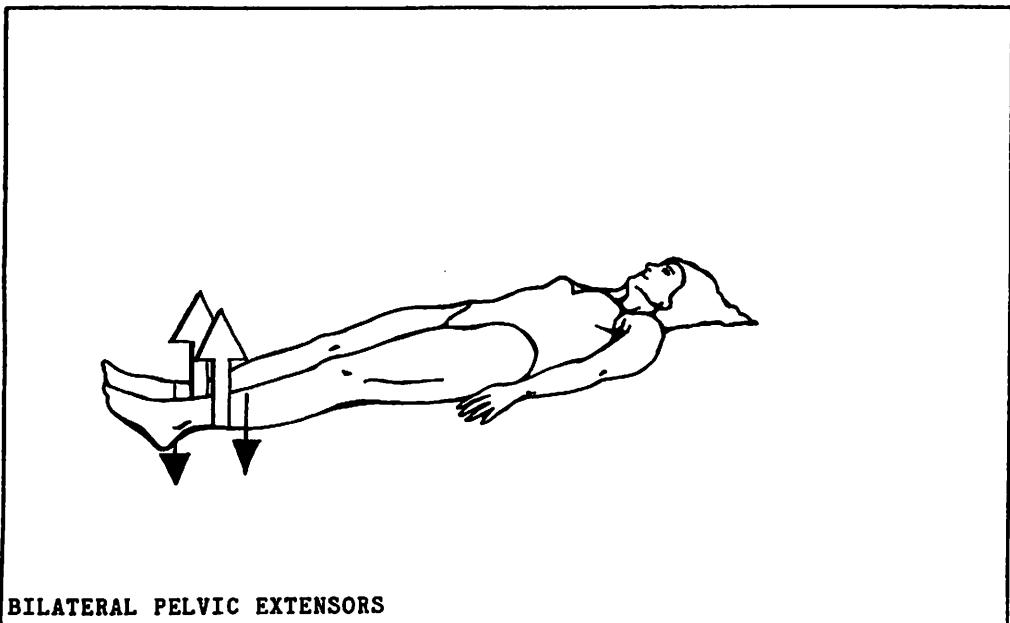
Patient: Supine. With full femur Dr.: Contact bilateral knee to extend flexion, flex pelvis on trunk.



BILATERAL PELVIC FLEXORS

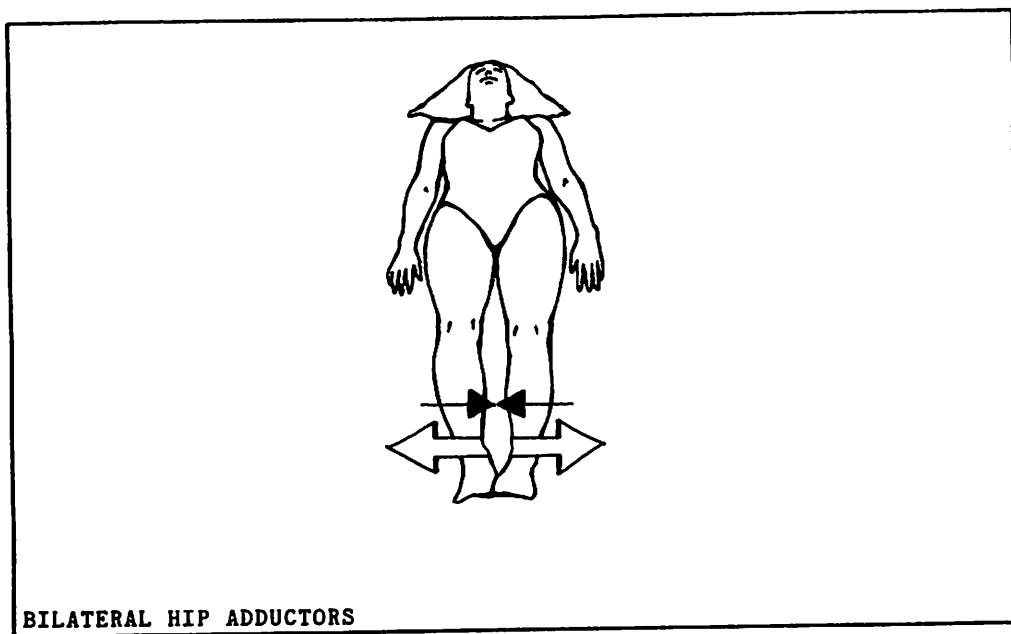
BILATERAL PELVIC EXTENSORS.

Patient: Supine. With thighs extended Dr.: Contact bilateral ankles to flex  
on pelvis, extend pelvis on trunk. pelvis on trunk.



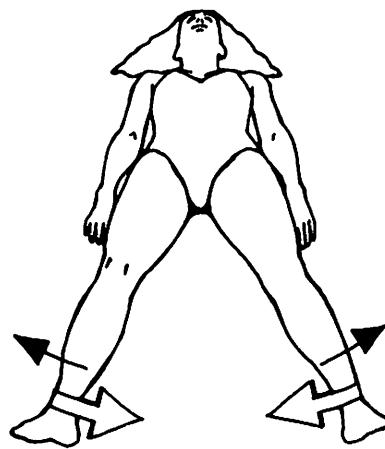
BILATERAL HIP ADDUCTORS.

Patient: Supine. Adduct knees, keep Dr.: Contact medial aspect of ankles,  
legs extended. abduct legs bilaterally.



BILATERAL HIP ABDUCTORS.

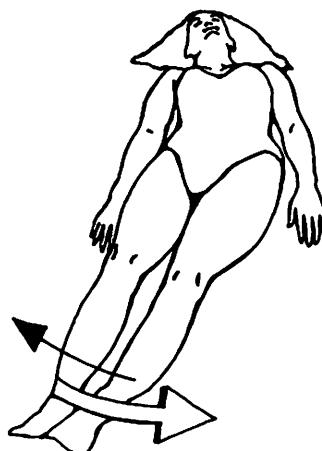
Patient: Supine. Abduct femur 30 degrees from midline. Dr.: Contact lateral aspect of ankles, adduct legs bilaterally.



BILATERAL HIP ABDUCTORS

LATERAL PELVIC FLEXORS - RIGHT

Patient: Laterally flex pelvis on trunk as directed. Dr.: Brace contralateral hip at greater trochanter and contact ipsilateral ankle to extend pelvis on trunk.

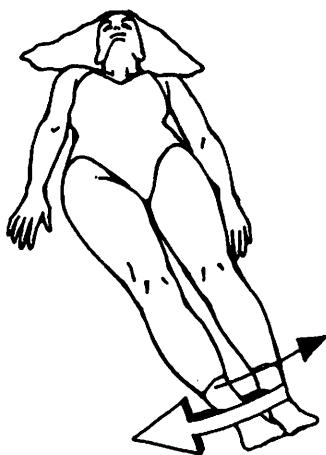


LATERAL PELVIC FLEXORS (RIGHT)

#### LATERAL PELVIC FLEXORS - LEFT

Patient: Laterally flex pelvis on trunk

Dr.: Brace contralateral hip at greater trochanter and contact ipsilateral ankle to extend pelvis on trunk.

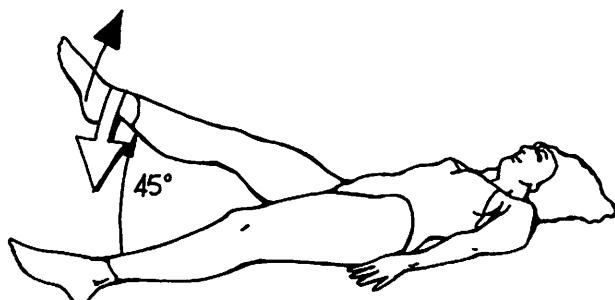


LATERAL PELVIC FLEXORS (LEFT)

#### IPSILATERAL HIP FLEXORS.

Patient: Supine. Flex femur on pelvis.

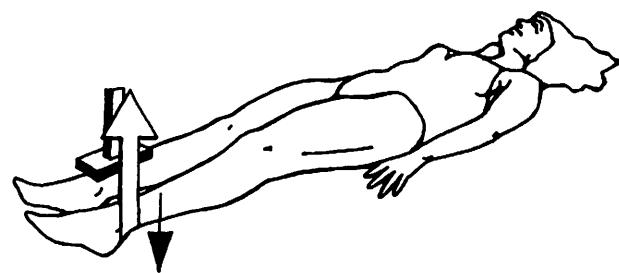
Dr.: Brace contralateral ankle and contact ipsilateral ankle to extend thigh.



IPSILATERAL HIP FLEXOR

IPSILATERAL HIP EXTENSORS.

Patient: Supine. Extend femur on pelvis. Dr.: Brace contralateral ankle, contact ipsilateral ankle to flex thigh.



IPSILATERAL HIP EXTENSOR

## Chapter IV

# The Display

### THE ROSICRUCIAN PRAYER

Not more of light we ask, O God  
But eyes to see what is;  
Not sweeter songs, but ears to hear  
The present melodies;  
Not greater strength, but how to use  
The power that we possess;  
Not more of love, but skill to turn  
A frown to a caress;  
Not more of joy, but how to feel  
Its kindling presence near,  
To give to others all we have  
Of courage and of cheer.  
No other gift, dear God, we ask,  
But only sense to see  
How best the precious gifts to use  
We have received from thee.  
Give us all fears to dominate,  
All holy joys to know,  
To be the friends we wish to be,  
To speak the truth we know;  
To love the pure, to seek the good,  
To lift with all our might,  
All souls to swell in harmony  
In Freedom's perfect light.

## THE DISPLAY

Muscles are the display units of the C.P.U. therefore, muscle testing is bio-computer evaluation. If the testing results are interpreted correctly and the computer is operating in a clear and precise manner adequate insight into body signs, symptoms and language are easily processed into meaningful information.

With this concept in mind, muscle testing takes on a new and exciting importance. The analysis of a muscle must be viewed differently than the initial strategy of Applied Kinesiology. This understanding reflects the ideology of our brilliant leader in the field of Chiropractic, Dr. W.D. Harper, who wrote "Anything Can Cause Anything". Muscle aberrations emanate from four different levels of expression:

1. Local Level. This level is the main concern of Applied Kinesiologists who treat the muscle as a separate unit of the body with specific needs i.e. vascular, lymphatic, acupuncture, etc.

2. Spinal Levels. This computer network can and does have dynamic affects on muscle function. The nervous system is free to utilize the muscle for many things, i.e. shifts in weight bearing, etc.

3. Glandular or Organ Levels. At this level the nervous system can alter muscle tone for purposes intimately related to their specific function.

4. Cerebral Levels. The primary computer can develop specific strategies for the organism as a whole utilizing specific muscles.

In this chapter we are mainly concerned with the local level of muscle function.

## MUSCLE TESTING

Muscle testing is the back bone of the Applied Kinesiologist's investigation. The method of diagnosis must be performed with scientific accuracy along with an understanding of the uniqueness of the art of muscle testing.

## MUSCLE ISOLATION AND TESTING PROCEDURES

The primary prerequisite for muscle testing is knowledge of the anatomy of muscles which includes their origin, insertion, action, and relationship to joints.

The goal is to achieve optimum isolation of muscle fibers with minimum recruitment of adjacent muscles.

### Procedure:

1. The body and joints related to the muscle to be tested should be positioned in such a manner as to most efficiently approximate the origin and insertion.
2. Dr.: Place hands in a position that assures adequate stabilization of the patient and support for the test.
3. Dr.: Place the contact hand in a position to most efficiently express the contraction of the muscle.
4. Have the patient resist against the force generated by the tester.
5. The doctor should watch the patient's jaw, eyes and related joints to insure adequate isolation and minimum recruitment.
6. It is important to note the character of muscle contraction.
  - a) Normal muscles are quick to react to testing and exhibit a locking quality.
  - b) Abnormal muscles are slow or sluggish in the state of contraction. They exhibit a spongy quality and often break down in contractile quality with repeated testing.
7. Muscles must be tested within the patient's normal resistive capabilities. Overloading the muscle does not elicit a valid test.
8. If the first test is inadequate, repeat. Normal muscle can handle several repeat tests.
9. Timing is an important factor. Let the patient initiate contraction into the Dr.'s hand.

## IMPORTANT FACTORS IN MUSCLE TESTING

1. Respiration often affects muscle contraction. Both the patient and the doctor should be relaxed and not in any specific phase of respiration.
2. Over enthusiasm usually results in operator prejudice.
3. The mental attitude of the doctor is important. A muscle test is an honest investigation with no personal

input into the outcome of the test  
4. Inappropriate contacts. Contact and bracing hands should always be comfortable to the patient and Doctor.

5. Pain in related or adjacent joints may impair the muscle test.  
6. Poor concentration on the part of the patient may inhibit a proper response.

7. Major muscle or nerve disease may inhibit normal muscle function.

Note: When muscles are tested they display their computer binary quality. This may be absent in certain diseases such as Myasthenia Gravis. The healthier the patient, the more distinct the binary or biphasic quality.

#### ISOLATED VERSUS GROUP MUSCLES

An area of criticism that has occurred in Applied Kinesiology is the straight arm test. It has been labeled as "inaccurate" and has been used by many who are not knowledgeable in the science and art of muscle testing. This statement does not address itself to the complexities of the issue.

The first question that should be asked is, "Is the straight arm test inaccurate?" The answer is yes if you are testing the lower Trapezius and no, if you are testing group muscles such as the Shoulder Flexors. The binary computer is capable of expressing itself through isolated muscles as well as group muscles. In fact, group muscles represent a consensus of opinion of an area of the body. A public opinion survey would not be complete with data from a single source. The opinion of numerous people is necessary. A scientific experiment does not draw conclusions from a single experiment.

It appears logical then, that group muscle testing has a certain advantage over isolated muscle testing. To contend that group muscle tests are invalid and isolated muscle tests are accurate is a rule which standard Applied Kinesiologists violate everyday by testing the Quadriceps and Hamstrings. The Hamstring muscle group consists of four isolated muscles: 1. Biceps Femoris, Longhead 2. Biceps Femoris, Shorthead 3. Semimembranosus 4. Semitendinosus.

These muscles are frequently used to challenge the pelvis and lumbar for subluxation, etc. If testing group muscles is invalid, then the challenges for all these tests are also invalid.

The overwhelming conclusion must be that group muscle tests are capable of binary computer function as well as isolated activity. The enormous clinical success using Hamstring muscle group testing provides evidence that the group muscle tests are valid and are here to stay.

In a survey conducted at a seminar of Applied Kinesiologists over 90 percent daily used the "straight arm test" in their practice.

#### BASIC SKILLS - THERAPY LOCALIZATION

Health practitioners and Chiropractors have used various methods of gathering information from their patients ranging from history taking, physical signs, laboratory, and X-ray analysis to the use of reflex techniques, motion palpation, Iridology and Acupuncture pulse measurements.

In recent years different types of biofeedback mechanisms have been developed which monitor the patient's immediate response to testing procedures. These include electronic instruments such as EKG, GSR, ECG, and vasculizer as well as non-electronic methods such as leg or arm length changes and muscle tone changes.

In Applied and Clinical Kinesiology the system of feedback is known as therapy localization (T.L.). This was discovered by Dr. Goodheart and is a feedback mechanism of changes in muscle tone - produced by touching the skin at specific areas of the body. It helps to identify the need for therapeutic correction. To T.L. a problem, one must first isolate a strong indicator muscle. Have the patient place the palm of their hand on an area of the body and retest the indicator muscle. If the area has a positive T.L., the previously strong indicator muscle will weaken. In general, T.L. can be used to locate areas of stress but does not tell whether it is a subluxation, organ reflex, neurovascular, neurolymphatic, cranial fault, etc. A more efficient method has been developed to identify specific tissues and that is accomplished by using the hand mode system.

## TWO POINT

Occasionally there is confusion concerning the terminology "positive T.L.", "negative T.L.", "two-point T.L.", "three-point T.L.", etc. When testing one should keep in mind the basic principle that muscle testing is a binary system of information feedback in an "on" or "off" state.

When isolating a muscle for T.L. the Kinesiologist is attempting to create optimum conditions for the "on" or "off" state. The muscle will register strong (on) or weak (off) when tested. Any area of the body that causes an alteration of tone in the indicator muscle when touched is called a positive T.L. Conversely, when an area of the body is touched and no change in tone occurs, the condition is termed negative T.L.

The mechanics of T.L. can be understood easily by using a system whereby positive is termed "1" and negative is termed "0". Just as a computer indicates "on" or "off" by means of a light, the muscle indicates this by means of altered muscle tone. It is important when testing to know the starting point. If starting from a positive (strong) muscle and therapy localizing a negative area, there will be no change in muscle tone,  $1 + 0 = 1$  or no change. When starting from a positive muscle and obtaining a positive T.L., the muscle tone will change, (become weak) i.e.  $1 + 1 = 2$ . Another set of possibilities arises when beginning with a negative (weak) muscle. A negative T.L. will add 0 with no change in muscle tone ( $0 + 0 = 0$ ) and a positive T.L. will add 1 with a change in muscle tone from weakness to strength ( $0 + 1 = 1$ ).

a) Strong muscle + Negative T.L. = No change, or muscle stays strong (+)  
 $1 + (-) 0 = (+) 1$ .

b) Strong muscle + Positive T.L. = Change or strong muscle goes weak (+)  
 $1 + (+) 1 = (+) 2$ .

c) Weak muscle + Negative T.L. = No change or muscle stays weak (-) 0 +  
 $(-) 0 = (-)$ .

d) Weak muscle + Positive T.L. = change or muscle goes strong (-) 0 +  
 $(+) 1 = (=) 1$ .

Any number of items can be tested to determine if there is a relationship between them. Each positive T.L. will change the tone of the indicator muscle. By knowing the starting point for the system, either strength (+) or weakness (-), one can build an equation or series of one-point, two-point and three-point therapy localizations.

Dr. Goodheart uses special terminology to distinguish between use of the doctor's hand and that of the patient to localize the problem on the patient. It is called Dr.'s T.L. and patient's T.L. At times the use of the doctor's hand is more practical. Our experience has indicated there are distinct conditions under which the doctor's therapy localization and the patient's T.L. will differ. These appear to be electromagnetic energy aberrations which can be minimized by utilizing the clearing techniques discussed in the chapter on clearing techniques.

## MUSCLE DIVISIONS

Included in the Instruction Manual is a list of all the muscles for which research has been completed. This list contains several muscles which have divisions not presently accepted in medical texts. These divisions are an out growth of personal research obtained while observing patients, studying anatomy books and dissecting cadavers.

Some divisions such as the Pectoralis Major, Clavicular Division and the Pectoralis Major, Sternal Division are already familiar. An additional division has been called the Pectoralis Major, Costal Division. These are the fibers that arise from the rib cage, and are tested differently, and have proven to have different NV, NL, visceral organs etc. The same idea prevails throughout the muscle divisions.

Some divisions are named according to the actions i.e. flexion or abduction. Others are named because of the different origin, i.e. Gluteus Maximus, Iliac Division, Sacral and Coccygeal Division. This first division is named for the fibers which arise from the Ilium, the second for the fibers which arise from the sacrum, etc.

## USING CLINICAL KINESIOLOGY WORKBOOKS

The Clinical Kinesiology workbooks cover the specific information necessary to test and evaluate over 300 muscles. Each workbook covers sections of the body and is a regional atlas of specific muscle tests and reflexes. One chapter gives an integrated view of the muscle reflexes displayed on cranial, full body, and skeletal drawings. Another chapter contains the muscle worksheets for each muscle discussed in that area of the body. Another chapter lists the reactive muscles associated with those muscles covered in the workbook.

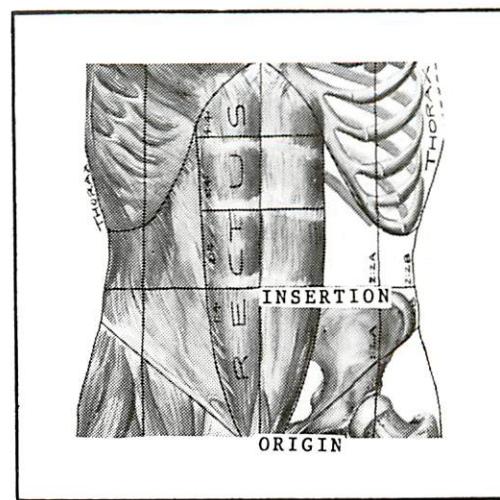
The composite drawings show all the reflexes in that particular section of the body so that relationships between the muscles discussed and other functions can be seen. These relationships are useful to identify and correlate the appropriate muscle circuit when a patient complains of a pain in a particular area. Refer to the drawings to see if a reflex point is listed in the area of complaint. Cranial views display the location of the neurovascular points used. Illustrations depicting the neurolymphatic and other points for the lower half and upper half of the body follow. Points located on muscular tissue are located on the tissue, whereas points located deeper near skeletal structures are shown on the bone part of the illustration.

The major and most important portion of the workbook is the muscle worksheet. Each muscle is presented in a structured format to provide the necessary information to properly test and evaluate possible functions. The information is displayed on seven pictorial drawings which include a word description to properly identify the related local joint reflexes. The meaning conveyed by each category is as follows:

**ORIGIN:** Indicates the area where the muscle origin is most effectively treated and will sometimes vary from the description commonly found in anatomy texts.

**INSERTION:** Indicates the area where the muscle insertion is most effectively treated. (see fig. below)

**TEST:** Describes the test position found to be most practical and efficient in isolating a particular muscle division weakness. Pt. refers to the patient in the description, Dr refers to the doctor (or one performing the test). Ipsilateral

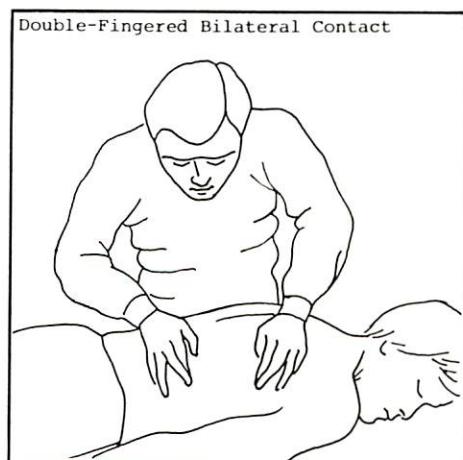


refers to the muscle being tested on the same side of the body, whereas, contralateral refers to the side of the body opposite to the muscle being tested. "Brace" refers to the area being held by the doctor to stabilize the patient for testing and "contact" refers to the area contacted by the doctor in order to test for muscle contraction.

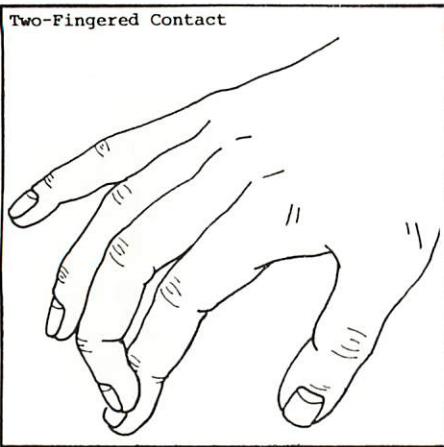
### PROCEDURE FOR MUSCLE CORRECTION

Synchronous Pulse and Double-Fingered Contact.

Based upon clinical experience over many years and trial and error testing of many techniques, certain procedures have remained dominant as being most effective when treating a muscle on a local basis. This procedure is the use of a double-fingered bilateral contact. (see diag.). The contact is held until a synchronal pulse is felt.



While stimulating any reflex point on the body, always use a two-fingered contact. (see diag.) This is a neutral contact as opposed to a positive or negative single finger contact.

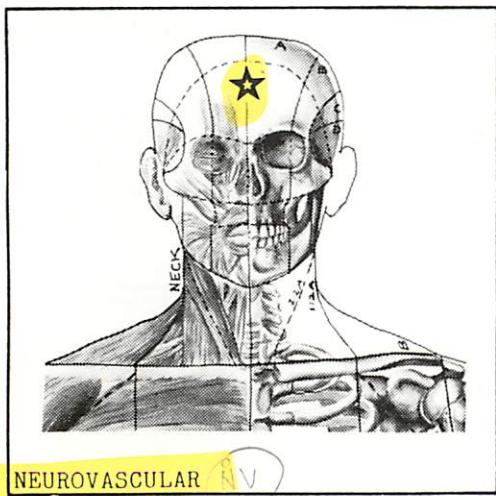


#### Procedure for Muscle Correction

On a local basis a muscle is directly influenced by one or more of the following factors:

1. Neurovascular NV (Cranial)
2. Neurolymphatic NL (Rib Cage)
3. Visceral Organ Reflex
4. Muscle Acupuncture Point
5. Vertebral Level and Myomere
6. Cranial
7. Nutrition

#### Neurovascular

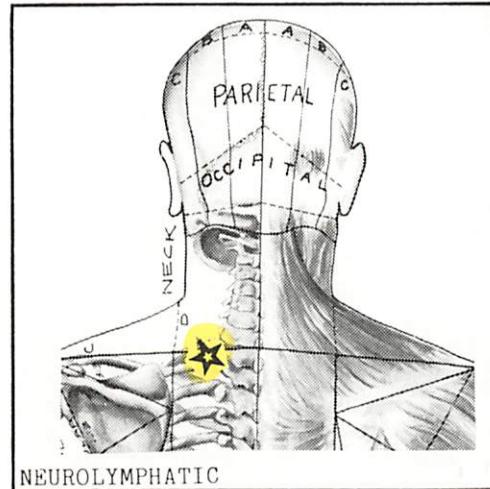


Description: NV Point generally found on the cranium.

Discussion: NEUROVASCULAR (NV): Vascular beds of the muscle needing treatment are influenced by using the following procedure until a synchronous pulse is felt. (see syn. pulse and two-fingered technique). A neurovascular reflex, which is generally located on the surface of the cranium, when activated by a light tugging double-fingered contact

O: rotary  
NVS: light tugging  
with one hand and a rotary stimulating contact with the opposite hand at the origin of the muscle, will restore normal circulation to the area associated with that reflex. These contacts are ipsilateral.

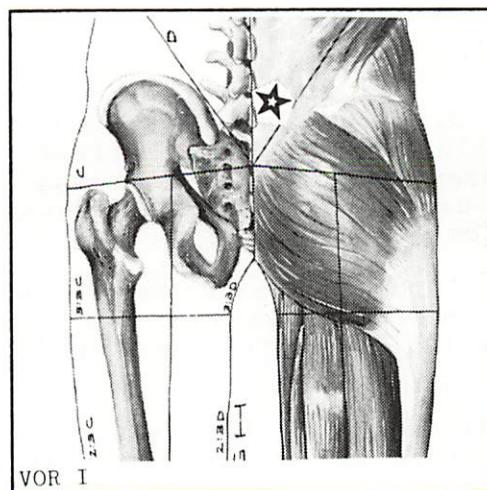
#### Neurolymphatic



Description: NEUROLYMPHATIC: NL. Generally found between the ribs.

Discussion: The lymphatics of the muscle being treated are influenced by using the following procedure until a synchronous pulse is felt. A neurolymphatic reflex, which is generally located in the rib cage, when activated by a rotary-stimulating contact with the opposite hand at the insertion of the muscle, will produce lymphatic flushing of the areas associated with that reflex. Both the right and left muscle group are treated by using the same reflex.

#### Visceral Organ I (VOR-I)



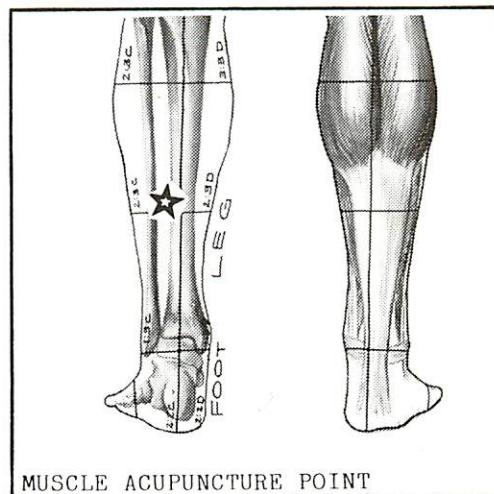
Description: VISCERAL ORGAN I: Primary visceral organ reflex (VOR-I)

Discussion: Somato-visceral influences and viscero-somatic reflexes are common feedback systems with the local computer. A muscle is primarily associated with two specific organs. They are listed as Visceral Organ I (VORI) and Visceral Organ II (VORII) and are treated as follows:

A VOR, which is generally located on the abdomen or other specific areas of the body, when activated by a rotary stimulating contact with one hand and a rotary stimulating contact with the opposite hand on the Muscle Acupuncture Point, will restore normal interaction between somato-visceral and viscero-somatic functions of the body. Following stimulation hold until a synchronous pulse is detected.

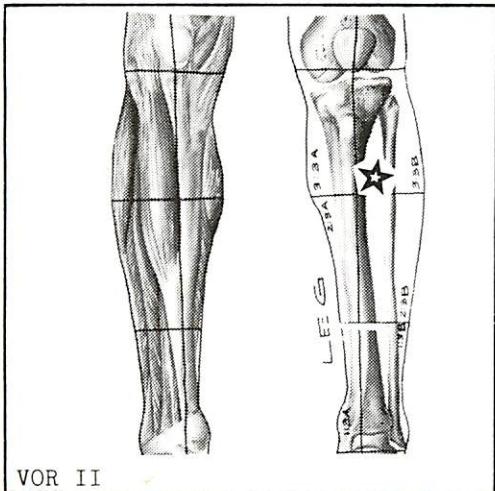
Visceral Organ II (VOR-II)

Muscle Acupuncture Point (M.A.P.)



Description: M.A.P.: The muscle Acupuncture Point is a specific reflex for the muscle being tested and is located contralateral to the muscle being tested.

Discussion: Each muscle has a specific acupuncture point located on the opposite side, which acts as an energizer and a point of circuitry overload, located within or around the normal acupuncture points as previously described by Felix Mann. (For treatment procedure of the MAP see VOR reflex treatment above).



Description: VISCERAL ORGAN II: Secondary visceral organ reflex (VORII)

Discussion: (VOR I)

VERTEBRAL LEVEL (VL) and MYOMERE (MM): There are two primary areas of neurological input from the spinal cord to each muscle. The first area is called the myomere and reflects areas of normal neurological innervation to a specific muscle. The vertebral level is a phenomenon not clearly understood but is frequently found associated with each muscle aberration. When either of these levels two-point with an NRL, adjust the area as indicated and tap for recall. Occasionally it is necessary to pulse the MM or VL or both to the muscle.

CRANIAL: Related extraspinal subluxation that occurs as a compensatory involvement in muscle aberration.

FOOT: Related extraspinal subluxation that occurs as a compensatory involvement in muscle aberration.

NUTRITION: Each muscle has a specific nutrient associated with it. Nutrition is indicated when the NL point is NOT an NRL and the insertion of the muscle IS AN NRL.

#### PRIORITY TREATMENT

1. Test and record all weak muscles.
2. Use computer clearout technique (see section on Clearing Techniques).
3. Retest the muscles to determine which one remained weak.
4. The weak muscle is considered a ONE-POINT.
5. Mark the major reflexes associated with the muscle--NV, NL, VORI, VORII, VL, MM, Cranial, Foot.
6. Have the patient therapy localize (TL) each reflex point while testing the muscle. The reflex that causes the weak muscle to become strong is considered the TWO-POINT.
7. Check the TWO-POINT reflex to make sure it is an NRL.

8. Treat the reflex that is the NRL in the appropriate manner. (see procedure for muscle correction).

NV - Origin

NL - Insertion

MAP - VORI

MAP - VORII

MAP - Muscle

VL - Adjust, then pulse to MM

MM - Adjust, then pulse to VL

Cranial

Foot

9. If two reflex points are indicated as NRL's, use the THREE-POINT technique. The three-point technique helps to determine which of the major reflexes is to be treated. The procedure is as follows:

- a) The weak muscle is the ONE-POINT.
- b) The reflex point that strengthens the muscle is the TWO-POINT.
- c) While the patient TL's the reflex point that strengthened the weak muscle, if any other reflex point changes the indicator muscle, it is considered the THREE-POINT and the major point to be treated.

## Chapter V

# Introduction to Modes

Our present technology is not a mistake--  
It is not possible to make a mistake--  
Rather it is an extremely primitive  
Precursor to the incredible organic technology  
That it is our destiny to construct/create in this universe.

We must not let our primitive playthings  
Restrict our creative genius!  
We must not cling to the past when  
There is so much to do in the present.  
If you would set to work creating the new technology,

Abandon all complex tools. They are misconceptions.  
All the brilliant discoveries and inventions of our times  
Will be made with our minds and hands and senses,  
Aided by simple tools and concepts.  
This is true now as it has been true throughout history.

--Paul Williams  
(Written and created by his readers.)  
das Energi

## HISTORY

My first interest in hand modes started in 1977. At that time our office was using standard Kinesiological procedures, i.e.: The five factors of the I.V.F. - origin, insertion, etc.

In May of 1978, Dr. George Goodheart described a phenomenon he called the "Scratch Test". He had found that many times the myomere, (the section of the spine where the nerve exits and travels to a muscle) would not have a positive T.L., but when scratched for a brief period, it would then illicit a positive T.L. Following my exposure to this material, our office decided to do a research project to discover the most frequent myomere level related to each muscle. This resulted in an article written for the 1978 winter meeting of I.C.A.K in Houston, Texas. In this research we implemented the first hand mode ever used in order to observe specific functions of the body. We called this "A Modified Scratch Test". We were very surprised that no one ever asked us to show them the modified scratch test.

With the growth and expansion of Applied Kinesiological procedures and the vast number of techniques available, it became very clear to us that there was a great need to have a way to specifically determine what was needed to correct a muscle. For example, if a muscle is weak does it require nutrition as opposed to origin - insertion work, acupuncture as opposed to nutrition, etc.

It was also necessary to be able to accurately determine what we were actually therapy localizing. Two systems of bodily investigation were paramount: 1) A system that could tell us what was wrong, and 2) a system that would include all of the therapeutics for correction.

We started with four basic modes in relationship to muscles. One mode which indicated the five factors of the I.V.F., one which indicated structural or spinal work, one which indicated nutrition and one which indicated acupuncture. Therefore, if you had a weak muscle you could simply ask the C.P.U. which factor it needed for resolution. The idea was simple and worked marvelously in many cases.

From four simple modes the number of different modes has expanded to over two hundred. These different hand positions symbolize different phenomenon about the body. They cover a wide range including subluxation, carbohydrate metabolism, disc, fascia, parasites, and many more. The potential is limitless.

## INTRODUCTION TO HAND MODES

The word mode is derived from the Latin word "modus" meaning measure or manner. It is defined in Clinical Kinesiology as a form or manner of expression of the hand. The hand held in a certain specific position has a significant effect on the body's communication and kinetic system. The hand mode is not in itself therapy, rather it is a diagnostic tool. It is a language or sign of the biocomputer. It is the symbol or keypunch board of the biocomputer. We contend that holding certain hand positions when used in conjunction with other diagnostic parameters, i.e.: 1) Muscle testing 2) The reactive leg check 3) Toftness Radiation Detection instrument, etc., provides a method of investigation that is truly biological technology. It establishes a line of communication into the body's C.P.U. The results of this procedure have been truly exciting.

## FUNCTION

The Applied Kinesiologist uses therapy localization many times daily during treatment of patients, rarely stopping to think about what is being therapy localized. A positive T.L. indicates something is wrong but doesn't tell what or why. Is it a cause or effect? Is it viscerosomatic? Is it Neurological? Is it Kinetic? Many times not knowing this may result in trial and error diagnosis and therapeutics.

When the patient fails to respond, it is because we have failed to recognize the needs of the biocomputer. Hand modes are symbols of biocomputer language that help set and lock it into a precise diagnosis. Modes, through their set and

hold abilities, help lock the display unit into a single display. It also helps hold a diagnosis while it is traced from symptom to cause.

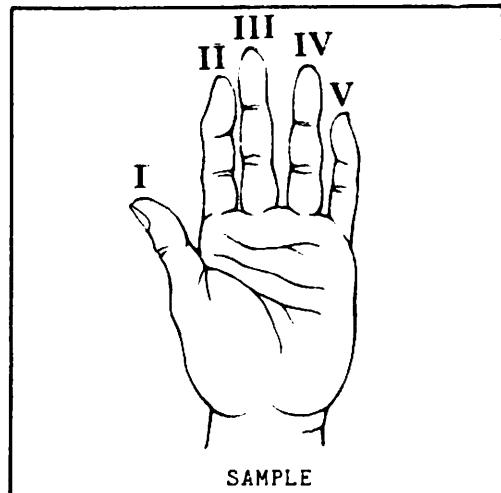
In this book we have limited the number of modes to be introduced to the musculo-skeletal practice and therefore include the spine, muscle and joints. In a later book we will cover the modes related to all the tissues, organs, chakras, endocrine systems and other general modes.

#### MODE IDENTIFICATION

As you will soon learn, the hand modes can become very complicated. Therefore, it is important to learn the system that has been created to identify fingers and areas of the fingers. Below you will see that each of the fingers is identified by a Roman numeral. Thumb - I, Index - II, Middle - III, Ring - IV, Little - V. Each finger has specific areas that are also identified.

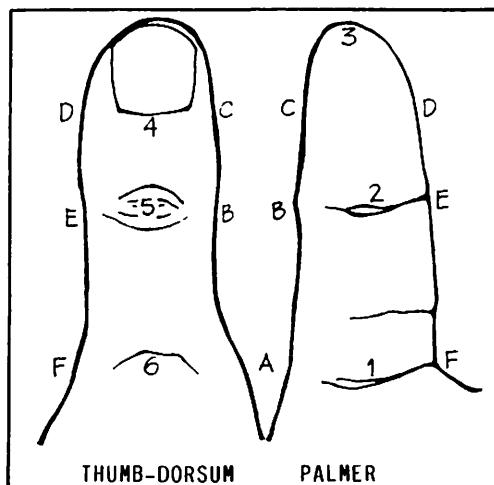
The thumb is labeled from the anatomical position, lateral to medial. The thumb as a whole is labeled Roman numeral I. The lateral and medial aspects of the thumb are labeled by letters beginning on the lateral and ending on the medial side. "A" represents the lateral junction of the 1st metacarpal and the proximal phalanx of the thumb. "F" represents the medial aspect of this junction. "B" represents the lateral junction of the proximal phalanx and the distal phalanx of the thumb. "E" represents the medial aspect of this junction. "C" represents the base of the cuticle on the lateral aspect and "D" on the medial aspect.

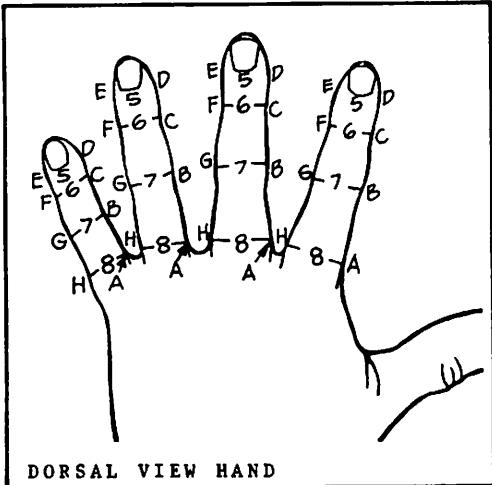
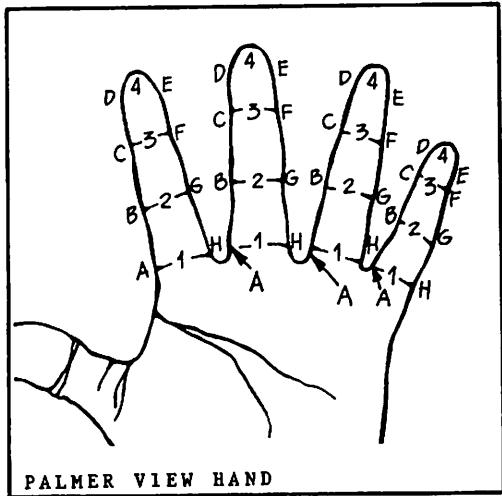
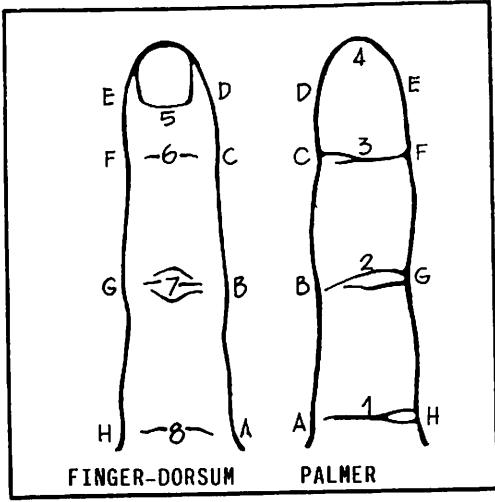
Numbers 1, 2, and 3 are on the palmer surface and 4, 5, and 6 are on the dorsal surface of the thumb. The small 1 and 6 on the thumb represent the center of the junction of the 1st metacarpal and the proximal phalanx. The small 2 and 5 represent the center of the junction between the proximal phalanx and the distal phalanx. The number 3 represents the tip of the thumb and number 4 the base of the nail. The rest of the fingers are labeled as indicated below - Index II, Middle III, Ring IV, and Little Finger V. The index as well as the rest of the fingers are labeled as follows.



The index to the little fingers are labeled from the anatomical position lateral to medial by the letters A, B, C, D all on the lateral aspect. The letters E, F, G, H are all on the medial aspect. Numbers 1, 2, 3, 4 are on the palmer surface. Numbers 5, 6, 7, 8 are on the dorsal surface. A, 1, and H are located at various areas of the distal metacarpal and proximal phalanx. B, 2, and G are located at the junction of the proximal phalanx and the middle phalanx. C, 3, and F are located at the junction of the middle phalanx and distal phalanx. Number 4 is located at the tip of the finger and number 5 at the base of the nail. Letters E and D are located at the base of each nail. (see fig. below).

A finger is designated as negative (-) anytime it touches the palm of the hand while in a mode, i.e. see Bone Injury Mode.





## GENERAL RULE FOR USING MODES

- 1) A "positive mode" is defined as a specific hand contact, which when held causes a previously intact muscle to test weak. This may also be reversed. A previously weak muscle will test strong when the patient holds a specific hand contact. A positive mode alters muscle tone and should be an N.R.L.
- 2) Hand modes are diagnostic procedures. The area under investigation should also T.L. in the clear and be an N.R.L.
- 3) While maintaining a mode as in step 1 (with weak straight arm), place the same mode in the opposite hand. The previously tested muscle should now test strong. (Key - biphasic computer).
- 4) It should be clearly understood that the hand contact is a symbol of the bio computer. The interpretation of the contact is a result of our research. It is possible the interpretation may change at a later date based upon further data.
- 5) While the patient is holding the hand mode the biocomputer scans the body looking for recorded data relating to the mode. This data is reflexed to the skin for a positive T.L., to the kinetic system for muscle change, and to the spinal column for alteration in leg length.

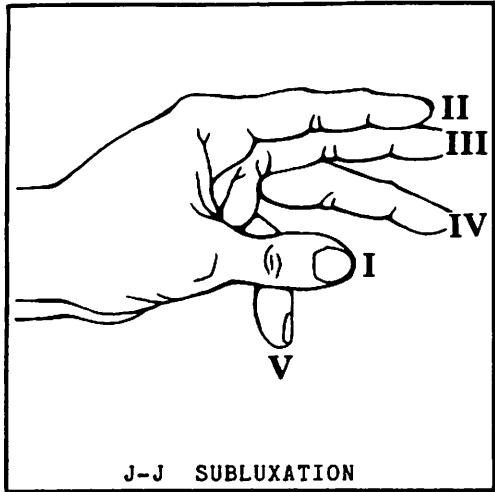
## SUBMODE

- 1) A submode (a hand contact or series of hand contacts) is considered positive if it fulfills the same criteria as "General Rules for Modes" 1-3 and is preceded by a positive specific hand mode.
- 2) The submodes are designated as negative (-).

## THERAPEUTIC HAND MODES

The following is a description of the hand modes of the spinal computer. Remember, as was discussed in the biocomputer chapter, the skin is the display unit for the C.P.U. Once you hold a hand mode, if the computer is functioning properly, the skin will display only those areas of positive T.L. related to the hand contact.

### 1) Subluxation mode



Discussion: The present interpretation of a fixation is that it is two or more bone units of the body that are fixed or locked together in a plane of motion.

#### Correction:

- Identify a positive T.L. over a bone surface.
- While maintaining a positive T.L., T.L. adjacent bones until a positive two-point is found.
- These two or more units are fixed in a plane of motion.

Most often motion palpation will establish the range of motion in which the bones are locked. Correctional force is applied until all units are free and moving independent of each other. Once the bones are moving independent of each other adjustments should be made. Correction should negate any positive T.L.

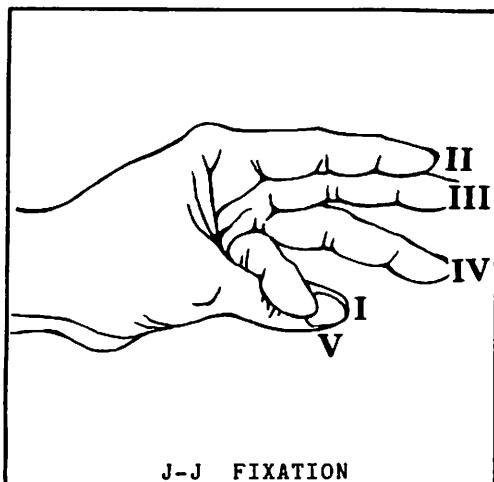
#### Description Ib - Vc

Discussion: This mode is presently interpreted to mean a bone unit in the body that is significantly out of alignment with adjacent bones.

#### Correction:

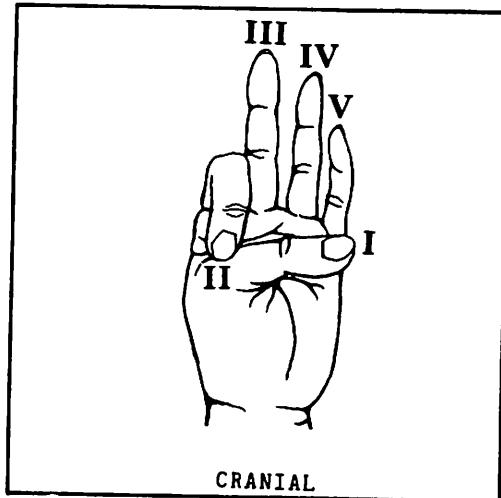
- Identify a positive T.L. over a bone surface.
- Find a direction which negates the positive T.L.
- Apply your correctional force in a manner that is appropriate to the circumstances of the patient. Older and very young patients usually require light adjustive corrections i.e.; Activator, Van Rumpt, Toftness, etc.

### 2) Fixation Mode



#### Description: Ie - Vf

### 3) Cranial (Structural) Mode



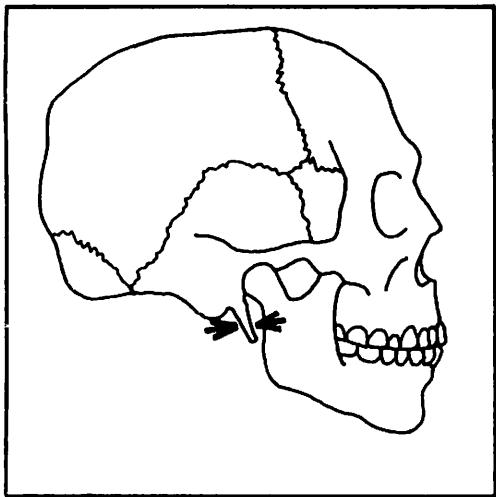
#### Description: I6 - II4

In computer language the cranium rarely shows a positive T.L. in relation to the subluxation or fixation mode, therefore a separate mode is necessary. There are two types of cranial corrections, one structural and the other muscular. This particular mode is structural in nature.

Discussion: This mode includes any bone of the cranium that has lost its proper relationship or has become fixed with any adjacent bone.

SEE PROCEDURES FOR CRANIAL CORRECTION IN VOLUME III, CLINICAL KINESIOLOGY. PAGES 89-99 EXCEPT FOR STYLOID CORRECTION SEEN BELOW.

## STYLOID

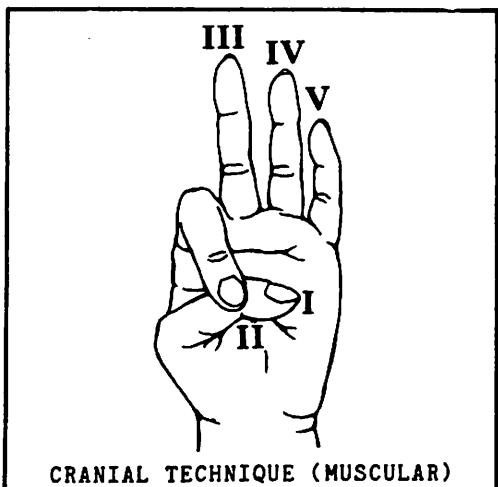


Discussion: T.L. any part of the styloid process of the temporal bone located anterior to the distal end of the mastoid process.

### Correction:

1. The plane of subluxation is normally anterior or posterior.
2. Corrective force is applied with the thumb or the index finger in a direction that negates a positive T.L.
3. Counter pressure is applied by the opposite hand supporting the direction of the thrust.
4. Follow general rules for cranial correction.

## 4) Cranial (Muscular) mode



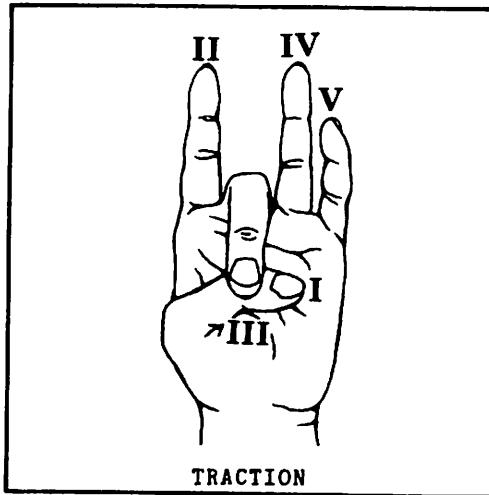
Description: I5 - III4

Discussion: Included in this mode is cranial stress of soft tissue origin. This type of stress is usually related to muscular spasm or dyskinesia.

### Correction:

- a) Identify the area or areas of positive T.L.
- b) Find the direction that negates positive T.L.
- c) Hold for 30 seconds to 1 minute or until you feel the tissue relax.

## 5) Traction Mode



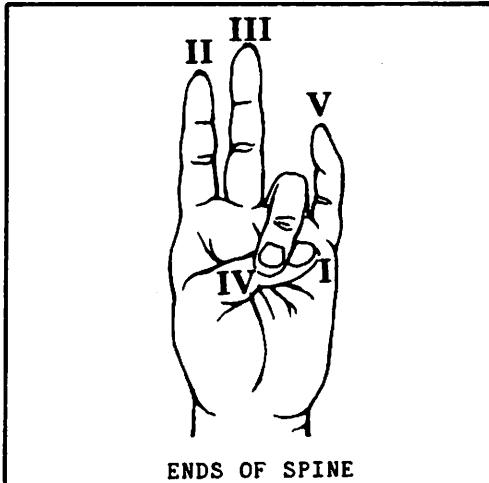
Description: I5 - III4

Discussion: This is a fixation at the facets which is resolved by traction.

### Correction:

Bilateral traction of the leg is applied while the Dr. pumps specifically diagnosed levels of the spine into motion which have been identified by positive T.L. (Note: Occasionally Cervical or Thoracic traction is indicated).

## 6) Ends of Spine (Toftness Technique)



Description I5 - IV4

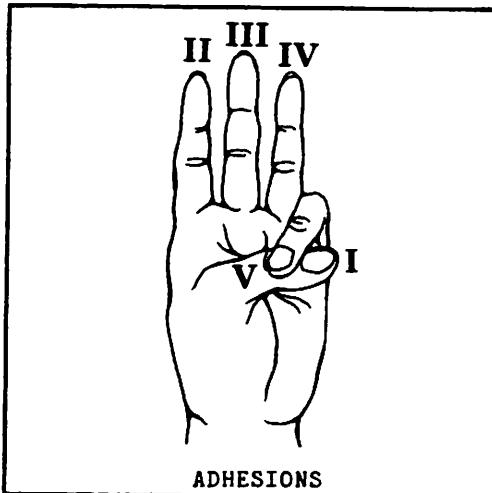
**Discussion:** This includes aberrant stress expressed at the pelvis and/or neck requiring centering technique.

**Correction:**

This procedure is an accumulation of several areas including the tonic neck reflexes, cloacals, visual righting reflexes, labyrinthine reflexes and their relationship to the altas.

- a) Check for a positive T.L. at the visual righting reflex center.
- b) Find a positive T.L. at the tonic neck area (C1 - C2 junction) usually on the opposite side of the neck.
- c) Find the involved anterior cloacal. (Usually opposite to neck).
- d) Pulsate all together.
- e) Put patient in prone position.
- f) Find the involved posterior cloacal. (Usually on the same side as the anterior cloacal).
- g) Find the involved side of the atlas. (Usually opposite to the posterior cloacal).
- h) Pulsate together.

**7) Adhesions**



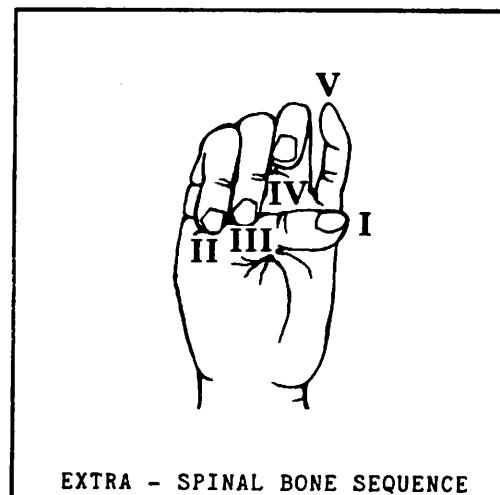
**Description:** I5 - V4

**Discussion:** Frequently adhesions occur in the peritoneum of the abdomen and pelvic floor.

**Correction:**

- a) Find the positive T.L.
- b) Find the direction that negates the positive T.L.
- c) Use a directional thrust to the site of the adhesions. Continue until the area no longer has a positive T.L.

**8) Extra-Spinal Bone Sequence Mode**



**Description:** I6 - (II, III)4

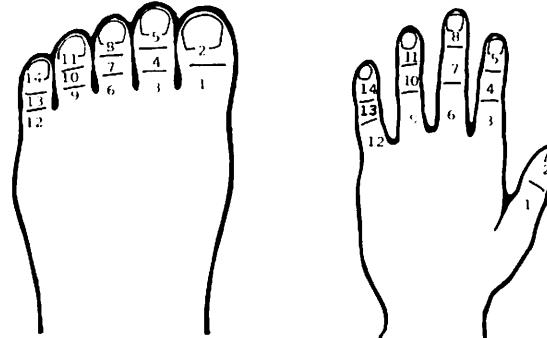
**Discussion:** When a subluxation occurs in an extra-spinal bone and is not corrected, it frequently causes a sequence or series of extra-spinal and atlas subluxations in a predictable manner.

**Correction:**

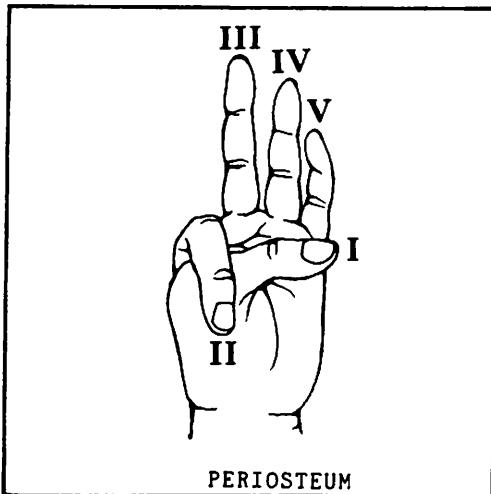
When this mode is positive and the patient is clear of all adaptations, all bones in the extra-spinal bone sequence will appear on display at the same time. All should be N.R.L. Find the direction that negates the positive T.L. Make the correction and retest. Move on to the next segment and repeat.

**CHART**  
To locate the related bones read the chart horizontally.

CRANIAL	OTHER BONES	ATLAS	PHA-LANX	METACA-METATA	CUNI-FORM	RIBS	FOOT	WRIST
1. Occiput	torque universal	Sacrum	Lat				Calcaneus	Pisi-form
2. Parietal	bulge descent	Ischium	Ant.				Talus	Lunate
3. Temporal	int., ext petrous	Ilium	Post.				Cuboid	Triquetrum
4. Frontal		Cavicle, Pubis, Scapula	Ant.				Navicular	Scaphoid
5. Ethmoid		Manubrium	Post.	1	1	1,2	Cuboid	Trapezium
6. Palatine		Fibula, Radius	Post.	1		1,2	Cuboid	
7. Vomer		Humerus, ASIS, Int.	Post.	2	2	3,4		Trapezoid
8. Maxillae, A-P		Gladiolus	Post.	6	3	3	5,6	Capitate
9. Sphenoid		Coccyx, Xiphoid	Post.		3	3	5,6	Capitate
10. Glabella			Post.		4	3	7,8	Capitate
11. Zygoma		Xiphoid	Post.	9	4	3	7,8	Hamate
12. Maxillae, Med-Lat.			Post.		5		9,10	
13. Lacrimal		Ulna	Post.	3				
14. Inf. Conchae		Patella	Post.	3				
15. Mandible		Radius, Fibula	Post.	1				
16. Nasal		Tibia	Post.	2				
17. Styloid		Femur	Post.	2				
18. Hyoid				12				
Incisors 1 & 2			Middle	2nd Phalanx	Hand			
			Distal	2nd Phalanx	Foot			
			Middle	3rd Phalanx	Hand			
Canine & Premolar 1			Distal	3rd Phalanx	Foot			
			Middle	4th Phalanx	Hand			
Premolar 2, Molar 1			Distal	4th Phalanx	Foot			
			Middle	5th Phalanx	Hand			
Molars 2 & 3			Distal	5th Phalanx	Foot			



## 9) Periosteum Mode



Description: IA - II4

Discussion: The spinal column acts as a computer. It is capable of interacting with both its internal and external environment. In this mode the spine shifts and subluxates as individual segments and as a whole. The display unit for the spinal computer is the reactive short leg. When the nervous system is under undue stress, it reflexes into the periosteum and muscles of the spinal column producing a contraction or expansion of the leg length. The short leg reflex is biphasic in nature and expression, giving us another method of communication with the biocomputer. When you have a positive hand mode kinetically, you should also have a positive reactive leg or short leg.

This reactive leg phenomenon, to my knowledge, was first discovered by an astute chiropractor from Santa Barbara, California, Dr. Van Rumpt. This concept was expanded and improved upon by two excellent chiropractors, Dr. Arlan Fuhr and Dr. W.C. Lee. They called the reactive leg the side of pelvic deficiency or P.D. If the leg was shorter on the right than the left, this became known as an R.P.D. If this occurred on the left it became known as an L.P.D. In this book the P.D. will be referred to as the short leg reactive side. The P.D. will be considered the same as a positive T.L. in Applied Kinesiology. Comparing a P.D. with a positive hand mode is another way of challenging the biocomputer to make sure it is processing data properly. If these two criteria do not agree, you should

review the clearing techniques.

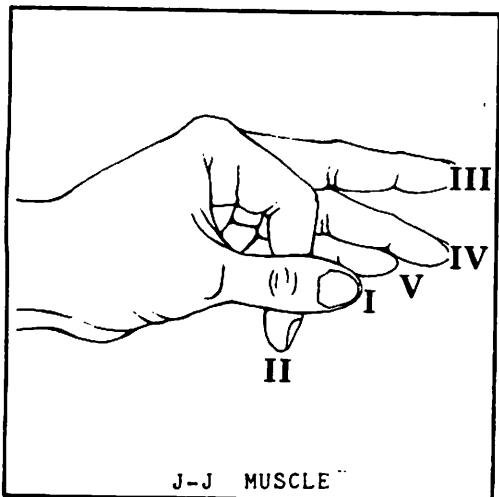
The periosteum hand mode is a reflection of the stress in the periosteum of the spine. It is a technique for the correction of the spine as a functional unit.

Correction:

- 1) Place patient in the mode and note the positive PD.
- 2) Place mode in opposite hand and turn patient prone to note if P.D. remains the same. If P.D. changes, return to clearing techniques. If it remains the same, proceed to 3.
- 3) Perform a Derfield test. This test is accomplished by lifting the legs into knee flexion and note the P.D. change. Potentially two things may happen:
  - A) The P.D. changes - short side becomes long in the Derfield position. This is a positive Pelvic Major and the spine as a whole must be corrected starting with the lower extremities and/or pelvis and moving up the spine ending in the neck or cranium.
  - B) The side of the P.D. will remain the same, that is, the short leg remains short in the Derfield position. This suggests that there is an Upper Cervical Major and the spine as a whole must be corrected from superior (head and neck) to inferior (pelvis).

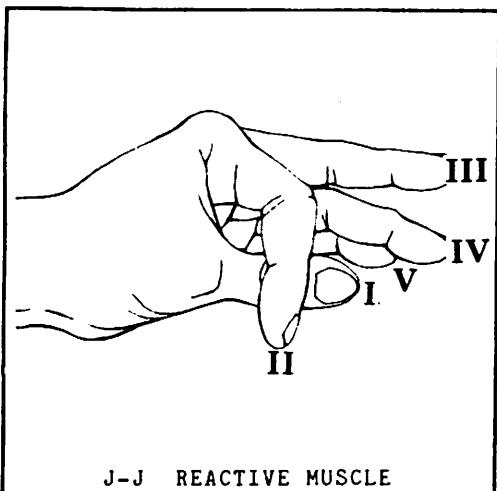
Note: The periosteum hand mode is the hand symbol for many of the concepts of the Activator Technique as originated by Drs. Lee and Fuhr. Due to the fact that their procedure is copyrighted material we recommend that you attend their seminar to learn their procedure.

10) J.J. Muscle Mode



Description: I2 - IIC

11) J.J. Reactive Muscle Mode



Description: I5 - IIF

Discussion: Muscles are perhaps the most active working tissue in the body. They are subject to unusual types of strains, sprains, spasticity and dyskinesia.

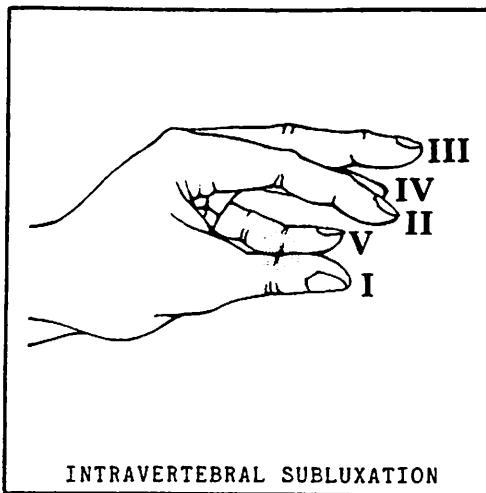
Correction:

- 1) Follow general mode steps 1-3 to arrive at a proper diagnosis.
- 2) Place starting hand in muscle submode.
  - a) [-I] Origin, insertion and spindle work, as defined in Muscle Section, without the use of the N.V. or N.L.
  - b) [-II] Fascial correction - see Fascial Section.
  - c) [-III] Muscle adjustment. Muscle tissue can be out of alignment in the same way as any bone tissue. Identify the direction of the corrective thrust.

(Usually perpendicular to the belly of the muscle). This is the most frequent submode in this list.

- d) [-IV] Reactivemuscle. Identify and correct aberrant related muscle tissue using the normal reactive muscle technique.
- e) [-V] Bio-computer adaptation. Repeat clearing technique.
- f) (I3- II4) Local Computer Factors. See section on local computer.
- g) (I3 - III4) Spinal Subluxation - Identify and correct all spinal subluxations.
- h) (I3 - IV4) Nutrition. See Local computer muscle worksheet for specific nutrition related to each muscle.
- i) (I3 - V4) Acupuncture. See section on M.A.P. in Muscle Correction.

12) Intravertebral Subluxation Mode



Description: I2 - V3

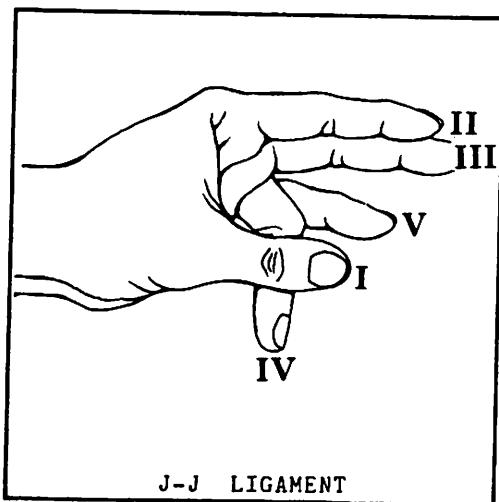
Discussion: This subluxation was introduced by Dr. George Goodheart at the 1982 summer meeting of the I.C.A.K. In this mode the bone has lost its ability to maintain intra-bone movements within and in relationship to all parts of the bone.

Correction:

- The goal in correction is to establish movement or intra-bone flexibility.
- 1) Follow General Rules for Modes steps 1-3 to arrive at proper diagnosis.
  - 2) The use of the hand mode can replace the dual hand challenge as presented by Dr. George Goodheart.
  - 3) Identify the vertebral level with a positive T.L.

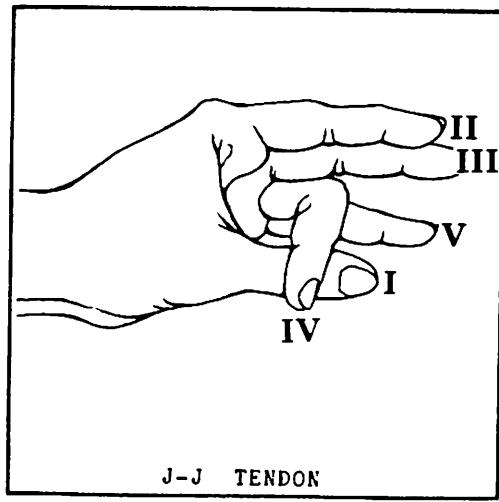
- 4) Find the areas of the vertebra that have a positive two-point.
- 5) Find the direction that negates the two-point. (Usually toward each other or apart from each other).

13) J.J. Ligament Mode



Description: IB - IVC

14) J.J. Tendon Mode



Description: IE - IVF

Discussion: Ligaments and tendons are subject to strains and sprains on frequent occasions. The therapeutic submodes are the same for both.

Correction:

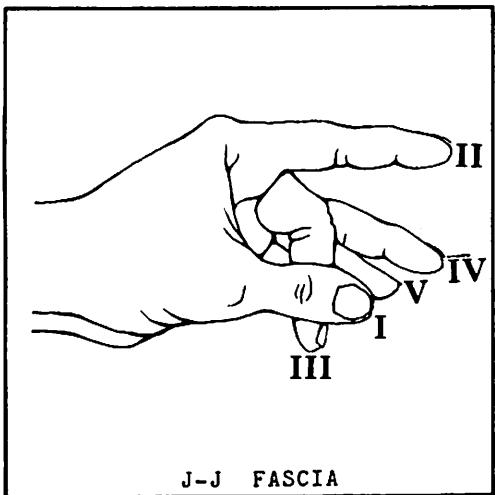
- 1) Follow General Rules For Modes steps 1-3 to establish a positive diagnosis.

- 2) Note whether the involved ligament is spinal or extra spinal. Place starting hand in ligament submode.

Submode:

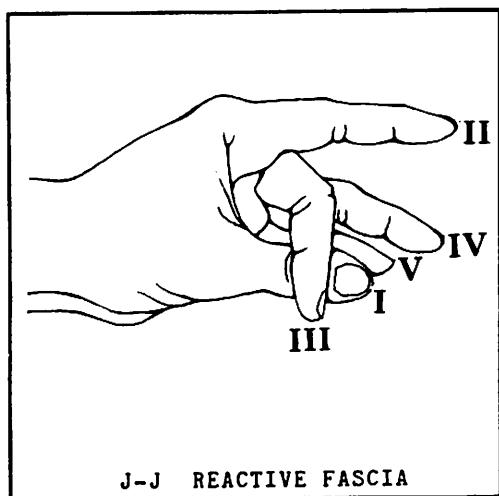
- a) [-I] Origin work as defined in Muscle Section without the use of the NV or NL. If spinal use Wintergreen and/or Spearmint oils. If extra spinal use Clove oil. Identify oils and apply pressure to the micro tears that have occurred to reinsert Sharpey's fibers. The same applies for the tendons.
- b) [-II] Insertion work. (Same as for origin).
- c) [-III] Collagenous Fibers. If spinal, use Myrrh oil. If extra-spinal use EE oil. Identify positive T.L. and use a directional thrust to reset the elastic fiber in the tissue.
- d) [-IV] Nutrition. The following nutrient sources have been valuable in solving ligament problems: Nutrimere (s), Ostogen (s), Protefood, Ligaplex II, Prostate, Uterus, Adrenal protomorphogens, Vitamin F (s), Cyruta + (s) (bioflavonoids), Fortil B12 (s).
- e) [-V] Bio-computer adaptation. Repeat clearing techniques.
- f) I3 - III4 Spinal Subluxation. Identify and correct all displayed subluxations.
- g) I3 - III4 Emotional Higher Self Balance the involved ligament with the frontal eminences.
- h) I3 - IV4 Emotional Lower Self Balance the involved ligament to areas that have a positive two-point in the thigh and groin area.
- i) I3 - V4 Another system is affecting this ligament or tendon.

15) J.J. Fascia Mode



Description: I2 - IIIC

16) J.J. Reactive Fascia Mode



Description: I5 - IIIF

Discussion: The fascia becomes aberrant and out of phase with its related muscle especially under heavy strain. This results in muscle dyskinesia and joint restriction within the area of the fascia. The reactive fascia rarely occurs. Therapeutics are the same as for the fascia.

Correction:

- 1) Place patient in mode and note if there is a positive reaction (intact muscle goes weak).
- 2) If positive, find the area by positive T.L. Determine the area

involved. It is usually in relation to a certain muscle or group.

- 3) Follow the General Rules for Modes to set submodes.

Submode

- a) [-I] Fascial centers are out of phase with the diagnosed fascia. The areas listed below are special areas which appear to act as fascial control centers.
  - a) Tensor Fascia Lata
  - b) All retinaculum
  - c) Posterior Infraspinatus area
  - d) Piriformis
  - e) Diaphragm
  - f) Tibialis Anterior
  - g) Forearm Extensors

Using an intact muscle, find a positive T.L. in one or more of these centers. Find a direction in the area which negates the positive T.L. and massage the center together with the previously diagnosed fascia. Wait for synchronal pulsation.

- b) [-II] Follow step 2 and find the direction which negates the positive T.L. Dermassage lotion has proved helpful when correcting a facial problem.

- c) [-III] Reactive Fascia  
When the fascia surrounding the area in step 2 is diagnosed, find a direction which negates the positive T.L. Work both fascial areas at the same time as they are out of phase with each other.

- d) [-IV] Nutrition.  
The following nutrients have been found effective in the Fascia mode.

- a) Betaine Hydrochloride
- b) Ligaplex I
- c) Kidney and Stomach protomorphogens
- d) Vitamin B12

- e) [-V] Computer Adaptation.  
Repeat clearing techniques.

- f) I3 - II4 Spinal level interference. Identify by T.L. and correct all spinal levels.

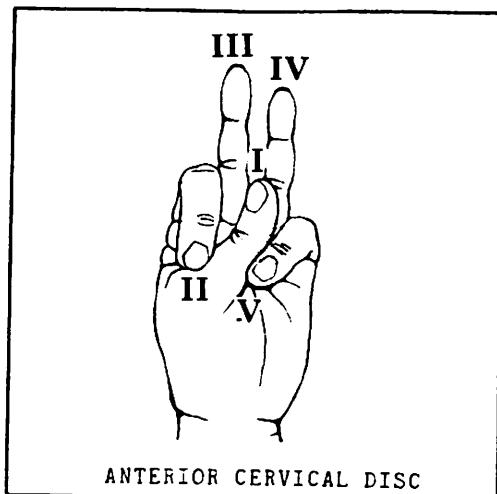
- g) I3 - III4 Diaphragm is out of

phase with the other primary fascial centers. Identify the area, correct and balance with synchronous pulsation.

h) I3 - IV4 Emotional Involvement to Fascia. Special areas located by Dr. Victor Frank of the I.C.A.K. seem to negate this mode. These areas are located bilaterally superior and medial to the eyebrows. Identify the positive side and balance to the tissue diagnosed in step 2.

i) I3 - V4 Another system is affecting the fascia.

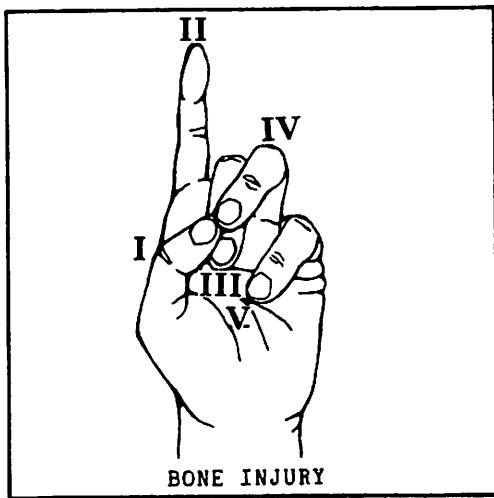
## 2) Anterior Cervical Disc Mode



## DIAGNOSTIC HAND MODES

This type mode is only used for diagnosis for it does not have inherent therapeutic properties.

### 1) Bone and Periosteum Injury Mode



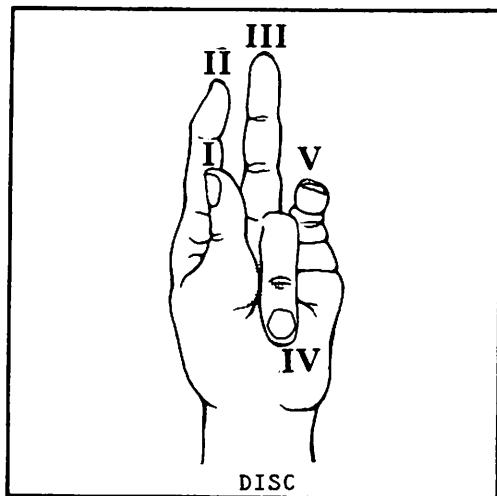
### Description I3 - IV4 - (III, V)

Discussion: Early diagnosis of bone fractures are paramount in any musculoskeletal practice. This mode was born with this need in mind. It is positive in our clinical practice any time there is a break or tear in the periosteum. It will be positive 2-4 weeks before a fracture is identifiable by x-ray. This has been particularly beneficial in the treatment of track and field athletes. A positive mode does not necessarily indicate that it can be demonstrated by X-ray.

### Description: I6 - II4, IB - VC

Discussion: This mode is positive when there is an injured, strained or degenerative cervical disc.

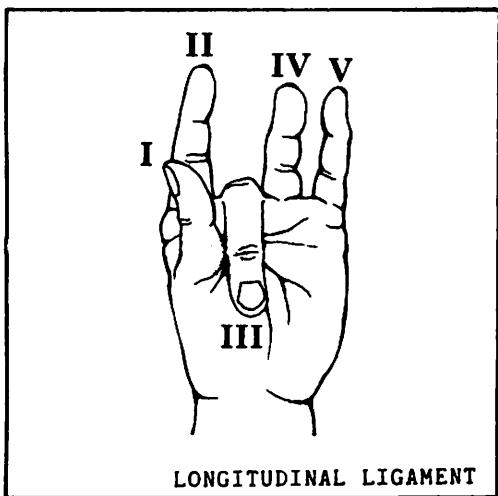
### 3) Disc Mode



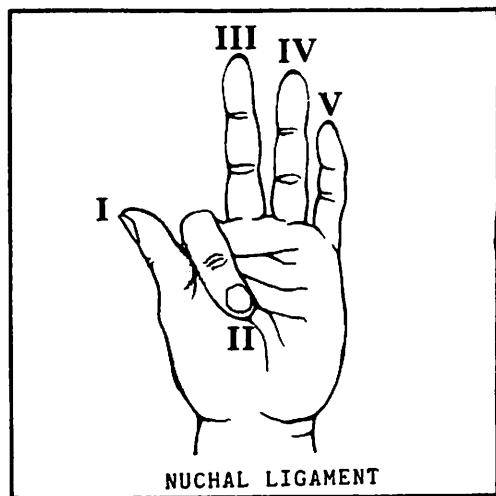
### Description: I1 - IVC

Discussion: A disc represents a common area of degeneration in the body that can lead to multiple symptoms. This mode is found at the end of many diagnostic sequences.

4) Anterior and Posterior Longitudinal  
Ligaments



5) Nuchal Ligament



Description: II - IIIIC

Discussion: Abnormal stress on the ligaments of the spine result in many unusual symptoms. Sometimes these are not correctable unless body language can be penetrated to find the correct file.

Description: II - IIIC

Discussion: This mode is positive in many cervical whiplash syndromes.

## **Chapter VI**

# **Cross Reference**

## A. ORGANS

### ADENOIDS

942 Adductor Hallucis Oblique Head, Peroneus Division

### ADRENAL

114 Masseter, Superficial Division  
302 Sternothyroideus  
326 Splenius Cervicis  
416 Deltoideus, Anterior, Scapular Division  
490 Pronator Teres, Humeral Division  
506 Flexor Carpi Radialis, Flexor Division  
614 Longissimus Thoracis, Upper Lumbar Division  
700 Rectus Abdominis, First Division  
726 Psoas Major, Diaphragmatic Division  
808 Gracilis  
810 Sartorius  
818 Vastus Medialis, Middle Division  
840 Articulari Genu  
854 Semitendinosus  
856 Semimembranosis, Tibial Division  
872 Soleus, Medial Division  
968 Interossei Dorsales Pedis, Third

### ANTERIOR PITUITARY

100 Orbicularis Oris, Lower Division  
314 Longus Capitis  
322 Splenius Capitus, Mastoid Division  
398 Pectoralis Major, Costal Division  
420 Supraspinatus, Fossa Division  
530 Extensor Pollicis Longus, Ulnar Division  
542 Flexor Digitorum Superficialis, Medial Division  
844 Adductor Magnus, Oblique Division  
872 Soleus, Medial Division  
902 Extensor Hallucis Longus, Interosseous Division  
922 Flexor Digitorum Longus, Medial Division  
924 Flexor Digitorum Longus, Lateral Division  
940 Flexor Hallucis Longus, Tibial Division  
950 Abductor Hallucis, Superior Division

### BLADDER

278 Scalenus Anterior  
290 Digastricus, Anterior Belly Division  
296 Mylohyoideus  
404 Trapezius, Lower Division  
426 Coracobrachialis, Septal Division  
440 Articularis Cubiti  
492 Anconeus, Olecranon Division  
548 Flexor Digitorum Profundus Manus, Lateral Division  
610 Spinalis Thoracis, Lumbar Division  
648 Serratus Posterior, Superior Division  
690 Pyramidalis  
708 Rectus Abdominis, Fourth Division, Lateralis

**BLADDER (Continued)**

- 726 Psoas Major, Diaphragmatic Division
- 842 Adductor Magnus, Vertical Division
- 852 Gluteus Maximus, Coccygeal Division
- 890 Peroneus Longus, Cuneiform Division
- 896 Peroneus Brevis, Septal Division
- 898 Peroneus Tertius
- 972 Interossei Plantares, First

**BROAD LIGAMENT**

- 844 Adductor Magnus, Oblique Division

**COLON (Rectal Area)**

- 722 Psoas Major, Lumbar Division
- 852 Gluteus Maximus, Coccygeal Division
- 874 Soleus, Lateral Division
- 948 Adductor Hallucis Transverse Head, Lateral Division

**COLON (Sigmoid)**

- 270 Trapezius, Upper Scapular Division
- 444 Biceps Brachii Shorthead
- 642 Levatores Costarum, Lower Division
- 734 Multifidus, Lumbosacral Division
- 824 Biceps Femoris, Shorthead

**COLON (Transverse)**

- 058 Levator Palpebrae Superioris
- 102 Buccinator
- 432 Latissimus Dorsi, Iliac Division
- 798 Pectineus

**COLON (Ascending/Descending)**

- 350 Interspinalis Cervicis
- 472 Deltoideus, Posterior, Lateral Division
- 518 Extensor Carpi Ulnaris, Adductor Division
- 692 Obliquus Externus Abdominis, Anterior Division
- 700 Rectus Abdominis, First Division
- 710 Iliacus
- 730 Quadratus Lumborum, Costal Division
- 790 Tensor Fascia Lata, Anterior Division
- 826 Biceps Femoris, Longhead, Fibular Division
- 876 Gastrocnemius, Lateral Division
- 918 Flexor Digitorum Brevis, Lateral Division

**COLON (Hepatic and Splenic Flexure)**

- 696 Obliquus Internus Abdominis, Anterior Division

DUCTUS DEFERENS

- 070 Depressor Septi Nasi
- 278 Scalenus Anterior
- 500 Flexor Carpi Ulnaris, Flexor Division
- 522 Extensor Digitorum Communis Manus, Medial Division
- 734 Multifidus, Lumbosacral Division
- 882 Tibialis Anterior, Cuneiform Division
- 920 Flexor Digitorum Brevis, Medial Division

DUODENUM (Horizontal Portion)

- 702 Rectus Abdominis, Second Division

DUODENUM (Ascending Portion)

- 706 Rectus Abdominis, Fourth Division, Medialis

DUODENUM (Descending Portion)

- 286 Platysma, Anterior Division
- 718 Transverse Abdominis, Lower Division

DUODENUM (Special Cells)

- 514 Extensor Carpi Radialis Brevis
- 816 Vastus Medialis, Upper Division
- 870 Gastrocnemius, Medial Division
- 890 Peroneus Longus, Cuneiform Division

DUODENUM (Superior Portion)

- 434 Triceps, Longhead

DUODENUM (L-Jejunum Junction; R-Ampulla of Vater)

- 800 Adductor Brevis

EAR (External)

- 394 Subclavius, Clavicular Division
- 476 Teres Major, Superior Division
- 958 Lumbricales Pedis, Second

EAR (Internal)

- 060 Orbicularis Oculi, Upper Division
- 272 Trapezius, Upper, Clavicular Division
- 406 Trapezius, Middle Division
- 496 Supinator, Radial Division

EPIDIDYMIS

- 864 Gemellus Superior

ESOPHAGUS

- 420 Supraspinatus, Fossa Division
- 466 Subscapularis, Second Division
- 504 Flexor Carpi Radialis, Abductor Division
- 596 Interossei Dorsales Manus, Third
- 706 Rectus Abdominis, Fourth Division, Medialis
- 938 Flexor Hallucis Longus, Fibular Division

EUSTACHIAN TUBE

- 434 Triceps, Longhead
- 486 Pronator Quadratus, Proximal Division
- 790 Tensor Fascia Lata, Anterior Division
- 824 Biceps Femoris, Shorthead

EYE

- 270 Trapezius, Upper, Scapular Division
- 298 Geniohyoideus
- 306 Omohyoideus
- 472 Deltoideus, Posterior, Lateral Division
- 696 Obliquus Internus Abdominis, Anterior Division
- 704 Rectus Abdominis, Third Division
- 738 Longissimus Lumborum
- 800 Adductor Brevis
- 964 Interossei Dorsales Pedis, First
- 974 Interossei Plantares, Second

EYE (Special Cells)

- 460 Infraspinatus, Middle Division

GALLBLADDER

- 098 Orbicularis Oris, Upper Division
- 274 Sternocleidomastoid, Sternal Division
- 282 Scalenus Medius
- 292 Digastricus, Posterior Belly Division
- 412 Deltoideus, Middle, Anterior Division
- 460 Infraspinatus, Middle Division
- 504 Flexor Carpi Radialis, Abductor Division
- 642 Levatores Costarum, Lower Division
- 732 Quadratus Lumborum, Lumbar Division
- 818 Vastus Medialis, Middle Division
- 880 Popliteus
- 892 Peroneus Longus, Metatarsal Division

GALLBLADDER DUCT SYSTEM

- 052 Occipitalis
- 134 Rectus Medialis Bulbi
- 300 Sternohyoideus
- 436 Triceps, Lateral Head
- 462 Infraspinatus, Inferior Division
- 530 Extensor Pollicis Longus, Ulnar Division
- 534 Extensor Pollicis Brevis
- 780 Gluteus Medius, Posterior Division

GONADS

- 100 Orbicularis Oris, Lower Division
- 102 Buccinator
- 124 Pterygoideus Lateralis (Externus), Upper Division-Disc
- 126 Pterygoideus Lateralis (Externus), Lower Division
- 308 Longus Colli, Vertical Division
- 408 Serratus Anterior, Superior Division
- 444 Biceps Brachii Shorthead

GONADS (Continued)

- 456 Teres Minor
- 480 Brachioradialis
- 496 Supinator, Radial Division
- 560 Opponens Pollicis, Flexor Division
- 586 Interossei Palmares, Second
- 784 Gluteus Medius, Anterior Division
- 806 Adductor Longus, Superior Division
- 814 Quadratus Femoris
- 840 Articularis Genu
- 860 Piriformis
- 888 Tibialis Posterior, Fibular Division
- 946 Adductor Hallucis, Transverse Head, Medial Division

HEART

- 326 Splenius Cervicis
- 390 Pectoralis Minor, Superior Division
- 402 Pectoralis Major, Clavicular Division
- 466 Subscapularis, Second Division
- 470 Subscapularis, Superior Division
- 492 Anconeus, Olecranon Division
- 566 Adductor Pollicis Transversus
- 610 Spinalis Thoracis, Lumbar Division
- 612 Spinalis Thoracis, Thoracic Division
- 656 Diaphragm Number One, Right Side, Lumbar Division
- 744 Pubococcygeus
- 812 Obturator Externus
- 864 Gemellus Superior
- 888 Tibialis Posterior, Fibular Division
- 900 Extensor Hallucis Longus, Fibular Division
- 908 Extensor Digitorum Longus, Medial Division
- 952 Abductor Hallucis, Inferior Division

ILIUM

- 500 Flexor Carpi Ulnaris, Flexor Division
- 566 Adductor Pollicis Transverse
- 704 Rectus Abdominis, Third Division
- 740 Coccygeus, Sacral Division
- 804 Adductor Longus, Inferior Division
- 820 Vastus Medialis, Lower Division
- 834 Vastus Lateralis, Lower Division
- 836 Vastus Intermedius, Medial Division
- 886 Tibialis Posterior, Tibial Division

ILIUM (Ileocecal Valve)

- 946 Adductor Hallucis Transverse Head, Medial Division

ILIUM (Special Cells)

- 480 Brachioradialis
- 574 Abductor Digiti Minimi Manus, Abductor Division
- 584 Interossei Palmares, First
- 858 Semimembranosis, Popliteal Division

#### JEJUNUM

- 446 Brachialis
- 562 Opponens Digi Minimi Manus
- 652 Serratus Posterior, Inferior Division
- 738 Longissimus Lumborum
- 796 Rectus Femoris, Straight Head
- 878 Plantaris
- 884 Tibialis Anterior, Metatarsal Division
- 930 Flexor Hallucis Brevis, Cuboid Division

#### JEJUNUM (Special Cells)

- 308 Longus Colli, Vertical Division
- 546 Flexor Digitorum Profundus Manus, Medial Division
- 906 Extensor Hallucis Brevis

#### KIDNEY

- 130 Rectus Superior Bulbi
- 284 Scalenus Posterior
- 302 Sternothyroideus
- 392 Pectoralis Minor, Inferior Division
- 404 Trapezius, Lower Division
- 424 Coracobrachialis, Coracoid Division
- 442 Biceps Brachii Longhead
- 484 Pronator Quadratus
- 488 Pronator Teres, Ulnar Division
- 508 Palmaris Longus
- 510 Extensor Carpi Radialis Longus, Extensor Division
- 516 Extensor Carpi Ulnaris, Extensor Division
- 528 Extensor Indicis Proprius
- 712 Iliacus Minor
- 722 Psoas Major, Lumbar Division
- 724 Psoas Major, Thoracic Division
- 870 Gastrocnemius, Medial Division
- 924 Flexor Digitorum Longus, Lateral Division
- 938 Flexor Hallucis Longus, Fibular Division
- 958 Lumbricales Pedis, Second

#### LARYNX

- 276 Sternocleidomastoid, Clavicular Division
- 822 Obturator Internus
- 920 Flexor Digitorum Brevis, Medial Division
- 926 Quadratus Plantae, Lateral Division

#### LIVER

- 098 Orbicularis Oris, Upper Division
- 134 Rectus Medialis Bulbi
- 138 Obliquus Superior Bulbi
- 140 Obliquus Inferior Bulbi
- 380 Constrictor Pharyngis Medius
- 396 Subclavius, Sternal Division
- 400 Pectoralis Major, Sternal Division
- 448 Rhomboid Major
- 450 Rhomboid Minor
- 498 Supinator, Ulnar Division

LIVER (Continued)

- 512 Extensor Carpi Radialis Longus, Abductor Division  
534 Extensor Pollicis Brevis  
546 Flexor Digitorum Profundus Manus, Medial Division  
576 Lumbricales Manus, First  
730 Quadratus Lumborum, Costal Division  
794 Rectus Femoris, Reflected Head  
806 Adductor Longus, Superior Division  
874 Soleus, Lateral Division  
876 Gastrocnemius, Lateral Division  
940 Flexor Hallucis Longus, Tibial Division  
952 Abductor Hallucis, Inferior Division  
962 Lumbricales Pedis, Fourth

LUNGS

- 114 Masseter, Superficial Division  
346 Obliquus Capitis Superior  
390 Pectoralis Minor, Superior Division  
392 Pectoralis Minor, Inferior Division  
408 Serratus Anterior, Superior Division  
410 Serratus Anterior, Inferior Division  
412 Deltoideus, Middle, Anterior Division  
414 Deltoideus, Middle, Posterior Division  
416 Deltoideus, Anterior, Scapular Division  
418 Deltoideus, Anterior, Clavicular Division  
426 Coracobrachialis, Septal Division  
478 Teres Major, Inferior Division  
524 Extensor Digiti Minimi Manus  
574 Abductor Digiti Minimi Manus, Abductor Division  
736 Iliocostalis Lumborum  
744 Pubococcygeus  
784 Gluteus Medius, Anterior Division  
786 Gluteus Minimus, Anterior Division  
816 Vastus Medialis, Upper Division  
822 Obturator Internus  
862 Gemellus Inferior  
894 Peroneus Brevis, Fibular Division  
898 Peroneus Tertius  
916 Flexor Digiti Minimi Brevis Pedis  
930 Flexor Hallucis Brevis, Cuboid Division  
932 Flexor Hallucis Brevis, Third Cuneiform Division  
944 Adductor Hallucis Oblique Head, Metatarsal Division

LYDEN GLAND

- 544 Flexor Digitorum Superficialis, Lateral Division

LYMPHATICS OF COLON

- 694 Obliquus Externus Abdominis, Lateral Division

LYMPHATICS OF DUODENUM

- 430 Latissimus Dorsi, Lumbar Division

LYMPHATICS OF FACE AND NECK

- 276 Sternocleidomastoid, Clavicular Division  
552 Abductor Pollicis Longus, Ulnar Division

**LYMPHATICS OF FRONTAL SINUS**

454 Levator Scapula, Superior Division

**LYMPHATICS OF GALL BLADDER**

132 Rectus Inferior Bulbi

494 Anconeus, Ulnar Division

**LYMPHATICS OF GALLBLADDER DUCT SYSTEM**

138 Obliquus Superior Bulbi

**LYMPHATICS OF ILIUM**

428 Latissimus Dorsi, Thoracic Division

796 Rectus Femoris, Straight Head

810 Sartorius

956 Lumbricales Pedis, First

**LYMPHATICS OF JEJUNUM**

140 Obliquus Inferior Bulbi

710 Iliacus

948 Adductor Hallucis Transverse Head, Lateral Division

**LYMPHATICS OF LUNGS**

458 Infraspinatus, Superior Division

648 Serratus Posterior, Superior Division

**LYMPHATICS OF RECTAL AREA**

288 Platysma, Posterior Division

580 Lumbricales Manus, Third

**LYMPHATICS OF SMALL INTESTINE (Inguinal Lymph Nodes)**

656 Diaphragm Number One, Right Side, Lumbar Division

**LYMPHATICS OF STOMACH**

728 Psoas Minor

936 Flexor Hallucis Brevis, First Cuneiform Division

**LYMPHATICS OF SUBMANDIBULAR**

282 Scalenus Medius

856 Semimembranosis, Tibial Division

**LYMPHATICS OF THROAT**

508 Palmaris Longus

**LYMPHATICS OF THYROID**

846 Adductor Magnus, Transverse Division

**LYMPHATICS OF TONSILS**

878 Plantaris

**MAMMARY GLAND**

400 Pectoralis Major, Sternal Division

448 Rhomboid Major

614 Longissimus Thoracicus, Upper Lumbar Division

724 Psoas Major, Thoracic Division

782 Gluteus Medius, Middle Division

NOSE

- 304 Thyrohyoideus  
424 Coracobrachialis, Coracoid Division  
502 Flexor Carpi Ulnaris, Adductor Division  
514 Extensor Carpi Radialis Brevis  
552 Abductor Pollicis Longus, Ulnar Division  
652 Serratus Posterior, Inferior Division  
690 Pyramidalis  
814 Quadratus Femoris  
846 Adductor Magnus, Transverse Division  
896 Peroneus Brevis, Septal Division  
916 Flexor Digiti Minimi Brevis Pedis  
944 Adductor Hallucis Oblique Head, Metatarsal Division  
954 Abductor Digiti Minimi Pedis

PANCREAS

- 110 Temporalis, Parietal Division  
136 Rectus Lateralis Bulbi  
274 Sternocleidomastoid, Sternal Division  
286 Platysma, Anterior Division  
322 Splenius Capitis, Mastoid Division  
370 Thyroarytenoideus  
428 Latissimus Dorsi, Thoracic Division  
520 Extensor Digitorum Communis Manus, Lateral Division  
528 Extensor Indicis Proprius  
544 Flexor Digitorum Superficialis, Lateral Division  
712 Iliacus Minor  
786 Gluteus Minimus, Anterior Division  
848 Gluteus Maximus, Iliac Division  
886 Tibialis Posterior, Tibial Division

PANCREAS (Inguinal Lymph Nodes)

- 662 Diaphragm Number Four, Left Side Lumbar Division

PANCREATIC DUCT SYSTEM

- 062 Orbicularis Oculi, Lower Division  
112 Temporalis, Occipital Division  
288 Platysma, Posterior Division  
290 Digastricus, Anterior Belly Division  
362 Cricothyreoides Lateralis  
394 Subclavius, Clavicular Division  
464 Subscapularis, Inferior Division  
494 Anconeus, Ulnar Division  
512 Extensor Carpi Radialis Longus, Abductor Division  
540 Flexor Pollicis Longus  
596 Interossei Dorsales Manus, Third  
618 Longissimus Thoracis, Middle Thoracic Division  
740 Coccygeus, Sacral Division  
788 Gluteus Minimus, Posterior Division  
798 Pectineus  
832 Vastus Lateralis, Middle Division  
834 Vastus Lateralis, Lower Division

**PANCREATIC DUCT SYSTEM (Continued)**

- 848 Gluteus Maximus, Iliac Division
- 858 Semimembranosis, Popliteal Division
- 906 Extensor Hallucis Brevis
- 934 Flexor Hallucis Brevis, Tendonial Division
- 964 Interossei Dorsales Pedis, First

**PARATHYROID**

- 070 Depressor Septi Nasi
- 126 Pterygoideus Lateralis (Externus), Lower Division
- 452 Levator Scapula, Inferior Division
- 578 Lumbricales Manus, Second
- 580 Lumbricales Manus, Third
- 892 Peroneus Longus, Metatarsal Division

**PENIS/VAGINAL VAULT**

- 058 Levator Palpebrae Superioris
- 332 Semispinalis Capitis
- 398 Pectoralis Major, Costal Division
- 478 Teres Major, Inferior Division
- 490 Pronator Teres, Humeral Division
- 708 Rectus Abdominis, Fourth Division, Lateralis
- 780 Gluteus Medius, Posterior Division
- 788 Gluteus Minimus, Posterior Division
- 792 Tensor Fascia Lata, Posterior Division
- 804 Adductor Longus, Inferior Division
- 880 Popliteus
- 926 Quadratus Plantae, Lateral Division
- 960 Lumbricales Pedis, Third

**PHARYNX**

- 110 Temporalis, Parietal Division
- 380 Constrictor Pharyngis Medius
- 522 Extensor Digitorum Communis Manus, Medial Division
- 558 Opponens Pollicis, Abductor Division
- 586 Interossei Palmares, Second

**PINEAL**

- 112 Temporalis, Occipital Division
- 124 Pterygoideus Lateralis (Externus), Upper Division-Disc
- 476 Teres Major, Superior Division
- 558 Opponens Pollicis, Abductor Division
- 612 Spinalis Thoracis, Thoracic Division
- 936 Flexor Hallucis Brevis, First Cuneiform Division

**POSTERIOR PITUITARY**

- 118 Masseter, Deep Division
- 120 Pterygoideus Medialis (Internus), Sphenoid Division
- 396 Subclavius, Sternal Division
- 406 Trapezius, Middle Division
- 450 Rhomboid Minor
- 470 Subscapularis, Superior Division
- 488 Pronator Teres, Ulnar Division
- 524 Extensor Digitii Minimi Manus

**POSTERIOR PITUITARY (Continued)**

- 560 Opponens Pollicis, Flexor Division
- 576 Lumbricales Manus, First
- 714 Transverse Abdominis, Upper Division
- 728 Psoas Minor
- 820 Vastus Medialis, Lower Division
- 850 Gluteus Maximus, Sacral Division
- 854 Semitendinosus
- 910 Extensor Digitorum Longus, Lateral Division
- 954 Abductor Digiti Minimi Pedis

**PROSTATE/UTERUS**

- 300 Sternohyoideus
- 314 Longus Capitis
- 334 Semispinalis Cervicis
- 370 Thyroarytenoideus
- 402 Pectoralis Major, Calvicular Division
- 438 Triceps, Medial Head
- 464 Subscapularis, Inferior Division
- 498 Supinator, Ulnar Division
- 502 Flexor Carpi Ulnaris, Adductor Division
- 516 Extensor Carpi Ulnaris, Extensor Division
- 698 Obliquus Internus Abdominis, Lateral Division
- 746 Iliococcygeus
- 782 Gluteus Medius, Middle Division
- 808 Gracilis
- 828 Biceps Femoris, Longhead, Tibial Division
- 842 Adductor Magnus, Vertical Division
- 850 Gluteus Maximus, Sacral Division
- 860 Piriformis
- 862 Gemellus Inferior
- 908 Extensor Digitorum Longus, Medial Division
- 950 Abductor Hallucis, Superior Division
- 970 Interossei Dorsales Pedis, Fourth

**SALIVARY GLANDS (Parotid)**

- 362 Cricothyreoides Lateralis
- 430 Latissimus Dorsi, Lumbar Division
- 440 Articularis Cubiti
- 452 Levator Scapula, Inferior Division
- 836 Vastus Intermedius, Medial Division

**SALIVARY GLANDS (Sublingual)**

- 334 Semispinalis Cervicis
- 436 Triceps, Lateral Head
- 584 Interossei Palmares, First
- 702 Rectus Abdominis, Second Division
- 828 Biceps Femoris, Longhead, Tibial Division
- 838 Vastus Intermedius, Lateral Division
- 918 Flexor Digitorum Brevis, Lateral Division
- 928 Quadratus Plantae, Medial Division

**SALIVARY GLANDS (Submandibular)**

- 714 Transverse Abdominis, Upper Division  
832 Vastus Lateralis, Middle Division  
932 Flexor Hallucis Brevis, Third Cuneiform Division  
974 Interossei Planares, Second

**SEMINAL VESICLE**

- 578 Lumbricales Manus, Second

**SINUS (Frontal)**

- 594 Interossei Dorsales Manus, Second  
692 Obliquus Externus Abdominis, Anterior Division

**SINUS (Maxillary)**

- 422 Supraspinatus, Spine Division  
484 Pronator Quadratus  
562 Opponens Digitii Minimi Manus  
956 Lumbricales Pedis, First  
962 Lumbricales Pedis, Fourth

**SINUS (Nasal)**

- 976 Interossei Plantares, Third

**SINUS (Sphenoid)**

- 468 Subscapularis, Third Division  
694 Obliquus Externus Abdominis, Lateral Division

**SPLEEN**

- 306 Omohyoideus  
332 Semispinalis Capitis  
346 Obliquus Capitis Superior  
414 Deltoideus, Middle, Posterior Division  
442 Biceps Brachii Longhead  
454 Levator Scapula, Superior Division  
474 Deltoideus, Posterior, Medial Division  
520 Extensor Digitorum Communis Manus, Lateral Division  
548 Flexor Digitorum Profundus Manus, Lateral Division  
594 Interossei Dorsales Manus, Second  
662 Diaphragm Number Four, Left Side Lumbar Division  
812 Obturator Externus  
826 Biceps Femoris, Longhead, Fibular Division  
882 Tibialis Anterior, Cuneiform Division  
966 Interossei Dorsales Pedis, Second  
972 Interossei Plantares, First

**STOMACH (Body)**

- 618 Longissimus Thoracis, Middle Thoracic Division  
922 Flexor Digitorum Longus, Medial Division

**STOMACH (Fundus)**

- 350 Interspinalis Cervicis  
486 Pronator Quadratus, Proximal Division

**STOMACH (Pyloric Antrum)**

510 Extensor Carpi Radialis Longus, Extensor Division

**STOMACH (Pyloric Valve)**

736 Iliocostalis Lumborum

**STOMACH (Pyloric Vestibule)**

518 Extensor Carpi Ulnaris, Adductor Division

**STOMACH (Pyloric Canal)**

742 Coccygeus, Coccyx Division

**STOMACH (Special Cells)**

130 Rectus Superior Bulbi

132 Rectus Inferior Bulbi

418 Deltoideus, Anterior, Clavicular Division

540 Flexor Pollicis Longus

928 Quadratus Plantae, Medial Division

942 Adductor Hallucis Oblique Head, Peroneus Division

**THYMUS**

062 Orbicularis Oculi, Lower Division

122 Pterygoideus Medialis (Internus), Palatine Division

272 Trapezius, Upper, Clavicular Division

304 Thyrohyoideus

410 Serratus Anterior, Inferior Division

422 Supraspinatus, Spine Division

462 Infraspinatus, Inferior Division

718 Transverse Abdominis, Lower Division

742 Coccygeus, Coccyx Division

830 Vastus Lateralis, Superior Division

902 Extensor Hallucis Longus, Interosseous Division

912 Extensor Digitorum Brevis

960 Lumbricales Pedis, Third

966 Interossei Dorsales Pedis, Second

**THYROID**

052 Occipitalis

060 Orbicularis Oculi, Upper Division

118 Masseter, Deep Division

120 Pterygoideus Medialis (Internus), Sphenoid Division

294 Stylohyoideus

298 Geniohyoideus

438 Triceps, Medial Head

456 Teres Minor

458 Infraspinatus, Superior Division

468 Subscapularis, Third Division

506 Flexor Carpi Radialis, Flexor Division

746 Iliococcygeus

792 Tensor Fascia Lata, Posterior Division

794 Rectus Femoris, Reflected Head

830 Vastus Lateralis, Superior Division

910 Extensor Digitorum Longus, Lateral Division

970 Interossei Dorsales Pedis, Fourth

**TONSILS**

- 122 Pterygoideus Medialis (Internus), Palatine Division
- 296 Mylohyoideus
- 446 Brachialis
- 474 Deltoideus, Posterior, Medial Division
- 542 Flexor Digitorum Superficialis, Medial Division
- 698 Obliquus Internus Abdominis, Lateral Division
- 732 Quadratus Lumborum, Lumbar Division
- 838 Vastus Intermedius, Lateral Division
- 912 Extensor Digitorum Brevis
- 934 Flexor Hallucis Brevis, Tendonial Division
- 976 Interossei Plantares, Third

**URETER**

- 294 Stylohyoideus
- 968 Interossei Dorsales Pedis, Third

**URETHRA**

- 284 Scalenus Posterior
- 432 Latissimus Dorsi, Iliac Division
- 884 Tibialis Anterior, Metatarsal Division
- 894 Peroneus Brevis, Fibular Division
- 900 Extensor Hallucis Longus, Fibular Division

**URETHRA (Membranous)**

- 136 Rectus Lateralis Bulbi

**VEINS OF STOMACH**

- 292 Digastricus, Posterior Belly Division

B. CERVICAL VERTEBRAL LEVELS

LEFT

RIGHT

C1

C1

C2 398, 576, 860

C2 844, 858

C3 058, 122, 290, 886

C3 098, 322, 698, 832, 902

C4 528, 840, 898, 928, 970

C4 464, 742, 848, 944

C5 408, 414, 424, 510, 652,  
882, 938

C5 402, 458, 954

C6 474, 534, 788, 852

C6 296, 430, 618

C7

C7 326, 404, 406

### THORACIC VERTEBRAL LEVELS

	LEFT	RIGHT
T1	100, 806, 916, 936, 960	T1 286, 514, 740
T2	130, 516, 808, 842	T2 300, 466, 488, 498, 864
T3	132, 134, 302, 468, 612, 642, 696, 796	T3 140, 438, 456, 838, 872
T4	308, 362, 460, 470, 704, 800L	T4 332, 732, 780, 794, 924
T5	110, 410, 426, 560, 736, 918	T5 392, 486, 496, 544, 736, 814, 896
T6	070, 314, 518, 522, 530, 830	T6 276, 546, 594, 610, 708, 920, 972
T7	136, 428, 478, 552, 578, 804, 966	T7 422, 450, 494, 540, 596, 714, 834, 888
T8	400, 448, 520, 614, 820, 892, 974	T8 062, 274, 412, 420, 752, 934, 976
T9	102, 490, 700, 712, 818, 874, 876, 906, 946, 974	T9 052, 298, 500, 508, 558, 822, 854
T10	272, 436, 562, 800R, 908, 910	T10 346, 586, 810, 846, 942, 956
T11	692, 894, 926, 958	T11 288, 394, 512, 566, 870, 890
T12	284, 484, 656, 726, 948	T12 138, 296, 334, 442, 662, 724, 792, 962

LUMBAR VERTEBRAL LEVELS

	LEFT	RIGHT
L1	126, 718, 722, 734, 816	L1 278, 462, 524, 694, 862, 880
L2	270, 396, 416, 472, 542, 648, 784, 884, 912, 968	L2 390, 452, 738, 746, 790, 900, 940
L3	060, 304, 454, 502, 504, 574, 580, 932, 950, 952	L3 112, 114, 306, 370, 380, 476, 506, 690
L4	118, 282, 418, 434, 706, 730, 782, 812, 878	L4 124, 292, 492, 548, 702, 710, 798, 828, 850, 922, 964
L5	350, 440, 446, 480, 826, 856, 930	L5 120, 294, 432, 444, 584, 728, 744, 786, 824, 836

C. CRANIALS

A - P Rocker	450, 722, 862, 884, 942
Ethmoid	284, 292, 420, 560, 566, 614, 696, 800, 890, 920, 950, 960.
Frontal	102, 296, 400, 462, 496, 580, 808, 810, 854, 872, 874, 882, 934.
Glabella	276, 290, 412, 542, 726, 816, 818, 918
Inferior Conchae	288, 456, 562, 574, 796, 848, 858, 938, 956
Lacrimal	120, 130, 298, 434, 524, 746, 836, 912, 970
Lateral Rocker	062, 122, 282, 392, 428, 432, 546, 840, 860 906, 958
Mandible	060, 114, 138, 334, 422, 734, 850, 902, 926, 946, 948, 962
Maxillary	272, 406, 410, 444, 464, 470, 478, 484, 486, 552, 576, 648, 656, 662, 698, 706, 712, 728, 738, 742, 780, 788, 798, 842, 908, 922, 932, 952
Nasal	458, 474
Occiput	270, 346, 476, 540, 558, 586, 692, 710, 744, 826, 846, 870, 876, 910, 944, 964
Palatine	126, 440, 466, 548, 732, 736, 740, 852, 900, 930

CRANIAL (cont.)

Parietal	098, 110, 140, 278, 402, 404, 408, 508, 520, 694, 718, 790, 792, 830, 834, 886, 892, 894, 924
Rotation Rocker	124, 326, 416, 724, 784, 794, 936, 968, 972
Sphenoid	100, 134, 302, 390, 394, 430, 460, 488, 494, 498, 500, 514, 578, 594, 612, 702, 832, 844, 856, 888
Styloid	294, 424, 438, 442, 504, 518, 814, 820, 928, 940, 966, 974
Temporal	132, 300, 306, 314, 322, 370, 394, 398, 446, 452, 468, 472, 480, 490, 502, 510, 512, 516, 528, 530, 700, 714, 782, 786, 804, 806, 812, 828, 838, 880, 896, 898, 916, 976
Vomer	112, 118, 426, 448, 534, 544, 584, 642, 690, 730, 822, 940, 966
Zygoma	274, 286, 304, 380, 396, 414, 418, 436, 522, 596, 704, 708, 824, 864, 878

D. FOOT

CALCANEUS	270, 346, 476, 540, 558, 586, 692, 710, 744, 826, 846, 870, 876, 910, 944, 964
CUBOID	132, 300, 306, 314, 322, 370, 390, 394, 398, 446, 452, 468, 472, 480, 490, 502, 510, 512, 516, 528, 530, 700, 714, 782, 786, 804, 806, 812, 828, 838, 880, 896, 898, 916, 976
NAVICULAR	102, 296, 400, 462, 496, 580, 808, 810, 854, 872, 874, 882, 934
TALUS	098, 110, 140, 278, 402, 404, 408, 508, 520, 694, 718, 790, 792, 830, 834, 886, 892, 894, 924
1ST CUNIEFORM	284, 292, 420, 566, 614, 696, 800, 890, 920, 950, 960
2ND CUNIEFORM	824, 864, 878
3RD CUNIEFORM	100, 134, 274, 286, 302, 304, 380, 396, 412, 414, 418, 430, 436, 444, 460, 494, 498, 500, 514, 552, 576, 578, 594, 612, 702, 704, 708, 742, 832, 844, 856, 888, 932
1ST METATARSAL	126, 440, 466, 548, 560, 732, 736, 740, 852, 900, 930
2ND METATARSAL	112, 118, 298, 426, 448, 534, 544, 584, 642, 690, 730, 822, 842, 908, 940, 966
3RD METATARSAL	272, 410, 464, 470, 488, 596, 656, 662, 726, 728, 738, 780, 788, 798, 922
4TH METATARSAL	274, 276, 286, 290, 522, 542, 816, 818, 918

FOOT (cont.)

5TH METATARSAL                    406, 478, 484, 486, 648, 698, 706, 712, 952

PROXIMAL PHALANX -  
GREAT TOE                        060, 114, 138, 334, 422, 734, 850, 902, 926,  
946, 948, 962

PROXIMAL PHALANX -  
2ND TOE                        120, 130, 288, 298, 434, 456, 524, 562, 574,  
746, 836, 848, 858, 912, 938, 956, 970

DISTAL PHALANX -  
GREAT TOE                        294, 424, 438, 442, 458, 474, 504, 518, 814,  
820, 928, 974

DISTAL PHALANX -  
4TH TOE                        796

**Chapter VII**

**Muscle List - Research Completed**

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052	Occipitalis	134	Rectus Medialis Bulbi
	Gallbladder Duct System		Gallbladder Duct System
	Thyroid		Liver
058	Levator Palpebrae Superioris	136	Rectus Lateralis Bulbi
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	Penis/Vaginal Vault		Urethra (membranous)
060	Orbicularis Oculi, Upper Div.	138	Obliquus Superior Bulbi
	Ear		Liver
	Thyroid		Lymphatics of Gallbladder Duct System
062	Orbicularis Oculi, Lower Div.	140	Obliquus Inferior Bulbi
	Thymus		Liver
	Pancreatic Duct System		Lymphatics of Jejunum
070	Depressor Septi Nasi	270	Trapezius, Upper, Scapular Div.
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	Parathyroid		Eye
098	Orbicularis Oris, Upper Div.	272	Trapezius, Upper, Clavicular Div.
	Gallbladder		Ear (Internal)
	Liver		Thymus
100	Orbicularis Oris, Lower Div.	274	Sternocleidomastoid, Sternal Div.
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	Gonads		Gallbladder
102	Buccinator	276	Sternocleidomastoid, Clavicular Div.
	Colon (Transverse)		Larynx
	Gonads		Lymphatics of Face/Neck
110	Temporalis, Parietal Div.	278	Scalenus Anterior
	Pancreas		Bladder
	Pharynx		Ductus Deferens
112	Temporalis, Occipital Div.	282	Scalenus Medius
	Pineal		Gallbladder
	Pancreatic Duct System		Lymphatics (Submandibular)
114	Masseter, Superficial Div.	284	Scalenus Posterior
	Adrenal		Kidney
	Lungs		Urethra
118	Masseter, Deep Div.	286	Platysma, Anterior Div.
	Posterior Pituitary		Duodenum (Descending Portion)
	Thyroid		Pancreas
120	Pterygoideus Medialis (Int.), Sphenoid Div.	288	Platysma, Posterior Div.
	Thyroid		Rectal Area
	Posterior Pituitary		Pancreatic Duct System
122	Pterygoideus Medialis (Int.), Palatine Div.	290	Digastricus, Anterior Belly Div.
	Thymus		Pancreatic Duct System
	Tonsils		Bladder
124	Pterygoideus Lateralis (Ext.), Upper Div.-Disc	292	Digastricus, Posterior Belly Div.
	Pineal		Gallbladder
	Gonads		Veins of Stomach
126	Pterygoideus Lateralis (Ext.), Lower Div.	294	Stylohyoideus
	Gonads		Thyroid
	Parathyroid		Ureter
130	Rectus Superior Bulbi	296	Mylohyoideus
	Kidney		Bladder
	Stomach (Special Cells)		Tonsils
132	Rectus Inferior Bulbi	298	Genichyoideus
	Lymphatics of Gallbladder		Eye
	Stomach (Special Cells)		Thyroid

300	Sternohyoideus	396	Subclavius, Sternal Div.
	Gallbladder Duct System		Liver
	Prostate/Uterus		Posterior Pituitary
302	Sternothyroideus	398	Pectoralis Major, Costal Div.
	Adrenal		Vaginal Vault
	Kidney		Anterior Pituitary
304	Thyrohyoideus	400	Pectoralis Major, Sternal Div.
	Thymus		Liver
	Nose		Mammary
306	Omohyoideus	402	Pectoralis Major, Clavicular Div.
	Eye		Heart
	Spleen		Prostate/Uterus
308	Longus Colli, Vertical Div.	404	Trapezius, Lower Div.
	Jejunum (special cells)		Bladder
	Gonads		Kidney
314	Longus Capitis	406	Trapezius, Middle Div.
	Anterior Pituitary		Ear (Internal)
	Prostate/Uterus		Posterior Pituitary
322	Spleniulus Capitis, Mastoid Div.	408	Serratus Anterior, Superior Div.
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	Anterior Pituitary		Gonads
328	Spleniulus Cervicis	410	Serratus Anterior, Inferior Div.
	Adrenal		Lungs
	Heart		Thymus
332	Semispinalis Capitis	412	Deltoideus, Middle, Anterior Div.
	Spleen		Gallbladder
	Penis/Vaginal Vault		Lungs
334	Semispinalis Cervicis	414	Deltoideus, Middle, Posterior Div.
	Prostate/Uterus		Lungs
	Salivary Glands (Sublingual)		Spleen
346	Obliquus Capitis Superior	416	Deltoideus, Anterior, Scapular Div.
	Spleen		Lungs
	Lungs		Adrenal
350	Interspinalis Cervicis	418	Deltoideus, Anterior, Clavicular Div.
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	Stomach (Fundus)		Stomach (Special Cells)
362	Cricothyroideus Lateralis	420	Supraspinatus, Fosse Div.
	Pancreatic Duct System		Esophagus
	Salivary Glands (Parotid)		Anterior Pituitary
370	Thyroarytenoideus	422	Supraspinatus, Spine Div.
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	Pancreas		Sinus (Maxillary)
380	Constrictor Pharyngis Medius	424	Coracobrachialis, Coracoid Div.
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	Pharynx		Nose
390	Pectoralis Minor, Superior Div.	426	Coracobrachialis, Septal Div.
	Heart		Bladder
	Lungs		Lungs
392	Pectoralis Minor, Inferior Div.	428	Latissimus Dorsi, Thoracic Div.
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	Lungs		Pancreas
394	Subclavius, Clavicular Div.	430	Latissimus Dorsi, Lumbar Div.
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	Pancreatic Duct System		Salivary Glands (Parotid)

432	<b>Latissimus Dorsi, Iliac Div.</b>		468	<b>Subscapularis, Third Div.</b>
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	Urethra			Thyroid
434	<b>Triceps, Longhead</b>		470	<b>Subscapularis, Superior Div.</b>
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	Eustachian Tube			Posterior Pituitary
436	<b>Triceps, Lateral Head</b>		472	<b>Deltoides, Posterior, Lateral Div.</b>
	Gallbladder Duct System			Colon (Ascending/Descending)
	Salivary Glands (Sublingual)			Eye
438	<b>Triceps, Medial Head</b>		474	<b>Deltoides, Posterior, Medial Div.</b>
	Thyroid			Spleen
	Prostate/Uterus			Tonsils
440	<b>Articularis Cubiti</b>		476	<b>Teres Major, Superior Div.</b>
	Bladder			Ear (External)
	Salivary Glands (Parotid)			Pineal
442	<b>Biceps Brachii Longhead</b>		478	<b>Teres Major, Inferior Div.</b>
	Kidney			Lungs
	Spleen			Penis/Vaginal Vault
444	<b>Biceps Brachii Shorthead</b>		480	<b>Brachioradialis</b>
	Colon (Sigmoid)			Ilium (Special Cells)
	Gonads			Gonads
446	<b>Brachialis</b>		484	<b>Pronator Quadratus</b>
	Jejunum			Kidney
	Tonsils			Sinus (Maxillary)
448	<b>Rhomboid Major</b>		486	<b>Pronator Quadratus, Proximal Div.</b>
	Liver			Eustachian Tube
	Mammary			Stomach (Fundus)
450	<b>Rhomboid Minor</b>		488	<b>Pronator Teres, Ulnar Div.</b>
	Posterior Pituitary			Kidney
	Liver			Posterior Pituitary
452	<b>Levator Scapula, Inferior Div.</b>		490	<b>Pronator Teres, Humeral Div.</b>
	Parathyroid			Adrenal
	Salivary Glands (Parotid)			Penis/Vaginal Vault
454	<b>Levator Scapula, Superior Div.</b>		492	<b>Anconeus, Olecranon Div.</b>
	Lymphatics of Frontal Sinus			Bladder
	Spleen			Heart
456	<b>Teres Minor</b>		494	<b>Anconeus, Ulnar Div.</b>
	Thyroid			Lymphatics of Gallbladder
	Gonads			Pancreatic Duct System
458	<b>Infraspinatus, Superior Div.</b>		496	<b>Supinator, Radial Div.</b>
	Lymphatics of Lungs			Ear
	Thyroid			Gonads
460	<b>Infraspinatus, Middle Div.</b>		498	<b>Supinator, Ulnar Div.</b>
	Eye (Special Cells)			Liver
	Gallbladder			Prostate/Uterus
462	<b>Infraspinatus, Inferior Div.</b>		500	<b>Flexor Carpi Ulnaris, Flexor Div.</b>
	Gallbladder Duct System			Ductus Deferens
	Thymus			Ilium
464	<b>Subscapularis, Inferior Div.</b>		502	<b>Flexor Carpi Ulnaris, Adductor Div.</b>
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	Pancreatic Duct System			Nose
466	<b>Subscapularis, Second Div.</b>		504	<b>Flexor Carpi Radialis, Abductor Div.</b>
	Esophagus			Esophagus
	Heart			Gallbladder

506	<b>Flexor Carpi Radialis, Flexor Div.</b>	
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	Thyroid	
508	<b>Palmaris Longus</b>	
	Kidney	
	Lymphatics of Throat	
510	<b>Extensor Carpi Radialis Longus, Extensor Div.</b>	
	Kidney	
	Stomach (Pyloric Antrum)	
512	<b>Extensor Carpi Radialis Longus, Abductor Div.</b>	
	Liver	
	Pancreatic Duct System	
514	<b>Extensor Carpi Radialis Brevis</b>	
	Duodenum (Special Cells)	
	Nose	
516	<b>Extensor Carpi Ulnaris, Extensor Div.</b>	
	Kidney	
	Prostate/Uterus	
518	<b>Extensor Carpi Ulnaris, Adductor Div.</b>	
	Colon	
	Stomach (Pyloric Vestibule)	
520	<b>Extensor Digitorum Communis Manus, Lateral Div.</b>	
	Pancreas	
	Spleen	
522	<b>Extensor Digitorum Communis Manus, Medial Div.</b>	
	Ductus Deferens	
	Pharynx	
524	<b>Extensor Digiti Minimi Manus</b>	
	Lungs	
	Posterior Pituitary	
528	<b>Extensor Indicis Proprius</b>	
	Kidney	
	Pancreas	
530	<b>Extensor Pollicis Longus, Ulnar Div.</b>	
	Gallbladder Duct System	
	Anterior Pituitary	
534	<b>Extensor Pollicis Brevis</b>	
	Gallbladder Duct System	
	Liver	
540	<b>Flexor Pollicis Longus</b>	
	Pancreatic Duct System	
	Stomach (Special Cells)	
542	<b>Flexor Digitorum Superficialis, Medial Div.</b>	
	Anterior Pituitary	
	Tonsils	
544	<b>Flexor Digitorum Superficialis, Lateral Div.</b>	
	Pancreas	
	Lyden Gland	
546	<b>Flexor Digitorum Profundus Manus, Medial Div.</b>	
	Jejunum (Special Cells)	
	Liver	
548	<b>Flexor Digitorum Profundus Manus, Lateral Div.</b>	
	Bladder	
	Spleen	
552	<b>Abductor Pollicis Longus, Ulnar Div.</b>	
	Lymphatics of Face/Neck	
	Nose	
558	<b>Opponens Pollicis, Abductor Div.</b>	
	Pharynx	
	Pineal	
560	<b>Opponens Pollicis, Flexor Div.</b>	
	Posterior Pituitary	
	Gonads	
562	<b>Opponens Digitii Minimi Manus</b>	
	Jejunum	
	Sinus (Maxillary)	
566	<b>Adductor Pollicis Transversus</b>	
	Ilium	
	Heart	
574	<b>Abductor Digitii Minimi Manus, Abductor Div.</b>	
	Ilium (Special Cells)	
	Lungs	
576	<b>Lumbricales Manus, First</b>	
	Liver	
	Posterior Pituitary	
578	<b>Lumbricales Manus, Second</b>	
	Parathyroid	
	Seminal Vesicle	
580	<b>Lumbricales Manus, Third</b>	
	Lymphatics of Rectal Area	
	Parathyroid	
584	<b>Interossei Palmares, First</b>	
	Ilium (Special Cells)	
	Salivary Glands (Sublingual)	
586	<b>Interossei Palmares, Second</b>	
	Pharynx	
	Gonads	
594	<b>Interossei Dorsales Manus, Second</b>	
	Sinus (Frontal)	
	Spleen	
596	<b>Interossei Dorsales Manus, Third</b>	
	Pancreatic Duct System	
	Esophagus	
610	<b>Spinalis Thoracis, Lumbar Div.</b>	
	Bladder	
	Heart	
612	<b>Spinalis Thoracis, Thoracic Div.</b>	
	Heart	
	Pineal	
614	<b>Longissimus Thoracis, Upper Lumbar Div.</b>	
	Adrenal	
	Mammary	
618	<b>Longissimus Thoracis, Middle Thoracic Div.</b>	
	Stomach (Body)	
	Pancreatic Duct System	
642	<b>Levatores Costarum, Lower Div.</b>	
	Colon (Sigmoid)	
	Gallbladder	

648	Serratus Posterior, Superior Div.	
	Bladder	
	Lymphatics of Lungs	
652	Serratus Posterior, Inferior Div.	
	Jejunum	
	Nose	
656	Diaphragm Number One, Right Side, Lumbar Div.	
	Heart	
	Lymphatics (Sm. Int.) - Ing. Lymph Nodes	
662	Diaphragm Number Four, Left Side Lumbar Div.	
	Spleen	
	Pancreas - Inguinal Lymph Nodes	
680	Pyramidalis	
	Bladder	
	Nose	
682	Obliquus Externus Abdominis, Anterior Div.	
	Colon (Ascending/Descending)	
	Sinus (frontal)	
684	Obliquus Externus Abdominis, Lateral Div.	
	Lymphatics of Colon	
	Sinus (Sphenoid)	
686	Obliquus Internus Abdominis, Anterior Div.	
	Colon (Hepatic and Splenic Flexure)	
	Eye	
698	Obliquus Internus Abdominis, Lateral Div.	
	Tonsils	
	Prostate/Uterus	
700	Rectus Abdominis, First Div.	
	Adrenal	
	Colon	
702	Rectus Abdominis, Second Div.	
	Duodenum	
	Salivary Glands (Sublingual)	
704	Rectus Abdominis, Third Div.	
	Eye	
	Ilium	
706	Rectus Abdominis, Fourth Div., Medialis	
	Duodenum (Ascending Portion)	
	Esophagus	
708	Rectus Abdominis, Fourth Div., Lateralis	
	Bladder	
	Penis/Vaginal Vault	
710	Iliacus	
	Colon (Ascending/Descending)	
	Lymphatics of Jejunum	
712	Iliacus Minor	
	Kidney	
	Pancreas	
714	Transverse Abdominis, Upper Div.	
	Salivary Glands (Submandibular)	
	Posterior Pituitary	
718	Transverse Abdominis, Lower Div.	
	Duodenum (Descending Portion)	
	Thymus	
722	Psoas Major, Lumbar Div.	
	Colon (Rectal Area)	
	Kidney	
724	Psoas Major, Thoracic Div.	
	Kidney	
	Mammary	
726	Psoas Major, Diaphragmatic Div.	
	Adrenal	
	Bladder	
728	Psoas Minor	
	Lymphatics of Stomach	
	Posterior Pituitary	
730	Quadratus Lumborum, Costal Div.	
	Colon (Ascending/Descending)	
	Liver	
732	Quadratus Lumborum, Lumbar Div.	
	Gallbladder	
	Tonsils	
734	Multifidus, Lumbosacral Div.	
	Colon (Sigmoid)	
	Ductus Deferens	
736	Iliocostalis Lumborum	
	Lungs	
	Stomach	
738	Longissimus Lumborum	
	Eye	
	Jejunum	
740	Coccygeus, Sacral Div.	
	Itium	
	Pancreatic Duct System	
742	Coccygeus, Coccyx Div.	
	Stomach (Pyloric Canal)	
	Thymus	
744	Pubococcygeus	
	Heart	
	Lungs	
746	Iliococcygeus	
	Thyroid	
	Prostate/Uterus	
748	Gluteus Medius, Posterior Div.	
	Gallbladder Duct System	
	Penis/Vaginal Vault	
752	Gluteus Medius, Middle Div.	
	Prostate/Uterus	
	Mammary	
754	Gluteus Medius, Anterior Div.	
	Lungs	
	Gonads	
756	Gluteus Minimus, Anterior Div.	
	Pancreas	
	Lungs	
758	Gluteus Minimus, Posterior Div.	
	Pancreatic Duct System	
	Penis/Vaginal Vault	

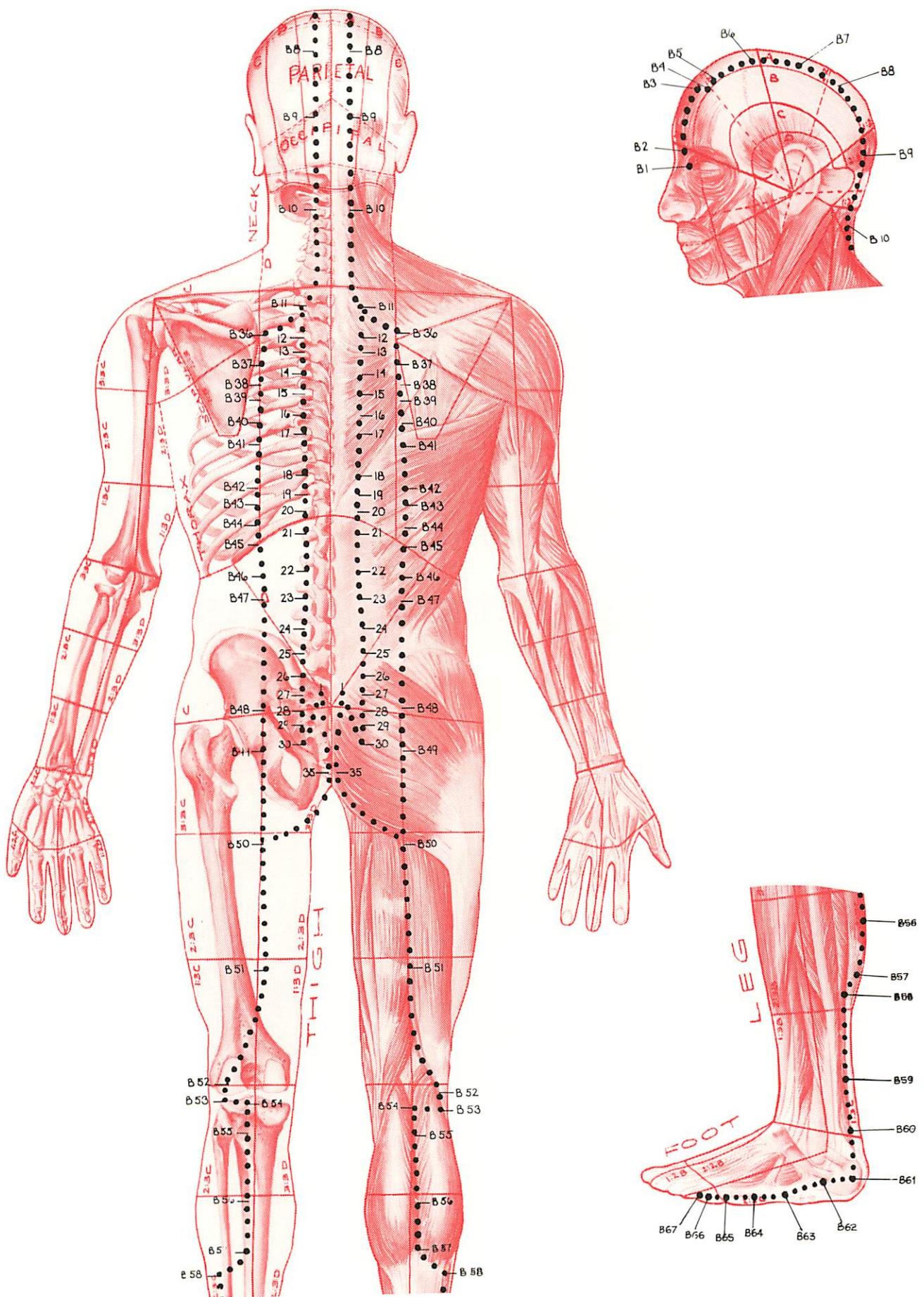
780	Tensor Fascia Lata, Anterior Div.		828	Biceps Femoris, Longhead, Tibial Div.
	Colon			Prostate/Uterus
	Eustachian Tube			Salivary Glands (Sublingual)
792	Tensor Fascia Lata, Posterior Div.		830	Vastus Lateralis, Superior Div.
	Thyroid			Thyroid
	Penis/Vaginal Vault			Thymus
794	Rectus Femoris, Reflected Head		832	Vastus Lateralis, Middle Div.
	Liver			Pancreatic Duct System
	Thyroid			Salivary Glands (Submandibular)
786	Rectus Femoris, Straight Head		834	Vastus Lateralis, Lower Div.
	Jejunum			Ilium
	Lymphatics of Ilium			Pancreatic Duct System
798	Pectenous		836	Vastus Intermedius, Medial Div.
	Colon (Transverse)			Ilium
	Pancreatic Duct System			Salivary Glands (Parotid)
800	Adductor Brevis		838	Vastus Intermedius, Lateral Div.
	Duodenum (L-Jejunum Junction; R-Ampulla of Vater)			Tonsils
	Eye			Salivary Glands (Sublingual)
804	Adductor Longus, Inferior Div.		840	Articularis Genu
	Ilium			Adrenal
	Penis/Vaginal Vault			Gonads
806	Adductor Longus, Superior Div.		842	Adductor Magnus, Vertical Div.
	Liver			Bladder
	Gonads			Prostate/Uterus
808	Gracilis		844	Adductor Magnus, Oblique Div.
	Adrenal			Anterior Pituitary
	Prostate/Uterus			Broad Ligament
810	Sartorius		846	Adductor Magnus, Transverse Div.
	Adrenal			Nose
	Lymphatics of Ilium			Lymphatics of Thyroid
812	Obturator Externus		848	Gluteus Maximus, Iliac Div.
	Heart			Pancreas
	Spleen			Pancreatic Duct System
814	Quadratus Femoris		850	Gluteus Maximus, Sacral Div.
	Gonads			Posterior Pituitary
	Nose			Prostate/Uterus
816	Vastus Medialis, Upper Div.		852	Gluteus Maximus, Coccygeal Div.
	Duodenum (Special Cells)			Bladder
	Lungs			Colon (Rectal Area)
818	Vastus Medialis, Middle Div.		854	Semitendinosus
	Adrenal			Adrenal
	Gallbladder			Posterior Pituitary
820	Vastus Medialis, Lower Div.		856	Semimembranosus, Tibial Div.
	Ilium			Adrenal
	Posterior Pituitary			Lymphatics of Submandibular
822	Obturator Internus		858	Semimembranosus, Popliteal Div.
	Lungs			Ilium (Special Cells)
	Larynx			Pancreatic Duct System
824	Biceps Femoris, Shorthead		860	Piriformis
	Colon			Prostate/Uterus
	Eustachian Tube			Gonads
826	Biceps Femoris, Longhead, Fibular Div.		862	Gemellus Inferior
	Colon (Ascending/Descending)			Lungs
	Spleen			Prostate/Uterus

864	Gemellus Superior	906	Extensor Hallucis Brevis
	Epididymis		Jejunum (Special Cells)
	Heart		Pancreatic Duct System
870	Gastrocnemius, Medial Div.	908	Extensor Digitorum Longus, Medial Div.
	Duodenum (Special Cells)		Heart
	Kidney		Prostate/Uterus
872	Soleus, Medial Div.	910	Extensor Digitorum Longus, Lateral Division
	Adrenal		Posterior Pituitary
	Anterior Pituitary		Thyroid
874	Soleus, Lateral Div.	912	Extensor Digitorum Brevis
	Colon (Rectal Area)		Thymus
	Liver		Tonsils
876	Gastrocnemius, Lateral Div.	916	Flexor Digiti Minimi Brevis Pedis
	Colon (Ascending/Descending)		Nose
	Liver		Lungs
878	Plantaris	918	Flexor Digitorum Brevis, Lateral Div.
	Jejunum		Colon (Ascending/Descending)
	Lymphatics of Tonsils		Salivary Glands (Sublingual)
880	Popliteus	920	Flexor Digitorum Brevis, Medial Div.
	Gallbladder		Ductus Deferens
	Penis/Vaginal Vault		Larynx
882	Tibialis Anterior, Cuneiform Div.	922	Flexor Digitorum Longus, Medial Div.
	Ductus Deferens		Anterior Pituitary
	Spleen		Stomach (Body)
884	Tibialis Anterior, Metatarsal Div.	924	Flexor Digitorum Longus, Lateral Div.
	Jejunum		Kidney
	Urethra		Anterior Pituitary
886	Tibialis Posterior, Tibial Div.	926	Quadratus Plantae, Lateral Div.
	Ilium		Larynx
	Pancreas		Penis/Vaginal Vault
888	Tibialis Posterior, Fibular Div.	928	Quadratus Plantae, Medial Div.
	Heart		Stomach (Special Cells)
	Gonads		Salivary Glands (Sublingual)
890	Peroneus Longus, Cuneiform Div.	930	Flexor Hallucis Brevis, Cuboid Div.
	Bladder		Jejunum
	Duodenum (Special Cells)		Lungs
892	Peroneus Longus, Metatarsal Div.	932	Flexor Hallucis Brevis, Third Cuneiform Div.
	Gallbladder		Lungs
	Parathyroid		Salivary Glands (Submandibular)
894	Peroneus Brevis, Fibular Div.	934	Flexor Hallucis Brevis, Tendonial Div.
	Lungs		Tonsils
	Urethra		Pancreatic Duct System
896	Peroneus Brevis, Septal Div.	936	Flexor Hallucis Brevis, First Cuneiform Div.
	Bladder		Lymphatics of Stomach
	Nose		Pineal
898	Peroneus tertius	938	Flexor Hallucis Longus, Fibular Div.
	Bladder		Esophagus
	Lungs		Kidney
900	Extensor Hallucis Longus, Fibular Div.	940	Flexor Hallucis Longus, Tibial Div.
	Heart		Liver
	Urethra		Anterior Pituitary
902	Extensor Hallucis Longus, Interosseous Div.	942	Adductor Hallucis Oblique Head, Peroneus Div.
	Anterior Pituitary		Adenoids
	Thymus		Stomach (Special Cells)

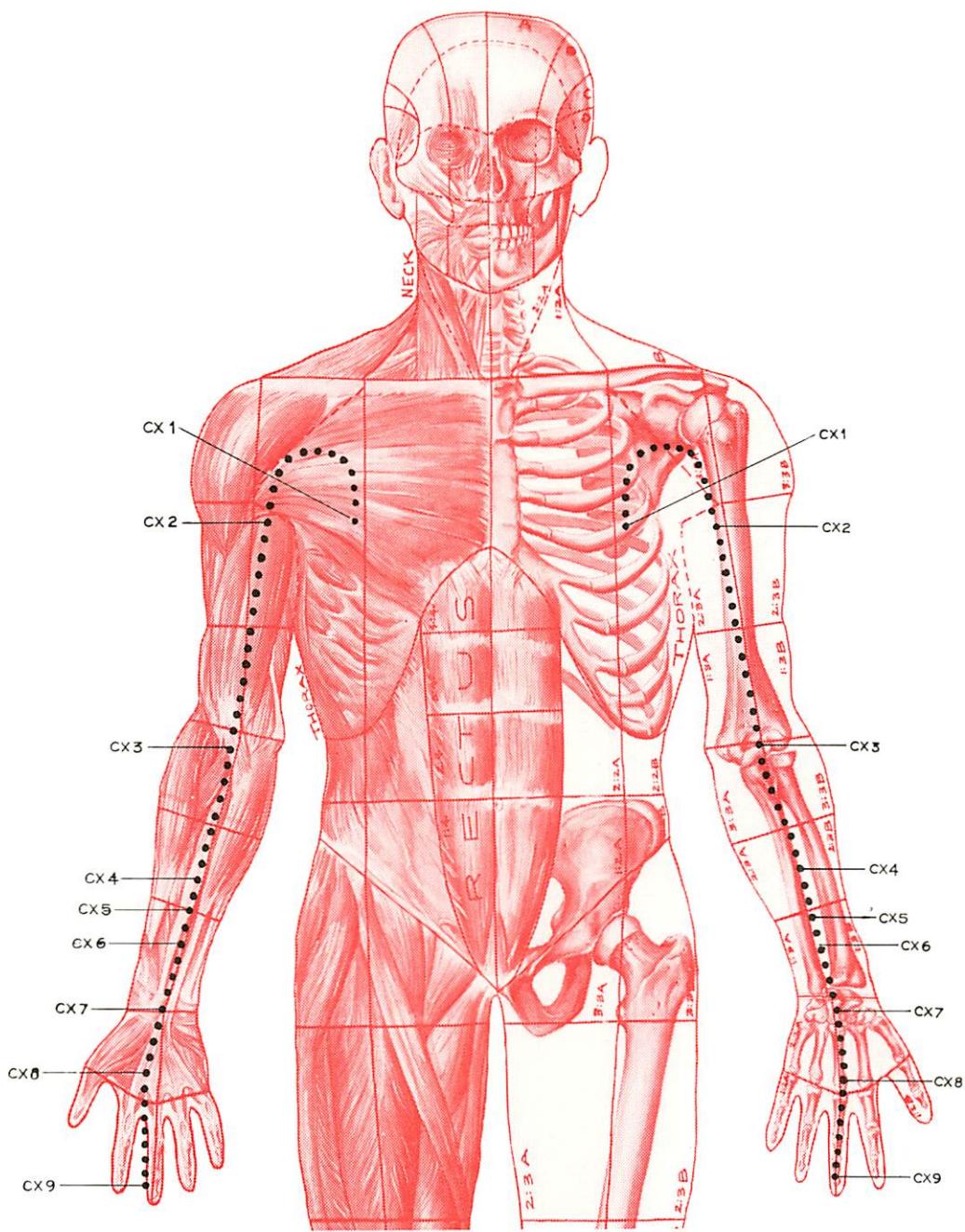
- 944 Adductor Hallucis Oblique Head, Metatarsal Div.  
Lungs  
Nose
- 946 Adductor Hallucis Transverse Head, Medial Div.  
Ilium (Ileocecal Valve)  
Gonads
- 948 Adductor Hallucis Transverse Head, Lateral Div.  
Colon (Rectal Area)  
Lymphatics of Jejunum
- 950 Abductor Hallucis, Superior Div.  
Prostate/Uterus  
Anterior Pituitary
- 952 Abductor Hallucis, Inferior Div.  
Heart  
Liver
- 954 Abductor Digiti Minimi Pedis  
Posterior Pituitary  
Nose
- 956 Lumbricales Pedis, First  
Lymphatics of Ilium  
Sinus (Maxillary)
- 958 Lumbricales Pedis, Second  
Ear (External)  
Kidney
- 960 Lumbricales Pedis, Third  
Thymus  
Penis/Vaginal Vault
- 962 Lumbricales Pedis, Fourth  
Liver  
Sinus (Maxillary)
- 964 Interossei Dorsales Pedis, First  
Eye  
Pancreatic Duct System
- 966 Interossei Dorsales Pedis, Second  
Thymus  
Spleen
- 968 Interossei Dorsales Pedis, Third  
Adrenal  
Ureter
- 970 Interossei Dorsales Pedis, Fourth  
Prostate/Uterus  
Thyroid
- 972 Interossei Plantares, First  
Bladder  
Spleen
- 974 Interossei Plantares, Second  
Eye  
Salivary Glands (Submandibular)
- 976 Interossei Plantares, Third  
Sinus (Nasal)  
Tonsils

**Chapter VIII**

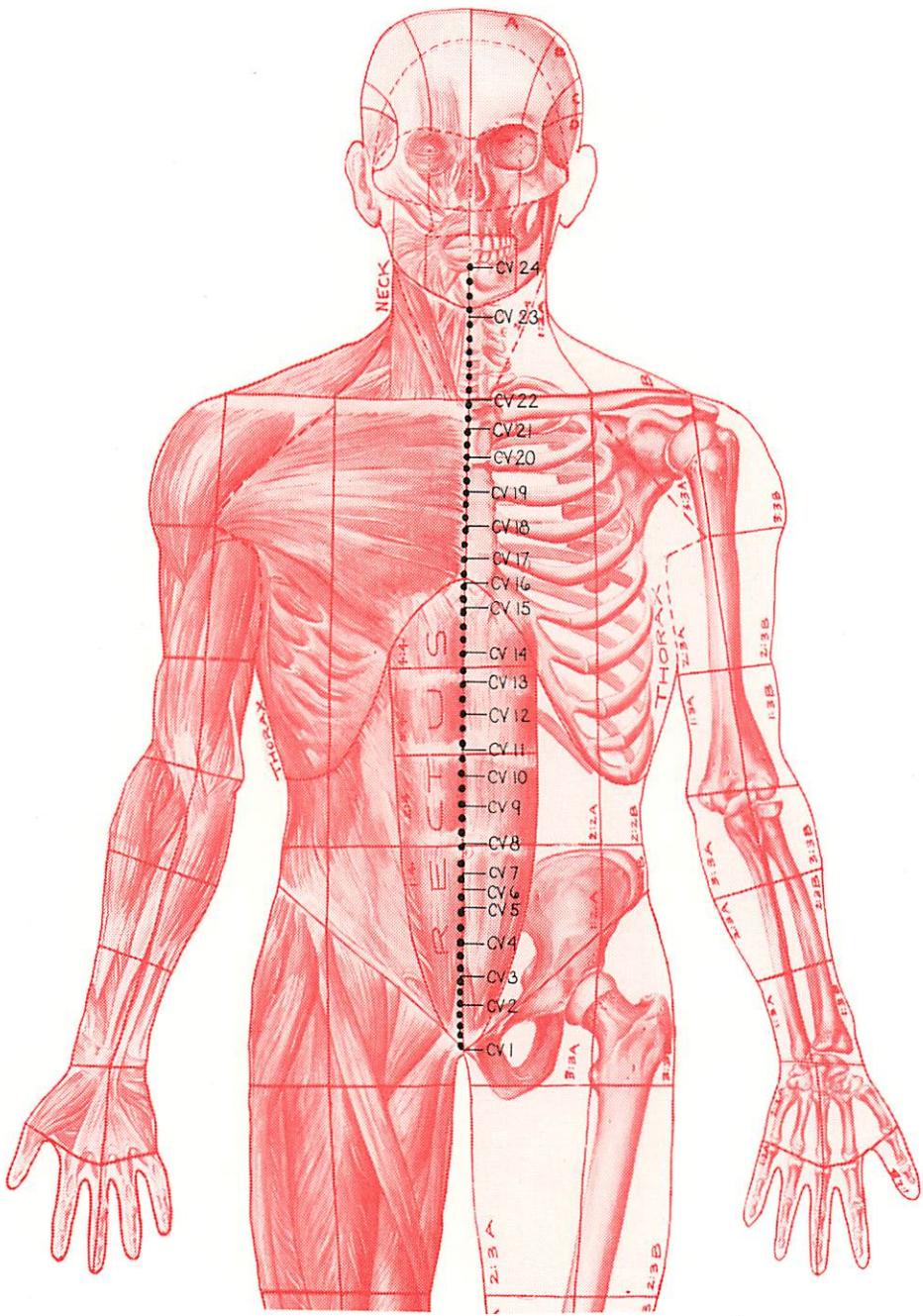
**Acupuncture Charts**



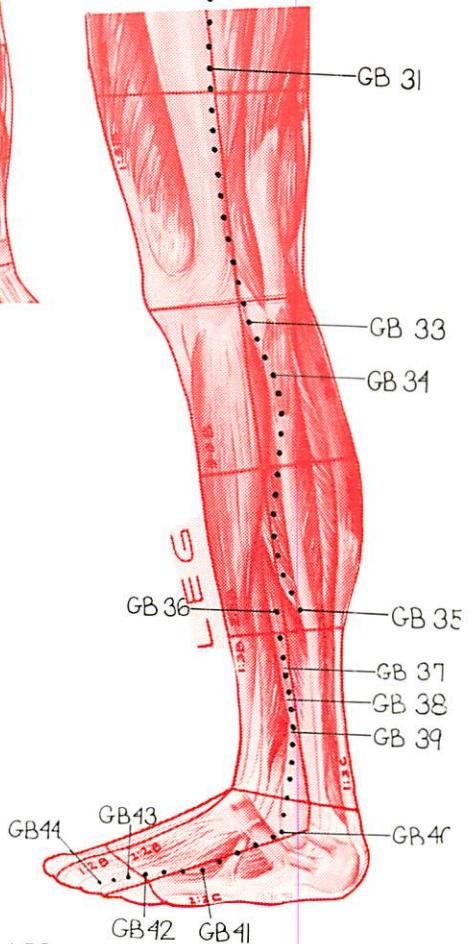
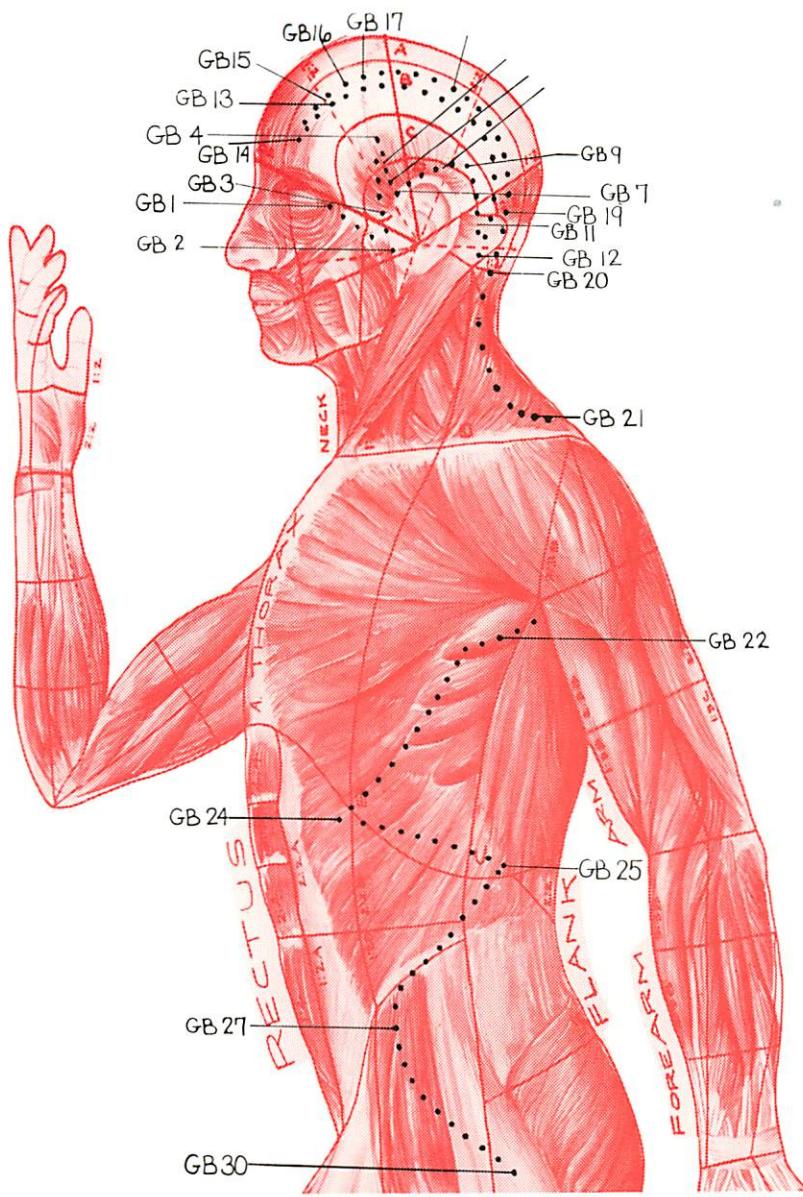
BLADDER MERIDIAN



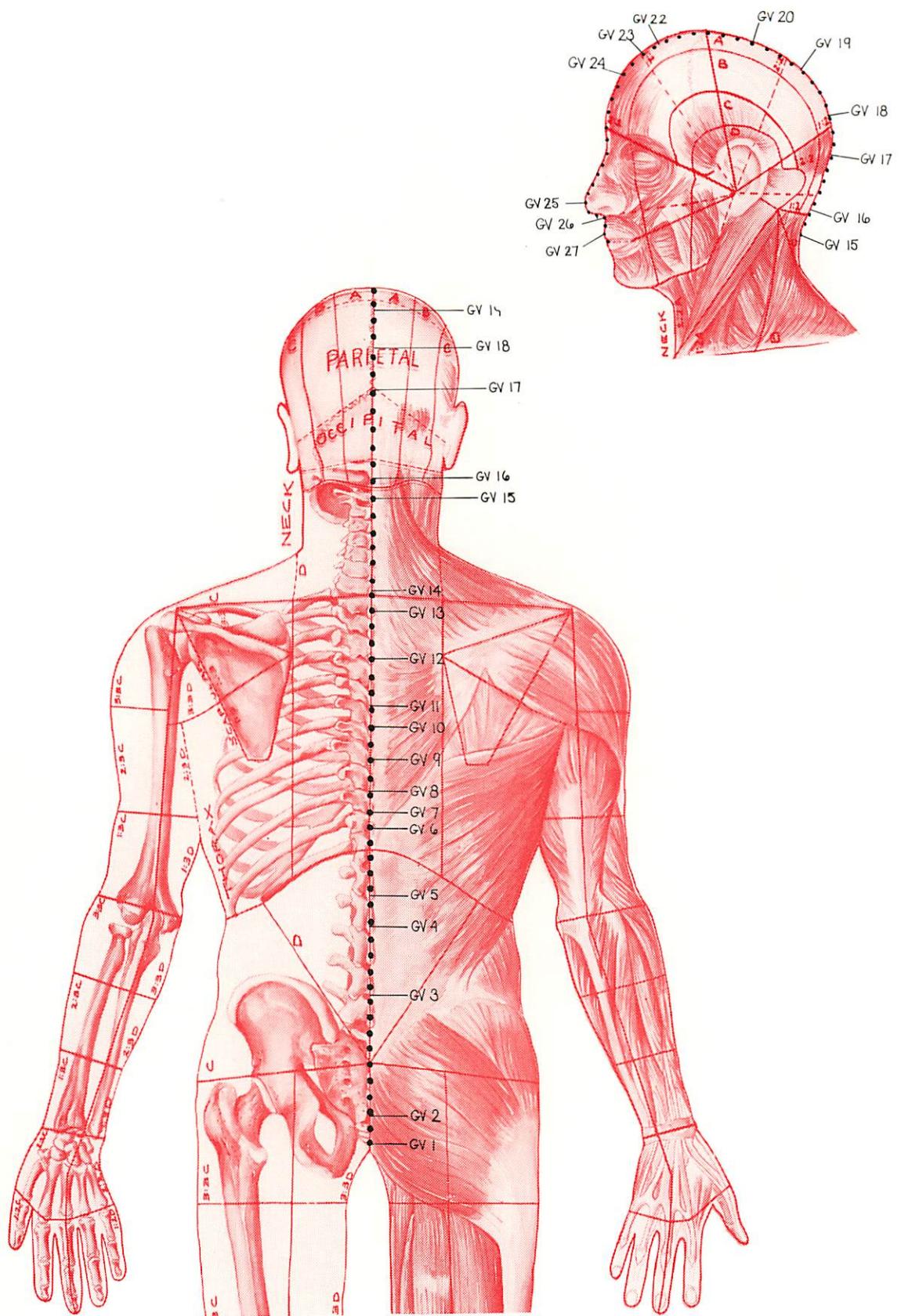
### CIRCULATION SEX MERIDIAN



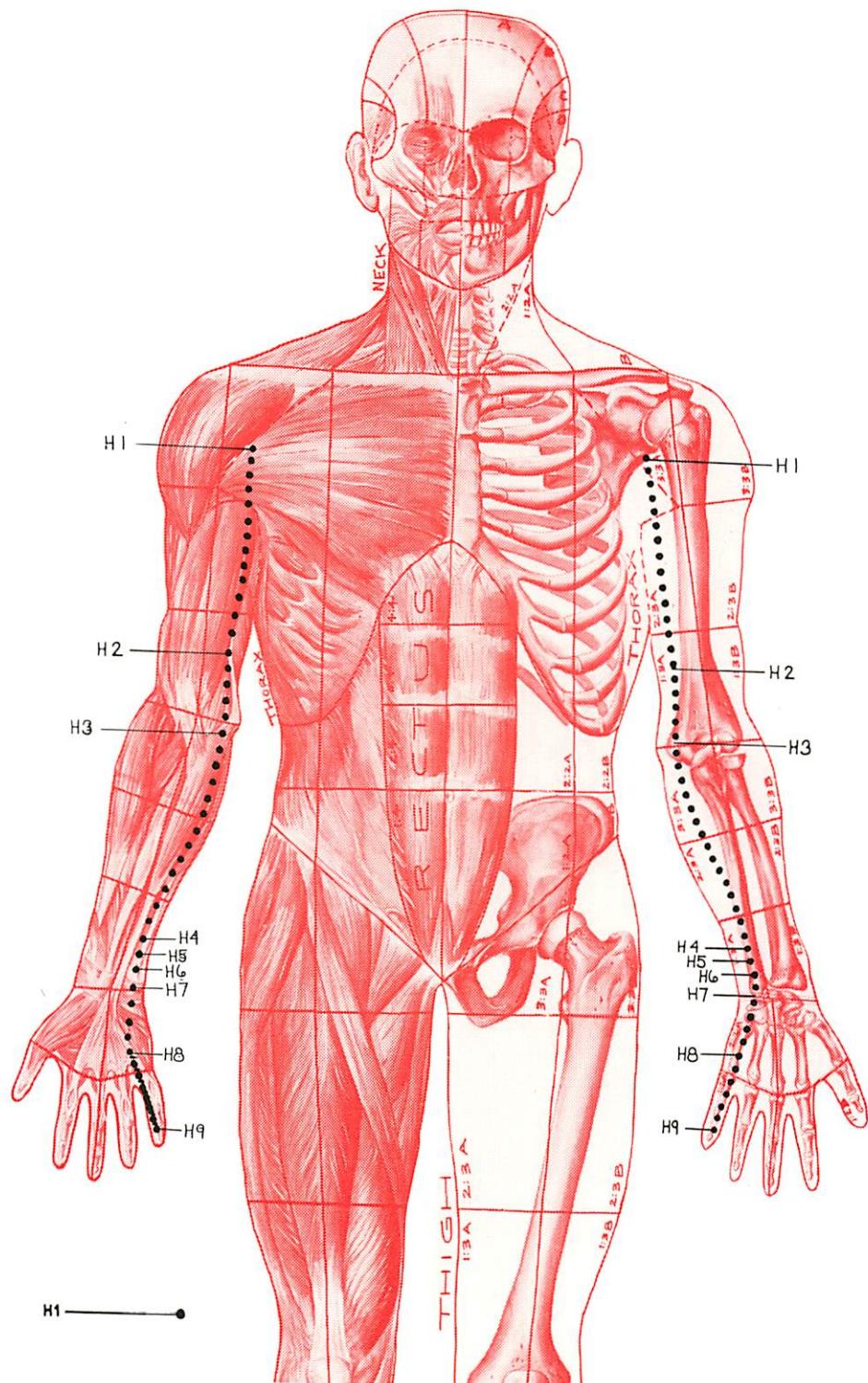
## CONCEPTION VESSEL MERIDIAN



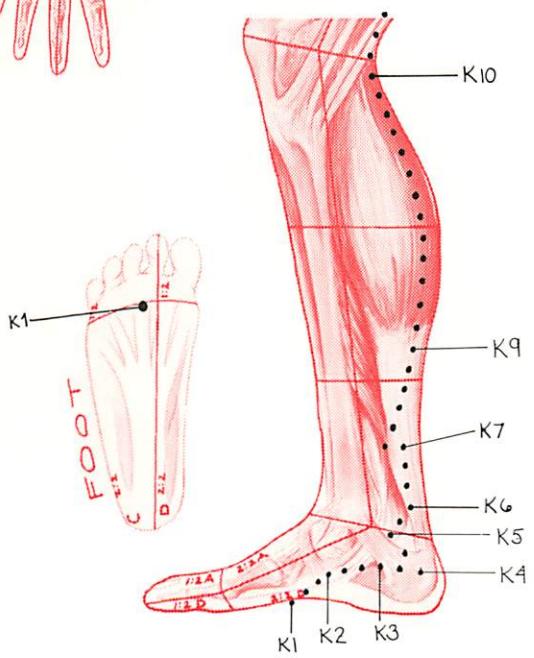
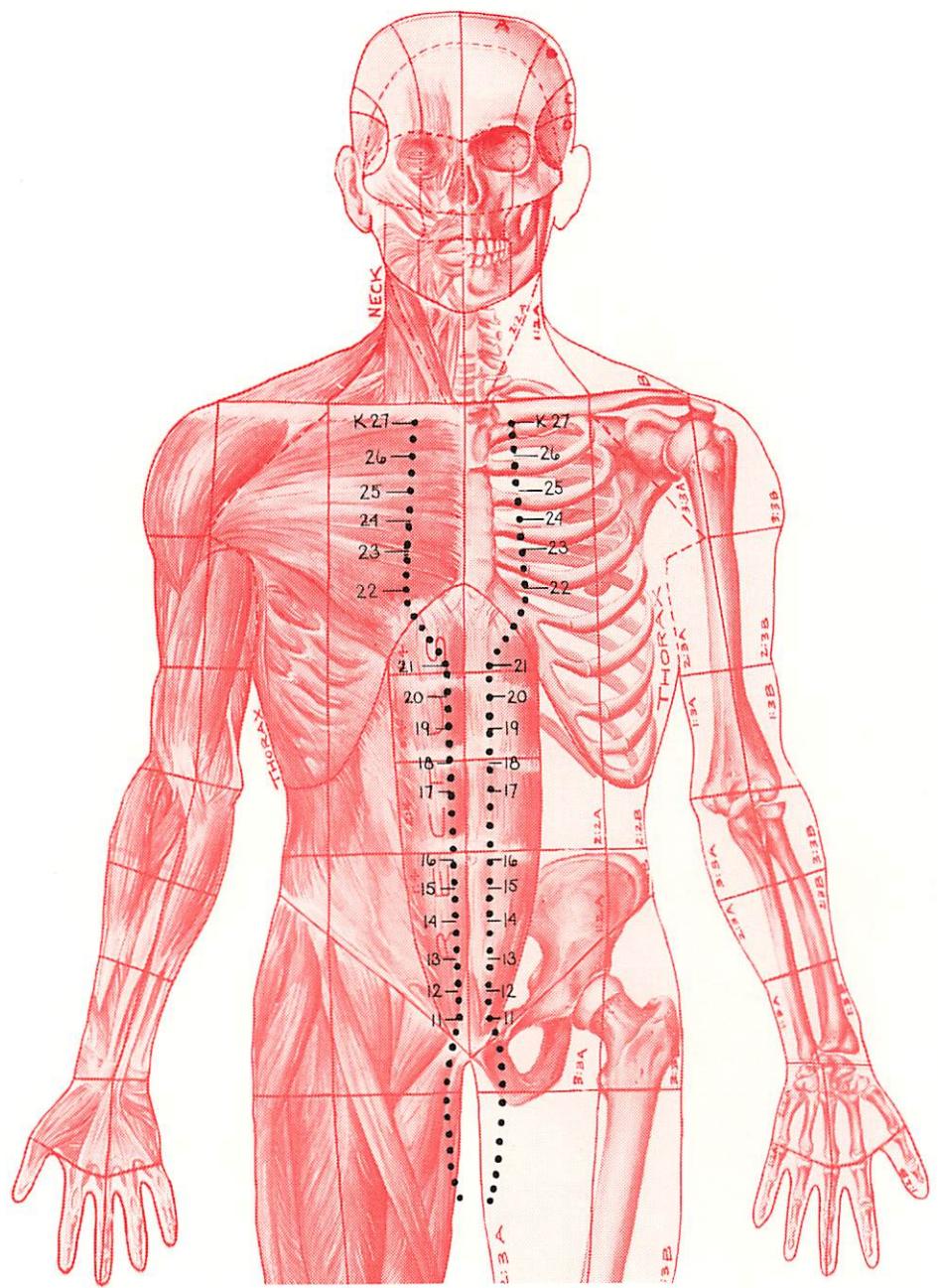
**GALL BLADDER MERIDIAN**



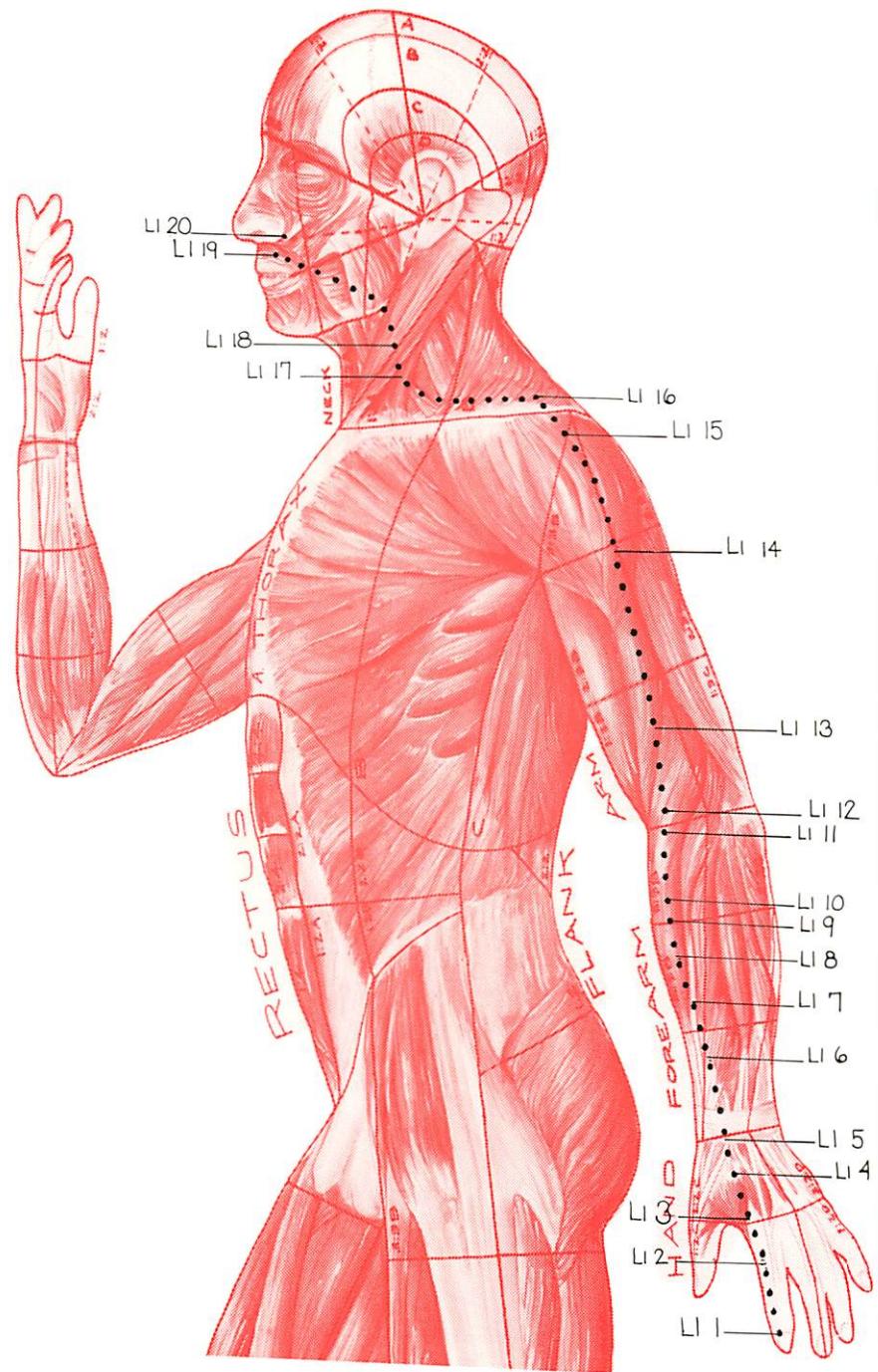
## **GOVERNING VESSEL MERIDIAN**



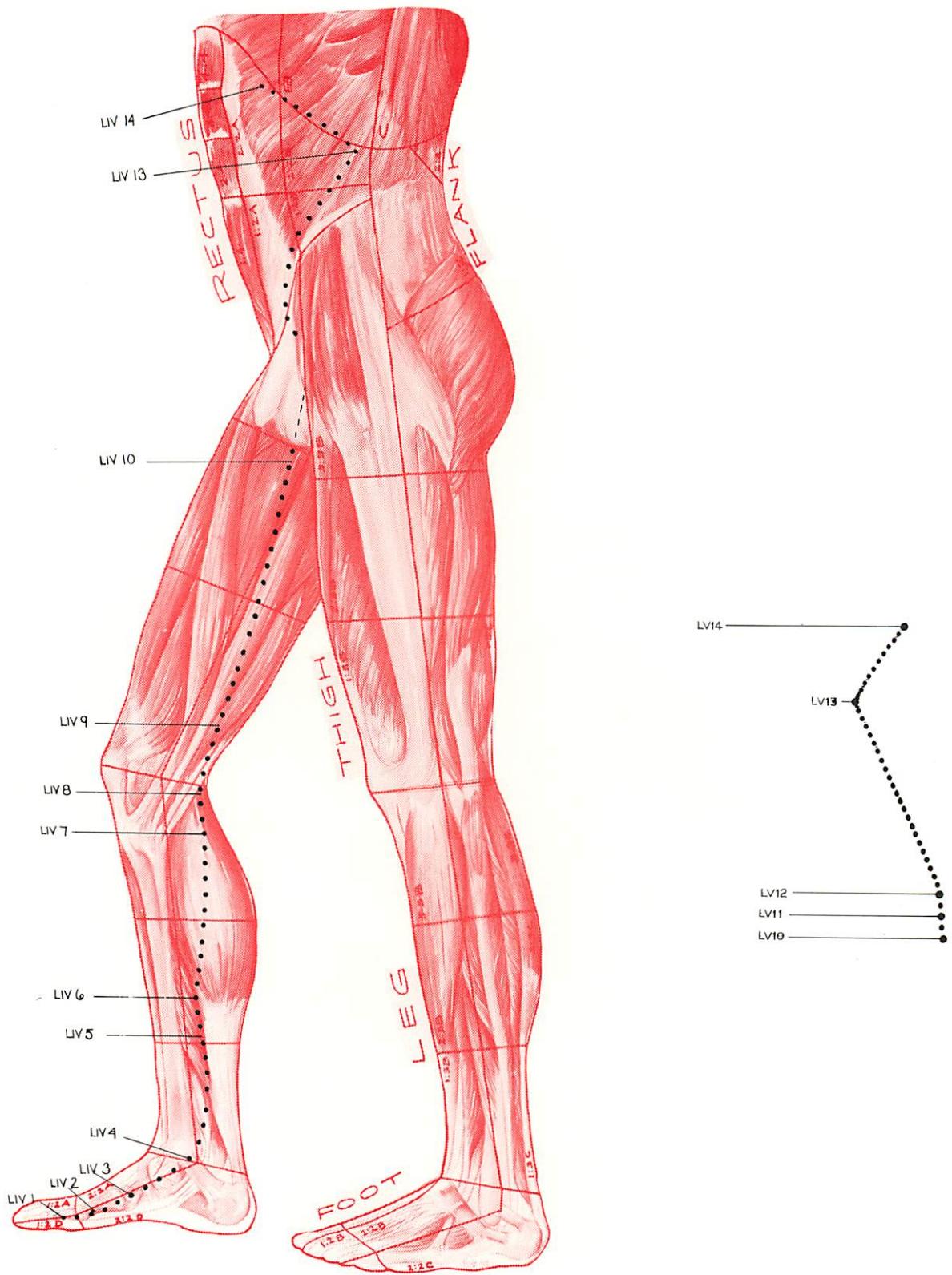
## HEART MERIDIAN



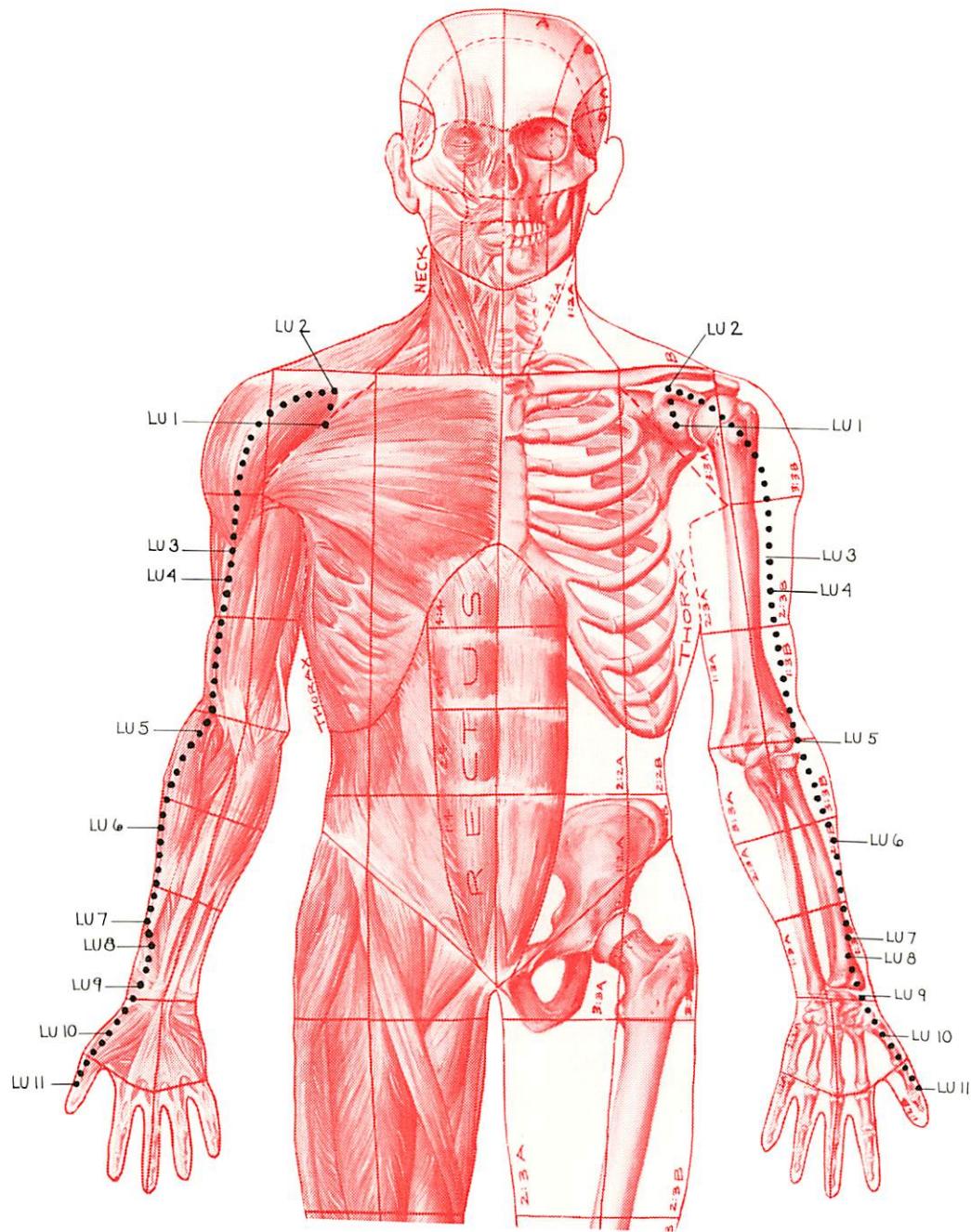
## KIDNEY MERIDIAN



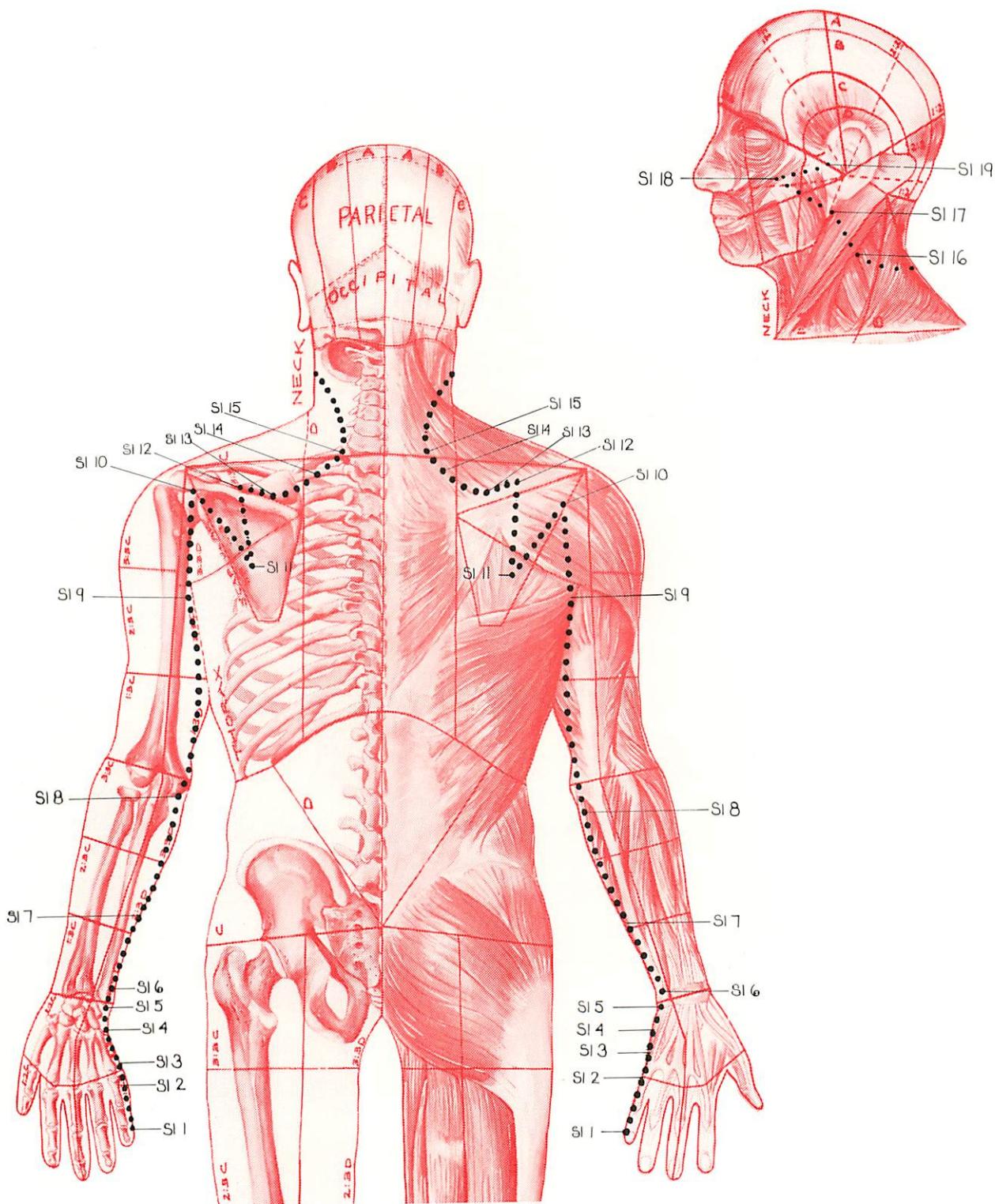
LARGE INTESTINE MERIDIAN



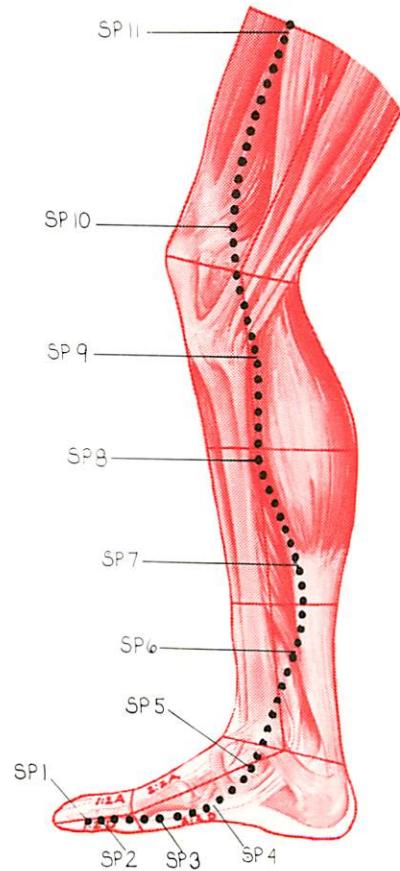
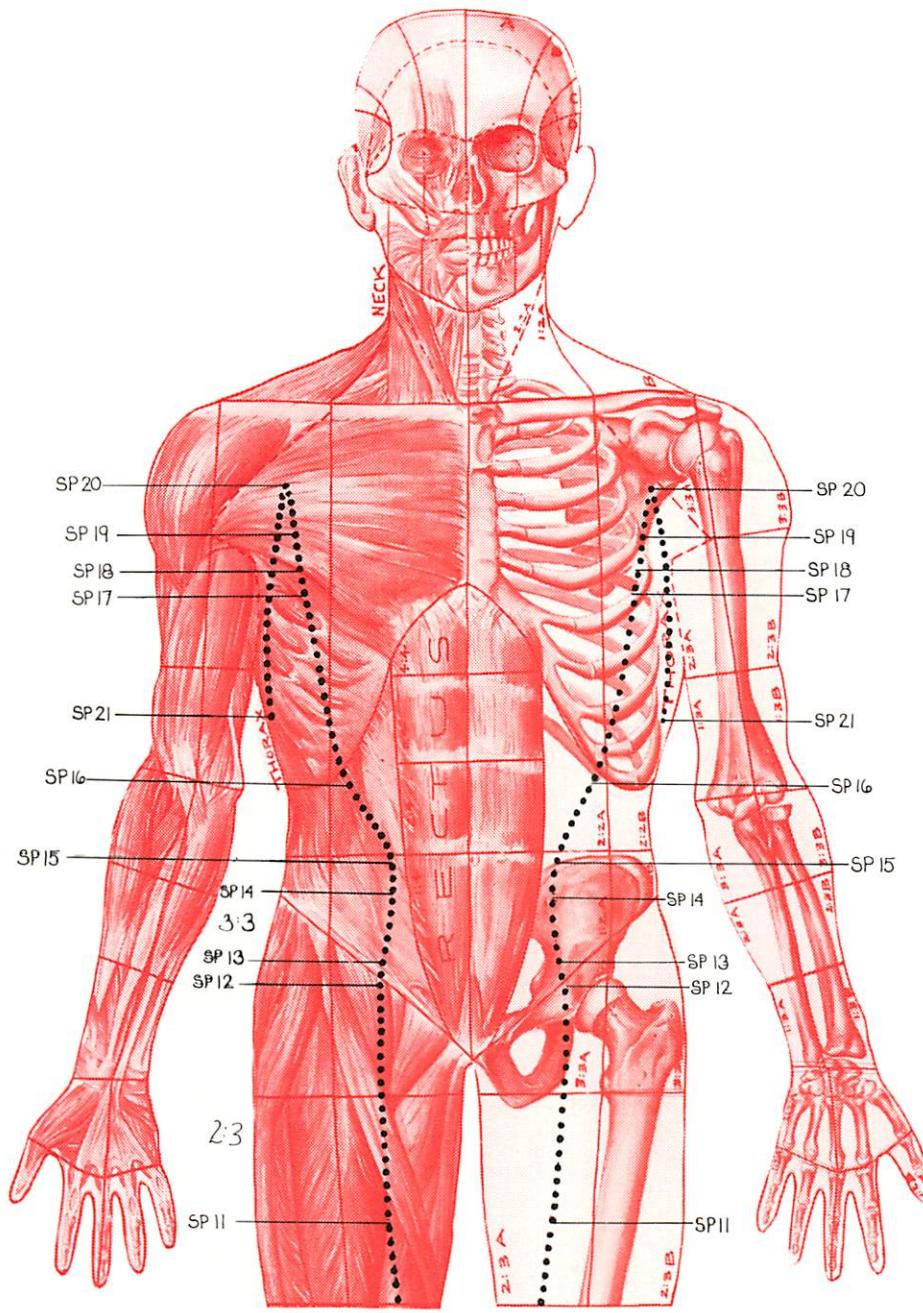
LIVER MERIDIAN



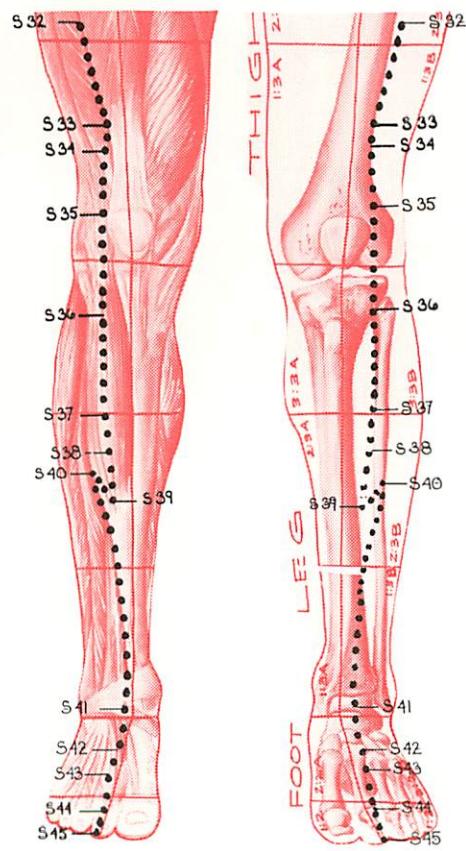
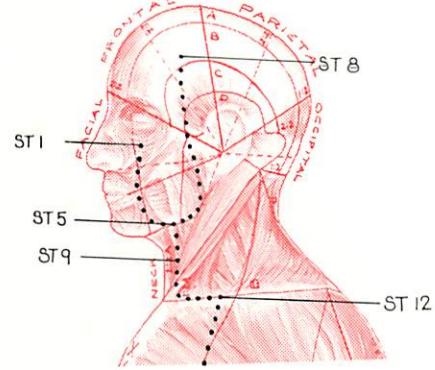
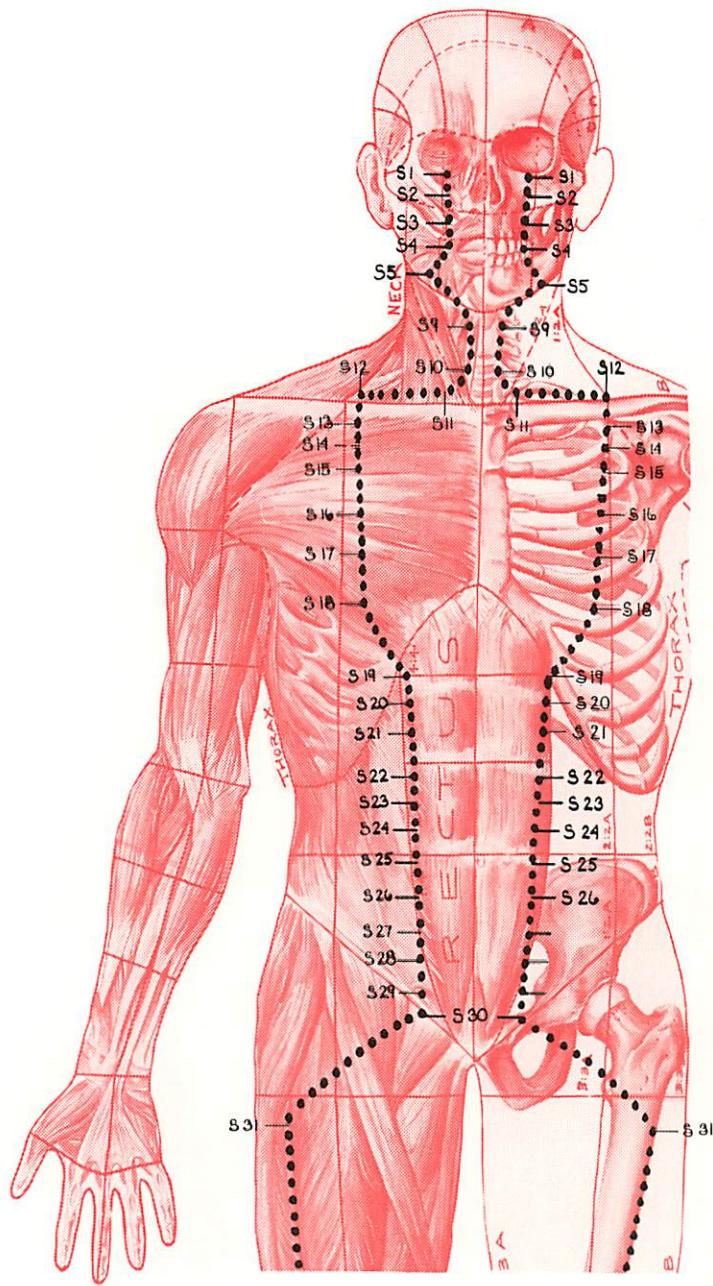
## LUNG MERIDIAN



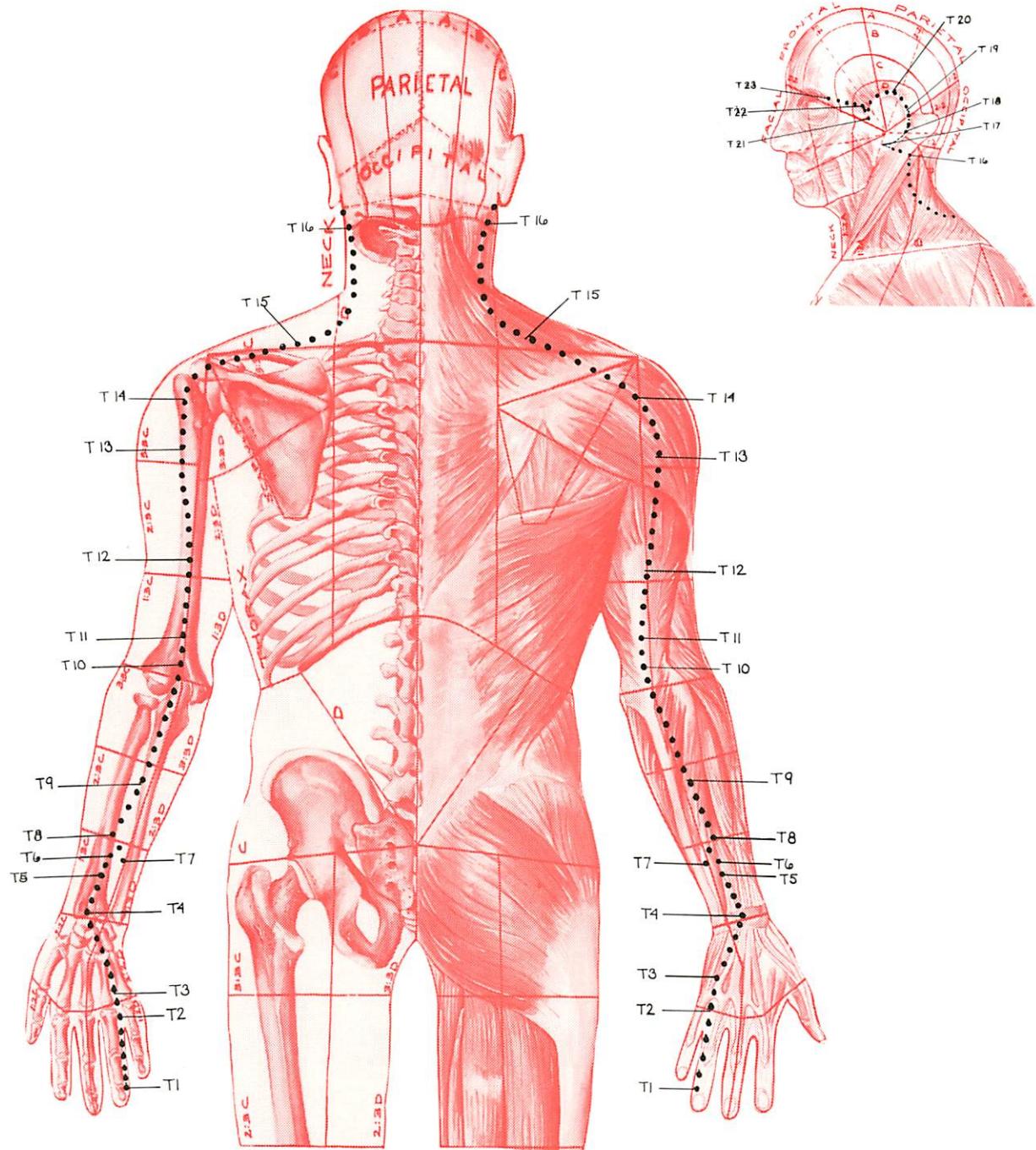
### SMALL INTESTINE MERIDIAN



## **SPLEEN MERIDIAN**



## STOMACH MERIDIAN



## TRIPLE HEATER MERIDIAN

## GLOSSARY-ABBREVIATIONS

A.E.C.A. - All essential components available  
A.E.C.N.A. - All essential components not available  
ANS - Autonomic Nervous System  
ASIS - Anterior Superior Iliac Spine of Ilium  
Contralateral - pertains to opposite side of body  
CPU - Central Processing Unit  
GAS (Beardall) - Glandular Adaptive Syndrome  
GAS (Selye) - General Adaptive Syndrome  
ICAK - International College of Applied Kinesiology  
Ipsilateral - pertains to same side of body  
LAS (Selye) - Local Adaptive Syndrome  
MAP - Muscle Acupuncture Point  
MM - Myomere  
NL - Neurolymphatic  
NRL - Non-respiratory lesion  
NV - Neurovascular  
PAS (Beardall) - Primary Adaptive Syndrome  
PD - Pelvic deficiency  
(S) - Standard Process  
SAS (Beardall) - Spinal Adaptive Syndrome  
T.L. - Therapy Localization  
V.L. - Vertebral Level  
VOR - Visceral Organ Reflex