Basic Workshop Manual

The Three Survival Systems

Originally developed by Dr. Carl Ferreri

Expanded by

Dr. Mitchell Corwin
2914 Domingo Ave
Berkeley CA 94705
(510) 845–3246
energymedicine@sbcglobal.net
www.drcorwin.net
© 2003-2004
NEURAL ORGANIZATION WORK

Basic Workshop Manual
The Three Survival Systems

Originally developed by Dr. Carl Ferreri

Expanded by
Dr. Mitchell Corwin
2914 Domingo Ave
Berkeley CA 94705
(510) 845–3246
energymedicine@sbcglobal.net
www.lastchancegarage.org/
© 2003-2004
# TABLE OF CONTENTS

Foreword  
Definitions and Terms  

<table>
<thead>
<tr>
<th>Section</th>
<th>Summary Outline of the Fight-Flight Survival Reflexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 1</td>
<td>Intro / theory Survival Systems</td>
</tr>
<tr>
<td>Page 2</td>
<td>Jaw Screening Protocol</td>
</tr>
<tr>
<td>Page 3</td>
<td>Atlas Stability thru Category I</td>
</tr>
<tr>
<td>Page 4</td>
<td>Posterior Switches &amp; Posterior Gait</td>
</tr>
<tr>
<td>Page 5</td>
<td>Femur Head Integrity &amp; Universal Cranial Fault</td>
</tr>
<tr>
<td>Page 6</td>
<td>Cranial Sutures &amp; Anterior Gait</td>
</tr>
<tr>
<td>Page 7</td>
<td>Cranial Injury Complex</td>
</tr>
<tr>
<td>Page 8</td>
<td>Defensive Jaw Complex</td>
</tr>
<tr>
<td>Page 9</td>
<td>Coccygeal Release &amp; Fascial Defense</td>
</tr>
<tr>
<td>Page 10</td>
<td>Pelvic Injury Complex</td>
</tr>
<tr>
<td>Page 11</td>
<td>Category II (Cranial Pelvis)</td>
</tr>
<tr>
<td>Page 12</td>
<td>Category II (Body Pelvis)</td>
</tr>
<tr>
<td>Page 13</td>
<td>Category III (Lumbar Discopathy)</td>
</tr>
<tr>
<td>Page 14</td>
<td>Scoliosis Protocol definition and evaluation</td>
</tr>
<tr>
<td>Page 15</td>
<td>Scoliosis Protocol steps (a) thru (e)</td>
</tr>
<tr>
<td>Page 16</td>
<td>Scoliosis Protocol steps (f) thru (n)</td>
</tr>
<tr>
<td>Page 17</td>
<td>Scoliosis Protocol steps (o) thru (z)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Summary Outline Limbic System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 1</td>
<td>Limbic System (Immune Complex)</td>
</tr>
<tr>
<td>Page 2</td>
<td>Spinal Fixations</td>
</tr>
<tr>
<td>Page 3</td>
<td>Organ Reflexes</td>
</tr>
<tr>
<td>Page 4</td>
<td>Digestive Complex (Universal Jaw Complex)</td>
</tr>
<tr>
<td>Page 5</td>
<td>Digestive Complex (Digestive Jaw Complex)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Summary Outline Endocrine System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 1</td>
<td>Endocrine System (Skin Reflexes)</td>
</tr>
<tr>
<td>Page 2</td>
<td>Primary Endocrine steps 1-3</td>
</tr>
<tr>
<td>Page 3</td>
<td>Primary Endocrine steps 4-5</td>
</tr>
<tr>
<td>Page 4</td>
<td>Cardiac Back Stress Syndrome</td>
</tr>
<tr>
<td>Page 5</td>
<td>Cardiac Back Stress Syndrome</td>
</tr>
<tr>
<td>Page 6</td>
<td>Blood Sugar Handling (Adrenal Protocol)</td>
</tr>
<tr>
<td>Page 7</td>
<td>Blood Sugar Handling (Adrenal Protocol)</td>
</tr>
<tr>
<td>Page 8</td>
<td>Digestive System Protocol</td>
</tr>
<tr>
<td>Page 9</td>
<td>Digestive System Protocol</td>
</tr>
<tr>
<td>Page 10</td>
<td>Ovary / Prostate Protocol</td>
</tr>
<tr>
<td>Page 11</td>
<td>Ovary / Prostate Protocol</td>
</tr>
</tbody>
</table>
Foreword

As a protégé of Dr. Ferreri since 1983, Dr. Mitchell Corwin has added many new dimensions to neural organization technique that are outlined in this and future manuals. It is Dr. Corwin’s belief that one can learn this work in a fashion that is exciting, well organized, and mentally challenging. It should not be taken as a cookbook protocol to healthcare but as an eclectic approach, that shares the wisdom and expertise of many practitioners.

This manual represents an updated version of the original work of Dr. Carl Ferreri. It incorporates all the basic concepts of neural organization technique with emphasis on understanding the theory and application. Although there are some differences in description, application, and emphasis, the basic philosophy remains the same. For those that have taken prior instruction from Dr. Ferreri and / or other instructors, differences in opinion will exist. This work should not be construed as a separate entity from the original concepts of Neural Organization Technique but a natural outgrowth.

Advanced workbooks I & II discuss methodologies in Learning Disabilities and Neuro-Immuno-Therapy Techniques.
Workbook I include concepts of related emotional clearing techniques (deep level and deep hidden switching) originally developed by Dr. Charles Krebs that add considerable deep to the original work of Dr. Ferreri’s learning disability protocols.
Workbook II is original work representing the latest enhancements of tissue and cellular repair and activation of the immune system. This work includes concepts developed by David Slater. His insights to the cause of disease bring forth a new ideas and concepts that allow the practitioner to actively address chronic health issues in a fashion that restores the original design and inborn wisdom of the immune and nervous system.

These manuals are written in a format that assumes one is familiar with basic kinesiology concepts and knowledgeable of the location of many of the common neuromymphatic and neurovascular reflexes. While this manual can serve as a reference and study aid there is no substitution for a live lecture. This manual maybe reproduced in any form for personal use. The content of N.O.W. manuals are copyrighted by Dr. Mitchell Corwin.

Acknowledgements

I would like to express my gratitude to the many colleagues that shared their knowledge, asked the right questions, and patients for presenting with challenging health conditions.

As with all new developments, a learning curve requires the meticulous process of pattern recognition and correlation with the commonality of reflex patterns of aberrant physiology and illnesses. This manual represents a culmination of over two decades of clinical work and study with Dr. Ferreri and contributing practitioners.

Dr. Mitchell Corwin
2914 Domingo Ave Berkeley CA 94705
(510) 845-3246 (510) fax 845-3255
drcorwin@prado.com
www.lastchancegarage.org
OUTLINE OF N.O.T. PROCEDURES

1) ATLAS STABILITY: Lateral Atlas if present.
2) CATEGORY I PROCEDURE: Bil. Ham. or C-3, L-3, S-2, Occiput.
3) POSTERIOR SWITCHES: Coccyx and K-27 bilateral.
4) POSTERIOR GAIT: Cloacal & Labyrinthine reflexes.
5) FEMUR HEAD INTEGRITY: Supine.
6) UNIVERSAL CRANIAL FAULT: Atlas anterior or lateral Occiput.
7) ANTERIOR SWITCHES: K-27 bilaterally.
8) CRANIAL SUTURES: Reset Cranial sutures is present.
9) ANTERIOR GAIT: Cloacal & Ocular reflexes.
10) CRANIAL INJURY COMPLEX: Labyrinthine to Ocular & TNRR, V.O.R.
    Weight Bearing: Stand and / or sit.
11) LIMBIC FIXATIONS: Not included in this manual. It is
    part of immune and digestive
12) UNIVERSAL JAW: survival systems.
13) DIGESTIVE JAW: Dural reset head neutral, rot. & twist.
14) DEFENSIVE JAW COMPLEX: Second half of dural release.
15) COCCYGEAL RELEASE: dis-arming of body fascia.
16) FASCIAL DEFENSE: Facilitation of pelvic muscles-
    left hand on right jaw.
17) PELVIC INJURY COMPLEX: Structural jaw complex.
    cranial pelvis: left hand on left jaw.
    body pelvis: block pelvis.
    left short leg & / or right long leg.
18) CATEGORY II: Vertebral Imbrication - block prone.
19) CATEGORY III: Lumbar Disc involvement - block prone.
    SCOLIOSIS: Prone, identify and activate reactive
    muscle pattern of the posterior paraspinal muscle and
    continue on bilaterally to upper trapezius where it
    becomes unilateral. Next sphenobasilar and unilateral VOR reflexes,
    fascial stretch, and weight bearing.
T.M.J. SCREENING PROTOCOL

Introduction: The T.M.J./jaw screening protocol has been added as a preliminary step to offer the practitioner a quick and effective assessment tool to evaluate the most appropriate starting point on a client. The purpose is to access if there is an emotional over-load or a physiological over-load that needs to be diffused first. Because both of these states involve a recruitment of the there respective jaws(s) (masseter & temporalis muscles) it has the potential to cancel out other T.M.J. work later performed.

Evaluation: Therapy localize (TL) the right and left jaw (masseter muscle) individually to determine if there is an immediate weak (TL) indicator muscle response. One should confirm this/these finding(s) by identifying the opposite inhibited (weak) gluteus medius.

Right jaw facilitation is indicative of an emotional over-load state. Verify the presence of ESR (stomach (NL). One can also evaluate for the presence of depression as outlined in Advanced I Workshop Manual section VII page 1.

Left jaw facilitation is indicative of a physiological overload state. With this condition there will be one or more organs in distress that will initiate a positive therapy location over the organ(s) or its reactive muscle(s). Additionally it would be prudent to evaluate for parietal descent discussed on page 6 indicating CNS stress (either physical or neuro-physiological).

Correction: Spindle down % fl the masseter and spindle down % fl the temporalis on the side of involved jaw. Then cross over to the opposite side and release the lateral pterygoid. Continue on to the masseter and temporalis (spindle down % fl ) and again cross over to the opposite side and release the lateral pterygoid. Note one finishes on the same side one started.

Note: It is strongly recommended that this jaw protocol be repeated twice and verified that is has been completed successfully.
If both jaws are involved reset both using the same procedure outlined above starting and finishing on the appropriate side. The order is irrelevant, just identify and correct when found.

Additionally, when finding the right emotional jaw one should note the occurrence /reoccurrence of this finding and utilize whatever knowledge one has in there tool box!

Comments: .................................................................................................................................
.......................................................................................................................................................
.......................................................................................................................................................
.......................................................................................................................................................

Page 2 ©
THE SURVIVAL SYSTEMS

The Survival Systems of man (Fight/Flight, Feeding, Reproduction) are not unlike those of lower forms of animals and represent the primitive part of our central nervous system (CNS). Essentially the survival systems function on a subconscious level i.e. under the control of the autonomic nervous system. They allow us to survive in a hostile or potentially hostile environment by fleeing from or fighting our predators/enemies, by gathering and assimilating food and by procreation of the species.

Although mankind has for the most part evolved as a peaceful being, our CNS maintains most of its primitive autonomic components that when triggered, responds in a preprogrammed fashion. These responses need to complete their normal cycle of activation-response-reset or they will leave us in an aberrant neural compensatory state. This state is often the reason for many of our chronic neuro-musculo-skeletal complaints and the origin of future systemic and degenerative health issues.

The purpose of Neural Organization Work is to re-establish neural function by resetting neural pathways and undoing compensatory states. By returning neural function back to its original state, the concept of rehabilitation and or retraining is irrelevant. An optimally functioning nervous system raises our vitality and improves longevity.

Neural Organization Work incorporates both basic and advanced applied kinesiological and other eclectic kinesiological techniques. Following in the tradition of holistic/integrative medicine, the emphasis is on return to homeostasis by combining the knowledge of functional neurology and the innate wisdom of our nervous system and immune/tissue repair system.

The first section involves the fight/flight system and represents the most complex of the survival systems. Even with the complexity of this system, the work should need to be done only once. The second section looks at the immune and digestive systems and the third section involves our hormonal/reproductive system.

The premise of Neural Organization Work is to evaluate how the input of sensory information is gathered then interpreted and monitor its output. Re-establishing neurology at the sensory input level is fundamental to NOW and this re-establishment is what makes the work unique in the healing arts. Its ease of application allows any practitioner with an understanding of basic neurology and competency in the art of muscle testing to become a successful and respected health care provider.

Comments: 

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
1. **ATLAS STABILITY**

Identify and correct lateral atlas if present. Can be a left or more commonly right atlas. Often found on initial evaluation and indicative of significant neural deficits within this survival system.

**Evaluation**  Prone: Release achilles heel tension by pumping action at ankle. Compress heels cephalad and compare leg lengths. Bend knees 90 degrees and compare leg lengths. If a short leg is apparent in both positions then this is indicative of a lateral atlas on that side. Alternate methods such as therapy localization and or direct osseous challenge is often helpful.

**Correction**  Lateral atlas correction can be made in any fashion that neutralizes the lesion.

2. **CATEGORY I PROCEDURE**

Category I is a primary neural deficit (sacral respiratory fault involving spinal dura) found in all neuro-musculo-skeletal conditions and can be very persistent.

**Evaluation**  Will manifest itself in one of three ways:

A) **Bilateral weak hamstring:**
**Correction**  Reset inferior occiput and posterior sacral base in any fashion that neutralizes the lesion.

B) **Right hamstring is weak:**
**Correction**  Manipulate C-3 on right in any fashion that neutralizes lesion. Next reset L-3 on right using respiratory correction (spread L-3 spinous and transverse process in opposite directions on inspiration 3-5 times). Next pump 2nd sacral segment on right and follow with action to occiput on the right. Next Release piriformis muscle on right with simple fascial flush. Right hamstring should now test strong, indicating Category I is clear.

C) **Intact hamstrings:**
**Category I lesion is absent and flight /fight survival reflex system is stable.**
3. POSTERIOR SWITCHES

Master neuro-lymphatic reflexes.

**Evaluation** Positive therapy localization of navel to coccyx represents lymphatic congestion of viscera. Positive therapy localization of navel to K-27 (right) represents lymphatic congestion of brain and lower third of spinal cord. Positive therapy localization of navel to k-27 (left) represents lymphatic congestion of spine, spinal cord and lower body.

**Correction** Rub tip of coccyx and K-27 (bilaterally).

**Correction** Rub tip of coccyx and navel simultaneously.

4. POSTERIOR GAIT

Neural coordination of posterior head righting and pelvic centering reflexes.

**Evaluation** Scan cloacal reflexes located on ischial tuberosities. Scan labyrinthine reflexes located within suture between temporal and occiput in both open and closed eye modes.

**Correction** Stimulate centering reflexes by either pumping motion to exaggerate movement of bone that reflex lies within or rubbing with exaggerated breathing (always in both eyes open and closed).

A) Reset centering reflexes as found individually, cloacal and labyrinthine.

B) Reset cloacal and labyrinthine centering reflexes in combination to each other as found. Centering reflexes can not be adversely over stimulated.
5. **FEMUR HEAD INTEGRITY**

Supine: Femur head integrity is necessary for proper muscle testing of gluteus medius.

**Evaluation** Lying supine, test integrity of gluteus medius. If weak (usually right):

**Correction** Rotate leg internally and with clenched fist apply a sharp blow to greater trochanter.

**Correction** If pelvic injury is found (ie two cloacal reflexes in same eye mode) there may be an additional involvement of either subtalar joint compression with anterior tibia and/or ilio-femoral ligament slip. Correct as found ie. subtalar release with anterior proximal and distal tibia and/or lift ilio-femoral ligament anterior while externally rotating femur.

6. **UNIVERSAL CRANIAL FAULT**

Universal cranial fault represents the main circuit breaker for the anterior body. If category I was intact universal cranial fault will also be clear.

**Evaluation** Identify anterior atlas or lateral occiput using right and left tongue protrusion test.

**Correction** If test shows weak pattern in both tongue direction than reset anterior atlas.

**Correction** If test shows weak pattern in one direction than reset lateral occiput in that direction.

7. **ANTERIOR SWITCHES**

Master anterior neuro-lymphatic reflexes.

**Correction** Rub K-27 bilaterally.
8. **CRANIAL SUTURES**

If one has suffered a significant blow to the cranium the sutures will often show a jamming or restriction of movement. Correction will minimize recidivism.

**Evaluation**  Test sutures for imbrication: Therapy localize parietal suture for imbrication or by direct challenge. If absent skip this step.

**Correction**  Gently spread parietal sutures with inspiration then proceed to remaining sutures. Once completed then lift parietals and correct homolateral left anterior and posterior gait (simultaneous correction of ocular and anterior cloacal with eyes open and closed). Next rub K-27 bilaterally. Spread maxillary suture and follow with parietal lift.

9. **ANTERIOR GAIT**

Neural coordination of anterior head righting and pelvic centering reflexes

**Evaluation**  Scan cloacal reflexes located on superior lateral border of the pubic bone and ocular reflexes located within supra orbital notch in both open and closed eye modes (same as posterior).

**Correction**  Stimulate centering reflexes by either pumping motion to exaggerate movement of the bone that reflex lies within or by rubbing with exaggerated breathing. Always in both eyes open and closed.

A) Reset centering reflexes as found individually (cloacal and ocular).

B) Reset pelvic and ocular centering reflexes in combination to each other.
9. CRANIAL INJURY COMPLEX

Neural coordination and resetting of the ocular, labyrinthine and vestibulo-ocular system.

Evaluation Access to this circuit can be obtained via any one of the following procedures:
- challenge anterior neck flexors.
- test left tonic neck righting reflex with right K-27
- test bilateral tonic neck righting reflex (TNRR) which is located within the lamina groove of C1-2-3.

Correction A) Simultaneous stimulation of ocular and labyrinthine righting reflexes as performed in previous steps.

Correction B) Rub TNRR (eyes open & closed).

Evaluate need to continue with V.O.R. system.

Correction C) Stimulate vestibular reflex (ear pull) while simultaneously rubbing ocular reflexes with eye movement (right, left, up, down).

Correction D) Rub TNRR with vestibular reflex with eye movement.

Correction E) Rub TNRR and ocular reflexes with eye movement.

Correction F) Rub TNRR while simultaneously activating sphenoid-basilar motion. Complete in two parts ie. rub TNRR and gently traction occipital EOP cephalad then secondly frontal bone eyes open & closed.

Correction G) Rub TNRR simultaneously with right and left lat. pterygoid muscles with eyes (R, L, U, D, C).

WEIGHT BEARING

Evaluation Standing and sometimes sitting check for anterior atlas using R/L tongue thrust. If indicator is absent then weight bearing cranial injury complex (CIC) is clear, proceed to next section.

Correction H) Reset ant. atlas in wt. bearing posture as found.

Correction I) Simultaneous stimulation of ocular and labyrinthine righting reflexes as previously performed.

Correction J) Rub TNRR (eyes open & closed).

Correction K) Stimulate vestibular reflex (ear pull) while simultaneously rubbing ocular reflexes with eye movement.
Defensive jaw complex represents the dural defense /arming mechanism of the body. Dural arming acts to protect the brain and spinal cord from direct physical trauma. This finding will follow cranial injury indicators.

**Evaluation**  
Supine: Therapy localize right jaw with right hand and test left gluteus medius. If left gluteus medius is not available for active resistive testing, then one may simply put it in the circuit by therapy localizing it. This step is necessary to open the circuit. Disarming the TMJ complex utilizes a defacilitation method of spindle cell compression (press towards belly of muscle => <= ) of the masseter, temporalis and lateral pterygoid muscles. Remember, start with right jaw representing the emotional filter then proceed with left jaw representing the proprioceptive /pain control filter.

**Correction**  
A) Spindle down right masseter, then right temporalis across to left pterygoid muscles, left masseter, left temporalis and end with right pterygoid muscle. Next repeat the same protocol but beginning on left; spindle down left masseter, then left temporalis across to right pterygoid muscles, right masseter, right temporalis and end with left pterygoid muscle.

**Correction**  
B) Check to determine need to repeat entire protocol (A) above with head rotation (ie. turn head right and therapy localize right masseter with right hand using left gluteus medius muscle). This step is found when sutural indicators are present and indicative of a significant head injury thus often associated cervico-brachial radiculopathy.

**Correction**  
C) Check to determine need to repeat entire protocol (B) above with head and pelvic rotation (ie. turn head right and pelvis / knees rotated left and therapy localize right masseter with right hand and left gluteus medius muscle). This step is associated with pelvic jury. (One will expect to find and need to correct pelvic injury complex step below).

**Please note:** Steps 10, 11, 12 represent the Limbic system. These notes are omitted in this manual as it deals with an additional/separate survival system. Sequentially it is numbered as step 10 through 12 as one will often include them in a treatment procedure to minimize turning the client from prone to supine several times during a treatment session.
COCCYGEAL RELEASE

Introduction: This procedure follows the Defense Jaw Protocol and essential represents the second part, i.e. dural release at its insertion, the coccyx.

Evaluation: Therapy localize (TL) the lateral sphenoid and challenge coccyx by pushing coccyx anterior. Usually accomplished in the supine position however if the person is large the prone maybe easier to manage.

Correction: Clients fingers are placed on the lateral; aspect of the sphenoid (instructional step) while an anterior pumping motion is applied to the distill sacrum/coccyx with 6-8 respirations.

FASCIAL RELEASE

Introduction: Fascial defense protocol has been enhanced to include three individual steps to accommodate the torso. Although it is important to understand that this systems primary role is to facilitate the protective/stabilization of the head on the neck during activation of the defensive jaw, there is an additional vital role of body fascia. This role is well understood in Rolfingh techniques. Our concern is with body torque as it relates to the pelvis and the skin reflexes.

Evaluation: Although one can assume this system is active if cranial injury and defense jaw are previous encountered, a direct challenge is possible. Method (a) stretch the neck fascia, (b) torque the body fascia (across midline, anterior or posterior).

Correction: Involves three components:
First identify the beginning point: spindle down \( \rightarrow \leftarrow \) (defacilitate) challenging right or left upper trapezius. Note the starting side will be consistent with scoliosis if present.

1) Corrective steps involve spindle up \( \leftarrow \rightarrow \) (facilitate) along “fascial trains” i.e. fascia between bony anchors across the torso posterior and anterior always finishing on the same side one starts and completed bilaterally (top to bottom-bottom to top).
   a) Between occipital ridge to spine of scapula.
   b) Between spine of scapula to contralateral lower ribs.
   c) Between lower ribs to contralateral iliac crest.
   d) Between iliac crest to greater trochanter.
   e) Repeat entire procedure on the other side beginning at step (a).
   f) Between inguinal ligament & pubic bone to contralateral lower ribs.
      Note it is indifferent as to which side one begins on.
   g) Between lower ribs to contralateral clavicle.
   h) Between clavicle to ramus of jaw.

2) General mobilization of subtalar joint (ankle) bilaterally.
3) Stair-step release of neck in the usual fashion.
14.

COCCYGEAL RELEASE

Introduction: This procedure follows the Defense Jaw Protocol and essential represents the second part, i.e. dural release at its insertion, the coccyx.

Evaluation: Therapy localize (TL) the lateral sphenoid and challenge coccyx by pushing coccyx anterior. Usually accomplished in the supine position however if the person is large the prone maybe easier to manage.

Correction: Clients fingers are placed on the lateral; aspect of the sphenoid (instructional step) while an anterior pumping motion is applied to the distill sacrum/coccyx with 6-8 respirations.

15.

FASCIAL RELEASE

Introduction: Fascial defense protocol has been enhanced to include three individual steps to accommodate the torso. Although it is important to understand that this systems primary role is to facilitate the protective/stabilization of the head on the neck during activation of the defensive jaw, there is an additional vital role of body fascia. This role is well understood in Rolphing techniques. Our concern is with body torque as it relates to the pelvis and the skin reflexes.

Evaluation: Although one can assume this system is active if cranial injury and defense jaw are previous encountered, a direct challenge is possible. Method (a) stretch the neck fascia, (b) torque the body fascia (across midline, anterior or posterior).

Correction Involves three components:

First identify the beginning point: spindle down $\dagger$ $\ddagger$ (defacilitate) challenging right or left upper trapezius. Note the starting side will be consistent with scoliosis if present.

1) Corrective steps involve spindle up $\ddagger$ $\dagger$ (facilitate) along “fascial trains” i.e. fascia between bony anchors across the torso posterior and anterior always finishing on the same side one starts and completed bilaterally (top to bottom-bottom to top).
   a) Between occipital ridge to spine of scapula.
   b) Between spine of scapula to contralateral lower ribs.
   c) Between lower ribs to contralateral iliac crest.
   d) Between iliac crest to greater trochanter.
   e) Repeat entire procedure on the other side beginning at step (a).
   f) Between inguinal ligament & pubic bone to contralateral lower ribs.
      Note it is indifferent as to which side one begins on.
   g) Between lower ribs to contralateral clavicle.
   h) Between clavicle to ramus of jaw.

2) General mobilization of subtalar joint (ankle) bilaterally.
3) Stair-step release of neck in the usual fashion.
If any combination of both right and left cloacal reflexes were seen in prior pelvic centering steps then the pelvic injury complex will be active. Essentially, in reaction to hypertonic T.M.J. muscles there will be hypotonic pelvic muscles (gluteus medius, quadratus lumborum, and adductors).

**Evaluation**  Therapy localize left hand on right jaw while testing with left gluteus medius.

**Correction**  Spindle up ( <=- muscle belly => ) facilitation of pelvic muscles; left gluteus medius, quadratus lumborum, across to right adductors, gluteus medius, quadratus lumborum and across to left adductor. Then repeat the same procedure beginning from the right side; right gluteus medius, quadratus lumborum, across to left adductors, gluteus medius, quadratus lumborum and across to right adductor.

**Correction**  Reset anterior and posterior pelvic cloacal centering reflexes with a two hand contact on jaw (left hand on right jaw, right hand on left jaw). Rub cloacals with the eyes open and closed. Rub lumbar righting reflex located adjacent to lumbar vertebrae.

**Correction**  The remaining combination of centering reflexes can now be addressed; ocular to posterior cloacal and labyrinthine to anterior cloacal (eyes open and closed). This step is most easily accomplished while standing thus usually done with the cranial injury complex (page 7).
Category II or the structural jaw complex, represents the weight bearing fault of the cranial and body pelvis.

CRANIAL PELVIS

Evaluation Therapy localize the left jaw with the left hand using the right gluteus muscle. If right gluteus medius is not available for active resistive testing, then one may simply put it in the circuit by therapy localizing it. This step is necessary to open the circuit and must be checked in both eyes open and closed.

Correction Cranial Pelvis. No pelvic blocks used. Appropriate eye option must be maintained throughout correction. Spindle down -> defacilitate <= left masseter and left temporalis. Reciprocal correction of temporal bones (lift left mastoid toward chin and pull right mastoid down) with 4-6 respirations. Rub neuro-lymphatic (NL) reflexes under left clavicle and C-2. Hold neuro-vascular (NV) point at angle of left jaw. Spindle down left splenius capitus. Spheno-basilar lift (gently traction occiput and frontals posterior) with 4-6 respirations. Rub lateral pterygoids.

If a pelvic injury or scoliosis was seen then a psoas muscle imbalance will exist. Rub psoas neuro-lymphatic located 1 inch lateral and 1 inch above umbilicus. Hold neuro-vascular located just lateral to E.O.P. of occiput.
BODY PELVIS

**Evaluation** Identify presence if any a pelvic imbalance (classic category II /leg length discrepancy). One may find any combination of the following: left short leg eyes open or closed, right long leg eyes open or closed. Therapy localization (TL) of 1st rib head is a reliable indicator. Using left straight arm test (anterior deltoid) TL 1st rib head on left eyes open and closed.

**Correction** Positive TL indicates a left short leg involvement requiring block placement under left PSIS of pelvis and right ischial tuberosity. Appropriate eye option must be maintained throughout correction. Note correction is the same as performed in step prior except now with block placement.

Spindle down (=> <--)left masseter and left temporalis. Reciprocal correction of temporal bones (lift left mastoid toward chin and pull right mastoid down) with 4-6 respirations. Rub neuro-lymphatic (NL) reflexes under left clavicle and C-2. Hold neuro-vascular (NV) point at angle of left jaw. Spindle down left splenius capitus. Sphenobasilar lift (gently traction occiput and frontals posterior) with 4-6 respirations. Rub lateral pterygoids.

**Evaluation** Identify presence if any of a pelvic imbalance right long leg with eyes open or closed. Therapy localization (TL) of 1st rib head is a reliable indicator. Using right straight arm test (anterior deltoid) TL 1st rib head on right eyes open and closed.

**Correction** Positive TL indicates a left short leg involvement requiring block placement under left PSIS of pelvis and right ischial tuberosity. Appropriate eye option must be maintained throughout correction. Note correction is the same as performed in step prior except now with right jaw.

Spindle down (=> <--)right masseter and right temporalis. Reciprocal correction of temporal bones (lift left mastoid toward chin and pull right mastoid down) with 4-6 respirations. Rub neuro-lymphatic (NL) reflexes under right clavicle and C-2. Hold neuro-vascular (NV) point at angle of right jaw. Spindle down right splenius capitus. Sphenobasilar lift (gently traction occiput and frontals posterior) with 4-6 respirations. Rub lateral pterygoids.
17. Category II  Body Pelvis  continued.

If pelvic injury was corrected prior, pubic bone correction can be made at this time. Using scissors action push left pubic bone inferior and right pubic bone superior.

If pelvic injury was corrected prior and pelvic blocking was performed, category III may exist.

Upon completion of category II corrections, leg lengths should be even. Persistent leg length discrepancy is suggestive of category III.

18.  

CATEGORY III

Category III indicative of vertebral involvement disc or imbrication.

LUMBAR IMBRICATION

Evaluation  Prone, tap lumbar spinous processes. TL top of sacrum with thumb and lumbar vertebrae with fingers using hamstrings. Positive therapy localization is indicative of category III involvement. Place blocks under pelvis to neutralize.

Correction  Thumb contact on L5 spinous process continuing to T12 lifting cephalad on 4-6 inspirations. Repeat process on cervical spine C1 through C7 pumping P to A on 4-6 inspirations. Use category III blocking.

LUMBAR DISC INVOLVEMENT

Evaluation  TL lumbar disc(s) (L5 thru L1) with knife edge using a convenient hamstring muscle.

Correction  Upon finding vertebral disc level involvement, traction spinous process above disc level cephalad using thenar base contact on inspirations. While maintaining contact, on expiration traction spinous process below disc level inferior. Repeat pumping process 4-6 times on involved disc level(s). Repeat process on corresponding cervical disc level using thumbs. Category III blocking is maintained.

Correction  Have patient place thumb on hard palate and press firmly on inspiration and release pressure on expiration. Using thumb contact as described above lift spinous process above disc level on 4-6 inspirations. Repeat process on each level involved. This step can be repeated standing.

Correction  Rub lumbar and cervical righting reflexes located within soft tissues adjacent to lamina bilaterally.
Scoliosis is an adaptive reactive compensatory muscle imbalance. This compensatory neurological reactive system is dependent upon a vestibular deficit with a concomitant gait involvement. Dependent upon whether or not one is in an active growing state (ie. puberty) will determine the presence of gross distorsional bending of the spine. Although one may use descriptive terms as adult, adolescent, pubescent, infantile, etc. the neurology and treatment is the same. Congenital scoliosis due to malformed vertebrae(s) may or may not involve the vestibulo-ocular reflex and gait system faults.

Minimum necessary prior completed steps are 1 thru 9. This will reestablish the primary neural mechanism of (neutral) gait and Vestibular ocular head righting reflex systems.

Note: If no vestibulo-ocular deficits were found in step 9 (cranial injury complex) than scoliosis will not exist on this level.

Evaluation PRONE: Identify location and side of primary reactive sacrospinalis muscle group (high side of curve). Although more commonly right side than left, previous indicators should have already assisted in determining the high curve side (ie. leg turn in or defacilitated PMC muscle test).

A) Myofascial stretch paravertebral muscle along entire length of spine then therapy localize any convenient joint on homolateral side. Positive TL confirms primary reactive side of sacrospinalis.

B) Location: (upper, mid, lower thoracic and occasional cervico-thoracic & thoraco-lumbar). One must use step 1 or 2 or 3 to open the circuit.

1) Next use pinch test over apex of curve as a challenge. Homolateral hamstring will test weak.
2) Direct TI over suspected paraspinal muscles using homolateral hamstring only.
- or -

3) Stress suspected sacrospinalis muscle group until muscle group fatigues. Homolateral hamstring will now test weak in the clear (hypo tonic) confirming access to this neurological program.

Correction
One must open the circuit to begin corrective steps.

A) SACROSPINALIS:
Spindle down ( -- > --<) hypertonic sacrospinalis,
Rub NL or hold NV reflexes. Next proceed to homolateral hamstring and spindle up ( <-- --> ) this hypotonic hamstring muscle, Rub NL or hold NV reflexes.

1) Repeat the same procedure on opposite side and on low side of curve.

Supine: Proceed with correction in a bilateral fashion until step F (upper trapezius).

B) QUADRICEPS; are now hypertonic in relationship to hamstrings. Spindle down ( -- > --<) hypertonic quadriceps, Rub NL or hold NV reflexes.

C) ABDOMINALS; are now hypotonic in relationship to quadriceps. Spindle up ( <-- --> ) hypotonic abdominals, Rub NL or hold NV reflexes.

D) PSOAS; are now hypertonic in relationship to abdominals. Rub NL and hold NV reflexes.

R) NECK FLEXORS; are now hypotonic in relationship to psoas. Spindle up ( <-- --> ) hypotonic neck flexors, Rub NL or hold NV reflexes.
Begin Unilateral Correction.

F) UPPER TRAPEZIUS; on high side of curve is now hypertonic in relationship to neck flexors. Spindle down ( -<> <- ) hypertonic upper trapezius. Rub NL or hold NV reflexes.

G) PECTORALIS MAJOR CLAVICULAR; is now hypotonic in relationship to upper trapezius. Spindle up ( <- --- > ) hypertonic PMC, Rub NL or hold NV reflexes.

H) GLUTEUS MAXIMUS; opposite side of PMC (low side of curve) is now hypertonic in relationship to PMC. Spindle down ( -<> <- ) hypertonic gluteus maximus, Rub NL or hold NV reflexes.

I) Piriformis; is now hypotonic in relationship to gluteus maximus. Spindle up ( <- -- > ) hypotonic piriformis. Rub NL or hold NV reflexes.

J) SPLENIUS CAPITUS; opposite side of gluteus medius (high side of curve, ie. return to side where one started) is now hypertonic in relationship to piriformis. Spindle down ( -<> <- ) hypertonic splenius capitus, Rub NL or hold NV reflexes.

K) SPHENO-BASILAR FAULT will now show (TL). Gently pull occiput from EOP and Frontals cephalad for several respirations. Release lateral pterygoids.

The next section is essentially the same as the cranial injury complex step 9.

L) Simultaneous stimulation of ocular reflexes and labyrinthine righting reflexes eyes open and closed (on high side of curve).

M) Rub TNRR (eyes open & closed).

N) Stimulate vestibular reflex (on high side of curve) while simultaneously rubbing ocular reflexes with eye movement (right, left, up, down).
O) Rub TNRR with vestibular reflex with eye movement.

P) Rub TNRR and ocular reflexes with eye movement.

Q) Rub TNRR while simultaneously activating spheno-basilar motion. Complete in two parts i.e. rub TNRR and gently traction occipital EOP cephalad then secondly frontal bone eyes open & closed. Next rub TNRR simultaneously with right and left lateral pterygoid muscles with eyes (R, L, U, D, Closed).

R) FASCIAL STRETCH: Stretch fascia posteriorly and anteriorly.

Weight bearing (standing or sitting).

S) Stimulate vestibular reflex (on high side of curve) while simultaneously rubbing ocular reflexes with eye movement (right, left, up, down).

T) Stimulate vestibular reflexes bilaterally while simultaneously rubbing pelvic cloacal reflexes with eye movement (right, left, up, down).

U) Stimulate ocular reflexes bilaterally while simultaneously rubbing pelvic cloacal reflexes with eye movement (right, left, up, down).

V) Stimulate /rub top of shoulders (acromial process) bilaterally while simultaneously rubbing pelvic cloacal reflexes with respiration and eyes open & closed.

W) Stimulate Diaphragm muscles using NL & NV.

X) Stimulate Psoas muscles using NL & NV.

Y) Stimulate Abdominals muscles using NL & NV.

Z) Stimulate Quadriceps muscle using NL & NV.

*) SPHENO-BASILAR FAULT will now show (TL). Gently pull occiput form EOP and Frontals cephalad for several respirations. Release lateral pterygoids.
Limbic System
Immune / Digestive Complex

Introduction: The limbic survival system is essentially divided into internal and external components; internal being the immune complex and external the digestive jaw complex. Usage of the term Limbic System is used in this text to denote the primitive brain functions of the basic immune response and digestion system.

Description and Theory: The immune complex is addressed in a simplistic fashion now and will be covered in detail in an advanced section titled “Core Level Immune Response System”. The spinal Limbic circuit breakers are first corrected and followed by a sequential activation of the key immune system organs.

The theory of application is to reset the immune system from a failed response following the successful infiltration from a systemic cold and / or flu or other infectious element.

Initial Evaluation: The initial evaluation of this system is done in the prone position and essentially represents the “circuit breakers” of the immune response and related organs. Of the three spinal fixations presented below, each implies a specific immune reactivity mode.

Note: This system is the most common to repetitively break down. It is not necessarily an indication of immune system deficiency, but that of a failed immune response. In the case of a cold and / or flu, although one will see the spinal fixation pattern, one will not necessarily see specific spinal “organ” reflexes active, as this may represent a past event. The organ reflexes (supine) follows activation of SP-21 & K-27 and will always follow the (prone) spinal fixations.

The limbic system is an “independent” survival system and can be implemented at anytime in a treatment protocol whether or not any other survival system has or has not been addressed.

Comments: 


Section II Page 1
Immune Complex

1. Spinal Fixations:
The spinal fixations or “circuit breakers”, if present, will demonstrate itself in one of three different patterns. The term (SP), spinous process and (TP), transverse process are used to describe the positional position of a vertebra as it relates to its rotation distortion i.e. subluxation.

Evaluation: Identify the fixation pattern of C-7 and T-1 spinal vertebrae.
Therapy localization (TL) of a vertebral fixlation requires a bilateral contact on C-7 and T-1.
1) C-7 TP prominence on right and T-1 TP prominence on left, i.e.
   C-7 SP is rotated left & T-1 SP is rotated right.
2) C-7 TP prominence on left and T-1 TP prominence on right, i.e.
   C-7 SP is rotated right & T-1 SP is rotated left.
3) Steps 1) & (2) are superimposed on each other.

Note: Pattern (1) above implies recent or chronic immune system embarrassment and /or blood sugar handling problem.
Pattern (2) above implies chronic allergen / protein (foreign) handling problem highly indicative of an allergy /sensitivity condition.
Pattern (3) represents the worst-case scenario of both (1) & (2) with chemical sensitivity.

Correction: If one has not already done so, stimulation of the coccyx & navel is appropriate at this time as they represent general congestion of the internal organs.
   a) Correct C-7 and T-1 spinal fixation pattern as found.
      i.e. with pattern (1); mobilize C-7 SP by pushing right and pushing T-1 SP left.
      i.e. with pattern (2); mobilize C-7 SP by pushing left and pushing T-1 SP right.
      i.e. with pattern (3); mobilize pattern (1) and immediately do pattern (2).

Vertebræ reactivity will be seen at the thoraco-lumbar junction of usually T-12 & L-1

b) Correct thoraco-lumbar spinal fixation as found with the identical fixation pattern as seen in (a) above.

2. Organ (spinal) Reflexes:
Spinal vertebræ circuit breakers that correspond to individual organs can be reset. The presence or absences of these “therapy localized circuit breakers” are indicative of the chronicity and or past history of the organ(s) involved.

Correction: Spinal adjustment, respiratory correction, or percussion is adequate to stimulate /reset the organ circuits of:
   a) T-2 (lung and / or heart) b) T-4 (gallbladder) c) T-6 (pancreas)
d) T-8 (liver) e) T-10 (small intestine).
2. Organ Reflexes:
In the supine posture, the following organ reflexes are stimulated in sequential order.

Evaluation: The anterior immune system circuit is open initially unilaterally by therapy localizing Left Sp-21. If one was using this as a screening only for immune system integrity, it is understood that the posterior spinal fixation pattern would also be in deficit.

Note: If not previously addressed, K-27 (bilateral) and /or with navel should be stimulated. When stimulating organ(s) stimulation should consists of minimally neurolymphatics (NL) and neurovascular (NV) reflexes points. In stimulating neurolymphatics (NL) points, it is always understood to mean anterior and posterior reflex sites. Neurovascular reflexes (NV) are generally found on the head and held for a minimum of 6 seconds.

Correction: Open immune system organ circuit by TL Left Sp-21 using a right side indicator muscle. This is a unilateral activation with step (m) completing the circuit.

a) Simultaneous stimulate left Sp-21 & right K-27 by tapping for 15 seconds.
b) Thymus NL (between 2nd and 3rd intercostals sternal junction right side).
c) Liver activate NL & NV.
   1) Rub Liver point #8 on temperal-sphenoidal (TS) line right side while holding CMRT liver point (angle of tenth rib on right).
   2) Stimulate Liv-8 & K-10 right leg.
   3) Liv –4 & Lu-8 on right ankle & wrist.
d) Small Intestine activate NL & NV with eyes closed.
e) Gallbladder: stimulate vertebral circuit breakers T-8 (liver) & T-4 (gallbladder) by adjustment or percussion.
f) Lift parietals bilaterally and rub gallbladder point TS #4 while holding CMRT gallbladder point, (Murphy’s point).
g) Stomach, activate NL & NV.
   1) Rub SI-5 & ST-41 (right wrist & ankle).
   2) Rub ST-43 & GB-41 (right foot).
h) Lift sphenoid and frontal bone bilaterally with head turned right with 5-10 respirations.
i) Reduce adrenal stress by spindle down É Â flexor hallicus longus tendon bilaterally then fascial flush (spread apart) the length of the (hypertonic) gastrocnemius muscle bilaterally.
j) Thyroid activate NL & NV.
k) Activate diaphragm by spindling up Â É the pec minor muscle
l) Activate pituitary by pumping mastoids on 12-15 respirations.
m) Activate reciprocal SP-21 to complete bilateral activity from step (A).
n) Reset eye muscle memory of immune system by;
   1) Eyes muscle fascial stretch up to the left.
   2) Eyes muscle fascial stretch up to the right.
DIGESTIVE SYSTEM COMPLEX

3) Universal Jaw Complex:
Universal Jaw represents the transition between immune system and the digestive system. It will be active whenever there is a mid-line structural problem and or a functional disturbance of one or more digestive organs.

Description and Theory: Universal Jaw protocol essentially functions as the compensation “circuit breaker” for right /left energy imbalances and corresponds to acupuncture meridian disturbances. This electromagnetic imbalance must be corrected before any systemic condition can be successfully addressed. Common systemic conditions that activate universal jaw are parasitic, fungal / yeast, liver toxicity, local bacteria and viral infections.

Note: The need for correction of universal jaw when addressing parasitic and fungal, infections may not necessarily be indicative of a collapse of other limbic protocols. It is additionally interesting to note that toxicity conditions such as heavy metals (mercury etc) will usually not trigger universal jaw.
If there was simple resolved past illness (cold/flu) that triggered the immune system deficit, universal jaw might be clear.

Evaluation: Bilateral therapy localization of jaw with;
1) Eyes open …indicative of active systemic imbalance(s).
2) Eyes closed …indicative of a chronic systemic condition.

Correction: If both eye modes are identified then extended universal jaw is involved.
If only eyes open mode is seen, completing step (A) ends universal jaw.
   a) Spread mandibular arch, release imbrication of bilateral condyles spread maxillary arch in eyes open mode.
   b) If eyes closed mode is found, repeat above with eyes closed.
      1) With steps (1) & (2) completed, identify and correct left anterior homolateral gait (left ocular and left cloacal reflex in the usual fashion).
      2) Rub K-27.
      3) Spread maxillary arch.
      4) Lift parietals bilaterally.
      5) Rub NL’s & NV’s of diaphragm, psoas, abdominals, and quadriceps muscles. Identify the need to correct diaphragmatic impingement of stomach and integrity of perineal diaphragm.
      6) Correct diaphragmatic impingement of stomach by pulling down adjacent to zyphoid and resetting diaphragm muscle insertions.
      7) Facilitate lower pelvic floor muscles by, resistive abduction of adductor muscles and/or with perineal punch.
      8) Sucking reflex: Discussed in section 4f.

Section II Page 4
4) Digestive Jaw Complex:
Digestive jaw complex plays a key role in the functional integrity of the digestive process. The movements of the jaw activate specific individual components of digestion from churning of stomach, peristalsis, and enzyme production to valvulæ control.

Note: The presence of the digestive jaw is initially common but has low recidivism. On follow-up visits, correction of the posterior and anterior immune system components and step (e) below will usually complete the entire Limbic section. This again is the common scenario seen on preventative visit(s) and indicative only of a past (resolved) illness.

Evaluation: Positive (bilateral) therapy localization of jaw with movements of;
1) Jaw open (full excursion) with or without
2) Lateralization of jaw.

Correction:
   a) Following activation of jaw (open mouth), release lateral pterygoids.
   b) If lateralization was identified above then proceed to medial pterygoids.
   c) Fascial flush buccinator muscle bilaterally.
   d) Chewing reflex; spindle down Œ Â masseter and temporalis muscles while chewing.
      1) If step (b) was incorporated then protrude mandible to access insertion of
         medial pterygoids with fascial flush motion under chin.
      2) Then retract mandible and spindle down Œ Â posterior aspect of temporalis
         muscles bilaterally.
   e) Swallow reflexes: Identify side of involvement by TL stylo-hyoid muscle
      1) After first swallow, spindle down Œ Â stylo-hyoid on side of involvement.
         Then stretch the same muscle to reset its antagonist, followed by rubbing of the
         tonic neck righting reflexes. The first swallow represents activity of valvulæ
         action of esophagus (cardiac valve).
      2) After second swallow; spindle down Œ Â opposite stylo-hyoid. Then stretch
         the same muscle to reset its antagonist, followed by rubbing of the tonic neck
         righting reflexes. The second swallow represents activity of valvulæ action
         below diaphragm (pyloric, ICV, Houstonian valve).
      3) Phonation reflex: while speaking, identify side of involvement (generally right
         stylo-hyoid), then stretch the same muscle to reset its antagonist.
   f) Sucking Reflex: A positive TL with bilateral contact to jaw while sucking.
      1) Flush buccinator muscle.
      2) Release lateral pterygoid muscle.
      3) Spindle down masseter and temporalis muscle.
      4) Release lateral pterygoid muscle.
      5) Repeat same process on other side.

Comments: ____________________________________________________________
Description and Theory: This protocol represents a five-organ endocrine sub-system reset composed of the stomach, pancreas, small intestine, large intestine, and kidney. It involves balancing both endocrine (secretin) and exocrine function as it relates to enzyme production, Ph, and the overall functionality of the digestive system. This protocol appears to be applicable in all individuals with digestive system imbalances that are often complicated by opportunist infections such as parasitic and fungal (candida yeast).

If the stomach pancreas and small intestine are not neurophysiologically intact, the procedure will appear to not hold and require multiple periodic resets. An additional tissue / cellular repair protocol will need to be implemented to strengthen these organs.

Evaluation: Supine, a positive (weak) therapy localization of the stomach neurolymphatic reflex using the left PMS will be seen. It should be noted that the left PMS and primary endocrine system is assumed to be intact as well as the five organs not showing a weak therapy localization by them selves individually or via SP-21.

Note: For the first step only, the left PMS (endocrine system) must be linked with the stomach reflex. Utilization of a sagital suture tap (a single tap on top of head with 2-3 lbs of pressure) is to allow one to collapse right and left brain hemispheric activation into one step utilizing a pause lock mode, well known within kinesiology techniques. Anterior atlas correction can be applied with minimal pressure. Eye muscle corrections must be held for a minimum of 3 seconds. It is always advisable to recheck your work by therapy localization all steps sequentially and / or the last step. This should be done with right and left brain hemispheres; meaning muscle test with right arm then repeat again with left arm. This protocol should only have to be done once.

Comments: ____________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Section III Page 8
Correction: DIGESTIVE SYSTEM PROTOCOL

1) Maintain one hand contact over left PMS and second hand over stomach. Next activate right / left brain activity by simply moving any large muscle group, i.e. lift one leg 12 inches or more off table. Then tap sagital suture (to place unilateral brain activity on pause). Then repeat same activity with other leg. Next activate brain integration by:
   a) Anterior atlas correction then immediately follow with
   b) Eye muscle fascia release up to the right
   c) Eye muscle fascia release up to the left
   d) Eye muscle fascia release up to the right.

2) Contact over pancreas with one or both hands and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

3) Contact over small intestine with each hand covering right and left sides of the small intestine and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

4) Contact over large intestine with each hand covering right and left sides of the large intestine and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

5) Contact over kidneys with each hand covering right and left kidney and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

   Section III Page 9
ENDOCRINE / REPRODUCTIVE SYSTEM

Introduction: This survival system represents the non-neural communication system of the body and central nervous system.

Description and Theory: This protocol is designed to rebalance hormonal activity and represents a beginning point of which to address the primary endocrine organs. There are four known subsystems (cardiac /circulatory system, reproductive system, blood sugar handling, and digestive system) within the primary endocrine system, which will be discussed at the end of this section.

Initial Evaluation: During the initial evaluation of an individual, this survival system will most often be opened up by therapy localization of the skin reflexes. On subsequent corrections, the endocrine system can ready be opened directly through the left pec-major sternal (left liver circuit).

Note: It should be understood that following any major correction of the fight/flight system one should recheck the need to repeat the correction of the endocrine system regardless if it was addressed prior. The skin reflexes, once corrected, usually do not need to be readdressed.

....Skin Reflexes (initial presentation):

This is an overlay system and usually only needs to be done once during the initial treatment of this section.

Evaluation: Identification of skin reflexes can be accomplished by therapy localization of any one of the following sites: left pec major clavicular muscle, nose, and neurolymphatics of the large intestine. The left pectoralis major sternal muscle will not show a weakness until this step is completed.

Correction:
   a) Stretch the skin in a cuadal direction over the nose.
   b) Stretch the skin in a cuadal direction over the lips.
   c) Stretch the skin in a cuadal direction over the breasts.
   d) Stretch the skin in a cuadal direction over genital area.
   e) Activate the stomach NL located on left side between ribs 5&6 & NV.
   f) Activate the pituitary utilizing a simple sphenoid-basilar pumping motion of lifting the mastoids anterior on inspiration with 12-15 repetitions.

Section III Page 1
Primary Endocrine System

1. **Left Liver Function /Pec Major Sternal**
The primary endocrine system begins by evaluating the ‘left’ liver for a functional deficit. If skin reflexes are not properly addressed in the previous step, this functional deficit will be hidden.

**Evaluation:** Identify the left pec major sternal muscle (PMS) involvement by either therapy localization directly over the PMS or manually test the muscle. If no deficit is found then the primary endocrine circuit is clear as well as the secondary cardiac and circulatory systems. One may proceed to subsystems (at end of this section).

**Correction:** When stimulating neurolymphatics (NL) it is always understood to mean anterior and posterior reflex sites. Neurovascular reflexes (NV) are generally found on the head and held for a minimum of 6 seconds.

- a) Activate NL of liver over lateral ribs 6-7 on the right.
- b) Activate NV reflexes on forehead at hairline.
- c) Rub T.S. line #8 on left side of head and angle of tenth rib on right.
- d) Activate meridian points: Liv 8 & K10 and Liv 4 & Lu 8 all on the left.

2. **Circulatory Function**
This reflex circuit once corrected usually does not re-appear. It is indicative of circulatory problems and will require completing the right/left heart rebalance, step #5.

**Evaluation:** Identify a right pec major clavicular (PMC) muscle weakness or positive therapy localization over the stomach NL. If this reflex circuit is absent, proceed to step 3.

**Correction:**
- a) Activate NL of stomach over lateral ribs 5-6 on the left and NV.
- b) Activate NL of liver over lateral ribs on the right and NV.
- c) Activate NL of large intestine on lateral aspect of the legs and NV.

3. **Adrenal Reset**

**Correction:**
- a) Spindle down Ė Ā flexor hallucis longus muscle of both feet.
- b) Fascial flush (hypertonic) gastrocnemius muscle bilaterally.
- c) Activate NL and NV of thyroid.
- d) Activate diaphragm by spindling up Ė Ė the pec minor muscle.
- e) Activate pituitary by pumping mastoids with 12-15 respirations.

Section III Page 2
4. Liver Reset
This section is similar to step (1a) above and is representative of metabolic right liver function.
   a) Activate NL & NV of liver over lateral ribs on the right
   b) Activate NL & NV of liver while patient is holding left SP21.
   c) Activate NL & NV of liver while patient is holding CV3.
   d) Activate NL & NV of liver while patient is holding right and left K27.

5. Circulation and Heart Rebalance
If step 2 was found above then proceed with correction. If step 2 was absent, then primary endocrine system is complete and subsystems can now be evaluated.

   Evaluation: Therapy localize over the right or left side of the heart to identify the deficient side similar to that of an acupuncture meridian (heart) imbalance.

   Note: Generally the right side is frequently found deficient. Once the first side is corrected, the opposite side will now show a deficit. If there is a blood pressure and/or heart problem, one may have to repeat this sequence until clear on therapy localization.

   Correction: Sitting. Right side of the heart stimulation requires a logic-brain activity (counting) and a left side of heart stimulation requires a gestalt brain activity (humming).
   a) Stimulate the deficient side of the heart as found.
   b) Stimulate the other side of heart.
   c) Re-evaluate if there is a need to continue or procedure is complete.

6) Subsystems:
   - Cardiac Back Stress Syndrome
   - Blood Sugar Handling (adrenal-thyroid)
   - Ovary / Prostate Reset
   - Digestive System Reset.

Comments: __________________________________________________________

___________________________________________________________

____________________________________________________________________________________

Section III Page 3
CARDIAC BACK STRESS SYNDROME

Description and Theory: Cardiac back stress syndrome represents one of the most common reoccurring secondary systems to repetitively break down. It is the most common complaint that brings the patient in for a non-scheduled office visit. It will manifest itself commonly as low back pain with or without sciatic type paresthesia. Additional symptomatology may include upper neck pain and not infrequently a feeling of cardiac distress. This protocol represents a reset of the cardiac circuit and will require the primary endocrine system to be addressed first. Additionally, an emotional clearing and a gallbladder reset will enhance this procedure as well as reduce recidivism.

Evaluation: In the supine position, positive therapy localization to the heart or in the prone position, a positive therapy localization of the sacral base will show the classic cardiac stress pattern.

Note: If one is beginning a follow up treatment session (post-prior completion of the fight/flight survival system) in a prone position, a bilateral hamstring weakness is seen, this should be your obvious clue of cardiac back stress syndrome and not a reoccurrence of a Cat. I fault.

Correction: Prone position with a positive therapy localization to sacral base.
   a) Correct posterior sacral base; can been done as an adjustment or with respiratory assist (pump sacral base on expiration).
   b) Inferior occiput; lift occiput with inspiration respiratory assist.
   c) Reset spinal circuit breakers with respiratory assist or adjustment on inspiration:
      1) T-2 Heart
      2) T-4 Gallbladder
      3) T-12 Diaphragm
      4) L-3 Reproductive organs.
      .....Supine (below steps are identical to steps within primary endocrine system
   d) Spindle down Ê A flexor hallicus longus muscle of both feet.
   e) Fascial flush (hypertonic) gastrocnemius muscle bilaterally.
   f) Activate NL and NV of thyroid.
   g) Activate diaphragm by spindling up Â Ê the pec minor muscle.
   h) Activate pituitary by pumping mastoids on 12-15 respirations.

Additional steps on page 5 (emotional clearing and gallbladder reset) can be utilized to enhance the cardiac back protocol and prevent recidivism.

Section III  Page 4
Optional Steps To Enhance Cardiac Back Protocol

1) Emotional Clearing / Gallbladder Reset: Optional protocol to normalize emotional stress and the gallbladder heart-brain triad.

Description and Theory: The steps listed below represent an enhanced protocol to de-stress the heart and its associated gallbladder circuit as well as an additional option to address deep hidden switching (a protocol involving an amygdala/corpus callosum reset).

Note: See section VI, advanced workshop manual for protocols utilizing deep hidden switching (corpus callosum/amygdala reset).

Correction:

a) Therapy localize gallbladder with patient’s left hand, [weak response], that is negated by therapy localization to right jaw (defensive jaw) with patient’s right hand.

b) Next, have patient raise one leg, tap sagittal suture then raise opposite leg and make eye muscle memory correction up to the left then up to the right.

c) Next, have patient therapy localize SP-21 and repeat correction procedure as listed in step (b).

d) Next, have patient therapy localize universal jaw and repeat correction procedure as listed in step (b).

e) While maintaining a (patient’s) contact with SP-21, therapy localize gallbladder and repeat correction procedure as listed in step (b).

f) While maintaining contact with SP-21, therapy localize heart (heart is treated as right and left) and repeat correction procedure as listed in step (b).

g) While maintaining contact with SP-21, therapy localize brain (brain is treated as right, middle, and left) and repeat correction procedure as listed in step (b).

2) Emotion Anchor Reset:
Emotional clearing technique, utilizing a five-step protocol adapted from neural linguistic programming (NLP) and modified by Dr. Carl Ferreri and associates.

Correction: Identify correct starting point for clearing.

a) Conscious emotion anchor: clearing counter clockwise.

b) Subconscious (eyes closed) emotion anchor clearing counter clockwise.

c) [Optional] Sleeping / dreaming: same as step (b) always starts at 9:00.

d) Catalogue procedure.

e) Skin reflexes.

f) Learned response: clearing clockwise.

Section III  Page 5
BLOOD SUGAR HANDLING PROTOCOL

Description and Theory: This protocol represents a five-gland/organ endocrine sub-system reset composed of the adrenals, pancreas, thyroid, pituitary, and hypothalamus. It involves balancing endocrine activity of the adrenals and thyroid as it relates to blood sugar requirements. This protocol appears to be applicable in all individuals and a necessary component for improving overall metabolic function and vitality. If the thyroid is not neuro-physiologically intact, the procedure will appear not to hold and require multiple periodic resets. An additional tissue / cellular repair protocol will need to be implemented to strengthen the thyroid.

Evaluation: Supine, a positive (weak) therapy localization of the adrenal neurolymphatic reflex using the left PMS will be seen. It should be noted that the left PMS and primary endocrine system is assumed to be intact as well as the five organs not showing a weak therapy localization by themselves individually or via SP-21.

Note: For the first step only, the left PMS (endocrine system) must be linked with the adrenal reflex. Utilization of a sagittal suture tap (a single tap on top of head with 2-3 lbs of pressure) is to allow one to collapse right and left brain hemispheric activation into one step utilizing a pause mode, well known within kinesiology techniques. Anterior atlas correction can be applied with minimal pressure. Eye muscle corrections must be held for a minimum of 3 seconds. It is always advisable to recheck your work by therapy localization all steps sequentially and / or the last step. This should be done with right and left brain hemispheres; meaning muscle test with right arm then repeat again with left arm. This protocol may need to be done periodically and thus an indicator of ongoing stress (physical, chemical, or emotional) and thus may have a different starting point (eye-option).

Comments: _____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Section III Page 6 ©
Correction: BLOOD SUGAR HANDLING

1) Maintain one hand contact over left PMS and second hand touching both adrenal neurolymphatics (2 inches up and 1 inch from navel).
   Next activate right/left brain activity by simply moving any large muscle group, i.e. lift one leg 12 inches or more off table. Then tap sagital suture (to place unilateral brain activity on pause). Then repeat same activity with other leg.
   Next activate brain integration by:
   a) Anterior atlas correction then immediately follow with
   b) Eye muscle fascia release up to the right
   c) Eye muscle fascia release up to the left
   d) Eye muscle fascia release up to the right.

2) Contact over pancreas with one or both hands and repeat right/left brain activity by utilizing individual leg lift as previously described above.
   Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

3) Contact over thyroid and repeat right/left brain activity by utilizing individual leg lift as previously described above.
   Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

4) Contact over pituitary reflex (bridge of nose) and repeat right/left brain activity by utilizing individual leg lift as previously described above.
   Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

5) Contact over hypothalamus reflex (located on mid line of mid-frontal bone and repeat right/left brain activity by utilizing individual leg lift as previously described above.
   Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

Section III Page 7 ©
OVARY / PROSTATE
REPRODUCTIVE ORGAN PROTOCOL

Description and Theory: This protocol represents a five-organ endocrine sub-system reset composed of the ovary/prostate, kidney, liver, adrenals, and hypothalamus. It involves endocrine gland activity related to hormonal balance of the reproductive system. This protocol appears to be applicable in all individuals that are sexually active. If the ovary/prostate is not neuro-physiologically intact the procedure will appear to not hold and require multiple periodic resets. An additional tissue/cellular repair protocol will need to be implemented to strengthen these organs.

Evaluation: Supine, a positive (weak) therapy localization of the prostate/ovary (CV-3) using the left PMS will be seen. It should be noted that the left PMS and primary endocrine system is assumed to be intact as well as the five organs not showing a weak therapy localization by them selves individually or via SP-21.

Note: For the first step only, the left PMS (endocrine system) must be linked with the prostate/ovary (CV-3). Utilization of a sagital suture tap (a single tap on top of head with 2-3 lbs of pressure) is to allow one to collapse right and left brain hemispheric activation into one step utilizing a pause mode, well known within kinesiology techniques. Anterior atlas correction can be applied with minimal pressure. Eye muscle corrections must be held for a minimum of 3 seconds. It is always advisable to recheck your work by therapy localization all steps sequentially and/or the last step. This should be done with right and left brain hemispheres; meaning muscle test with right arm then repeat again with left arm. This protocol should only have to be done once.

Comments: _______________________________________

_________________________________________________

_________________________________________________

_________________________________________________

_________________________________________________

_________________________________________________

Section III Page 10
Correction:  **OVARY / PROSTATE**

1) Maintain one hand contact over left PMS and second hand over ovary / prostate (CV-3). Next activate right / left brain activity by simply moving any large muscle group, i.e. lift one leg 12 inches or more off table. Then tap sagittal suture (to place unilateral brain activity on pause). Then repeat same activity with other leg.
Next activate brain integration by:
   a) Anterior atlas correction then immediately follow with
   b) Eye muscle fascia release up to the right
   c) Eye muscle fascia release up to the left
   d) Eye muscle fascia release up to the right.

2) Contact over kidneys with both hands and repeat right / left brain activity by utilizing individual leg lift as previously described above.
Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

3) Contact over liver and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

4) Contact over both adrenal neuro-lymphatics (2 inches up and 1 inch above navel) and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

5) Contact over hypothalamus reflex (located on mid line of mid-frontal bone and repeat right / left brain activity by utilizing individual leg lift as previously described above. Next activate brain integration by:
   a) Anterior atlas correction
   b) Eye muscle fascia release up to the right
   c) Then muscle fascia release up to the left
   d) Then muscle fascia release up to the right.

Section III Page 11