Episode Five - FSM Podcast

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Kim: [00:00:03] There are so many questions that came in this last week, so yeah, yeah.

Carolyn : [00:00:09] Good, good. Good. Yeah, I was telling Danielle if because we get calls from people that are wanting to talk to document making and ask her questions and stuff, yeah, you should tell them to just get on the podcast recording. They can ask their questions there. Then everybody benefits.

Kim: [00:00:23] Exactly. Hello. Hello. You're like making your red carpet entrance right now.

Carolyn : [00:00:29] Yeah. How do we start? Ready? Oh yeah, we're. We're six minutes early, I know.

Kim: [00:00:35] But there's like seven people here already, and Kevin and I just wanted to catch up.

Carolyn : [00:00:40] But I was seeing patients this morning and I got home in time to put food in my mouth, put makeup on my face. There's only so many things a girl can do. You know what I'm saying?

Kim: [00:00:50] That's my day. I'm actually going to stop. I think seeing patients on Wednesdays just so I can focus on this stuff because

Carolyn : [00:00:57] It's supposed to be my day off. But I remember that a patient from California who flies up. And I have a patient who's. He's in between. The Silicon Valley, and now he's moving to some Jackson Hole.

Kim: [00:01:20] And we'll talk about this after the podcast, but you and I are seeing somebody together, he's seeing you and then he's flying back to see me.

Carolyn : [00:01:26] Yeah, right. And that's he needs you. I'll fix what I can fix. But there is more to it than meets the eye that I didn't find out until yesterday.

Kim: [00:01:37] Isn't that always the truth? It's never what you get on paper or what you think it is.

Carolyn : [00:01:44] Is it normal for someone to say, I can feel my Doura is stuck here? And then when you fix that, oh, now it's stuck here and then it, that's like, Yeah. So I'll try and fix that before he comes to you.

Kim: [00:02:02] That would be fantastic.

Carolyn : [00:02:05] I just figured out what it was yesterday. Wow. So that's that. I think it's fixable. We'll see.

Kim: [00:02:12] Crazy.

Carolyn : [00:02:14] It's it's been an interesting week. You know, that weird protocol that we do called PH.

Kim: [00:02:22] Ok, can you get out of my brain for just like forty three seconds because it's on my list to talk about today?

Carolyn : [00:02:29] Well, we're here. So PH is that protocol that is there wasn't my fault to begin with. Right? It was patient who came up from Los Angeles and she'd had fibro. She we got her better, took, stayed two weeks. She got better. She went home six months later. She comes back like with the determination look in her face, and she says, it's like I have a target on my back, right? Bad stuff happens to me and it's not my fault. And it's like I have energetic cooties that just. Draw. Negative things. So she went home, she was home for two weeks. She fell down the stairs and sprained ankle. Then a week later, her son broke his arm and two weeks after that, her husband hurt his back and was home on work comp. And it was just about every two weeks. Something came

on and she came in and she said, This is not normal and it's not my fault. And it's energetic cooties and and I think you can figure out a way to fix it with frequencies. And I backed up about two feet and said, that's not quite my skill set, but Ryan is here. So Ryan Wilson was a Naturopathic student who worked in the office and Ryan. He was good at. He called it scanning, but it was kind of a muscle testing, self muscle testing thing. So he'd get an idea in his head and he would muscle test for it and he'd come up with frequencies. And I said, How about you and Ryan go into room four and you muscle test and see what he can come up with? So they came out with.

Carolyn : [00:04:32] Six pairs. Of their a b pairs. And then the last one, the seventh one is eighty eight and sixty five, which happened to be an AB pair from Harry van Gelder called resistance to Healy. The original six that Ryan came out with had names that are really just too weird to even talk about. It was basically. Energetic cooties. So Pat Lawler's, who's an acupuncturist in Berkeley, Pat Lawless and Sandra Mencken named them DMTs definitely more than one where. The best way to describe it is where the patient's history makes the hair on the back of your neck stand up. Yeah, right? There's just creepy, icky stuff that shouldn't happen to people. Mm hmm. Or when the other thing I've learned is that when they say they've been doing energetic work, so they're were trained in energy work. My experience having been having worked with people who have been trained to do energy, work like my sister and other people. Before you train someone to do energy work and these are air quotes for those of you that are listening and not looking at my fingers before you train someone to do energy work. It's like giving a three year old an Uzi, you have to they have to be prepared and centered and grounded and safe. Or when they do energy work, they. They take their own personal energy and spread it out, so. The one of the patients I saw recently, I can kind of like anybody that's listening could if you put your hands together there, there comes a point if you close your eyes and you put your hands together.

Carolyn : [00:07:00] There comes a point where you can feel where just resistance. It just feels warm or defer. Or not just air, right? It's OK. So I do that with patients sometimes when it's appropriate. So when this guy started telling me about. His energy work that he had been trained in. I reached out and tried to find his field the edge of his field. It was back past the wall behind my back, and he was six feet in front of me. And it's like in your energy field is like a ball around you, and it's like, OK, so let's move your field. I want you to move it forward closer to you. How do I do that? I said, we'll figure it

out. And so pretty soon it comes in where I can find it. And then. Finally, got it where it where I think it belongs. It's denser and it's closer to your body. Right. So that's my next project. With this particular patient is to run PH on him, because when you're when you're not in your body, when you are so strung out, or when you've used a lot of drugs or had a lot of surgeries or just weird stuff happens. It's like you leave your house and the doors are open and the lights are on. And. Energetic entities. For those of you that don't think this is too weird. Make themselves at home. Come on in. I'm all good. The concept behind this was.

Carolyn : [00:09:16] That there are energetic entities that literally feed on. Negative emotions, negative events, fear, pain. That's her that's her jam, that's that's what that's what makes them feel good. So if they are in residence, they. Attract that to you. So after we after Ryan developed this protocol, I'm thinking, OK, whatever. And I ran this on this lady for five days in a row, fibromyalgia went away, bad stuff stopped happening and I'm like, OK, maybe OK. So then about three months later, I happened to have an office manager who was clairvoyant like he could really see the energy field. I can't see stuff like that. So. David would come into the room and just lean up against the door and watch me work, and he would give me comments out in the hallway afterwards, and this is what the patient's permission. So. I had a patient where I knew this was an issue. So David's leaning up against the door and he looks down at the patient and then all of a sudden he looks up and then down and then out and then down and over and down. And so 20 minutes later, we go out in the hallway said, What were you doing? And I said, what did you see? And he said, well, there was this black balls and squiggly things flying out of the patient's field. That's fine. Where do they go? Right, the important thing for me was, are they sitting in the on the ceiling in room 3 waiting to jump on me? So this was before I ever taught it. Before I teach anything, I make sure that it's safe.

Carolyn : [00:11:22] He said No, they went out the back wall. He said, I wouldn't want to be in the pub next door. So I found out they were safe and then I started teaching them and they ended up on the laminate. They're called the tendency to have bad things happen to right because if you call it definitely more than one Dapto, yeah, it's too weird for people. But the whole concept of energetic entities that climb on you is outside the realm of most people's belief systems. I've seen it work enough. That so if you get a class of one hundred FSM practitioners in a room and you ask them. You know, if you ask them. Could you run your practice without the concussion protocol? Absolutely.

Nobody would raise their hand. How many of you have used? And about 50 60 percent raise their hand. Could you run your practice without that protocol? Absolutely. Nobody will raise their hand when you need it. And for me, it's embarrassing that it's taken me so long with some patients to recognize it. But some patients, it's the first thing I do. Yeah, get through the history, the hair on the back of your neck. Nobody should have that much bad stuff. Or they have a history of drug abuse or alcoholism or abusive parents or whatever. So you're in concussion and Vagus and PH, and I'm really tempted with one of my patients to actually combine them. So she runs at three times a week. Ok. Ok. Was that on your list?

Kim: [00:13:14] Hey, the list

Carolyn : [00:13:15] Just

Kim: [00:13:17] Morphs. We know that that happens. So it's funny. It's been a voracious week of questions. People have been hitting me on all sorts of platforms Facebook, Instagram, emailing. There's a new web or sturrup email list that I have like a landing page so people can put some questions on there so you can go to FSM. You know, I'm just trying my best here, so. So the the journey today was going in a lot of different directions, but there is one word that it just kept encompassing and that was irritation. So it's an interesting base. I've had patients that have just had irritating injuries, nothing hugely traumatic, nothing that's going to make the back of your neck hairs stand up, but these chronic irritating.

Carolyn : [00:14:17] So it's the patient, not you.

Kim: [00:14:20] Well, I've been irritated myself. I'm glad. So this is where I want to start. I want to like, just like, give this to the podcast right now. So the most irritating thing that somebody can. Give me is a garbage can diagnosis, and you have to be in the same business and I can see your face and those of you who are just listening. It's like the face. So when somebody comes in and they say I was diagnosed with fibromyalgia, I was diagnosed with frozen shoulder. The list can go on and on any time for patients that are listening to this podcast any time you hear the word syndrome. This is because a bunch of people got together and sat in a room and couldn't figure it out. What really is

the problem? So like, let's just give this a name. So, right? So why are we still having the need to throw irritating labels on conditions?

Carolyn : [00:15:20] Well, my approach to that? Is sometimes irritating the patient, but they come in and they tell me I have X. Yeah, and it's like. And in the back of my head, I'm saying X is a garbage can diagnosis. X is B.S. Yeah. So the way I handle it with the patient, because the patient is now at least they have a name for it. The patient is now attached, defined by their diagnosis because it was this guy in a white coat that they paid $400 an hour or two and he gave them the diagnosis. So now that's a real thing. Yeah. And so my approach is, OK, wait, just just give me a second here. Let's pretend. That you didn't that we don't have that word. And that stops the patient because I don't let them get very far with that. Yeah. Let's pretend we don't have that word. Tell me what your symptoms are, right? Ok. Because X. I can't even think of I know what you mean, like fibromyalgia, chronic fatigue is the other one. Right? That is like such a really? Yeah. So let's pretend. Just tell me what your symptoms are. Right? Fatigue. Ok. What does that mean? Um. Uh, sleep disturbance, body pain. When did it start? Oh, I've had it my whole life. I think I was born with it. It's like, OK, nobody is born with fibromyalgia, Suttich or chronic fatigue. Right? So tell me what you did in high school. Oh, I was I did gymnastics, and I I was on the the. What do you call it, the drill team? And I played soccer. I said, OK, so you didn't have it in high school.

Carolyn : [00:17:36] What did you do in college? Well, the first two years I did this, this and this. And then what happened? When did this this level of symptoms, because what happens is once once the symptoms start and once the limbic system gets involved. And the midbrain gets involved. You don't need to remember anything except how you got away from the tiger the last time. Right? So of course, they've had it their whole life because every little symptom that any of us ever had when we were six, seven or eight, when you had the flu or you had your tonsils out or you broke your arm or you fell off your bike or whatever and you get over it. Now, all of a sudden, now that you have this catastrophic diagnosis. And that's not to say that there aren't catastrophic diagnoses, but now that you have this diagnosis, now you can collect them all together and it's all related to the tiger. So I just I just. I don't buy it. And just stop them, it's like, OK, let's pretend that that's yes, I understand. But let's pretend you don't have that word. Tell me what your symptoms are and tell me when they started and I hardly ever let them get away with. Since birth, unless their Aloe Ehlers-Danlos right Ehlers-Danlos is. Even

even the like the mild AIDS patients. They've had sprained ankles, they've had body pain because they have LOX ligaments in their discs, and so they end up being 40 and 10 patients. Mm hmm. And. So, yeah, my favorite my favorite story. If I don't get. Can I tell a story?

Kim: [00:19:39] Of course you can. Stories are the best part.

Carolyn : [00:19:41] Ok, so my favorite story is the lady. I have a picture of her someplace in one of the webinars. She was the friend, close friend of a student at a seminar in London. No, Chester. And they brought her in. This was it brought her in on day to. And her diagnosis that she'd lived with, now she's fifty eight. And she's live with this diagnosis, and she was 40, so 18 years, I have chronic fatigue. She has me miles, something encephalopathy, right? So it's I have chronic fatigue. When did it start, when I was 40? It was after I had my son. And. And my arms were so painful and sore that I couldn't lift him. And I was tired all the time. How many children did you have? He was the seventh. Ok, that's a good face. That was my first reaction. Really? And she said, John, before that, I worked on the farm. I cooked breakfast, lunch and dinner for all the farmhands and my husband and the kids, and I worked on the farm and. And I did all this stuff, and then I got pregnant. How old were you when you got pregnant? Thirty nine. And tell me what the delivery was like. I was long labor, and there was a lot of a lot of pushing, right, so when when you're holding on to something with your hands and you're pushing, you're putting a lot of strain on your neck. And.

Carolyn : [00:21:49] I did a reflexes. And she had a really simple cervical trauma fibro for 18 years. Because of the way she delivered the baby. Mm hmm. And then when her son was, maybe she was thirty two. When her son was seven, I asked her when her son was seven, she took the child and she left the other six children and her husband. And I said, Was he abusive? Oh yeah. And she detailed some of that. So she left with the kid, and now he's grown and she's got body pain, fatigue, all the neuroendocrine stuff of fibromyalgia. So I ran 40 and 10 on her. All I had to do was a reflexes and 40 and 10. She's out of pain, ran it for an hour, run concussion and Vagus. The next night she came back and we ran it again. And then she left for two days, and she had to she came back on Sunday for show and tell, and she came back and she said, I, I miss the train or I was late for the train, so I ran the last two blocks. Scuse me. Around the last two, LOX, she had no body pain. She lived with this pardon my French, this book

diagnosis for 18 years. All you know. Nobody knows where it comes from. And she's so I have a picture of her in leggings and a red top and a blond hair basically doing kick ups. And that's

Kim: [00:23:45] Yeah.

Carolyn : [00:23:46] So if you if you let her get away with the diagnosis and you don't do the history. When did it start? What? Just what are the symptoms?

Kim: [00:23:59] Yeah, it's really important. It's funny. I had two patients in the last 10 days that came to me with here's air quotes, frozen knees. Frozen knees. So just like frozen shoulder, now we get to slap frozen knee as something

Carolyn : [00:24:22] That's new

Kim: [00:24:24] To patients in 11 days. Yeah.

Carolyn : [00:24:26] So one was a replacement.

Kim: [00:24:30] No, this is just frozen knee. Someone can't bend their knee. Wow. So one patient is an existing patient. Yeah. And so when she had come to see me for some back pain, which turned out to be what you would expect in a 60, some odd year old back, some degeneration. Some stenosis. Nothing. Nothing we can't handle. Nothing scary whatsoever, but did have a lot of limited knee flexion that someone slapped osteoarthritis on.

Carolyn : [00:25:05] It's like we can get your knee osteoarthritis on it without an x ray and MRI.

Kim: [00:25:12] Yeah, I believe I believe the x rays were fine. So anyways, long story short, got some more imaging of the back showed some stenosis to this generation. Ok, we can work with this no big deal. And then came back and said, Yeah, now I have frozen knees and I saw the report or the referral from the doctor to the PTC with frozen knee like written down. I'm like, You've got to be kidding me. So I see here in the comments. At least part of the syndrome thing and labeling itself is a symptom of a

health care system that speaking as a primary care physician makes the sort of behavior, the path of least resistance and even possible in the world of 15 minute visits. Not to justify this behavior, but if we don't call out the system, we won't be able to fix it. Thanks for pointing this out. So thanks for that comment that we just got, but it's it can be it can be debilitating if somebody gets labeled with something. I get it. People have to call, call it something. But why do we have to label something like frozen knees?

Carolyn : [00:26:23] Well, wait, somebody go look up. There is no I will bet you money. No, no ICD 10. Is there an ICD 10 diagnosis?

Kim: [00:26:36] I don't know. But I had to google this because, like I said, I got two cases in 10 days. So the existing patient, when she came in, I looked at it and I rolled my eyes and she started laughing and she's like, I know you get irritated with this kind of thing. And I said, Yes, I get really irritated because you came to see me for back pain, leg pain, and that's exactly what we're going to do. We're going to fix your back pain and we're going to get your knees moving, whether or not we slap a label such as frozen knees. And it doesn't change where we're at today. It doesn't change where we're going to be in two weeks or a month from now. So that's kind of where the word irritation is circulating this week. So, yeah, frozen needs. I didn't even think that was a thing until,

Carolyn : [00:27:23] Like I said, quite the diagnosis for frozen

Kim: [00:27:26] Knees. I don't know. I'd like I'd like to to see. But if you Google frozen knees, it's it's ridiculous. It's just knee immobility, not due to any specific cause.

Carolyn : [00:27:37] So it comes from space.

Kim: [00:27:40] It comes from space. But I think this is kind of this is exactly what irritate irritates me the most is when we get so caught up on on the the symptoms and the present right, where did it come from? That is what you always have to be asking ourselves as any kind of practitioner, let alone what we do, right? It's. I get that your back hurts. But again, where did it start? It's all about going way over here to find the cause.

Carolyn : [00:28:16] I got one. Yeah. If frozen frozen knees or lack of knee mobility? Yeah. Look at the neck, yeah, feel the tone in the. Our Dr. brothers, the quads, the calves and the hamstrings. Um, if you run eighty one, if they're all tight. You can't flex your knees because your quadriceps is so tight, are so tight. You run. Eighty one in ten. That all starts to smush, then, you know, it's coming from the neck. Now for the patients that are listening. Eighty one is the frequency for increasing secretions and 10 is the frequency for the spinal cord. So. I know from personal experience, I had a cervical 9 allopathy that made my left leg really stiff. And when we ran eighty one and 10, the stiffness went away. Then I got this autoimmune thing that interferes with GABA and eighty one and ten is how increasing secretions in the spinal cord were increasing descending inhibition of tone. Now this isn't spasticity like cerebral palsy. Although eighty one in ten works Versed cerebral palsy, but increasing descending inhibition is increasing GABA, we think. Because the tone just relaxes. Now, will it stay relaxed? Maybe, maybe not. You run it, the patient goes, Oh, I can bend my knee, did you do anything to the knee? No. What did you do? You relax the tone in the quadriceps and the hamstrings and the lower leg muscles that were preventing the knee from bending. Right? So where do you go from there? You work on their neck. My next step with a frozen knee patient would be an MRI of the cervical spine. Hmm. The physical exam that would justify or elucidate, you know, tease out what's up. What are her knee reflexes like? Are they really, really brisk? What are her upper reflexes like? Yeah, because stiff knees. Without any arthritis in the X Ray,

Kim: [00:30:53] Yeah, also went for a joint infusion because I sent her to somebody local here in California that I love, that does all sorts of injectable fun things. She's like, Yeah, these aren't too bad. I pulled some fluid, but she's fine. She just needs tracking and stability exercises. I love that. So here's the thing how can you call something frozen knees? Because what are your active passive and resisted tests so to patients when in their sixties with the history of stenosis and disc degeneration? Like you said, issues with the cervical spine actively hardly any range, but passively. Once I get her dorft, I can pull an extra 40 degrees of knee flexion. So how is that frozen knees? How is that frozen, if I can actually get it to move, but I'm not sure who did their tests didn't get her sedated enough. She's afraid to bend your knees.

Carolyn : [00:31:52] Another patient. Too much tone.

Kim: [00:31:55] Or exactly. Other patient, mid-twenties used to be a triathlete. Frozen knees.

Carolyn : [00:32:06] Oh, I'm sorry. That's just like. And how did you deal with that?

Kim: [00:32:12] Ok, so this is where like irritation, why? That's the theme of the last seven days. I'm like, You don't have frozen knees, you've got some tracking issues, you've got a little bit of conundrum, Alicia Patella going on. Nothing that we can't fix again. It's figuring out what stuck, what's resisted. What's weak, what's inhibited.

Carolyn : [00:32:33] Yes. How much of the muscle stuff do we fix by running 13 or removing adhesions between the nerve and the muscle? Right? The cerebellum is not going to let you move a muscle or joint when the nerve is adhered.

Kim: [00:32:53] That is a huge part, and I know we're really targeting that a lot more teaching the core, but that is the basis of every thought that I have when I have a patient that has a restriction. Um, yeah. Your cerebellum is not going to let you rip a nerve.

Carolyn : [00:33:10] Yeah. Not going to not going to do it. And the challenge that we have with being FSM practitioners is nobody else thinks about it because they can't do anything about it. So why would they think about it? Right. I think it's the muscle. And. It's not the muscle isn't weak, it's inhibited, the muscle isn't tight. The cerebellum has prevented it from moving. Because and then you tease out the history. Oh yeah, I fell in bruised or I had a what is that groin pull? That's my other favorite one. Yeah, yeah, yeah. One of the patients I have seen in the recent past, he's had five surgeries. To release scar tissue between the nerve and the fascial. And he wonders why his sciatic nerve is sort of tethered and scarred up nerves, but right where that incision is.

Kim: [00:34:25] Could there be a better transition then my next question here, because this is going to go perfectly, I'm going to just glance at my phone really quick because I had to take a screenshot. This came to us from a practitioner that was posted this on my Facebook page. I'll just read you the question out loud here, and then you can chime in because it goes exactly with what you were just saying. A patient with chronic fatigue tethered cord syndrome contacted me because she is interested in FSM to dissolve any

scar tissue from the surgery. She has had to release the tethered cord. She is worried that the surgery could result in adhesions and the need for more surgery. I do not know very much at all about her condition and have never met her, but wondered what protocols one would use in a case like this. What would be a frequency of the treatment B, and what duration would it need to be administered?

Carolyn : [00:35:24] You start now, and this is why we run concussion and Vagus on ourselves five nights a week, right? Yeah, so the I've seen. Tethered cord patients who are Ehlers-Danlos patients and. The way they're diagnosed with tethered cord. Is that's that's the first thing. That there. How was this diagnosed? All right. How big? I mean, I've seen patients with diagnosed tethered cord. They did. Mg yeah. And he had pain in his face, his neck range of motion, like he couldn't tip his head more than maybe 10 15 degrees in flexion. And when he did, it hurt in his sacrum and his tailbone, and it hurt up in his head, right? That was the first tethered cord patient I ever saw. And it's like it was three sessions. It was easy, right? But when there. There's. The last 3 tethered cord patients I've seen don't make any sense to me. There's one that has has been told by a physical therapist that she has. Cranial cervical COX C1 instability. How is this demonstrated? Well, they did this video x Ray. So. Ok. Did did they do flexion extension and upon side bending? No, no, they did. This video in this chiropractor tells me that my COX C1 is unstable. Ok. And then. And then we I I don't know how to handle this because they are so convinced that, well, they're terrified because the Vagus doesn't work. Mm hmm. And they're so convinced that these two physical therapists that they saw were correct. And they have tethered cord and they're unstable at the same time. Does that make sense to you?

Kim: [00:38:00] No.

Carolyn : [00:38:01] Ok. Because I'm asking because I don't know what to do with her. It's like she's it's I. I don't understand tethered cord, the ones I've treated that were truly tethered cord. And not hyper mobile, just truly tethered cord 3 sessions. Like it's what we do in the core after you treat fibro. Right? Wrap around the neck talent of the feet. You have them sit up on the edge of the bed and then you have them. I don't ever start them with neck flexion because if if the dura is really adhered inside their skull, it's too hard on the frame and magnum. So I have them just start with trunk rotation, 5 10 degrees and trunk flexion. And when you ask them to flex their trunk, they flex from the

hips forward. It's like, no. Then I put my hand and write it just below the ribs and it's like, I want you to bend your spine.

Kim: [00:39:03] And what are you running?

Carolyn : [00:39:05] 13 and four. 40 3, right? And 13 and 10 you can flip back and forth.

Kim: [00:39:10] Do you normally start with the dura first?

Carolyn : [00:39:13] Yeah, I do, too. So scratching on the dura, scarring on the cord and you have them because the dura has rotary fibers as well as the straight up and down ones, right? And. Flecks at the trunk rotate. And then. Then they can start moving their neck. And when it feels tight, they stop. Yeah, go back to neutral. You wait a few minutes. The other way to treat them is laying down. And it's you see me do it in seminars, you just bend their knees. Yes. Guy that got hit in the neck with a hockey stick. And his knee flexion was 90, just 90 degrees, while the pelvis won't move because the dirt is a Teres, bend his knees and his head pops forward or his head pops back and it's like, Oh, your daughter should hear it? Mm hmm. So you're a cord flexion knee flexion and in 20 minutes is knees up to his chest. And yeah, that's yeah, I'm with you. There are patients where that is. Just like the diagnosis makes no sense.

Kim: [00:40:28] I challenge any patients out there who are listening, who have got anything that said that ends in syndrome. Ask your person who slapped you with this diagnosis to explain it to you, say, Well, what does that mean? Because sometimes that can make it easier when you when somebody comes to see me. Most of them are in a state of panic, like my chronic pain patients. Their. They've got this condition, they've had it for a long time, maybe they have new labels that are attached to it right now. And a lot of times it's just taking them off the ceiling for the first like 20 minutes like this is not new. This just means you can't move your knee and we'll figure out why that is

Carolyn : [00:41:12] The the other. The other thing that I say that seems to make a difference is. Nothing you have scares me. Yeah. There's they have this whole laundry list, and they're terrified. And you look them in the eye and say, Yeah, nothing you have scares me because. With using FSM, you have the ability to take it apart. Yes. So you look at this whole laundry list and you say, OK, that's 40 and 10. That's straightforward.

That's abdominal adhesions. That's a Vagus and that's abdominal. It's not that hard enough, and that's just Teres Ehlers-Danlos, right? Right. That's the one that they're Ehlers-Danlos patients just. I don't know how when I say, well, it's like, yeah, it's not that hard to fix, right? It will only last week, right, but here. You do the bait and score, and there are eight out of nine or seven out of nine or nine out of nine. And you look at their pain diagram and it's a 40 and 10 diagram. So you ran torn and broken in the connective tissue from Netter feet. You're an inflammation of the spinal cord from neck to feet. You run the vagal tone straight up vagal tone from neck to abdomen. And. Usually you have to treat irritable, irritable bowel, but if you take it apart into things that we can each treat, it's not that scary, right? Telling them, You don't scare me, I always scare doctors, I scare me. It's like, it's not my first rodeo. Have a seat.

Kim: [00:43:10] Yeah, I'm like that as well, I mean, yeah, there is a certain amount of, I guess confidence that comes after a little while, and I think that's one thing too. But I think we have to start preparing people who take the core like we talked about. We we talk a lot about the failures. We don't prepare people for the successes. We're also not preparing them for the big cases that come from space into your clinic because that is a real thing of getting the really complex patients. And sometimes it happens really fast after a week of training, or sometimes it happens a bit more. But yeah, I think there has to be a certain amount of confidence that you have as an FSM practitioner because you have this amazing tool belt that not a lot of practitioners I know of that. Do anything else have access to nobody?

Carolyn : [00:44:05] It's why they don't. They think, God bless my fascial therapists and physical therapists. They think it's the muscle because that's what they feel. And in our world, you feel a tight muscle in the I don't know about you, but the first thing I think of is eighty one and 10. Increase descending inhibition. And 40 and 396. Quiet down the nerve and the muscle goes much, right? Ok. That wasn't that hard. Now we have to figure out what irritated nerve in the first place, correct? And what is it that's interfering with descending inhibition? Right? But there's nobody else if you don't have a tool that lets you do that. There's nobody else that's going to think that way, right?

Kim: [00:44:54] I think a lot of us, if that is a whole other part of the FSM training is to you're reinventing yourself as a diagnostician because yeah, if you're in physical medicine, you think it's the muscle because that's all you know, how to feel, and that's

all, you know, how to treat. But again, you know, going back to I had ridiculously good training back in Canada in the nineties, and the people that trained me was never OK. Patient comes in and their shoulders sore. Look at the shoulder. It's like, OK, make a note that they have pain in their shoulder, but your job is to assess and figure out. Biomechanically, what's off,

Carolyn : [00:45:39] It doesn't come from space.

Kim: [00:45:40] It never comes from space

Carolyn : [00:45:42] And for the visceral medicine patients and practitioners out there. Mm-hmm. The thing that makes FSM practitioners different is irritable. Bowel is never irritable bowel. It doesn't come from space. I did functional medicine for probably eight, 10, 12 years before I discovered the fact that the vagus nerve controls T cells and macrophages. So. Treating irritable bowel, even inflammatory bowel disease when you're a functional medicine or medical provider. Takes a really long time, really restrictive diet age supplements twice a day. It's it's a real project, and for us, it's like, well, yes, so we treat your bowel. Get rid of the inflammation, the histamine, and we treat your vagus nerve. And irritable bowel is like two weeks. Not for years, just two weeks. So it's we have a tool that makes us think about diagnosis differently than other people. Yes, and the people that have just taken the core. Oh, should I apologize now I have to. The thing is that we we can't tell you this in the pain and injury or the neuro visceral. If you if you open up the whole. Thing all at once, you get scared to death. Yeah. So you have to start with the small steps and say, well, this is nerve pain, then I think you learn as much from your failures as you do your successes. Maybe more. Yeah, it's like, OK, that didn't work. And if you're lucky, the patient comes back and you get another shot at it. Right? And in between times, you rethink it.

Kim: [00:47:56] Right. And I think that's so another point to drive home why we start with the nerve, right? When I took the core, it was treat the nerve, treat the joint, treat the muscle like that was just like and I didn't think about why I did it. It's kind of like, if you're a Catholic and you just stand up, and I would say to my husband, Why are we standing up by this party? Like, Oh no, we're just standing up here. We just do it. We just treat the nurse first while you do it. But it makes sense why we do it, because what we were just talking about, cerebellum is not going to let you move if a nerve is stuck,

but also forget our diagnosis and forget our job. You want to get the patient out of pain. So 40 and 3 90, six and 13 and 3 ninety six is going to at least take pain down for the most part, if you're not getting anywhere with 10, with 40 and 10 or eighty one and 10.

Carolyn : [00:48:50] Well, the nice thing is you can treat both at once exactly somebody with nerve pain. Or even knee pain? Yeah, there, since the spinal cord is sensitized, thank you, Two-channel, whose fascial is coming back this year, I'm so excited. Yes, we can all love his life. It's a whole day of joy. Anyway, so spinal sensitization and central sensitization. But in order for you to touch somebody that has nerve pain or sciatica, the first thing you do is you set them up from neck to feet and you quiet the inflammation of the sensitization in the court while you're setting up the other machine that's going to treat the nerve. Right? And they say, What are you? What are you doing that thing for my neck, to my feet for? So I go, That's just a quiet down your spinal cord. Ok. And they they accept that.

Kim: [00:49:46] Totally.

Carolyn : [00:49:47] Yeah, it's like they don't believe. I'm not sure they believe you or know what that means, but you can explain it later after they're stoned.

Kim: [00:49:54] Yeah, yeah. Sometimes depending on the patient, I'll just say, Oh, this is just this machine is going to help me do something else over here. Like, Yeah, OK, yeah,

Carolyn : [00:50:04] In general,

Kim: [00:50:05] Yeah, you don't need to explain too much. It's so funny how our transitions from topic to topic just go so organically. It's just for those of you who are listening and watching. We really prepare zero. Like what you see is kind of what you get. So I jot down stuff with my pencil right before we come on and here we are. One of the things that I get questions about. I'm sure you do, too, is about some practice management stuff, how to incorporate into your practice. But I get a lot of questions about do you rent CustomCare's? And if you do, how much do you rent them? And I know you're rolling your eyes right now so that this you and I tend to agree on, I would

say, like ninety nine point three percent of things. This may be the one thing that we differ on quite a bit, and maybe I'll join your camp and a couple more failures.

Carolyn : [00:51:00] But TENS. Yeah. The month that I lost 3 CustomCare's one month in nineteen. 9 De. Notice when they first wasn't CustomCare's, it was actually the little Rehabil care unit that we had weren't that expensive. But the lady brought it in literally in a Ziploc bag. And she said I dropped it in the driveway, then I ran over it with the car. And then the next one came in two weeks later and the dog had chewed the end of it off. I have a puppy now and now I understand.

Kim: [00:51:49] Speaking of puppy minds in the room with me and she might bark.

Carolyn : [00:51:52] But hi honey. And it's like, if you can't, if they can't afford to buy it, they can't afford to replace it. So my approach has been. Only. Oh, only rent units that you can afford to lose. Right, right. Credit card deposit.

Kim: [00:52:15] Yeah.

Carolyn : [00:52:16] So that they have that they know and their practitioners that rent them, that have these great rental agreements, I don't rent them because I suck at that. Yeah. So I'll take your rental agreement and maybe I'll change my approach.

Kim: [00:52:32] I've had I've had multiple different approaches with it, so working from home has its perks because you get to hang out with your dog and all the fun stuff that comes with it. So I had I I love sending patients home with CustomCare's because I think it really helps my job when I see them the next time. So you have this awesome bridge of continuing treatment, so sometimes I will rent them, lend them, loan them a CustomCare because they need it. And I want to get that case closed and seven treatments in the clinic, as opposed to one hundred and seven if they didn't have this tool. So sometimes it's totally selfish. I'm like, Here, take this, rent it. Come back on Tuesday because I can't see them in between all that. Yeah, the other. So I have a funny story. I was in Canada practicing. There was a young college broke athlete that I had lovingly taken into the practice to help him, and he took the CustomCare. He was getting really great results. He had an out of country track meet that. He's like, Can I please take it with me on my track? Mean, like, yes, because I wanted to help him and I

wanted him to be the next Canadian Olympian. So I took it when I was track meet had a phenomenal track meet.

Kim: [00:54:04] I said, Make sure you come in and see me. When you're back, I'll take the CustomCare, I'll make sure your knee is holding up. He comes back. No CustomCare. Said word, the word, the CustomCare go. He's like the airline lost my luggage. Mike, the airline lost your luggage. That doesn't really happen that often, and why did you have it in your luggage and not your carry-on? He's like, yeah, I I just totally forgot. I'm like, OK, well, I had a phenomenal rental agreement in place and I said, OK, we'll give the airline a couple of days to maybe get the luggage back. Otherwise you put a claim in. I'll talk to your coach. I'll talk to the university. They'll have to make a claim. I'll have to let them know how much this cost. And he got all kind of nervous and weird, and he's like, Well, maybe they'll find it. So I went back and I looked at it as CustomCare agreement. I pulled that up. I pulled up the the file on the on the mode bank like on our software that we had. And I realized that it expired in one day the prescription. Wouldn't you know that the day after the machine expired, it magically appeared?

Carolyn : [00:55:23] I found the luggage. They found the luggage frantic day

Kim: [00:55:29] After the expiration. So clinicians out there who rent out your CustomCare's. There is a handy dandy expiration date when you program these devices, and it's really important because these machines are useless if there is no prescription on there. So sometimes you can get sloppy and you're in a hurry and you'll just program it to the year two thousand ninety nine. But that is a huge component, and in the in-between time, I told this young man, I said, Well, I'm going to have to charge your credit card because you didn't bring it back when you said you did, and when the airline reimburses you for the lost stuff, we'll figure it out. Then I tried to charge his credit card and he had canceled it. Because that's what you can do, so with patients that I don't know very well or I don't have a lot of they don't have a lot of street cred with me. And it will cost you a little bit more with your credit card billing, but I will charge them two thousand dollars and then reverse the charge when they bring it back. So but it's like you said, if people don't have two thousand dollars as a credit limit, I mean, you're it's this kind of here or there. I don't know.

Carolyn : [00:56:44] I would appreciate if you send me a copy of your rental agreement, that would I will.

Kim: [00:56:50] Yeah, it's

Carolyn : [00:56:51] Because so many of my patients come from out of town. Yeah, it's. And because. Seeing me cause, you know, one hundred and fifty or two hundred dollars an hour, then. And they see me for two or three hours at a time. It doesn't take its arithmetic, doesn't take a lot to figure out that it's less expensive to be able to treat yourself at home and see me once every three months. Right? How much it's already paid for itself. Right. And this the other reason that I. Make them invest in it is. It's important for especially for pain patients, athletes. It's a business expense that's easy, right? Yeah. But for pain patients, all of the literature shows that the patients do better when they have control over their pain. I want you to be able to get yourself out of pain any time you want. You don't need me. And this is all of the things that have been done to them are passive. It makes me crazy. A little crazy. Well, a little crazier than I am anyway. But it just every everybody goes to see somebody. I have to see my chiropractor twice a week. Why? Well, because my atlas slips out. Did he give you exercises? No. Oh, OK, so we can we can talk about that. I want you to be able to treat yourself and this gadget will do that. So then you do the supine cervical practicums you get there out as just sort of goes thunk when you treat torn and broken in the ligaments. Right? And it's algebra. I mean, it's not even algebra. It's arithmetic.

Kim: [00:59:00] It's straight up math. Yes.

Carolyn : [00:59:02] Yeah, do the math. So the rental agreement makes sense. Except. I want the patient to have some skin in the game. Yeah, and paying me to treat them, possibly. Doesn't. Doesn't get it.

Kim: [00:59:22] That's a really good point. With with my pro athletes, they want one like like 10 minutes into the conversation for the same reason they want to have the the kryptonite. You know, they want to have that magic wand should something happen and they know they are going to get injured, they're going to need it for recovery. When we start talking to patients about this, I had a couple of patients when I said, you know, maybe it makes more sense for you to buy a CustomCare and to see me once a month

for some maintenance. Why do you think I'm going to have this condition for the rest of my life? Why would I need this? Why can't you fix this? And I'm like,

Carolyn : [01:00:00] Oh, whoa, whoa,

Kim: [01:00:03] Stop, take a breath. This condition is easy to manage, but you will have something at some point like, we're all. Exposed to, you know, injuries, viruses, stress, digestive issues. Oh, I I didn't know it could do all that. I'm like, OK, so peel you off the ceiling and like,

Carolyn : [01:00:29] Then I told them, it's like, I treat myself every single night. Yes. Do what's the matter with you? It's like, Well, I'm seventy five. You aren't. Yeah, yeah, I am. And it's like concussion and emotional relax and balance. They said, Well, what's that about? It's like, Well, do you listen to the news? Oh yeah. Do you do you drive on the freeway? Oh, oh yeah, OK, that's that's trauma. I've got a question here. Yeah, let's get to the questions. Yeah. Becoming an FSM practitioner, can you tell me how much do you CustomCare's cost? Tried to email the company. The precision distributing doesn't publish prices. So until you're a practitioner, so if you if you take the course, then the price of the machines, they're not outrageous, they're what like two thousand.

Kim: [01:01:33] I think maybe a bit more, but around there? Yeah.

Carolyn : [01:01:36] And well, then you have the software that you buy once and then you can program forever. And the same lady, I'm looking into the abbasiya yet. No, no, no. It doesn't do FSM. You need two channels and the CustomCare is programable, and it allows you to create protocols and customize protocols for patients.

Kim: [01:02:07] And it comes with a fantastic mode bank to get you started like you don't. You're not stuck having to program stuff. So it has a lot of good things.

Carolyn : [01:02:17] I wanted this. I want that my patients having their hip replaced and then I just tell the story about I have I had my hip replaced and I didn't bruise. Excuse me. And I was walking upstairs with a reciprocal gate in eight days. No, and then so that usually takes care of that and then the post and the skin anti-ageing. I've had patients by a CustomCare just just for the anti-aging stuff.

Kim: [01:02:48] Yeah. The follow up question is what's the minimum training for the CustomCare? It's any of the devices are the same you don't need. The CustomCare doesn't have any less training than any of the other devices.

Carolyn : [01:03:01] Yeah, it's one of the three day modules pain and injury. If that's if that's what you see or do, if you're just going to train your, if you're just going to treat yourself. What are you interested in it and what do you have? It's. It's hard to say it's kind of like eating popcorn, it's hard to stop with just one, so you think you're going to just take the pain and injury and then the next weekend is the neuro visceral. And then there's a webinar and then there's the sports course and there's the sports course and then there's podcast and then there's an advanced and then it's just.

Kim: [01:03:44] It evolves, it evolves and evolves. Yeah. Are there any trained FSM therapists in Denmark, Linda would like to know

Carolyn : [01:03:53] Netherlands, where's Teddy? Teddy Versed, Becky, I think he's in the Netherlands and I think of, you know, Denmark, the Netherlands, that whole, you know, it's like the way we think of New England. There's a you throw a rock and you cross three state lines. Yeah, well, that's the way I think of my geography for that part of the world is not great. But Teddy, where's Becky? Is and is an M.D. and the first course I taught in Germany, we had one of the most difficult CGRP patients I've ever ever treated. And Teddy was brand new to FSM, but he's a pain specialist and an M.D.. With a good knowledge of neurology, and so the two of us just bonded over getting this patient out of pain in it took us 3 Practicums over two days. Yeah, but so Teddy is just the best. Ok, so he's my go to guy.

Kim: [01:05:02] Ok, I'm sure if you looked on the.

Carolyn : [01:05:06] Oh, oh, and Joanna Vanderbilt, oh of course, how could I think about. Yeah. John Causalgia boat is in the Netherlands as well. Yeah, yeah, Kevin can search, you can go on the FSM website, the international search is a little difficult because there's there's no zip codes and you just you click on View Advanced Search and you can view, OK, view advanced search options and then choose and then choose the country. There you go, how you find the ones name of this doctor.

Kim: [01:05:50] Yeah. So just go to advanced

Carolyn : [01:05:52] Advanced search options. And what was her name? Which one? The lady? Oh, Joanne. Oh yeah. Joanna Vanderbilt took the course a million years ago, and the MD is Teddy. Where's Becky and Leif? Was there a Zoom podcast last week? Absolutely. Was it recorded? Always. Is it available? Kevin puts them on the website under Frequency Specific Microcurrent website or on YouTube. Fax IgE website there on the website or on YouTube. Apple Podcasts, Apple Podcasts. We are everywhere. There were everywhere. It's which is why I put on makeup. Once I found out they're actually putting him on YouTube, it's like, No, no, no. Yes. Yes, yes.

Kim: [01:06:44] It's the fun part. People need to see us laughing. I missed the frequencies for PH. That was the first question.

Carolyn : [01:06:51] A while back, I call it six, 10 and four 50 in 24 years. I have never this. This protocol was developed in nineteen ninety seven ninety eight when Ryan was there. Right. Twenty four years. I've never memorized it.

Kim: [01:07:09] You don't need to. There's enough stuff in your beautiful big brain. You don't need room for that. That's why there's

Carolyn : [01:07:16] Six, 10 and four fifty four fifty six forty. And then after that, I lose it. So it's on the CustomCare. There's no circumstance under which it's on the AutoCare, it's on the CustomCare. There's no circumstance under which you would run this by hand. No, no. You just you could even put it on a Magnetic Converter. Yeah. And run it on that while you're doing other physical things. Yeah.

Kim: [01:07:44] All right, we are out of time already. It hasn't been an hour, it's been over an hour because we even start. We've been starting earlier and earlier and, you know, we just have so much fun.

Carolyn : [01:07:54] It is. I like the fact that it's unscripted and we just sort of. Come from one topic to another.

Kim: [01:08:04] I'm glad that you and I are having fun anyways, and it works for us because hopefully it's not too crazy to follow but keep everybody's questions coming so you can head over to FM 3 six 5. There's a whole landing page on there and you could pop your questions in. You just kind of join on to the list and send your questions to contact at Frequency Specific Microcurrent you could find us on. I think those are the two best ways to send your questions or even on Instagram. So it's FM Sports 3 six 5 is the handle on Instagram. If you put the questions up, too many places are too hard to gather them up, but I think we have so many great topics and questions and fun things ahead that we'll just keep doing it this way until we're told otherwise.

Carolyn : [01:08:53] Yeah, and we've said, what time did you start? I think you started about five, six, five or six minutes till

Kim: [01:09:01] Kevin and I got on a little bit early just to say hi to each other.

Carolyn : [01:09:05] Yeah, up on. It's like, I hope I will never see patients on Wednesday, but these these two people are here for five days in a row. Yeah, yeah.

Kim: [01:09:17] Anyway, you have to do it.

Carolyn : [01:09:19] There you go. I hear that it was pretty fun.

Kim: [01:09:22] Always fun. I love doing it. Yeah. Until next Wednesday,

Carolyn : [01:09:29] I can hardly wait.

Kim: [01:09:31] Me too. All right. Everybody, take care. Thanks. See you all next week.

Carolyn : [01:09:38] See you next week!

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