Episode Nine - When There's Not Pain

Carolyn McMakin, MA, DC & Kim Pittis, LCSP, (PHYS), MT

**this transcript is computer generated*

Kim: [00:00:04] Hi, everybody. And we're just waiting for. Dr. McMakin to join us, I hope everybody is doing great, it's the Kim show for the next minute or so. There were a lot of great questions that came in already, so I'm going to gather those up while we wait for the real star of the show to join us and. We can get started. I'll take care of Kevin's job if you're joining us and you already have questions, you can go ahead and pop those in the question and answer or the chat so we can see them as we go. We've got a lot of really cool things to talk about once again today. But if you have a question that you haven't submitted yet on the forms or through Facebook or through Instagram, or all those other ways that you've been submitting questions and there with this live go ahead and pop those in the Q&A and chat whenever you feel like it. And we typically try to look at it as we go to make sure everybody gets their questions answered. Hi. I think you're muted.

Dr. Carol: [00:01:18] There you go. Hardly ever. Go ahead and try.

Kim: [00:01:25] My I just did my little solo because I was talking to myself for a minute, so I just said to everybody, you know, ask your questions, do your thing.

Dr. Carol: [00:01:34] What? We have three minutes left. We were in the middle of another meeting. I also required two.

Kim: [00:01:40] Yes. Well, you're high in demand.

Dr. Carol: [00:01:45] Well, it's Wednesday is meeting day. Yes. 3 go. Yes. Oh, you got your nifty necklace on you too.

Kim: [00:01:54] It's my Scorpio necklace.

Dr. Carol: [00:01:56] Yay. And we're both blue today. What's up with that?

Kim: [00:02:00] Well, we have this thing, right?

Dr. Carol: [00:02:02] Yeah, well it's a thing. It's a mind-meld thing.

Kim: [00:02:07] Yeah, I love it. My list is exploding today.

Dr. Carol: [00:02:11] Oh, OK then.

Kim: [00:02:14] Ok. It was a busy week.

Dr. Carol: [00:02:16] Yeah, it just was.

Kim: [00:02:18] And I'm going to be selfish because I have a personal list that I need to discuss today.

Dr. Carol: [00:02:23] Ok.

Kim: [00:02:23] So it's all about me. It is my birthday. So it's all about me. Day today for your birthday. It is this very day. This day.

Dr. Carol: [00:02:32] Happy birthday. I'm so glad you were born.

Kim: [00:02:36] Thank you. I'm pretty glad I was born, too.

Dr. Carol: [00:02:38] And you just so you know, I'm terrible at birthdays, so I have to put it in the calendar. Otherwise like I.

Kim: [00:02:47] Yeah, I hear you. I have the exact same problem. So I had to put not only in the calendar, but an alarm with the calendar because sometimes I just like, yeah, go through it. So no, so it's all about me today. Ok, so you've had a good couple of days. You look rested and rejuvenated.

Dr. Carol: [00:03:10] Light suntan?

Kim: [00:03:11] Yes. Yeah.

Dr. Carol: [00:03:13] Yes. I came home to 50 degrees in pouring rain and wind. Yes. How was your rainstorm terrible?

Kim: [00:03:21] Half of my neighbor's tree collapsed into my backyard, so oops. It was crazy. My flight got canceled. And then the next one was canceled. And then I was rerouted and it was delayed. But I got home.

Dr. Carol: [00:03:38] Yay.

Kim: [00:03:39] Throughout the worst turbulence, I've ever had in my entire life.

Dr. Carol: [00:03:42] Oh my god.

Kim: [00:03:44] I was that person like hanging on to the back of my plane seat on the plane. Yeah.

Dr. Carol: [00:03:50] So, yeah, it's hard not to throw up

Kim: [00:03:53] Trying really hard not to throw up, wishing that my CustomCare wasn't above me, that I would have had it on to run like PTSD or something.

Dr. Carol: [00:04:01] Yeah, the worst one I've ever had was flying into Washington DC and about, I don't know, forty-five minutes out. We hit turbulence and you're still it. You're coming down. You're about twenty-five thousand feet. Got really bumpy. They still had our desktops down, my laptop was on my on the tray table in front of me. Yeah, we hit an air pocket that dropped us had to be ten thousand feet because my laptop floated off it, floated off the tray table. It floated. Then it went slamming down. The stewardesses said, put everything away. They strapped in. We were left to put our stuff away and we were on the ground in something like three minutes. It's kind of like the plane said to the tower, We're coming in now. That's crazy. Drop. And then another 5. She's like in a 747 737. Yak yak. Anyway, anyway, the list,

Kim: [00:05:25] So I want to start with something fun, OK? And then we're going to get into more serious stuff as we go. How about that? Ok, so I have really noticed in the last week we have a lot of patients listening and joining us on the podcast later. It feels like

our live audience is more practitioner based and then patients and laypeople and so on and so forth are listening to us later. So I want to make sure that they feel included because they're not the ones that are adding questions live as we go.

Dr. Carol: [00:06:00] Hi patients!

[00:06:00] Hi! So we started our first, our first podcast. I was asking you if you only had like five frequencies that you could use, what would they be? And we kind of struggled with that because there's a lot.

Dr. Carol: [00:06:17] Well, it's inflammation torn and broken. Stop bleeding like if you were on a desert island and Kate 5.

Kim: [00:06:26] So this is exactly my question. You were on a desert island, and I'm not going to make you choose frequency pairs. I'm going to let you choose programs that we have in our CustomCare mode bank. So I'm going to let you pick four of your top. So you have a CustomCare, you know, you're going to an island you can't reprogram on the fly, what for are you choosing?

Dr. Carol: [00:06:53] I wouldn't go to the island.

Kim: [00:06:57] That's like when I ask my kids, you know, like you have 3 magic wishes, but are they? Well, to wish for our wishes like, you can't say that. Ok, so

Dr. Carol: [00:07:06] Probably concussion and Vagus. Yeah, that one. But then you have to have plain concussion because there are times when you don't want to turn the Vagus on. So that's like difficult. It's a toss-up between acute soft tissue and wound healing. So if you could merge the two of those, that would be a thing. T1 and broken in the connective tissue, OK? And that's just a single frequency combination. That covers most ligaments, even tendons, ligaments, tendons, connective tissue. Yeah, if you're on a desert island, you really want to have acute fracture. Yep, that's when you don't want to be without. If you're on a desert island, you don't need emotional relax and balance because you know you got the ocean, you got the sun.

Kim: [00:08:13] It's just the stress of, you know, that wild animals and not being rescued. And but you have concussion and Vagus for that.

Dr. Carol: [00:08:21] Yeah, exactly. And. Is that for?

Kim: [00:08:26] I think that's probably six. But what if, OK, let's change. Let's change the dynamic on a desert island, but you're not deserted. There is. Many people.

Dr. Carol: [00:08:45] So you're supposed to take care of many people, maybe.

Kim: [00:08:49] Hmm. I'm just trying to throw one of my other favorites at you, which would be immune support or our cold flu-like our virus stuff?

Dr. Carol: [00:09:00] Yeah, yeah. Cold and flu, for sure. Yeah. I would go with that. Yeah, you win.

Kim: [00:09:08] Ok? No, no. It's not about winning. So the reason why I'm going with this is I've seemed to have been like setting up a lot of patients on CustomCare's lately. And what I do is that practitioner is when I have a patient that's come in to see me for a long time, I take it for granted that they know how to use a CustomCare because they've rented it from me before or I've gifted it over a weekend. But when they purchase one and they have their own, it seems that I need to go through a whole new set of counseling with them because sometimes they go from having 3 programs or 5 to OK, I'm going to give you 20 because this is yours. So I guess the other where I want to kind of go with the programing is when you have a new patient that comes to see you and decides to purchase a CustomCare, how many programs do you give them right off the bat

Dr. Carol: [00:10:07] When they first come in and they purchase the CustomCare? Yeah, they only going to. I own the prescription, so I've set it to out date in a month or two, right? And they get five to 10 that are immediately useful for their particular, can get conditions right, and they graduate from care and they're either moving to another country or I know I'm not going to be seeing them for a year. Yeah, I'll put thirty-five or forty on there and I have an Excel sheet that has direct where I've written directions. So for all of the programs that I use routinely, like, there's 50 or 60 of them. I read the

directions use this protocol. When so for post-operative, hip, post-operative, whatever fracture wound healing, skin anti-aging. Extremity joint, joint pain, neck pain, neck pain in low back pain are different because neck pain, you have a spinal cord in low back pain, there's no court, there's just nerves and facets and discs asthma. Liver support. Kidney support. So they will get shingles. Everybody leaves with shingles on their unit, everybody leaves with fracture because when somebody breaks the bone, you can't you don't want it on them within four hours of the time of the fracture. So that has to be on there. A general post like a post-op hip, it can sort of generalize to any post-operative limb. Knee is a little bit different. Shoulder is a little bit different, but the tissues, in general, are similar. But one post-op sequence on there?

Kim: [00:12:18] Yeah.

Dr. Carol: [00:12:19] Everybody gets wound healing. Everybody gets skin anti-aging. Everybody gets shingles. Everybody gets. Sunburn. Hmm. Everybody that lives in Australia or Germany gets hangover. Which we just did a meeting with a software designer who is in Australia, and he was looking at our mode bank and he said, Do you have a protocol for hangover? And it's like, Yeah, that protocol was designed. It was written in Australia on the last day of our 5-day core because the night of the fourth day, we had a big banquet and karaoke night. Oh, fun. And there were two. There was one girl that was so hungover she was not. You know how you can't lift your head up and the room is spinning and you're nauseated and you have a headache and right. So we ran liver support because the girl next to her was a naturopath. And of course, it's her liver that Peter had immediately to the restroom. And so she came back, it's like, Well, that didn't work. It's like, well, the same. It's actually the same thing as with chemotherapy. Chemotherapy makes you nauseated because the effect of the toxins on the Medulla and the midbrain right, it does nothing to do with your stomach and the same thing with a hangover. The toxins created by the alcohol metabolism affect your brain, not your stomach. Right? So we ran the 3 frequencies for toxicity, combined with the Medulla 3 frequencies for toxicity, combined with the midbrain. And she was asleep in 10 minutes and when she woke up at the 30-minute mark, it's all better.

Kim: [00:14:09] That's crazy. So it makes sense, right? And maybe you could even like, infuse the water and then you could hydrate them at the same time because hangover patients hangovers are your dehydrated, for sure. So interesting.

Dr. Carol: [00:14:23] So that's so it really depends when we send practitioners when we send patients who are military people who go to places where they can't tell you where they're going and they're doing things where they can't tell you what they're doing. Yeah, they have fractures, soft tissue injury, concussion, concussion in the different brain parts. Wound healing, acute laceration fracture. All of the sorts of things. And then we know we're not going to see them again. Yeah, they pack it and take it in their go-bag. Right. So you. Customize what you send them out with, but all once I know they're off on their own and I'll put 30 or 40, but I send it with an instruction sheet that where in the instruction line it tells them what it's for. When do you use it? How long do you use it? Where to put the pads? All that stuff is included in that. Is that what you meant?

Kim: [00:15:31] Yeah, for sure. I think that's helpful for our practitioners that are listening because it can be overwhelming setting a device up for a patient. There's so many options and it's overwhelming for us as practitioners sometimes to set them up, and it's overwhelming for the patient if they're not used to using a CustomCare if you give them something with 40 5 protocols right off the bat. They're going to get overwhelmed and it's going to end up in the back of their closet. So I think you said it right. If you if that patient is somebody that comes to see you regularly, give them 5 10 to start off with as they're getting more and more savvy and they realize what to use and when then give them a couple options. But yeah, if you have a patient that you know you're not going to see for me, for my athletes, I get all the devices back in whatever off-season they are. I set up a Zoom call and make sure that I'm doing all the tweaking that I need to and I give it to them for the year. So it'd be the same thing. You want a ton the acute soft tissue fracture. Those are so important that they have that like emergency first aid kit pretty much ready to go. Those protocols I've never really had to tweak. You don't have to pull anything out. Everything that is on that software is perfect. So you leave that alone. And then, yeah, the immune support, you know, the virus stuff, like you said, like those things, I tend to.

Dr. Carol: [00:16:58] Well, then I modified we had common cold sinus and common cold throat. And what I found was when you do common cold sinus, it Typekit chases it down to the throat. So I just made I combined them and did Common Cold Combo, and that's in the new software, but it's a user program that I created. The other thing is for the average patient. Subacute facet and subacute disc is what we get. There's hardly

ever a time when you need to stop bleeding and right, the average patient is, yeah, it's that disc thing like I lifted something and it's acute on chronic. Yes, that's what we've named week one to week four or subacute. And that's mostly. I don't I can't remember the last time I put chronic disk or chronic Bessette.

Kim: [00:18:00] Thank you.

Dr. Carol: [00:18:01] It's always acute on chronic. Yeah, because chronic, yeah,

Kim: [00:18:07] Chronic to me in that scenario is almost asymptomatic, right? When they're coming to see you there, there's a; it's flared up, right? Something that's chronic is actively causing pain and symptoms. Yes, good, so we have all the software stuff that I wanted to talk about. Moving right along and we kind of are segueing organically as we typically always do. So we're talking about something as a chronic condition maybe doesn't have pain. So that's why we're treating things in that subacute program. But let's talk about when there's not pain, because the last seven podcasts that we've done, we talk a lot about when there's pain, and that's typically when patients come to see you because there's pain, unless there's not pain. And pain is, as you know, it's subjective. When I think of my athletes, my firefighters, my law enforcement, even certain personality types, they are not going to admit something hurts them to the level that they feel. And granted, everybody's pain tolerances are different. So I think it's important that we talk about using other kind of measures as opposed to a pain scale to measure progress.

Dr. Carol: [00:19:34] When I send a new patient paperwork, I always send them neck and lower back Oswestry, which or TAOS, you can do S1 and that measures function.

Kim: [00:19:46] Yes.

Dr. Carol: [00:19:47] And that's the thing. The other thing that I do is when a fireman football player, a professional athlete, even former. Firemen, policemen, athletes, their pain score is if they tell you it's a four, it's a six if they tell you it's a 5, it's a seven and it's not that they're lying, it's that they suppressed the part of their brain that suppresses pain works so well. Um, that you just in my head, I know that it's different. So the other way to approach that is, so what are you having trouble doing?

Kim: [00:20:38] Yes.

Dr. Carol: [00:20:39] Right. So that's a verbal Oswestry. Yeah. S1 quantifies it and you have a number. Yeah. But what are you? What are your treatment goals? What do you want to be able to do? I want to be able to put my shoes on. Ok. That gives you an idea of where they are. Yeah. And. The hard one for me is where the physical doesn't match. The. The physical exam, the physical findings, reflexes, sensation, range of motion, muscle strength doesn't match what the patient. Reports. The patient has. The normal reflexes, normal sensation, appropriate range of motion, but she's somehow convinced that she's got a tethered cord or upper cervical instability, and she can or arms are so weak that she can't cut vegetables. That's where I have trouble, and I think that's pretty rare. I don't run into that very often, right? So I'm going to leave that one out. Ok. Extreme. Yeah.

Kim: [00:22:04] Right. Um. One thing that I've encountered with that kind of demographic that we talked about athletes, firefighters, police officers, paramedics, certain CEOs, kind of they all kind of fall into the same sort of phylum of I'll deal with the pain later. I have a job to do. I'll even put moms into that category. So like I said, there's certain people that and when you say, Well, OK, nothing's hurting, what can I help you with? Why are you here? What do you want to get back to doing, whether it's an activity putting their coat on? And then you start treating them and then. I will hear time and time again. I didn't realize what it is like to be out of pain or I didn't. I just got so used to that feeling or not moving. I thought that was normal.

Dr. Carol: [00:23:06] Yes, exactly.

Kim: [00:23:09] Yeah, and then sometimes you have a pretty substantial emotional kind of fallout after because either they get mad for the time that they lost or so on and so forth. So I think it's important and this is going to segue into one of my other comments that we got is your intake has to change and it has to expand and multiply and grow because I think we're you're going to start dealing with more and more, whether it's functional biomechanics, whether it's taking their complete history, because what did we hear over the weekend? The mystery is in the history.

Dr. Carol: [00:23:57] Well, it's the other thing that I found is I do. I have a fairly simple intake sheet than I do. I actually don't read it. Then I do a verbal history, but I ask patients now to do a linear. Dated history, so the patient had this happen in 1989, and then this happened in 1991 and then 1993 auto accident. And then all of the other things that the patient's current complaint. Falls out after the 1993 auto accident, I took the patient to the 1993 auto accident, she said. Well, if we talk about that, we won't have time to talk about all the other things. And I said, Well, all the other things didn't happen. Until the 1993 things, so let's go back to where it started, so the dated history, that's the place to start. Yes. And then. So where did it start and then; then things fall out into all of this is vagal dysfunction and all of this the anxiety, the depression, the fatigue, just dizziness. Well, does the room spin? No, I just don't know where I am in space. You have a Versed. So this was my first Zoom patient. You have a Vestibular injury or what? Tell me how you were hit. In that accident, it was a 40 mile an hour head-on collision, followed by a side impact, and my head was turned.

Dr. Carol: [00:25:51] And she is exhausted, she has trouble reading, she doesn't know where she is in space, so her first. Her before she even sees me, she's going to an FCOVD optometrist. And I have questionnaires now for the River Meade head injury questionnaire and the Brain Injury Visual System Symptoms questionnaire, so I have different questionnaires based on the patient's symptoms and complaints. And then so going back to what you said. You do the intake history you treat X. And the second visit. Most of X is gone, right? Right, if you guessed right. Mm hmm. And then then there's why. So now my neck is fine, but my mid-back and my shoulder bother me. Of course, they do. Not a problem. And then you fix the shoulder and then next time they come back, it's their chest or their low back. So each time they see you. There's a subjective part of your notes and each visit, there's 10 to 15 minutes dedicated to. So when did this start bothering you, right? And the emotional component, you're absolutely correct, especially fibromyalgia patients or abdominal adhesion patients that have had 3 surgeries they didn't need in the first place. And you there's a. A predictable pattern of emotional response. There's. Um, anger. Which they feel guilty about, so you're treating anger and resentment at the same time.

Dr. Carol: [00:27:56] And that is layered under that is grief for what they've lost. But the first stage is anger at the people that couldn't help them. Anger at themselves, sometimes for having gotten into this mess and saying yes to the 3 surgeries they didn't

need. Yeah, and resentment because nobody understands them and nobody. Nobody could help them and then grief because I lost 17 years of my life, right, so because of my background. And this is for practitioners as well as patients. It's the only way I keep my sanity treating the patients that I treat, right? It's like, OK, everything. That comes into your life, has a gift. There is something you are supposed to learn, it doesn't mean it's convenient, doesn't mean it's comfortable, but it teaches you something. Yeah. So because you have had this hip, knee fibromyalgia, chronic fatigue because you've had this for. 15, 17 years. You learn something, right? And they look at you like you're from Mars, it's like, what are you talking about? It's like, Well, you learned that the world will not come to an end if you don't take out the trash. Well, yeah. And you learn to accept help from your husband, partner, kids, friends. Well, yeah. Did you know that before? No, would you have learned that if it wasn't for this? Oh. No, I guess not. I see now, if we're lucky, you get to keep and you have more empathy.

Dr. Carol: [00:29:56] How do you feel when you see someone walking with a limp going down the street? How do you feel when you see someone leaning up against a building to rest? You feel differently than you would have felt 15, 20 years ago, right? Oh yeah. I just; I feel sorry for him. Yeah. Whereas before you might have been a little, you know, buck up. Butto. And so now if we're lucky. You get to keep all the wisdom and get rid of the pain. Or the condition? And that's it's called reframing in my world, you just reframe it so they can see it from a different perspective, and it helps them through the emotional phase. So when we treat fibromyalgia patients? You treat them twice a week for four to six weeks, and then once every two to three for two to four weeks after that, and all of the fibromyalgia patients that stuck with treatment recovered in four months. A good portion of that for months was the emotional getting used to not being a patient. Getting, getting, reconditioned, and getting. Caught up to where their bodies are in the recovery process. Mm hmm. But there's I mean, the challenge with FSM is we change things so fast. It's there's no analogy to it in medicine.

Kim: [00:31:34] No, right, no, it's true. One of the. To stay on this for a little while, one of the comments I got from a practitioner was all of the sudden, I feel not qualified to treat patients anymore.

Dr. Carol: [00:31:50] Oh, I'm sorry.

Kim: [00:31:51] Yeah. And I get that because you go from this before you take the course you go from, you have a very safe scope of practice, right? And you know that you touch muscle and you stretch muscle and you strengthen muscle or, you know, whatever it is. And then you take the core and you're thinking about Vestibular and abdominal things and digestion and chemotherapy and hangovers and chemical exposure. And you do. There's something very earthshaking after you take that core because you feel that you need to know more.

Dr. Carol: [00:32:34] It's intimidating.

Kim: [00:32:36] It can be. And this is the whole lake. You're welcome. And I'm so sorry because and I've always said like, I'd have all the training I've ever received. These courses have been the big pivotal ones because it forces you to research a bit more. Your intake goes from one page to four. So I'm going to just share what I've done a little bit with my practice, where if I had a new patient, I maybe have an hour and a half. I typically run my sessions seventy-five minutes, so I'd be like, Hey, new patient 90 minutes do my assessment, blah blah blah blah blah. I don't. You can't do that because there's so much history that you need. So I've changed. My new patients have to do a Zoom call with me first or verbal phone call that way because I don't have a background in pharmaceuticals. I don't have a background in functional medicine. I don't have a background in a lot of different things, but I need to know basics. So I feel like if you are like me and maybe are a bit of a slow learner or need some more time, or your practice is really busy and you don't have three hours for a new patient, do a new patient intake over the phone or a Zoom call. That way, you've got a couple of days to kind of sift through the information. I'm kind of like you. I like to see a linear chart and that was just learning the hard way of having a patient that I'll talk about in a minute. But I had to go back years and I wasted five appointments with her until I could be like, Hey, why am I failing? Scrap it? Go back to the beginning. What did I miss? What surgery did you have? What reaction? What illness? So if you need time to look up medication and side effects, you mean you're very lucky you have a background in pharmaceuticals. So you know certain at least classes that could cause certain side effects. Majority of us, especially in physical medicine, we don't, you know, so that

Dr. Carol: [00:34:45] There's no reason you should.

Kim: [00:34:47] I mean, no, but like so I said, if you do, I mean, you're if you and I are screening the same new patient, you could be like, Oh, they were on gabapentin. So this could have this and this could have that or this is why they were prescribed that me. I'd have to write it down. Look it up. Ok, this is what's happening. So I used to think I don't have time to do these Zoom calls, but it actually turned out to be a big time-saver so that when they are in the clinic with me, I have a better foundation to start from because I have a better history, so I get it. You feel like you're not qualified anymore, but you. Another thing I want to say, too, is you don't have to be an expert in all these branches, but I would advise you to find an expert in all these branches. So you and I were talking about Vestibular stuff. Yes, you should be able to screen for it, or at least to have enough information to identify where Vestibular could be in place. But that's not your job is to treat it.

Dr. Carol: [00:35:48] No. Well, in point of fact, we can't treat it, and the only reason I talk about it is that there's one frequency pair that Vestibular patients react to. That's the only reason I include it. But there are key phrases that make you identify. And that part's easy. All of medicine is pattern recognition, right? Just pattern recognition. So the patient says, I have a terrible time reading. I can't read and I have trouble using the computer or I have panic attacks. Those two phrases? One hundred percent of the time, our Vestibular one hundred percent, there's no. So then well, you think they are? So you send them that questionnaire. The other thing is that. Contrary to what people are, what we're hearing, like, I don't feel qualified, I don't have. Um. I don't get everything in the history, so the patient has low back pain. It's like, well, OK, they just they circle their low back and their hip and maybe the front of their thigh. Well, I've got these charts on the wall. Scleratomal pain, myofascial trigger points. And so I know that if they circle that, I'm looking at either of a set and I know that because the poster is on the wall and I put the posters on the wall. To pretend that it's so the patient can be educated in point of fact, it's so I don't forget that that pattern goes with that joint and that pattern goes with that muscle.

Dr. Carol: [00:37:44] So I put my hands on the patient and there's so they're left. Soe's lights up like a Christmas tree. You touch it and they flinch. It's like, OK, number one, the SOE's should never be that tender. So then you ask because it's no place in the history, and I don't ever ask anybody, did you ever had a kidney infection or kidney stone until I put my hands in there? So eyes and they jump. And then you say. Oh. Did

you ever have a kidney stone? Oh, yeah, in whatever year. Did you ever have a kidney infection? Well, no, I had a really bad bladder infection. So I didn't get that in the history, but I found it with my hands. And then you need to look at, OK, where did that? So as is never, ever, ever the problem, sir. For all of the SOE's people that are convinced it's the muscle, it's the ureter. And then once you find the ureter, then you're pretty sure that if you reach around the back and you feel the QLs, they're going to be like a brick.

Dr. Carol: [00:38:57] Why on earth would that particular muscle be a brick only on the left? Right? Ok, then you ask them, Did you ever fall flat on your back? Well, duh, right? Or did you ever have a kidney stone or kidney infection? So you don't always have to get it in the history, right? You find the muscle and then you ask, So the history physical is an organic process. And there's like I remember the French physical therapist that came and talked about thoracic outlet. He is in national health care. They have 30-minute appointments. And he had a patient that was scheduled for a thoracic outlet surgery. He got her completely recovered and either eight or 10 sessions, 30 minutes apiece. Treating disc nerve-muscle. 30 minutes. Wow. And one of the advantages to FSM is like, Don't be scared. Treat the obvious first. I mean, Kim Humira talk, talk a lot about zebras, but almost everything that walks into your office is going to be a pony or a horse. Right, right. Yeah. It looks like a horse. We talk about zebras because we get a lot of zebras, but most of the time you can do 80 percent of what walks in your office with what you learn in the core.

Kim: [00:40:30] Yeah, right. Yeah. I think the longer you practice, the more picky and, you know, spoiled you get because you get those crazy results and you want to replicate that with every appointment, with every treatment. I want a story. Tell quick about something that we were just sort of talking about with the history. I had a woman come to me and I wrote this as part of my certification, so I wrote this case report up and I put it in the sports course. Even though she wasn't an athlete, it's important to talk about this woman had low back pain kind of went lateral across the ilium, down the lateral leg, and then would go medial to the knee. She had this pain for she said substantially for four years, and she had seen it religiously two times a week for the past year and paid cash. Twice a week for an entire year. And I said, why did you stick with that so long? And she said, Well, I'm like, You must have had really good results. She said, no, it only maybe got 10 percent better, but he told me because I had it for so long, I had to keep coming.

Kim: [00:41:48] So when I hear, you know, low back, she was in her late fifties, early sixties would walk in, had a walker and or a cane. Had disk imaging that was pretty normal for that age group, so I started treating this was new. I was maybe one year into FSM at that point. So back then it was treat the nerve, treat the joint, treat the muscle right. So treating the core, treating the peripheral nerve would easily take pain down 50 percent. So that was easy. I could get muscles to soften and back then to I was really hell-bent on just using musculoskeletal frequencies because that's all I knew. You say it time and time again, you treat the muscle because that's all you know, how to treat. So I easily got her, I'd say, 50 percent out of pain within five treatments, but it was never sticking like she would feel great. And after a day or two, pain would jog back up again. But she was motivated because at least the pain went down 50 percent, so that was something already that she hadn't experienced

Dr. Carol: [00:43:02] Instead of 10 percent.

Kim: [00:43:04] Exactly. So I was treating the psoas in shame because that is all we know how to do right. And I had treated her for abdominal adhesions because I saw in her history that five and a half years ago, she had her gallbladder removed. Do you remember this story? This is when I think one of the first times actually called you or texted you. So I knew she had surgery, so I treated for abdominal adhesions. But the old school way, right? So I didn't treat any specific organ because why the heck would I? Because I've never treated a bile duct before or a small intestine or any of that. So even though my point is that even though I had the history, I knew she had her gallbladder out. I thought I treated that because I treated the abdominal adhesions from the surgery. But it wasn't until she started talking about this highly sensitive metal allergy that she has. And then I was looking she doesn't have anything on her like zero jewelry, she said. It's highly, highly sensitive. So then I'm looking at her MRI and her ultrasound, and you see this giant clip that's in her abdomen. And then that bird tells you she has an allergy to metal, and she has a giant clip in her gut, and the symptoms didn't start until 18 months after the surgery. So how that scar tissue could have presented over a year and two years and three years and four years.

Kim: [00:44:51] And yes, she's getting visceral manipulation. But was she treated for allergy? No. So this was cool. This was our sixth appointment. She already knew how

the frequencies felt. And then so it was sort of blinded I was running. I think this is what I texted you can you have phantom gallbladder pain because she doesn't have a gall bladder, but a clip where the gall bladder could be? So I actually ran allergy in the gallbladder first, even though she doesn't technically have one. And she said, Oh, I don't know what you're running, but that feels so good. It feels so warm. And I was like, No way. So then I had to get Netter out because I don't know my organ anatomy the way I know my musculoskeletal. So I'm OK. What else is over there? What else could be, you know, small bile ducts, like all everything that had attached, I ran allergy 9 and it got better. Like, like zero pain drop. The Walker dropped the cane. She bought a CustomCare because we would get her. I think about 10 days out total like zero pain and then it would start coming back. So a patient like this? Yeah, buying a CustomCare is probably the only solution. And then it came to the point where she would run this specialized program that we designed once every two weeks just to maintain everything. And it's been eight years and she's still pain-free.

Dr. Carol: [00:46:24] Yep, that's exactly that's you get extra points. I would throw chocolate if I could throw it through the air. There you go. It's there is, and there's no way to explain it until you experience it, right? I can. I talk about it. It's one of the things that makes the five-day course so awful and so intimidating and so wonderful at the same time because I put all that in so that you'll know that it's possible, but then it's kind of overwhelming. But on the other hand, if you leave it out, you don't know what's possible, so you won't even try it right. And I'm not going to make people. I have a personal prejudice about techniques that make you take 5 levels before they tell you all the secrets. Yeah. Like if the one core seminar was the only course you ever took, you can do 80 to eighty-five percent of what walks in the door. If you take the 5 de corps. Yeah, and you just have to watch it 20 times. So we've had practitioners that came to their first corps in 1998 and their last tour when she retired in two thousand eighteen. She took the corps every single year for 20 years. Yeah, and she said every single time she heard, she heard something new. I might have said something different. And certainly, the content has changed over time. Yeah, but yeah, it just, you think a whole different way.

Kim: [00:48:17] I think the greatest shift from the way it's taught now is the prompting to critically think what is wrong and where is it happening? But how did it get there and what else is around it? So it's not just that recipe list. So I think that's been the biggest

shift, probably in the last, maybe five, three years that I've been teaching. It is. And again, you don't have to know the answer, but just enough to start posing the questions like, I have no shame in opening up my Netter and going, I just need to take a look at what is here. You don't need to know where the small bile duct is because you have a book that can show you that you just have to have enough bandwidth to pose the question, you know, and to start thinking. And again, with that patient that I was treating abdominal adhesions, I can do visceral manipulation. But it wasn't. Why is it scarred? Why is there scarring in the gut? Why had surgery? Now there's more to it than that. It's because the allergy reaction like. This is no bigger than just something being glued. What do you like for out for abdominal adhesions? What frequencies do you go with?

Dr. Carol: [00:49:42] It's really interesting to the, you know, you have Netter in front of you and you have and you have your fingers. So you. 13 and 77, the adhesion itself is scarring in the connective tissue, and in that one rat, well, 3 rats, it just liquefied the adhesions between the bowel and the peritoneum. So 13 and 77 is where I start. Yeah, but then for the patients? Because back in the day between 97 and 2002, I worked with an OBGYN that would let me sit in or come in on my patient surgeries with her. She would send me patients so I know in my own surgeries like, OK, this is weird. I don't want to creep anybody out, but they were going to take out an eight-centimeter fibroid off my uterus. And I did not trust to male surgeons and an anesthesiologist to leave my female organs in, even though he promised he would. There's that little thing in the consent that says, OK, if you really have to, yes, you can take it out. It's like, I didn't know. So I made them give me an epidural and leave me awake. Ok. Yes. So once

Kim: [00:51:11] When you couldn't be a bigger rock star in my brain, you tell me

Dr. Carol: [00:51:14] This story, so so once my autonomic settled down after they got everything right, then the anesthesiologist said, I said, What are you guys doing down there? He said, Well, you want me to bring the mirrors. And I went, Oh yeah. So he brought the OB mirrors so you could look in the mirror and see what they're doing. And he there. So he said, OK, here's the catheter. There's your bladder, there's your uterus, there is your ovary. Now you see your sigmoid. This is your sigmoid colon. What's it doing? He said, well, it's attached to your left ovary. It is my sigmoid colon where it normally would be in the pelvic bowl over there, right? It was midline wrapped around my ovary, so he very carefully went in with scissors and he cut it loose. Clotted, right,

and he put the sigmoid back where it belongs. So and I had seen something similar, but not that. Overheard in a previous surgery, so now I'm palpitating this patient and I'm over in the pelvic brim where this sigmoid belongs. Well, by the time you get to the sigmoid, the colon is still pretty liquid. The descending colon should be, you know, about that big and it's squishy because there's still a bunch of water in the stool content, so you get down to where the sigmoid should be. And there's nothing there. And so I had the patient feel it's like, OK, feel this appearance, she's where the descending is.

Dr. Carol: [00:52:59] I feel that, OK, that squishy thing, she's very slender. That's squishy thing is your colon now feel down here. She puts her fingers there, and she said, There's nothing squishy there. I said, Yeah, go over medial. And until you find something squishy, it's like, What's it doing over there? He said it's adhered to your left ovary and the bladder. Oh, right. So the thing that FSM, the thing that we teach in the practicums is that soft touch. Relax your fingers, put your eyes and your brain at the end of your fingers. Get Netter and your. I didn't know anatomy until I spent literally five years, 10 hours a day. Eight to 15 patients a day with Netter open next to me, so you palpate it, you find the sigmoid what's it glued to? Well, what else is there? There's the ovary. Oh, there's the tube, there's the bladder. Oh, there's the uterus. And there's that, OK? And you start running the frequencies for scarring in the different organs and then you switch to the right side and it's the Cecum, the ascending colon, the ovary, the tube, the bladder. So the. Your palpation teaches you as much or more than the history. So your discovery of the metal allergy. We had a similar sort of thing in a patient that had a knee replacement and they could not get her to activate her quadriceps passively.

Dr. Carol: [00:54:53] The leg would straighten. She could not hurt, quadriceps would not engage. And it wasn't neurologic, we treated the nerve that wasn't it, and then there was this. Ok. What is it? So I was working with the PTA that was working on her, and I said, well. If you were the cerebellum. Would you let? And you're allergic to stainless steel. There's something ridiculous like. Seven. Forty-three percent of the population is allergic to chromium, which is the ingredient in stainless steel. What percentage? It's I looked it up one time. The number that sticks in my head and it could be wrong. As 40 3, it's 43. It's huge. Wow. 17 percent of the population is allergic to titanium surgical grade titanium alloy. So anyway, so we ran the frequency for metals allergy. In the bone marrow. And the bone and the curiosity metallic allergy, 16, metallic toxin, 16 in the bone, the bone marrow and the Perry system instantly 100 percent strength and in

contraction and the quadriceps she could strengthen or she could straighten the leg. Amazing. Well, the cerebellum let you drive a metal into the bone marrow to which you are allergic. No. No. But had I ever in my life done that before? No, no. Just like, oh, it made perfect sense once I figured it out because nothing else that should have worked right.

Kim: [00:56:51] So this is when we say necessity is the mother of all invention.

Dr. Carol: [00:56:56] Exactly right. Well, once you figure out that the frequencies always do exactly what they're described as doing right, and that took five years and about, I think, fifty thousand patient visits, different sessions at 90 patients a week, fifty-two weeks a year for five years, we did the math one time. Maybe it was, however, many, fifteen thousand, but it was a lot and it took that long for me to become convinced that the frequencies always do what they're alleged to do. Even when I don't expect it to work, right?

Kim: [00:57:32] Yeah. Yes. Because there's that. Yeah, there's that. When I get to some questions on here and make sure that everybody is taking care of before we do our sign-off. Now that you mentioned about Hangover, do you have any frequencies that you can use to counteract or prevent side effects of medications such as myalgia or body pain from taking Fosamax?

Dr. Carol: [00:57:58] Oh yeah, no. The short version is no, not that I've found because Fosamax is not a toxicity minute. That's a really good question. Fosamax is it's not a toxicity problem. It's a calcium handling problem and look up the mechanism of muscle pain or body pain from Fosamax. And the answer is to use a different drug. Because the newer versions of Fosamax have a lower side effect profile. They're more expensive, but they're less toxic. And the biggest problem with Fosamax, I just heard I can't remember who was lecturing me was Candace Elliott was lecturing me, and she said the research they've done is that the biggest problems with Fosamax happen when the patient has been on it longer than 10 years if they have the muscle pain or body pain. Straight off the bat within the first year, they need to take a different drug and they need to be willing. I think one of our roles is to empower patients to. Have a conversation with their doctor. Yeah, we listened to them because that's what tells us what to do. And. So I have the conversation with the patient, you need to go back to your doctor. And

sometimes I just google it side effects from, I don't know the side effects of every drug. Yeah. Side effects from. And go back to your doctor telling me you're having this muscle pain. And don't let him get you. Just give you flex rail or Advil for the muscle pain. Right? Ask him to put you on a different drug. I can do that. What if he gets mad at me? If he gets mad at me, he's mad at you. He's the wrong doctor. Find a different doctor. Yes, there are six different medications that now do what Fosamax? Does. Right? So it's OK to ask. He works for you. You pay him right. He gets paid because you go back to him. Right. And there's lots more fish in the sea. So if he does, you know? Yes.

Kim: [01:00:30] Good one next question how do you treat a knee that has no pain and no swelling, but very restricted range of motion? I've run your general treatment protocol page. Thirty-two of Module one and many of the Med technology knee protocols multiple times with little effect.

Dr. Carol: [01:00:48] And that's not what it is. It's like the standard protocols no pain, no swelling, but restricted range of motion. No one following what? Right. Following what restricted means, so it won't flex or extend. Look or extend. So for me, when the leg muscles are really, really tight, so the quads are so tight, the knee won't bend and the hamstrings are so tight, the knee won't extend the. This is really going to hurt your brain. The obvious answer is it comes from the neck. And it's eighty and 10. So there is a situation called loss of descending inhibition. So if you reach down and you, it's usually going. If it's only on one side, then it's a disposed, usually on the other side of the neck. There is a constant dial tone that comes down the spinal cord to the lower extremities and the body that says Don't increase tone, don't spasm. And if that dial tone is interrupted by a disc bulging and neck or thoracic spine. Then the lower extremity muscles increase tone. It's not spasticity. But its tone, so if you reach down and you feel that patient's leg. Feel the quadriceps, feel the hamstrings if they're really tight and they may be tied on both sides, right? No pain, no swelling, but the leg is really tight. Go up to the groin and the worst one that will be tender will be the pettiness and the adductor brevis.

Dr. Carol: [01:02:48] And then the hamstrings are tight, the quadriceps are tight. You put one contact around the neck, one contact round the feet and you run increased secretions in the spinal cord. And the pattern is the muscles soften up the front, the breakfast goes last. The abdominal sometimes will relax, then calf muscles and the

hamstrings go AST, so it goes up the front and then up the back, I don't know why. And then the patient, if what you describe is correct, it's not the knee. So then what is it? And. The. This. Observation about the about tone, its tone, it's tight. It's not spasticity, it's not cramping its tone. An increase in tone will prevent that knee to the knees, not painful. It doesn't, it's not the knee, OK? Obviously, since you've treated it six times. It's not the knee muscles move bones. Why are the muscles tight? There's no reason the hamstrings and the quadriceps should both be tight. Where is it coming from? Loss of descending inhibition, I don't spend enough time on it in the core, it's too 3 slides, maybe. And it has been magic. So that's Patricia. Try it, and I don't know anything about what's on the mind, except that the protocols are a few years old.

Kim: [01:04:39] Can I jump in? Go.

Dr. Carol: [01:04:43] I'm counting on it.

Kim: [01:04:45] So what you said, obviously to start, that would be my first go-to again, something I didn't want to think about right off the bat. But time and time again, it proves me wrong. So yeah, is this happening on boat? Is this a bilateral condition? When things are bilateral, you can bypass all your muscle testing peripheral stuff. You need to go right to the court or right to a disc that is coming from central nervous system. That is not a peripheral thing if it's happening on both sides. It's also not a peripheral thing if it's happening in both ranges. So if flexion is restricted and extension is restricted, that means again, that tone is abnormal. It's abnormally tight. This isn't an adhesion. This isn't one muscle that's scarred to another muscle. This is groups of muscles. These are families that are irritated. It's coming from the court. Number two, if it's happening just on one side, anything that is affecting the knee is being affected by the hip, which is being affected by the sacrum and the lower back and the end, the cord right and the ankle. I tend to go up first because more often than not, it is coming more from a pelvic spinal cord sort of situation, and it's easier to kind of rule out than going back down again. So, yeah, what range is in the restricted its quads or its hamstrings? Go up and do your hip assessment

Dr. Carol: [01:06:17] The other one scarring in the nerve? Yeah. If so, if the femoral plexus is adhered between the abductors and the quads, there's no earthly way that the cerebellum is going to let you bend that knee just isn't going to happen, right?

Kim: [01:06:32] And again, this is kind of going back to why we're changing. The way the core is being taught is because now this is a way of thinking this isn't protocol 124. This is what is happening because throwing, you know, I don't know what page, whatever is of whatever throwing like MFTP at it or whatever. You're cycling through a bunch of protocols where maybe only two minutes of that hour-long program is what they need. So bypass it, troubleshoot it. And it's so easy to write a line, whether it's 124 and 77, like torn and broken the connective tissue or just putting a one-liner on their CustomCare like scarring in the nerve, like you just said, because that's probably going to be the problem or something with the cord. Yeah, we are out of time. You know, fine because it's all about me today.

Dr. Carol: [01:07:28] Could we get? Well, it didn't seem like it's like, did we get everything off your list except for, Happy Birthday,

Kim: [01:07:35] My list is never all scratched off. It just kind of goes over to the next week. But yes, we got through all the main things. I think we got the questions answered. The only thing people are asking about is Arizona for our next advanced course and I can't every year. I'm like, I can't wait for it, but I really can't wait for Arizona this year, so

Dr. Carol: [01:08:00] I am so excited. That's what I did yesterday was I got the Arizona schedule then. Yeah, and it's worth three days this year because it's the best part about the symposium. One of the best parts besides Jim Oshman and our special speakers is the case reports. So we have effectively two days of advanced David Musnick you and I'm so excited. Shirley Hartman holds the record. She took the core when it was two days in 1998 or '99. She got lost on the way between the airport and NCNM, so she didn't get there till ten o'clock and we started at 9. She came in Sunday with the entire core laminate memorized. So freaky, right? Yeah. Her lectures at the advanced over the years have been Channel A frequencies you never thought of running. So we'd be having a case presentation and Shirley would say, Well, why don't you run 139 prolapse? I said That's a frequency. Well, yeah, it's Channel A. It's right there. So Shirley Hartman has. When I first met her in 98, she had beat Sarcomere, she had Sarcomere in her left shoulder. So she beat that and with just a simple surgery, she avoided all the other bad things.

Dr. Carol: [01:09:49] Two years ago, maybe three, two years ago. Anyway, she got pancreatic cancer. And then. She could get stage four pancreatic cancer. With metastasis to right. Shirley, did all of the alternative stuff, vitamin SIBO and all of the things she's going to tell us about. She did FSM, she did chemotherapy, but she argued with her oncologist and did her own literature search. This chemotherapy has the best outcomes in this particular kind of tumor, so we're going to negotiate and. Long story short, she ended up the tumor was big enough that she had a Whipple, which is completely rerouting your digestive system to remove your pancreas. She has zero. Zero circulating tumor cells and Shirley Hartman is going. I got goosebumps. I've been holding my breath for the last two years waiting to know what happened to Shirley. Shirley Hartman is going to do 90 minutes, hon. The combination of conventional medical treatment. Alternative medical treatment and FSM and the treatment of cancer, and she's going to tell us how she survived and there is a blood test that you can do on yourself for circulating tumor markers that will show tumor markers for years before cancer ever shows up. Wow. So Shirley Hartman is 90 minutes.

Kim: [01:11:44] And you better not have anybody up against her.

Dr. Carol: [01:11:47] You better just go, No, no, no, no, no, no. These are combined tracks. John Rusedski is the PRISM optometrist, the FCOVD that treated treats my patients and me. I have Meniere's, so rescue is doing 90 minutes, and that will include a demo about I told him to bring his fake lenses and prism glasses so you can see the way they change my gait. Awesome, right? And then William Clearfield is coming from Reno, and he will lecture on the endocrinology effects of traumatic brain injuries. So people wonder, OK, I treated this patient for concussion and stroke, and why aren't they better? Because sometimes it's more than that. So these are sort of stable state lectures. And then Sunday is almost all case reports, except I'm trying to gather a panel of people that talk about how to how do you use Epsom in practice

Kim: [01:12:50] If you're not? A couple of years ago, I think it was valuable to have some different Cairo acupuncturists, MD, just to how to integrate it.

Dr. Carol: [01:12:58] And so it's really popular. So yes, Phoenix and we will do in-person and live stream. We've got our cameraman and Kevin will handle the live stream

part, and we have a cameraman from Phenix that will do B-roll and crowd shots and questions and answers. So I'm just so excited to be moving again and gathering the community. And Arizona has no limits right now on size, so we have the whole ballroom. We can have anyplace from one hundred to two hundred and fifty in that room. Yeah, and there are no vaccine requirements. You can do whatever you're comfortable with. Some people wear masks, some people don't. And those of you that can't travel, that are in Europe or in parts of the United States where you don't want to travel will do the it will be live-streamed people that will be doing virtual presentations. Ben Kapolei from Cincinnati Children's. Dave Burke. I think Laura Keiles, those will be prerecorded. We're not going to take a chance on Zooming them live. So some of most of them will be in-person, but some will be live. I'm just I can hardly wait for Phenix. I'm so excited.

Kim: [01:14:23] Me too. I'm going to add the sports course. The next live sports course is also during the advance. I think February 22 - 23. And then we have the new Sports Master's or Advanced Class, which is a one day following the sports course. So yeah, it's going to be the first time I know it's so exciting to gather.

Dr. Carol: [01:14:45] Yeah, get the family together again and I get the feed. Everybody, I'm Italian. That's like I got a feed

Kim: [01:14:52] And we love to eat. So it works for everybody. All right, we are out of turn out yet another fabulous Wednesday. Got it! All right. Bye, everybody. Talk to you soon.

Dr. Carol: [01:15:05] Love yeah.

Speaker3: [01:15:07] The Frequency Specific Microcurrent podcast has been produced by frequency specific seminars for entertainment, educational, and information purposes only. The information opinion provided in the podcast are not medical advice. Do not create any type of doctor-patient relationship and, unless expressly stated, do not reflect the opinions of its affiliates, subsidiaries, or sponsors or the hosts or any of the podcast guests or affiliated professional organizations. No person should act or refrain from acting on the basis of the content provided in any podcast without first seeking appropriate medical advice and counseling. No information provided in any

podcast should be used as a substitute for personalized medical advice and counseling. Fss expressly disclaims any and all liability relating to any actions taken or not taken based on or any contents of this podcast.