

## **Episode Eleven – Building FSM For The Future**

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**Kim Pittis:** [00:00:04] Hello. Hi.

**Kim Pittis:** [00:00:07] Happy Wednesday.

**Dr. Carol:** [00:00:09] Oh, you got the color code memo.

**Kim Pittis:** [00:00:13] Well, you know, black and gray and we just.

**Dr. Carol:** [00:00:16] What's not to like, right?

**Kim Pittis:** [00:00:17] You just go with that. Yes, it's kind of a weird day here in California. It's like the cool wind, but like the warm sun. So it's like,

**Dr. Carol:** [00:00:26] It's like autumn in Oregon. Warm while sun is warm if it wasn't fifty-one degrees outside. Right, right. Your idea of cool and our idea of cool slightly different.

**Kim Pittis:** [00:00:40] My idea is cool as a Canadian who has been transplanted to California and is all over the place.

**Dr. Carol:** [00:00:46] Yeah, like 27 is toasty.

**Kim Pittis:** [00:00:49] Yes. Not anymore.

**Dr. Carol:** [00:00:53] How was your rain last week? Didn't you guys get like dumped on?

**Kim Pittis:** [00:00:57] Yeah. My clinic bathroom ceiling caved in.

**Dr. Carol:** [00:01:02] No. And we're doing mold remediation as we

**Kim Pittis:** [00:01:07] Speak, as we speak. I should be back in there tomorrow or Friday.

**Dr. Carol:** [00:01:11] Oh my gosh. Did the ceiling came in, cave in from the floor above or from the roof

**Kim Pittis:** [00:01:18] Or I'm in this beautiful, historic building and my bathroom in the big treatment room is the old elevator shaft. Oh, so there's the square where the water just sits and we got all that dumpy rain and it just sat there. So when I opened up the clinic door last week, I was like, What's that smell? It smells like grandma's basement in Canada after like, look, I know this smell.

**Dr. Carol:** [00:01:50] Yes. And got a good smell.

**Kim Pittis:** [00:01:52] Not a good smell. And I opened up the door to the bathroom and the ceiling was literally just the plaster. So it

**Dr. Carol:** [00:01:59] Was good.

**Kim Pittis:** [00:02:00] Wasn't good? No, but it's OK. We'll survive. We'll get there. Yeah. What was your how was your week?

**Dr. Carol:** [00:02:08] It was really good I had interesting patients and the FSM clinic, maybe I should save that for when we're live or

**Kim Pittis:** [00:02:20] We're kind of live, but yeah,

**Dr. Carol:** [00:02:22] So the FSM clinic website launched well, it launched last week, but we announced it this morning. Oh, the emails like ten donations to buy computers and fund pro bono patient treatments? Yes. This Monday, what's today, Wednesday? This week, they're putting in floors, and that means next week my pilates reformer gets delivered. So excited. Yes, I know you're going to. You'll be there. We're saving advice. Yes. And they're putting they've put in the cabinets and I probably in two weeks, the countertops go in in the training area and the residents and interns study area. We have four desks, one of which belongs to probably Candace Elliott as our research coordinator. And then the other three are for practitioners in training. Yay.

**Kim Pittis:** [00:03:30] Oh, excited. I'm so excited. When is the official opening again?

**Dr. Carol:** [00:03:35] January, January 10th? And that's assuming, like next week, I found out that in order to have a business license in trouble, you have to have a phone number. So I, the first time I can meet with the guy who does phone numbers is next Wednesday. Got it. So he'll do phone numbers and internet, and then there's business license, and then there's software. But I have December off from seeing patients, so that's when I get everything done, I hope.

**Kim Pittis:** [00:04:11] Perfect. December's always been my slowest month.

**Dr. Carol:** [00:04:14] Yeah. Well, it's for me. It's been. It's December has been the month to have surgeries, right? So those that were could be put off. Yeah, we're put off to Thanksgiving week or now it's after San Francisco. No surgeries this year. That's the plan. Yep. And clinic-wise, when you're only seeing two or three patients a day, there is no slow month. They book out whenever they can. Yes. So it's pretty fun. And we have, still have, like today on the clinic website, there was a place do you want to be; sign up for training? We had 12, 12 people signed up. This Me looking at Kevin. 12 people sign up to be to be interns for training. Yeah. Reserve a spot. So we're it's pretty exciting. It's like it's really going to happen.

**Kim Pittis:** [00:05:19] It's really going to happen. And it's so overdue. Like, it's so great that it's you're able to do this right now because it's

**Dr. Carol:** [00:05:29] It makes me wonder about my sanity. But people have been asking for it literally since 1999. Yeah. So 20 years and but in '98 or '99, they started asking for a consumer book and it's like, No, that's not how it works. So if you write a consumer book first. You never have credibility. So first, you have to publish papers, so they were collected case reports, but we published, what, 10 papers? Yeah. And then the textbook came out, so it's published papers than the textbook. And then 10 years later, the resonance effect came out. And then after that, the training center has some validity. The next step is actually to have the word, some sort of university affiliation that gives it status or some sort of official designation. So right now, all you get is a plaque, we'll make it fancy, to put on your wall that says you've done a one-week, two-week, or four-week internship. And at the end of the two-week and the four-week training sessions, you don't know what we're going to call them yet. You'll have a paper ready to submit for publication. That's that is the endpoint. The two-week and the four-week

at the end of the two-week, you'll have the outline at the end of the four-week. It will be ready for submission. So on your CV, it is John Smith or Jane Doe, whatever your clinical degree is. And any place you've lectured, how long you've been in practice, and your published papers. And that's how you build a CV, and that's how you become credible and that's how FSM becomes credible. So we're doing it in order. My little Virgo self had to do it the right way.

**Kim Pittis:** [00:07:43] I didn't understand that until I have a daughter. That's a Virgo. And so now I get what you just said has to be in order has to be the right way. And you know, I think you've always been renowned for that, doing things the right way with safety and integrity. And I think that's what sets our FSM practitioners apart from so many different modalities out there is that we have a high standard.

**Dr. Carol:** [00:08:14] Yeah, it's not about the money. It's like you want to do something else, do something else you want to know.

**Kim Pittis:** [00:08:20] And once again, this is just such an organic Segway to some of the list of topics that I'd like to talk about today. So welcome everybody who's joining us live right now to our I don't know what number this is, I think number nine, 10,

**Dr. Carol:** [00:08:35] 11

**Kim Pittis:** [00:08:36] 11.

**Dr. Carol:** [00:08:37] Geez. Three months. That's no. No. Ok, fine.

**Kim Pittis:** [00:08:43] Fine. It's our 11th podcast. Welcome practitioners and patients and everybody else who ends up listening to the two of us go on and on and on about FSM and all the fun things that we get to do with it. So it was kind of a slow week for questions. So I'm not sure if we're doing such a fantastic job at explaining everything because normally when there's questions that tells us what we need to do a better job explaining or teaching.

**Dr. Carol:** [00:09:09] There was a comment on Facebook about something we said last week, and that is if you're treating the same thing over and over again, you're missing something. And I had to explain it's like, Well, it's that's true generally in musculoskeletal, yes. And where there's a stable state problem. Yes. So you're going to work on shoulder until the C-5-6-disc is fixed, right? Fixing repairing the C-5-6-disc, which irritates the Subscap Ulnar nerve and the subscapularis muscle. Fixing the C-5-6-disc is like fixing a sprained ankle. You have a sprained ankle in your neck that takes six weeks, so the patient sees you with even with musculoskeletal. It's twice a week for four to six weeks, and if you're done in three weeks, then you turn them loose and that makes you a hero. Yay. But if they expect twice a week for four to six weeks, you have a sprained ankle in your neck. It's going to take six weeks to heal, and that is only true if you don't do something. My language because I'm older than I can get away with it. My language is if you don't do something stupid, right? Right? Bending over to pick up 15 pounds of laundry when you have a C-5-6-disc, is stupid. It's not a good thing to do. Saying it's stupid is probably not correct, but it's going to hurt, hurt the disc. And so you're healing your six weeks starts from the time your arm or shoulder pain comes back and you do something silly, like lift 15 pounds of laundry in visceral conditions like asthma, SIBO gastroparesis.

**Dr. Carol:** [00:11:15] There's stable state issues that can be really complex, so. This. This issue. Let's just say SIBO started when you had a really bad throat infection, so SIBO and gastroparesis, let's pick that. You had a really bad throat infection when you were twenty-seven and now you're 40-five and you've got allergies and this digestive thing and your you bloat up and you've constipated all that stuff. All right. How do you get rid of SIBO and gastroparesis? Well, you treat the SIBO and the gastroparesis, but you have to get the Vagus to work. So you're 40-seven now at the age of twenty-seven? When did all this start? I don't know. I had a really bad flu and a sore throat that lasted for like two or three weeks. Ok. What is what turns off the Vagus? Infections, stress, and trauma. So at the age of twenty-seven, she had this really bad viral infection. And while she had the best viral infection, she and her husband split up. So there's infection and stress. And four weeks later, she broke her leg. Ok, then infections, stress, and trauma turned off the Vagus in order to fix the SIBO and gastroparesis 20 years down the road, she's already done the impossible diet for 10 years.

**Dr. Carol:** [00:12:52] That's not working and the naturopath says Just be patient, it'll work. Eventually in the MD loads on another anyway, so you go back. And you treat the Vagus for infection. How do you treat stress, concussion? Maybe PTSD, trauma? Maybe you have to go back and treat where the leg was broken and since the leg was broken in a certain place, she has this chronic tendon apathy in her ankle that you actually might not think is connected to the SIBO and gastroparesis. But if there are tissue fragments from the tendon empathy, how do you get the Vagus to turn back on? You treat the tender Naturopathic. What turns off the Vagus infection, stress, and trauma, so you treat vagal tone, but you add. All the viral frequencies, plus malignant virus, plus common cold virus. Blah blah blah strep staph, whatever. You treat the Vagus for the infection. You treat

the stress concussion protocol, PTSD, if it's still really obnoxious, maybe you don't have to. And then she says, Oh yeah, by the way, when we're done with my. Intestines, my right ankle, I have this tendency, not it's just the thing in my ankle. Thing in your ankle. And the major part of what I do, I don't know what you got you all do, but is educating patients. It's like the thing in your foot, the living tissue fragments are coming off that tendon that's actually related to your SIBO and gastroparesis.

**Dr. Carol:** [00:14:45] Get out. It is not. No, really. Truly it is. So that's so that's the. It's not one and done, as you would say, it's connected, especially in visceral condition. Same thing with asthma. Same thing with any autoimmune disease if you have any autoimmune condition. You don't have an autoimmune condition of the Vagus is off. So I saw a lady yesterday. Is it OK, if I keep talking because I'm okay, all right. So I saw a lady yesterday, her first visit. And she. She comes in and she's I'm glad you're sitting down already. All right. She said her husband recruited her as a patient and said, OK, I need to bring my wife to you. She has fibromyalgia. Ok, so she walks in and I have her new patient paperwork and there is no pain circled, little circle on the right side of her neck. And that's it. And then a little circle in between her shoulder blades. And her left eye point straight ahead and her right eye points about 50 degrees off to the right. And she reports that she's blind in her right eye because of a thing and then what she can see out of her left eye, so I make eye contact with her left eye, try and ignore the right one. And then she says, I've got. Irritable bowel, slow motility, it takes your stomach five to six hours to empty. Ok, so she's close to being diagnosed as gastroparesis, and her major complaint is that she's dizzy.

**Dr. Carol:** [00:16:51] And I said that's a good face. And I said, so when did you start being dizzy? Oh, about three years ago when I got a really bad



ear infection? Yeah. So I didn't it was so obvious from her symptoms that. Trouble going to sleep. Sleeps two hours at a time. Anxiety worse when it rains, can't read. She has got simpler stuff. Yeah. So I did put the tuning fork on the forehead and she heard it only in her left ear and then did the tuning fork side to side. And it was hyper-sensitive on the left. Couldn't hurt much on the right. And it's like, I don't know what tier is busted, but one of them is and I swear to you, they put her on antibiotics. She's got all this fluid in her ear. She's seen neurologists and t's. She's only got vision in one eye. And she lost her ears. So. And then she said and I said, why? He said you were coming in for fibromyalgia. What's that about? Oh, my left arm gets really painful. That's a good face. It's a 5. Your left arm gets painful when I don't know, just sometimes it gets really, really bad, but the right side of my neck hurts. My neck hurts pain in between the shoulder blades on the right. And oh, I know her diagnosis is, is snowflake esophagitis.

**Dr. Carol:** [00:18:43] That's the diagnosis and gastroparesis eosinophilic esophagitis. Most of you know what that is, but it's an immune system reaction in the esophagus. And it's like the only people I know that have Eosinophilic Esophagitis are gluten sensitive. We're trying to eliminate gluten. That's hard. No, actually, in Oregon, it's really, really, really easy. And no wheat, no corn, no milk. Well, already no corn of milk. But OK, we'll get serious about the wheat. So I said, Do you lift anything like, how did you? Do you lift does that make your arm hurt? I don't know if something random makes it hurt. We live on a 5-acre farm with chickens and I live 40 pounds. sacks of chicken feed. It's a good face, and so, OK, so the patient education part was number one, you cannot have fibromyalgia of the left arm twice a month that just after you live chicken feed, that's not fibromyalgia, right? Right. So there was that. So I treated the left arm and I did. Nobody had done a sensory exam. Nobody had touched her. She had no tender points. Sensation in C-6 and C-5 were gone. They were dull.

Nothing hypersensitive. So it's just these two nerve roots, hyperactive patella reflexes only on the left. So she has a broad-based central disk bulge at C-5-6. That's easy. Reflexes were normal. It was just sensory and in deep tendon reflexes, so that was easy.

**Dr. Carol:** [00:20:43] So I treated the disk from her neck to her chest, treated the nerve from her neck to an arm. So I used an AutoCare and a PrecisionCare for that ran concussion and Vagus from her neck to her pubic bone and then treated her esophagus, so treated inflammation in the esophagus of palpate in her abdomen. 40 and 26 inflammation in the esophagus. And she went, Oh. I feel so good. At which point she got a little drowsy, then allergy reaction, then trauma. Then the Vagus than I did ninety. Well, 40 and 89, so concussion and Vagus is running on a CustomCare in the background. And then I did quiet the midbrain, quiet the Medulla trauma in the Vagus when I put increased secretions in the Vagus from the neck to the pubic bone. She passed out. And we ran increased secretions in the Vagus and vitality in the Vagus for 40 five minutes, it's the first time she'd slept in three years. So she was, you know, REM sleep dreaming the whole thing. She came in dizzy. I gave her the air because I have Meniere's, I have a barometer app on my phone, so. I gave her a Meclizine because they are pressure yesterday was... 29.9, you feel pretty good. 29.6 You feel pretty awful. So he gave her a one Meclizine before we even let her down and then gave her another one when she got up off the table.

**Dr. Carol:** [00:22:47] I send her to Dr. Rischi, the FCOVD optometrist that's lecturing at the advanced AI Center to the only ENT left in town that I trust for Vestibular injuries. I said, You need a diuretic, you need Meclizine, you probably need Valium, but I don't think he's going to prescribe it, and you need a diuretic to get the fluid out of your ear, and then you need airdrops

with glycerin. They're using over-the-counter drops. They're not using the prescription drops to pull the fluid out of the air. So and then. Risky A.. Oh, yeah, and oh, by the way, she had a big AST 5 centimeter by four-centimeter squamous cell cancer on her; middle of her back. And her doctors at Kaiser described a surgery that was so horrible that she opted to treat it with natural means, and I went, No, no, no, no, it's good. Here's a dermatologist. It's worth the four hundred dollars. Go talk to him. There are other things you can do besides the scary surgery. So I saw her for three hours. She gave me four hundred and fifty dollars. And we took care of all of it. And fully 50 percent of what I did was education an hour and a half a treatment with 3 machines and. Um, yeah, so that was my date yesterday. How fibromyalgia of the left arm twice a month, yeah.

**Kim Pittis:** [00:24:37] Did she come up with that herself or was that given to her by a medical professional?

**Dr. Carol:** [00:24:42] A real, real well, an M.D. help cover the white coat name embroidered on the coat stethoscope?

**Kim Pittis:** [00:24:51] I think there's a huge increase in these what I call garbage can diagnoses, whether frozen shoulder fibromyalgia, my favorite this year has been frozen knee, you know, frozen knee syndrome. What? That's not even a thing. It's the thing you can google it. People are making it a thing. So please stop making frozen things like things frozen ankle, frozen wrist. It's all going to start. Oh yeah. What did Kevin say?

**Dr. Carol:** [00:25:22] What froze? It was frozen, unable to go.

**Kim Pittis:** [00:25:29] It'll be a thing you watch. So, yeah, patient education. I wanted to just touch on first time you see a patient. I want to

talk about that a little bit for the practitioners who are just starting to implement FSM. And for those of you who have been using it for a little while, I know it can be overwhelming because maybe you're used to doing 10 minutes of assessment the first time you see a patient and then 40 minute treatment. I don't know about you, but you need a lot, a lot longer for a new patient. When you start using FSM, then without it. Right. We're asking better questions. We're doing a more thorough exam. There's just more to it, and you should be compensated for that. Like, you shouldn't just be treating somebody for three hours and not get paid. So I think the investment with FM is, yes, it's the education, it's the devices. But you get paid back very fast with the way you implement this into your practice.

**Dr. Carol:** [00:26:37] So well and the patients, if you're in a totally insurance-based practice, every everything becomes 9 9 to L5 and a nine nine four one 5. Everything becomes complex. You have multiple diagnoses and even if you have, especially if you have a cash practice. These people are not wealthy, but I was the first physician who listened to them. Everybody else they see has seven to 10 minutes for a new patient history and physical. That's no. And the patients know that they're being shoved out the door as they enter. Yeah. When you sit down and say, So, tell me when this started. And then you follow up. They appreciate it, especially when you can explain why you're asking and why it is, you're going to do what you do. The other the thing, the place I thought you were going with that was how do you explain what you're about to do? So I get this patient on the table and I've got about to put wet wraps around her neck, wet wraps on her left hand, a washcloth on her belly. And as just before I'm applying all this sweat stuff or just as it's like, so I'm going to I'm going to use Frequency Specific Microcurrent on you. It's current, you can't feel. So it's not like any current you've ever had before and the frequency-specific part. I got a list of frequencies from an osteopath. Who bought a

practice in nineteen 40 six that came with a machine that was built in nineteen twenty-two.

**Dr. Carol:** [00:28:45] And that machine came with a list of frequencies. I got the list in nineteen ninety-five and we started using them. Now for practitioners, you just say, I'm going to use Frequency Specific Microcurrent current, you can't feel it's the same kind of current your body produces on its own. So you can't feel it, but your body gets to use it directly to increase energy in the cells, so that's pretty cool. And I got this list of frequencies when I took this course, and you can read about it on the internet. I'll tell you about it, but I got this list of frequencies when I took this course, and the lady that taught the course got the list from an osteopath who bought a practice in nineteen 40 six that came with a machine that was made in 1922. And that machine came with the list of frequencies, and then they started using them in 1995. So it's been in use, what 26 years? And the frequencies appear to do exactly what they're described as doing. So the frequencies, you can't hear their electrical pulses, but that's what I'm going to do. Is that OK with you? So there you've got done what is called pacu procedures. Alternatives, usually they've already had all the alternatives. Precautions. Do you have a pacemaker? Are you pregnant, right? And content is is that OK with you? And then it's always OK because they usually find us after they've been everywhere else, and at that point, I've got a wrap around her neck, a wrap around her hand and I tell her It's like this, this machine here is going to treat your left arm, so it doesn't hurt anymore.

**Dr. Carol:** [00:30:37] So we did sensations, you know, it was numb. And then 40 five minutes sensation was normal, so it checked sensation beforehand, moved her, and this one is going to be for the disk. And this one is to treat your esophagitis. So we got to turn the Vagus back on. And

for somebody who has one eye and a Vestibular injury in the missing in the ear that goes with that eye. So your Vagus is constantly being turned off because about every hour and a half. The lizard brain part of your brain thinks you're falling off the edge of the planet, right? So there's constant stress, so this isn't going to last. You're going to need a CustomCare because it's silly to come and pay me. And they said, Well, we're going to have to save up for a couple of months. Said, That's fine. You'll feel better for, I don't know, two or three days, maybe a week. So that's cool. But at least now, everything you have makes sense. Yeah. And I'll see you in January. So. So that's the first visit. Right?

**Kim Pittis:** [00:31:54] Very good.

**Dr. Carol:** [00:31:56] Short version,

**Kim Pittis:** [00:31:57] I want to just go on to the chat quick because there's a question kind of regarding this says here. If the frequencies mix in the towels, then when you were treating the vagus nerve on one machine and you have the leads for another machine on the same towels, do you have to be aware of not running anything with 40 on A on the other machine?

**Dr. Carol:** [00:32:20] Denise, that's a really good question, and you see this look on my face like that didn't even occur to me because they know. I did. Maybe I should. I'm not 40 and 396 needed to run for 40 minutes and then I ran 81 and 396

**Kim Pittis:** [00:32:41] And you ran 40 and whatever the esophagus is,

**Dr. Carol:** [00:32:46] Yeah, 40 in the esophagus, 40 and 89. 40 and 94. I. Using multiple machines. Works. And. If you don't understand why you can,

you and me are on the same page because I don't understand it either. So it's a really good question, and no, it didn't even occur to me

**Kim Pittis:** [00:33:13] Because how we normally explain it, I think I've heard you say it if you've got, you know, so you've got 40 and esophagus running. The machine that's running the Vagus, those two contacts are just talking to each other, correct, if I'm wrong. So it doesn't mix, so the 40 doesn't mix with the other B channels from one machine, they just are having their own conversation. So I can't remember who it was. It was like Roger Bilko. Or maybe it was Dr. Musnick. It was at the advanced could have even been Paris. We were talking about multiple machines. And was it Dr. Oshman? I don't know. It was somebody brilliant speaking who said it's like the equivalent of having five different conversations happening in the same room. We're not mixing words, but each person is having its own conversation, even though there's multiple words being spoken.

**Dr. Carol:** [00:34:14] I think that's the best description I've heard, George said. The two machines don't see each other,

**Kim Pittis:** [00:34:23] See each other. Ok, so same thing. Speak, Yeah, OK, can we use to Magnetic Converter is running at the same time with different frequencies?

**Dr. Carol:** [00:34:32] I think so. I mean, I don't see why not? It would be the same principle, right? Right. Converters have both channels in both magnetic heads. Right. If any of it makes sense, then all variations of it would make sense, right?

**Kim Pittis:** [00:34:53] Yeah, I'm not sure how I could practice with just one machine anymore. You go from practicing to I don't know how I could

practice without a machine to. I don't know how I could practice without multiple machines.

**Dr. Carol:** [00:35:07] When we start the clinic, there's going to be a fair amount of equipment expense because we have four treatment rooms and a gym. And so that's 5 and every room will have to PrecisionCare Teres. Maybe I can get some AutoCare Teres and to COX one or two CustomCare's, plus a laptop that's able to reprogram the CustomCare's as you need to. Because you can you can have clinic CustomCare's where you can just have four or five programs on it. Exactly. And then reprogram it. Ok, this one this lady around concussion and Vagus without 94 and 94 because she was so bad, so dizzy already that I didn't want to take a chance on that reaction. Right. So that's yeah, I don't. I routinely use four or five machines on one patient. I still haven't matched Ben Katholi record of seven machines on a two-year-old. Wow. Seven. And I still don't know how he did it.

**Kim Pittis:** [00:36:15] I'm trying to. There must have been some sort of like puppet show going on that this child was able to sit still to for so long.

**Dr. Carol:** [00:36:22] Well, the kids get stoned. Yeah, I mean, you know, you've ever treated a horse or a dog? The dog dissolves on, the horse goes, Oh, bursa's are amazing. Yeah. And so the. They start the concussion protocol, so first, so the kid gets floaty and children who are in rehab hospital are used to being messed with, right? And so they have learned from a very early age to just be patient and let people mess with them. Right. The Pittis, you know, play with them with toys. And then when they get stoned, it's just really easy, right?



**Kim Pittis:** [00:37:07] I just want to mention something here going back to our first patient or our first visit with a patient. It's overwhelming. I mean, you've been doing this for so long, so you can your your cerebral mode bank is not like the rest of us, and I want to just have everybody come down off the ceiling. All the practitioners that are listening, you are not expected to have all this in your brain. So and if you can't fathom seeing a patient for three hours, like what I do is I try to do a very thorough intake before they come in. So if you can't do a Zoom call or something to dig into their history, have them write a chronological kind of history, have them email it to you. So sometimes that helps me at night before I see a new patient, I can read it so you can at least jot some notes down that, OK, maybe there could be virus or there could be Vestibular. Just something to get you thinking, because if you have a new patient and they are throwing all of this at you and you're not really that savvy with your frequencies, it can be really overwhelming. And I think some practitioners panic and then they back away so

**Dr. Carol:** [00:38:22] Well and the in my new patient information. And they are asked to provide a chronological history. Right, and her new patient form was completely blank. So it's like, OK, when did this start? Well, when I was in that, the history took about 40 five minutes, so if you make it linear now, it's really challenging when you have patients that have brain injuries, so they. They provide what is called a tangential history. They bounce all over the place. And after the first or second bounce, you say, Wait, wait, wait, wait, wait. Let's go back. 1997. You were in a 50 mile an hour head-on collision, let's start there. Well, if I, then I won't get to everything else, I said. Everything else after that date is irrelevant. Let's start from there and you really have to dig your heels in and make them be linear. Ok, then what was the next thing? Well, then I had a hysterectomy in 2000. Ok. And then I had this, and then I had, and you have to. You can direct the history you

are allowed, they are paying you to direct the history just because they want to be all over the map doesn't mean you have to let them right. And so I asked them to provide a linear history. I have a history form, but the most important part is the pain diagram.

**Kim Pittis:** [00:40:16] Yes.

**Dr. Carol:** [00:40:16] And then the history form. But you're right it can be overwhelming. And I've been doing this for twenty-five years.

**Kim Pittis:** [00:40:24] Right. So a lot of us have not been doing it that long. Some of us have been in practice for twenty-five years, but not with this amazing new tool that changes everything that you know about everything. So I just wanted to, like I said, I wanted to calm down all the practitioners listening. And for the patients that are listening, there is a reason why you're you have to be so detailed with your history for us and be patient with the exam in the beginning. So take your time, everybody be detailed. And a lot of times patients, they think they've given you everything and then you start treating them and then it's like this memory. These memories come up and it's,

**Dr. Carol:** [00:41:09] Oh yeah, I forgot I broke those three ribs that actually happened to me. Yes. I mean, I'm so patient. Did that? Yeah, I had those three broken ribs, and then two years later, I broke them again. Right, right. I know it's fantastic. You forget 3 broken ribs.

**Kim Pittis:** [00:41:29] Well, when you have other things to think about, like raising a family or playing a sport and you just have to get through it. I want to talk a little bit about the investigational frequencies that we have or the advanced laminate. So for those of you who have taken the court, you get

a laminate with the list of frequencies and then you come to the advanced and we rewrite the narrative and traumatize everybody all over again. But the

**Dr. Carol:** [00:42:04] We make more brain connections SIBO as implementing brain plasticity on a regular basis.

**Kim Pittis:** [00:42:13] Oh, that's a beautiful way of digesting that makes it sound so fluffy and yummy and inviting and not as scary

**Dr. Carol:** [00:42:21] And as you would say, you're welcome. And I'm sorry.

**Kim Pittis:** [00:42:25] That's exactly. I will never forget walking into my first advance, and I thought I had some swagger because I'd been doing this for a while. And I'm like, How much more complex could it get? And then I took my little lamb in it, and I saw there was for laminate and I was like, Well, now this just can't be. It can't be that many people

**Dr. Carol:** [00:42:48] For metaphors going on in your head.

**Kim Pittis:** [00:42:51] Yes. So how much of the four pages of advance frequencies do you use?

**Dr. Carol:** [00:42:58] Um, that's a really good question.

**Kim Pittis:** [00:43:03] Because we all tend to have our favorites, right, we have our core connective tissue like we have our core solid go-to frequencies. But are there times where you're like, No, it's not periosteum,

it's clavicle or whatever clavicle is like, how specific do you personally get with these?

**Dr. Carol:** [00:43:23] Eighty-five percent, eighty to eighty-five percent of every patient you see, you can treat successfully with what you know in the court and the webinars. So that's why the Vagus nerve got moved from the advance to the core. Yes, it's just you can't. And that's why the court has gone from two days to three days to four days to five days. And that's why we split it into two three-day modules. And both three-day modules contain the Vagus because you can't and the Vagus used to be in the advanced only. Yes. So. Eighty-five percent of what you need to do on anybody is in the core. The other 15 percent. The. The Channel A frequencies are the ones that are the most different. If you ask Ben COX the channel B frequencies, so his case report this year is on small fiber neuropathies, which I've never seen, never heard of. But Ben sees a lot of them because he's a physiologist at the biggest rehab hospital in the country. And George came up with the frequency for small fibers, which are the little fibers at the end of the main nerves, where the little nerves split off. And so Ben's going to do a case report on that. So if you ever see somebody with a small fiber neuropathy, it's there in the investigational list. Virtually all of our investigational frequencies are ones that George came up with. He has a way of dousing for them, and I put a little eye next to them and I use them in their own little separate box. Yeah, they're in. They're in quarantine until we get objective proof. Yep, right there. Oh, look at that. That's so cool. Until we get objective proof with irrefutable clinical response that is so clear, it couldn't be anything else.

**Dr. Carol:** [00:45:43] So we had somebody with a known pond's stroke. Twenty-two years old had a pan stroke when she was 16. She was completely rigid and spastic, and I and we had the pond's frequency and I

ram increased secretions in the ponds and then 30 minutes, she could be passively ranged with no spasticity whatsoever. Known lesion only possible response, the little I went off, the frequency of the ponds that aids 454. Um, the dura used to be investigational more than that. Not anymore. I'm thinking small fiber neuropathy is going to come off sooner rather than later. Mm-hmm. Try to keep the original list clean, even the West Indies frequencies where they match most of the time. Wander off right there, not ones you use all the time. So there's a frequency in the West Indies frequent West Indies list, which would give out at the advanced for wheat. And corn. The chicken feathers, I lose it a chicken feathers, but let's say wheat and corn. And I never used one of our practitioners, she's somebody that worked in my office in 1998 and living them on emailed me and said, Hey, I have a patient who has joint pain and she's gluten-sensitive. And I ran the frequency for wheat in the joint capsule, the cartilage, and the synovial fluid. And the joint pain went away. So I get out. So when we do the advance, that's the section that I do while you're off teaching your 3 our specialty workshop, right? And so the Channel A frequency so malignant virus is now in the visceral core laminate. What's the one for catarrh? Could Toridol toxin is an AB pair on the Abram's list?

**Kim Pittis:** [00:48:12] Yes, it's 52 on A 72 on B,

**Dr. Carol:** [00:48:16] And in twenty-three years I had never used that combination on the advanced. There's a frequency 17 for Cotterell toxin, which you, I think it's 17. Maybe it's 14 anyway and you combine that with the lung. What is the toxin

**Kim Pittis:** [00:48:37] Trying to find that? I have to look at the body? Maybe. Oh, a 17?

**Dr. Carol:** [00:48:42] Yes, it is. 17. Ok. So I was in Germany and we were treating this lady from India who at the core. And she stayed at the end of the day and she said, You promised you were going to treat me and she had the ugliest, wettest asthma I've ever heard. Like when she inhaled, that was like she was, you know, a little, little like there were bubbles. And so. I ran the normal asthma stuff, and then it's like I ran scarring in the bronchi. So asthma is bronchial not lung around scarring in the bronchi. And at that point, she started coughing spells just spasmodically, and she coughed up, we hand her a Kleenex. She coughed up this glop of green mucus. It's like you and one of the ladies in the group said, that's catarrh. I went. It is I've never known what Katrina was, so we ran Sinoatrial toxin, whatever that pair was. And we ran catarrh Toridol toxin in the bronchi. And now there is a frequency for the bronchioles, thanks to George that's got a little eye after it. And that's thanks to Dana Pletcher and. She coughed up more green goo. But her asthma, she fell asleep. We treated her for 20 minutes.

**Dr. Carol:** [00:50:35] Her asthma completely went away. And I said the mucus in your lungs is green, you've had an infection since you were 12. You're now 40 something. I know you're a naturopath, but you are to go home and go on antibiotics for 10 days. Or. Uh-huh. It's green. Green is not a good color for mucous. Yeah, but the only way I found it out was by treating the bronchi for fibrosis. And then when she coughed up this green goo. Somebody else had to tell me what Qatar was, right? So. On the advance list, you're mostly going to use the Channel A's, so if you look in the compendium, there is a Shirley Hartman. Lecture. That is. The channel is you never think of oh, because Shirley Hartman, I believe, is the only person on the planet that has the entire Channel A list memorized. Don't like. We were we would be talking about a case and surely would say, well, why don't you use so-and-so, which is the frequency for whatever? And it's

like, there's a frequency for that. Chase. And for me, I have to look down the list, so I still cling to my laminate even though I have the buddy.

**Kim Pittis:** [00:52:11] I was just going to say there's something sometimes when again you get overwhelmed like there's so many frequencies go with what you know or go in the neighborhood close to your hypothesis, right? And as they're marinating, I take off my list. And then this is what my patients say. I'm like, I'm just going to marinate for a few minutes and then there's something inspiring and

**Dr. Carol:** [00:52:39] It's like it just stands out on the page.

**Kim Pittis:** [00:52:41] Yes, it comes to you. So when you're looking at whether it's in a two-channel or be two-channel, what am I missing? There is something helpful to have this piece of paper with you to even if it's totally different than what you think you're looking for. Like, no, it's not scarred. It's sclerotic or it's hard or it's not the stomach or and then you have your Netter is open. And then that's the other thing. Sometimes you're looking through your frequencies, and sometimes I'm just looking at Netter going, OK, what's near that? Maybe it's not this because I'm pretty good, pal Peter. But we don't have x-ray vision. We can't always feel exactly what vessel structure, fascia, organ nerve.

**Dr. Carol:** [00:53:29] The patient that swore, swore that all of his pain was from scarring in the nerve. And I looked at where he was pointing. And it was connective tissue. And. The only thing that worked. Scarring in the nerve didn't work. So I ran that 15, 20 minutes and did all my thing, and it just kept getting more aggravated. So I opened Netter and there is this big band of connective tissue right under where that nerve is. It's like it couldn't be that easy. After wasting spending 20 minutes on it, so I run 124 and

connective tissue because of Netter. And the scar tissue and the nerve pain went away. Right? And then the other thing that's in the advanced is more details. So the kidney is in the core, that's 23. In the advanced, there's the kidney tubule. And if you've ever been to. Uh, the plastination, the body worlds, if you've ever been to PDI worlds, yes, and you've seen the kidney where they take away the kidney and all that's left is this lace of capillaries. So the kidney is the tubules, but every teeny tubule has a capillary, so the kidneys are not just 20 3 of the kidney. Sometimes it's 60 3 the tubule and it's one. It's not arteries because the last artery is what goes into the kidney when you get into the kidney tissue. It's capillaries 162, right? Right. So how often do I use that? Once every two years, what I keep those frequencies in my head well after twenty-five years, once every one or two years, eventually you remember them, right? You look at the laminate and like you said, What am I missing, right?

**Kim Pittis:** [00:55:46] Well, that's how I fell in love with hypoxia. When on earth would I ever think twice about something that said hypoxia?

**Dr. Carol:** [00:55:55] I didn't. I'm but I believe you.

**Kim Pittis:** [00:55:59] Well, and then once you get results with it, it's you can't not see it. You can't not think about something like that. And I refuse to believe that the osteopath in the twenties were that literal thinking. Something is hypoxic. But when we think of anything that hasn't moved in a while, it doesn't get normal supply. So, you know,

**Dr. Carol:** [00:56:22] 880 and 7.4 used to have a little I. Next to it, that's a George frequency from 1998, probably. And we used it in COPD and the patient goes from greater pink. So that's when the "i" came off. Yeah, in about 2002, when I treated my third or fourth high hypoxic COPD patient.



Yeah, it's like, OK, I give up, took the eye off and then apply it only with asthma and COPD, and that's about it. So when you put it into the musculoskeletal section, it's like, Oh, OK,

**Kim Pittis:** [00:57:07] This makes make sense, right? When you can apply things locally. And that's why I think what we do, how we've changed the way that we're teaching it. This triggers that chain of critical thinking of what's wrong with it. Like, if I didn't think like that, I would have never thought to use that. What's wrong with it? It hasn't had supply. It hasn't had a blood supply because it's been scarred and stuck.

**Dr. Carol:** [00:57:33] So I just said I use hypoxic brain injuries. Absolutely right. Yeah, the new practitioners don't panic. I've been doing this for 10 years, 12.

**Kim Pittis:** [00:57:49] So almost 13, almost 13.

**Dr. Carol:** [00:57:52] I've been doing it for 25. And when we talk about using 5 machines and getting six things done in one session, I don't want to create the expectation that you're somehow failing if you don't do six things on the first session, right? Use the expectation you create with the patient is twice a week for four to six weeks. That gives them time for the stable state to create a stable state. It gives you time to figure out what else is going on because I swear to you anything. That happens on the first session you're going to have in the back of your head. What's left so the patient comes back, right? And managing patient expectations. Before I touch anybody on the first visit. The thing that I say out loud is my goal today is to not make you worse. They have been made worse by so many therapists, doctors. Chiropractors, whatever. My goal today is to not make you worse. Oh, OK. So that sort of lowers the expectation bar because an

awful lot of people, when they find us on the internet, they come in expecting Harry Potter, right? And Madam Pumphrey, just like magic, it's going to be all. No. So twice a week for four to six weeks. And my goal today is to not make you worse.

**Kim Pittis:** [00:59:40] Yeah, that's fantastic for the patients, too. Yeah. I mean, we're working Oshman's. This is not fairy dust and all the other things. And yeah, if you can make an, you know, you say, my goal is to make you worse, I'll say something similar like my goal is to just make a dent in this today. You know, so especially that first one, because you're trying to digest it, you're trying to figure out. And that's what I said for those new patients. Even if you get the most thorough, most comprehensive history that with all the imaging and they didn't miss a thing, it is so hard to pick up on. Where do I start and how long do I run this? And you can't do it on one treatment.

**Dr. Carol:** [01:00:26] You peel the layers off until it becomes. It's like second nature. So you look at the pain diagram and you listen to the history. And every single time I get excited and I don't do a sensory exam and I don't do reflexes. Every single time. Yeah, I get nailed. Oh, I know what this is. No, no, I didn't.

**Kim Pittis:** [01:00:54] And the sensory exam similar to using active-passive resistance range of motion, even though I know for a fact what's tight, what's restricted, what scarred. It's a good marker, especially if you have a patient that's a little bit hesitant or a nonbeliever. At least they have something in their head going, I could only bring my shoulder up to here and then. Now it goes up to here and it doesn't hurt. So similar to the sensory exam, it's such a great marker. You start and it's hyper on one side and then halfway through you check. And now it's kind of numb and you're

like, Oh, that's great. And they're like, What do you mean? It's great? Well, it used to be really icky, and now it's kind of numbing. The next time we do it, it's probably going to be normal. Or maybe you don't say that out loud, but in your head, you're saying

**Dr. Carol:** [01:01:41] This well, you say to the patient is when it's if it's they go from normal to hypersensitive to numb. So when it's numb, they go from numb through hypersensitive back to normal. So it's kind of that train. So, yeah, exactly. So it's. So range of motion. And any time you're dealing with a shoulder, you always have to check sensation because 100 percent of the time. Shoulder issues are - start with a C-5-6 disc that makes the subscap tight that causes the partial-thickness tendon tear that causes the super splenius bursitis or infraspinatus bursitis. That's what they think they're coming for, right? Right. So yeah, I have bursitis and I can only go to here, huh? How's that? Oh, what is that? Igg. And then you put your finger in their armpit and that it's then you explain how all those things are connected.

**Kim Pittis:** [01:02:57] Right? And that's not to say you can only treat the disk until the shoulder pain goes away. You have to treat things. No, you make that face. But sometimes we're hearing things differently, right? Yes, it's because you said one hundred percent on time, it's coming from the disk. It is for sure. But that's not to say with multiple machines, with multiple treatments, you're not going to gain some benefit. But yes, you have to treat the disc,

**Dr. Carol:** [01:03:24] Treat the nerve, the nerve one or broken in the; most of the tendons, except for the supraspinatus. Nato's most of the tendons in the shoulder are flat. Yes, weighs 124 and 77, but none of that matters unless you take the scarring out of the subscapularis. Right, right, right. It's

like it and it becomes. I am hoping that as we say this, more and more times the pattern will become because all of medicine has pattern recognition, correct? Right. So what we think of as the shoulder in the pattern recognition part is disc to 5-6 nerve to subscap to tendinitis. Tendon apathy to bursitis because it doesn't. Um. And when the humeral head goes down, that's called whatever that word is,

**Kim Pittis:** [01:04:27] Depression and rotation. Yeah. So.

**Dr. Carol:** [01:04:31] So all of that's all one sentence, correct? You see it. You can't ever unsee it. Right?

**Kim Pittis:** [01:04:38] You and all you have to do is treat someone's desk and palpate their subscap. And then all of a sudden it lets you in because you're treating the disk and the nerve. And that wouldn't make sense normally because having somebody stick your thumb in their subscap is never a pleasant experience

**Dr. Carol:** [01:05:00] Unless you run 40 and 396 first.

**Kim Pittis:** [01:05:03] Correct. So when people are saying, Well, what do I run first? Well, it's the nerve and the disk, and why is it tight? And then it's the whole conversation.

**Dr. Carol:** [01:05:12] It's supine neck and shoulders. So when we do so excited, we just we made plane reservations and hotel reservations for San Francisco, for the Practicums,

**Kim Pittis:** [01:05:23] And I'm bringing the big screen in my truck.

**Dr. Carol:** [01:05:25] So woo-hoo. And so the supine neck and shoulder, that's why that's the first practicums. Yeah, because it puts all of those together. The thing I have to change in that practicums is to include the concept in the slides. So remember the part where I gave you the slides for that today, Kevin. Yeah, I gave Kevin the slides for that practicums. I lied. I'm going to change them a little bit so. So it's too late. So we have to introduce the concept of connecting the dots with multiple machines, treat the disk, treat the nerve, treat the shoulder, at least treat the disc, then treat the nerve. Right. So you can use a PrecisionCare and a CustomCare to treat the disc. That's that would be that would work. Yes. Okay. Well, let's just go.

**Kim Pittis:** [01:06:30] Yes, we are almost out of time. We got through half of my list today, but you had so many great stories, so we couldn't.

**Dr. Carol:** [01:06:41] We have two minutes. We can do some lists. There's no question. So.

**Kim Pittis:** [01:06:45] That's this is going to pop up because for sure, patients are going to pressure people listening are going to have questions because it always happens towards the end. Yeah, but just really quickly I had a comment about treating kids and teenagers. It was a couple of weeks ago that I have been dancing around and I treat a lot of young little athletes. And it is surprising in the last 10 years for sure of my practice how many teenagers are coming in with repetitive strain injuries?

**Dr. Carol:** [01:07:14] What's up with that?

**Kim Pittis:** [01:07:16] Well, they're being forced to specialize. Right? 20 years ago, sports were seasonal in Canada and the winter you all played

hockey, and in the summertime, you played soccer or baseball or football, and you had a change of muscle pattern. But now everybody is forced to hyper-specialize so young. So we're seeing kids burnt out mentally and physically now. So aside, when anybody comes into your practice with anything that says repetitive strain, you should be screaming, your brain should be screaming one frequency on that channel.

**Dr. Carol:** [01:07:51] 124.

**Kim Pittis:** [01:07:52] Exactly. It's torn and broken, it's fatigued, it's pissed off, it stretched. It's frayed, it's giving you a giant like middle finger to the world

**Dr. Carol:** [01:08:01] And concussion and Vagus because the Vagus. So when they're under that much stress and there are tissue fragments, the Vagus gets turned off by infection, stress, and trauma. The kids are stressed. They have tissue fragments floating around. The Vagus gets turned down and the Vagus has its job to suppress inflammation. So when so that the two kind of go together, but the way to get the Vagus to stop being messed up is to do T1 and broken. And yes.

**Kim Pittis:** [01:08:33] So that's yes, so it's not that complicated, so people, whenever we see repetitive strain, whether it's like a worker's comp claim or somebody that's cashier and always doing the same thing. You're right, it's more than just torn and broken that will definitely get the pain and inflammation down. But yeah, there's the concussion and Vagus component to it as well.

**Dr. Carol:** [01:08:58] Well, I'm torn and broken. The pain goes down in five minutes.

**Kim Pittis:** [01:09:02] Yes.

**Dr. Carol:** [01:09:03] That's a sucker play. The pain goes down in five minutes, but they need to marinate. Yes, for a while.

**Kim Pittis:** [01:09:11] Yes, they do. I want to just make mention. We have a new website for the clinic, right? It's yeah, I want to make sure we can direct people to that.

**Dr. Carol:** [01:09:21] Yeah, fsmclinic.com,

**Kim Pittis:** [01:09:23] fsmclinic.com. You can see everything being built. It's like when you're watching a zoo baby being born and you're watching the webcam on the mama, so you can see the clinic being born and then frequency specifically, you can go to look at all the courses that are coming up. There's a list of when there's Practicums coming up, the advanced sign-ups are there. We have an end-of-the-year sale coming up after Thanksgiving for devices I believe.

**Dr. Carol:** [01:09:51] Cyber-Monday through December 31st, OK?

**Kim Pittis:** [01:09:57] If you need devices, that's a good time to purchase them.

**Dr. Carol:** [01:10:00] Oh, I'm so excited we get to go to Cleveland. I get to give Dave Burke a big hug and January anywhere in the Midwest. You got Cleveland in January and we're going to Chicago in the fall for the two-day practicums so

**Kim Pittis:** [01:10:16] Nice and people can look on the website right for all that information and

**Dr. Carol:** [01:10:21] Your course in Phenix.

**Kim Pittis:** [01:10:23] My course in Phoenix. Super excited. If you want to take the normal sports course, it's the Monday and Tuesday of the advance. You can sign up on Frequency Specific Microcurrent and then we have the coveted Sports Advanced Course for one day, so it's going to be so much fun. And then there's a whole bunch of great things after that.

**Dr. Carol:** [01:10:40] So training two on the Monday

**Kim Pittis:** [01:10:43] Instructor training the following Monday, right after the advanced right. Perfect. Well, all that information there. It was so great to see you again. Fastest hour of the week right here.

**Dr. Carol:** [01:10:54] Yep, absolutely.

**Kim Pittis:** [01:10:56] So keep the questions coming. And yeah, we'll see you next week.

**Dr. Carol:** [01:11:01] See you next week. Get ready.

**Kevin:** [01:11:03] Hey, by. The Frequency Specific Microcurrent podcast has been produced by frequency-specific seminars for entertainment, educational, and information purposes only. The information and 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



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