

Muscle Testing & Manipulation—A Talk with the Pioneer of Applied Kinesiology, George Goodheart, D.C.

by David Leaf, D.C., DIBAK, Chairman, ICAK-U.S.A.

GEORGE GOODHEART IS A SECOND GENERATION DOCTOR OF Chiropractic and graduated from National College of Chiropractic in 1939. In 1964, Dr. Goodheart began making a series of revolutionary observations about muscle function and health and disease that evolved into applied kinesiology.

By stimulating various neurological receptors and observing excitatory and inhibitory responses of muscles to manual testing, Dr. Goodheart was able to identify optimal treatment methods to restore normal muscle function for structural stability. Dr. Goodheart synthesized methods from many disciplines into AK, using the body as a diagnostic tool. He has annually published his observations since 1964.

One of Goodheart's most used observations is that stimulation of taste buds with nutritional substances that are appropriate for a patient results in an excitatory response of a weak testing muscle. Similarly, oral exposure to toxic or allergic substances will result in muscle inhibition of previously strong testing muscles. Application of these concepts, in combination with laboratory, history, and other exam findings, allows for precise targeting of a patient's unique biochemical needs.

His correction of a chronic problem of a doctor on the United States Olympic Committee's Sports Medicine team afforded him an appointment as the first Doctor of Chiropractic on the USOC Sports Medicine Team, whereupon he served at the 1980 Lake Placid Winter Games. This opened the door for chiropractors' participation in the USOC movement that continues to this day.

Dr. Goodheart is the Research Director for the International College of Applied Kinesiology, a multidisciplinary group of physicians with chapters all over the world. Hundreds of doctors have presented thousands of clinical observations at ICAK meetings, based on Dr. Goodheart's original findings. Muscle testing has become an unparalleled diagnostic tool for real-time evaluation of a patient's status and response to treatment.

In addition to being an exceptional and prolific clinical investigator, Dr. Goodheart is the consummate family doctor. He has delivered over 100 babies and tended to the family health

needs of some families for over five generations. And if all of this isn't amazing enough, today, at 87, he still works in his office in Grosse Pointe Woods, Michigan, and lectures many weekends of the year.

At the request of *The American Chiropractor*, Dr. David Leaf, Chairman of the International College of Applied Kinesiology, recently interviewed Dr. Goodheart, an amazing chiropractor and a legend among us, whose work has profoundly impacted the lives of so many.

Leaf: Dr. Goodheart, the impression held by many chiropractors is that doctors using applied kinesiology do not manipulate the spine. How would you respond?

Goodheart: Personally, I manipulate 100 percent of all of my patients. Since the beginning, in 1964, spinal manipulation has been at the heart of applied kinesiology. Whether you are talking about structural or chemical problems, every one of the patients will have a subluxation and or a fixation complex as part of the treatment. For example, Felix Mann, in his classic book on acupuncture, *Reinventing Acupuncture: A New Concept of Ancient Medicine*, stated "every meridian imbalance would have a spinal imbalance."

Leaf: There are many different treatment options that you have at your disposal in applied kinesiology. Where do you put the spinal manipulation?

Goodheart: Over the years, we have taken the concept of muscle testing and

found many ways to determine which treatments were appropriate for a patient. For example, trigger points can be treated in many ways. We have developed methods to determine which one is correct for a specific trigger point in a patient. I fit the treatments needed to the needs of the patient instead of fitting the patient to my treatment. However, correction of the related spinal subluxations is primary and, without this, the success rate with the patient is greatly diminished.

Leaf: Can you give an example of where muscle testing is an aid in the analysis of the patient's spine?

Goodheart: Chiropractors are well trained in finding sublux-



Dr. George Goodheart, D.C.

ations, but many patients suffer from fixations. These vertebrae are not "out of position" but, instead, locked in place by contraction of muscles. Motion palpation may be used to find these, but we have found that muscle testing helps us to find them. Each area of the spine has classic muscle weakness patterns that help us isolate these fixation patterns. One of the advantages of using muscle testing as a diagnostic tool is that it can be used with the patient in different positions. Sometimes, these fixation patterns will only be found with the patient supine, or standing or in a work position. The muscle test screening procedure also lets us, as well as the patient, know when we have corrected the problem. This is one of the great advantages of using muscle testing. The patients are impressed with the changes in their musculoskeletal systems as a result of the treatments.

Leaf: In what area or areas do you find the most important subluxations and fixations?

Goodheart: When lecturing, I like to describe the dura. As you well know, the dura attaches firmly in the pelvis and the sacrum, in the upper cervical area, and

inside the skull, in what the osteopaths call the cranial bowl.

The first two great schools of chiropractic centered their treatments in the pelvis and the upper cervical area. Sacro Occipital Technique and Craniosacral therapy have also advanced these original findings. Using muscle testing, we are able to uncover many hidden problems in the functioning of the sacrum and in the upper cervical area. Proper functioning of the piriformis is critical for stabilization of sacral problems. In the upper cervical area, we find not only subluxations but also fixations and micro fixations. These imbalances have many deleterious effects on the body.

The dorsolumbar junction is the area of the most common fixations. D.D. Palmer first wrote about this and I concur. Most of the patients that you see will have a gait imbalance. They walk with one stride longer than the other. This pattern causes changes in the mechanics of the spine and fixations, especially at this level of the spine. Correction of the fixation complex normalizes the bilateral muscle weakness that is associated with it. This is the key. The weakness pattern confirms the palpatory findings, and the correct spinal

manipulation is confirmed by strengthening of the muscle weakness pattern.

Leaf: What advice can you give the readers?

Goodheart: When confronted with a problem, ask, "Why?" Why do people walk the way they do or move in a certain way? Then, test and measure something. Treat the patient and then re-test. If you are stumped, first reduce the pelvis and upper cervical areas to a zero defect level and let the person walk about. Then, re-test for changes.

Finally, keep an open mind and continue to learn. I have been practicing for over 60 years and am continually amazed at what we can learn from our patients and how we, as chiropractors, can better their health using applied kinesiology.

Dr. David Leaf is the current Chairman of ICAK-U.S.A. He has conducted seminars in AK throughout the world since 1977. He has treated numerous professional and Olympic athletes, including the Italian professional soccer team AC Milan. He has authored numerous papers and has produced a series of educational videotapes on AK. Dr. Leaf currently practices at 159 Samoset Street, Suite 4, Plymouth, MA 02360, and can be reached by phone at 508-746-6441. TAC



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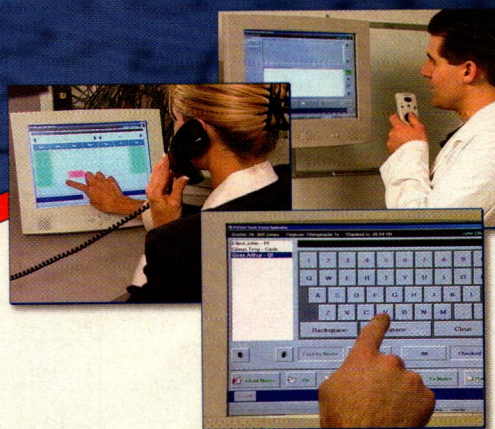
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