

Fundamentals

The Activator Method
Basic Scan Protocol

Dr Jamal De Vita

University of Vermont – 2000

New York Chiropractic College – 2004

Certified Chiropractic Sports Physician – 2011

Practice in Acton, MA -2005

CrossFit Level 2 Trainer

Anatomical vs. Functional Short Leg



The initial short leg may be evidence of a general **postural adaptation** due to insufficient lumbopelvic stabilization.



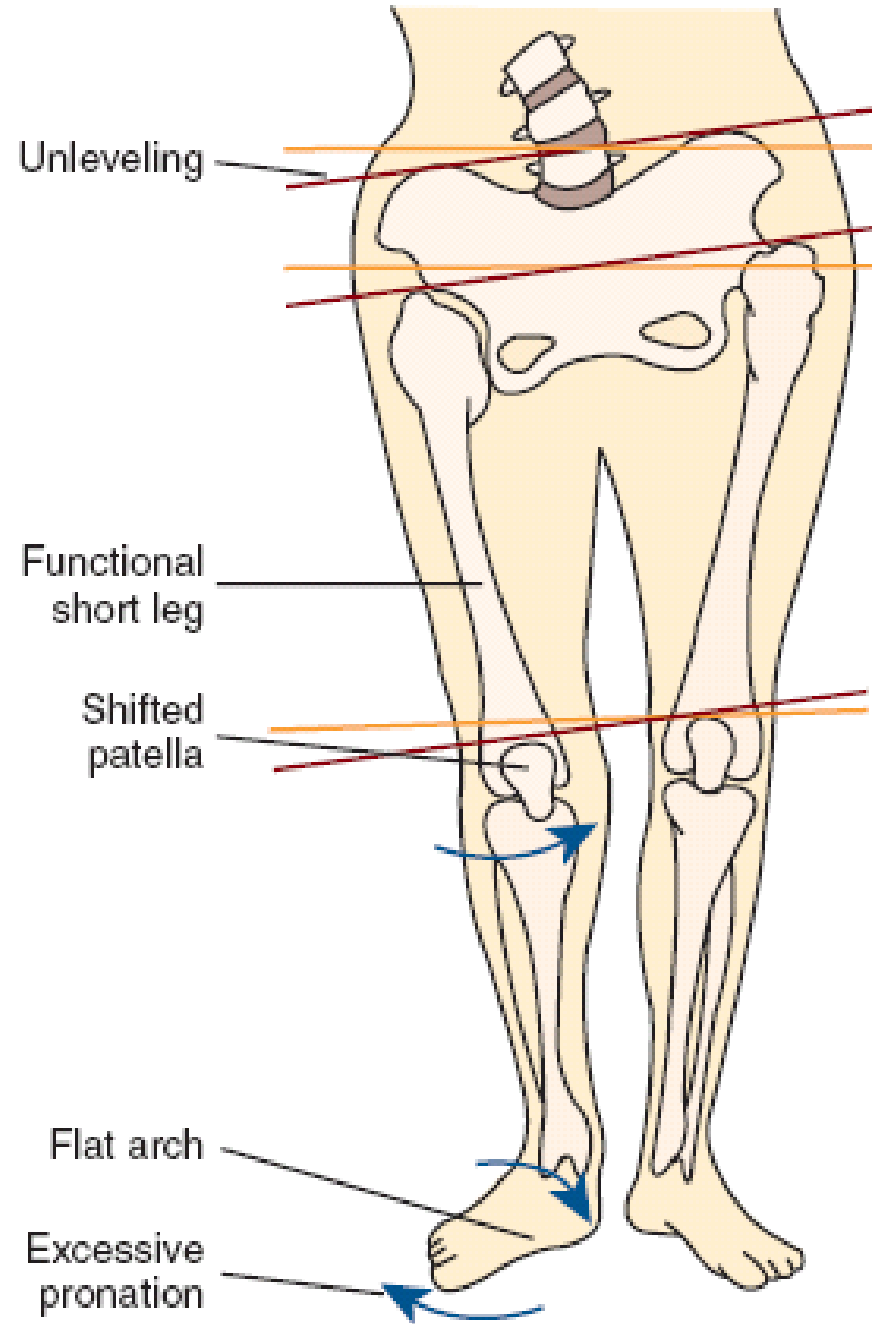


Figure 5-3 Excessive pronation consequences.

Our current hypothesis:

AM Leg Length Analysis gives the clinician the ability to access different levels and **unique “kinetic” chains** of neurological information.

The **stance** phase of gait and **push-off** phase may be simulated through the different AM Tests and Positions.

The Activator Method

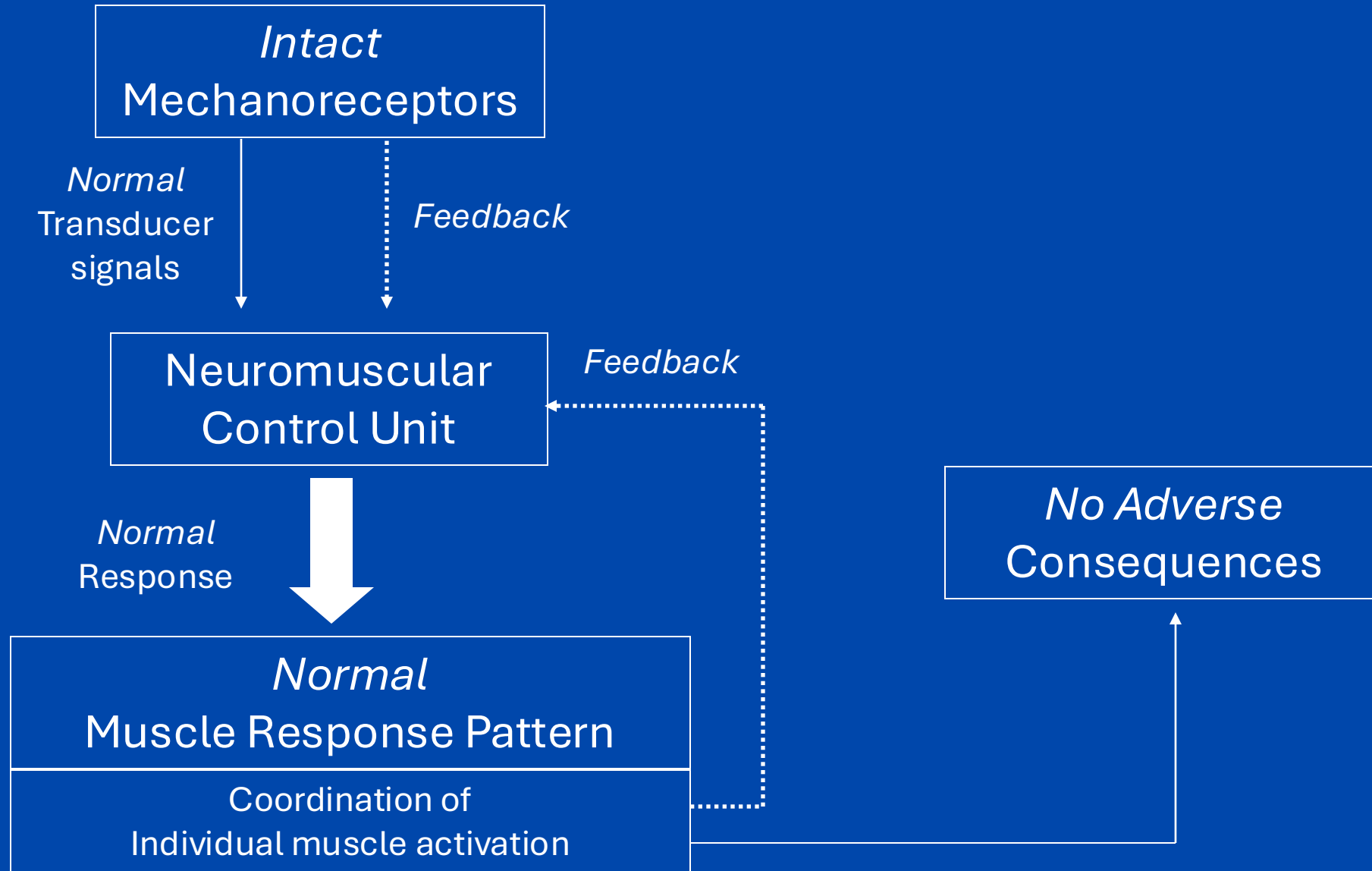
Leg Length Analysis is used to isolate **biomechanical or nervous system** “errors.”



RESEARCH ARTICLE

A HYPOTHESIS OF CHRONIC BACK PAIN: LIGAMENT SUBFAILURE INJURIES LEAD TO MUSCLE CONTROL DYSFUNCTION

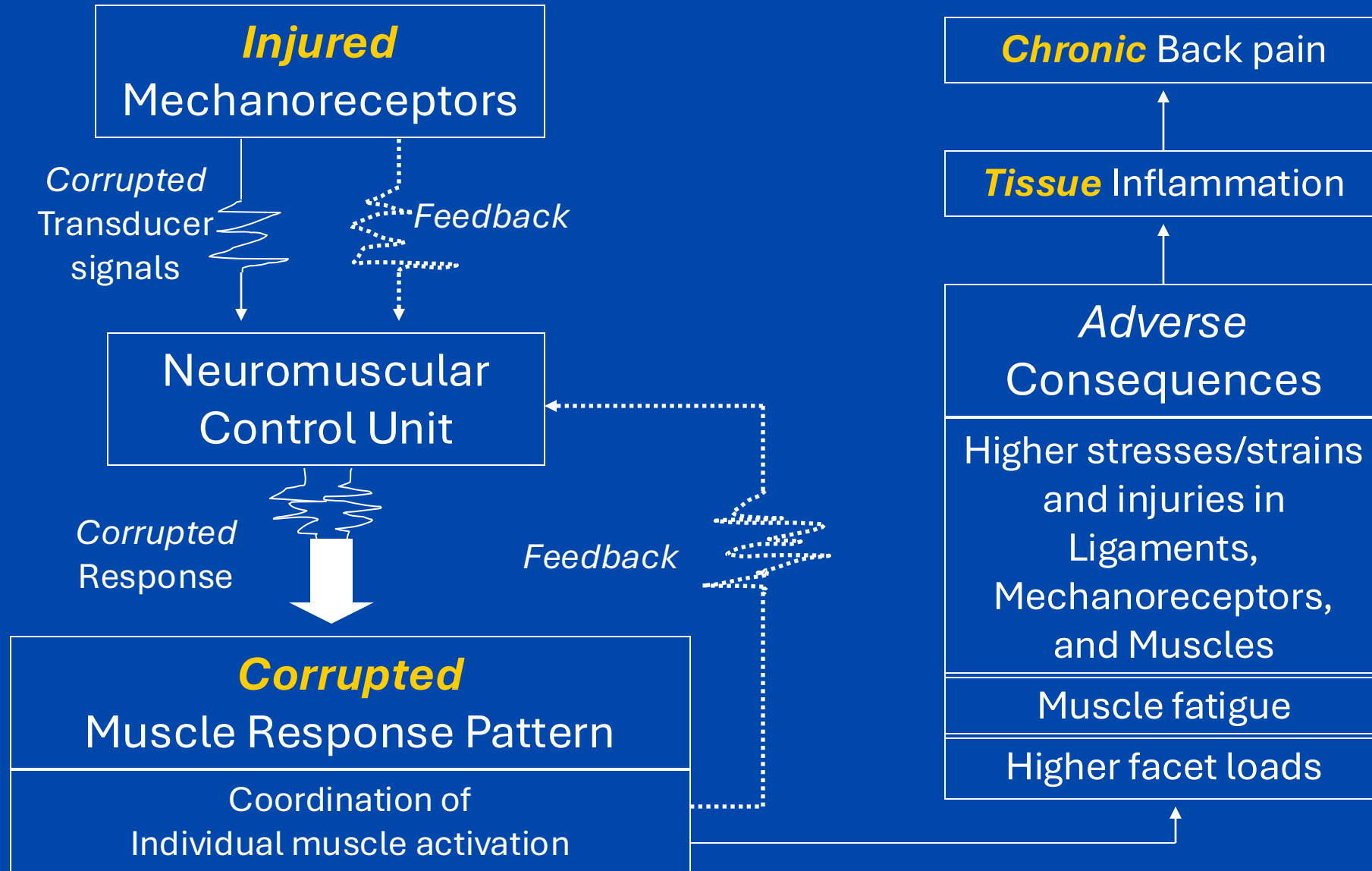
Manohar M. Panjabi, PhD
European Spine Journal
2006; 15:668-676



Panjabi MM. A hypothesis of chronic back pain: ligament subfailure injuries lead to muscle control dysfunction. Eur Spine J (2006) 15:668-676

“The injured spine behaves differently.” –M.M. Panjabi, PhD

“When the spine performs a routine task or responds to an external challenge, the disrupted / injured mechanoreceptors produce corrupted transducer signals, **describing vertebral position, spinal loads, etc. for each spinal level.**”



Panjabi MM. A hypothesis of chronic back pain: ligament subfailure injuries lead to muscle control dysfunction. Eur Spine J (2006) 15:668-676

T12 Isolation Test



feed**BACK**

feed**FORWARD**

feedFORWARD

“Occurs when the central nervous system **predicts** the effects that movement will have on the body.”

Hodges PW, Richardson CA. Relationship between limb movement speed and associated contraction of the trunk muscles. Ergonomics 1997;40(11):1220-30

Role of Intrinsic Spinal Muscles

Contraction of spinal intrinsic muscles occurs **in advance** of the muscles responsible for movement of the extremity, i.e. spinal stabilizers

Example: Transverse abdominis and deep multifidus muscles demonstrate activity prior to that of deltoid muscle when standing subjects were asked to move their arm.

Hodges, Richardson, Experimental Brain Research, 1997; Bouisset, Zattara, Neuroscience Letters, 1981; Aruin, Latash, Experimental Brain Research, 1995.

feedFORWARD

“This prediction involves a **coordinated effort** of local and global systems to stabilize the spine, **allowing for extremity movement** and incorporating the impending speed and resistant forces that may occur during limb movement.”

Hodges PW, Richardson CA. Altered trunk muscle recruitment in people with low back pain and upper limb movement at different speeds. Arch Phys Med Rehabilitation. 1996;80(9):1005-12

feedFORWARD Mechanisms

Segmental dysfunction may result in an **inability of the intrinsic muscles to stabilize** segments during the active movement of an Isolation Test:

- Recruiting Global Muscles
- Resulting in Leg Length Reactivity

Leg Length Reactivity



Sign of Nervous System “Error”

RESEARCH ARTICLE

OPTOELECTRIC MEASUREMENT OF CHANGES IN LEG LENGTH INEQUALITY RESULTING FROM ISOLATION TESTS

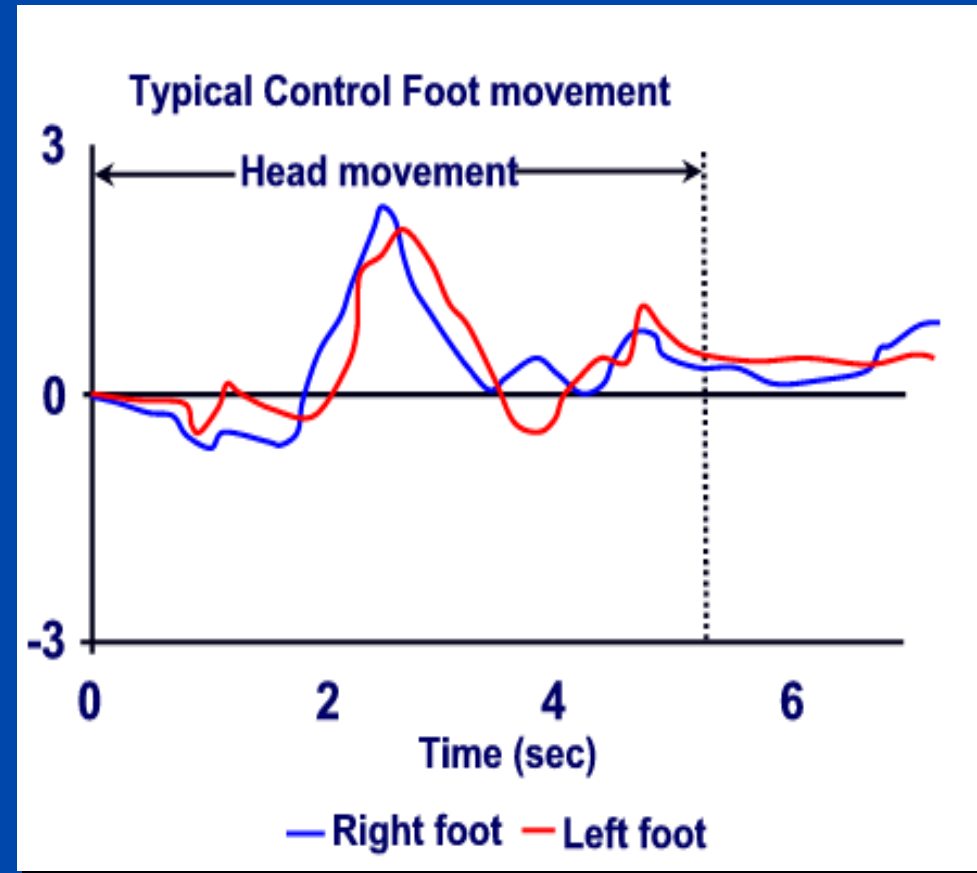
Dewitt JK, Osterbauer PJ, Stelmach GE, Fuhr AW. JMPT 1994;
7(8):530-8



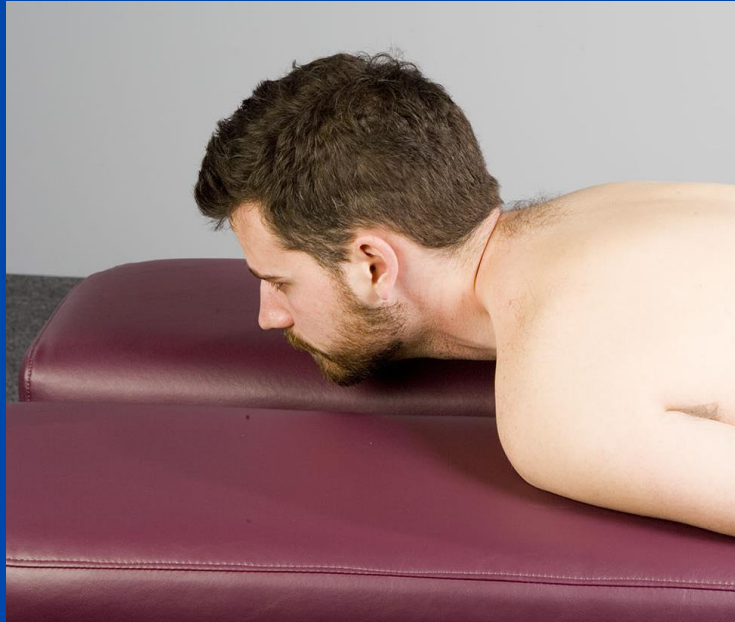
C5 Isolation Test Showing Patient Without Neuroarticular Dysfunction



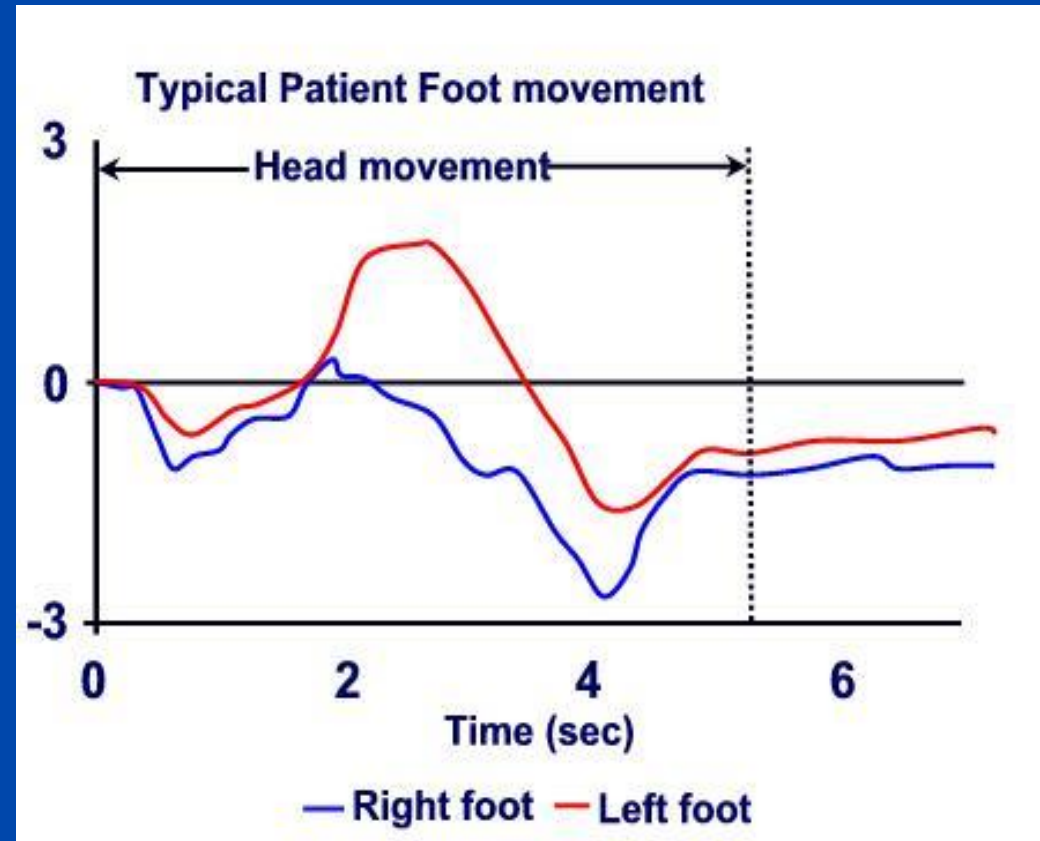
Box 7-1 (p191)



C5 Isolation Test Showing Patient With Neuroarticular Dysfunction



Box 7-1 (p191)



Leg Length Analysis

1. Interexaminer Reliability of the Prone Leg Length Analysis Procedure
2. Interexaminer Reliability of Relative Leg Length Evaluations in the Prone Extended Position.
3. Optoelectric Measurement of Changes in Leg Length Inequality Resulting from Isolation Tests.
4. Comparison of Leg Length Inequality Measurement Methods as Estimators of the Femur Head Height Difference on Standing X-ray.
5. Interexaminer Reliability of Activator Method's Relative Leg-Length Evaluation in the Prone Extended Position
6. Reactivity of Leg Alignment to Articular Pressure Testing: Evaluation of a Diagnostic Test using a Randomized Crossover Clinical Trial Approach
7. Leg Length Inequality and the Side of Low Back Pain - A Pilot Study
8. Optoelectric Measurement of Leg Length Changes Before, During, and After Isolation Tests.
9. Measurement of Soft Tissue Strain in Response to Consecutively Increased Compressive and Distractive Loads on a Friction-Based Test Bed
10. Optoelectric Measurement of Leg Length Inequalities Before, During, and After Isolation Tests.
11. Inter- and intra-examiner reliability of leg-length differential measurement: a preliminary study.
12. Responsiveness of leg alignment changes associated with articular pressure testing to spinal manipulation: the use of a randomized clinical trial design to evaluate a diagnostic test with a dichotomous outcome
13. Precise measurement of functional leg length inequality and changes due to cervical spine rotation in pain-free students
14. Interexaminer Reliability of Eight Evaluative Dimensions of Lumbar Segmental Abnormality
15. Motion Analysis as a Means to Objectify Changes in Apparent (Prone) Leg Length

Clinical Trials

1. Effects of chiropractic treatment on blood pressure and anxiety: a randomized, controlled trial. Yates RG, Lamping DL, Abram NL, Wright C. *J Manipulative Physiol Ther.* 1988 Dec;11(6):484-8.
2. Treatment and biomechanical assessment of patients with chronic sacroiliac joint syndrome. Osterbauer PJ, De Boer KF, Widmaier R, Petermann E, Fuhr AW. *J Manipulative Physiol Ther.* 1993 Feb;16(2):82-90.
3. The immediate effect of activator vs. meric adjustment on acute low back pain: a randomized controlled trial. Gemmell HA, Jacobson BH. *J Manipulative Physiol Ther.* 1995 Sep;18(7):453-6.
4. Comparison of two chiropractic techniques on pain and lateral flexion in neck pain patients: a pilot study. Yurkiw D, Mior S. *Chiropractic Technique.* 1996 Nov;8(4):155-162.
5. The effects of spinal manipulation on the intensity of emotional arousal in phobic subjects exposed to a threat stimulus: a randomized, controlled, double-blind clinical trial. Peterson KB. *J Manipulative Physiol Ther.* 1997 Nov-Dec;20(9):602-6.
6. A pilot randomized clinical trial on the relative effect of instrumental (MFMA) versus manual (HVLA) manipulation in the treatment of cervical spine dysfunction. Wood TG, Colloca CJ, Matthews R. *J Manipulative Physiol Ther.* 2001 May;24(4):260-71.
7. Chiropractic treatment of temporomandibular disorders using the activator adjusting instrument: a prospective case series. DeVocht JW, Long CR, Zeitler DL, Schaeffer W. *J Manipulative Physiol Ther.* 2003 Sep;26(7):421-5.
8. A randomized clinical trial of manual versus mechanical force manipulation in the treatment of sacroiliac joint syndrome. Sheerar KA, Colloca CJ, White HL. *J Manipulative Physiol Ther.* 2005 Sep;28(7):493-501.
9. Immediate effect of activator trigger point therapy and myofascial band therapy on non-specific neck pain in patients with upper trapezius trigger points compared to sham ultrasound: A randomised controlled trial. Blikstad A, Gemmell H. *Clinical Chiropractic* (2008) 11, 23—29.
10. Relative immediate effect of ischaemic compression and activator trigger point therapy on active upper trapezius trigger points: A randomised trial. Gemmell H, Allen A. *Clinical Chiropractic* (2008) 11,175—181.
11. Effects of a manually assisted mechanical force on cutaneous temperature. Roy RA, Boucher JP, Comtois AS. *J Manipulative Physiol Ther.* 2008 Mar;31(3):230-6.
12. Heart rate variability modulation after manipulation in pain-free patients vs patients in pain. Roy RA, Boucher JP, Comtois AS. *J Manipulative Physiol Ther.* 2009 May;32(4):277-86.
13. Relative effectiveness and adverse effects of cervical manipulation, mobilisation and the

The Activator Method

Basic Scan Protocol

Module 1: Conducting the
Initial Leg Check

p 112-117

Objectives

- ◆ Activator Method Protocol *p 112*
- ◆ Footwear and Clothing *p 113*
- ◆ Patient Placement *p 115*
- ◆ Visual Observation *p 116*
- ◆ Position #1 Procedures *p 117*

Activator Methods Protocol

- ◆ Description
- ◆ Significance
- ◆ Research and Clinical Experience
- ◆ Functional Short Leg

What is the AM protocol?

- ◆ The central feature of the Activator Method protocol is Leg Length Analysis (LLA)
- ◆ LLA is a series of repeated, systematic measures of prone extended and flexed Leg Length Inequality (LLI)

What is the significance of the AM protocol?

LLA enables the practitioner to identify neuroarticular dysfunction **confidently** and **consistently** even when a patient suffers from atypical (or no) symptoms.

Measuring LLI using the AM protocol enable the practitioner to:

- ◆ Isolate neuroarticular dysfunction of the axial skeleton and extremities
- ◆ Determine the direction of misalignment
- ◆ Confirm the direction of adjustment
- ◆ Confirm post-adjustment assessment

keypoint

The AM Leg Length Analysis (LLA)
is used to help determine:

- ◆ WHERE to adjust
- ◆ WHEN to adjust
- ◆ WHEN NOT to adjust

What do research and clinical experience show?

Proficiency-rated doctors who use Activator methodology have **good to very good** intra-examiner reliability when evaluating Pelvic Deficiency (PD), or Leg Length Inequality (LLI).

See Table 6-1 (p 134) of **The Activator Method**, Second Edition

What is a functional short leg?

- ◆ While not anatomically shorter, the functional short leg appears shorter during analysis and treatment
- ◆ Traditionally designated as the Pelvic Deficient, or PD leg
 - Also referred to as the reactive leg

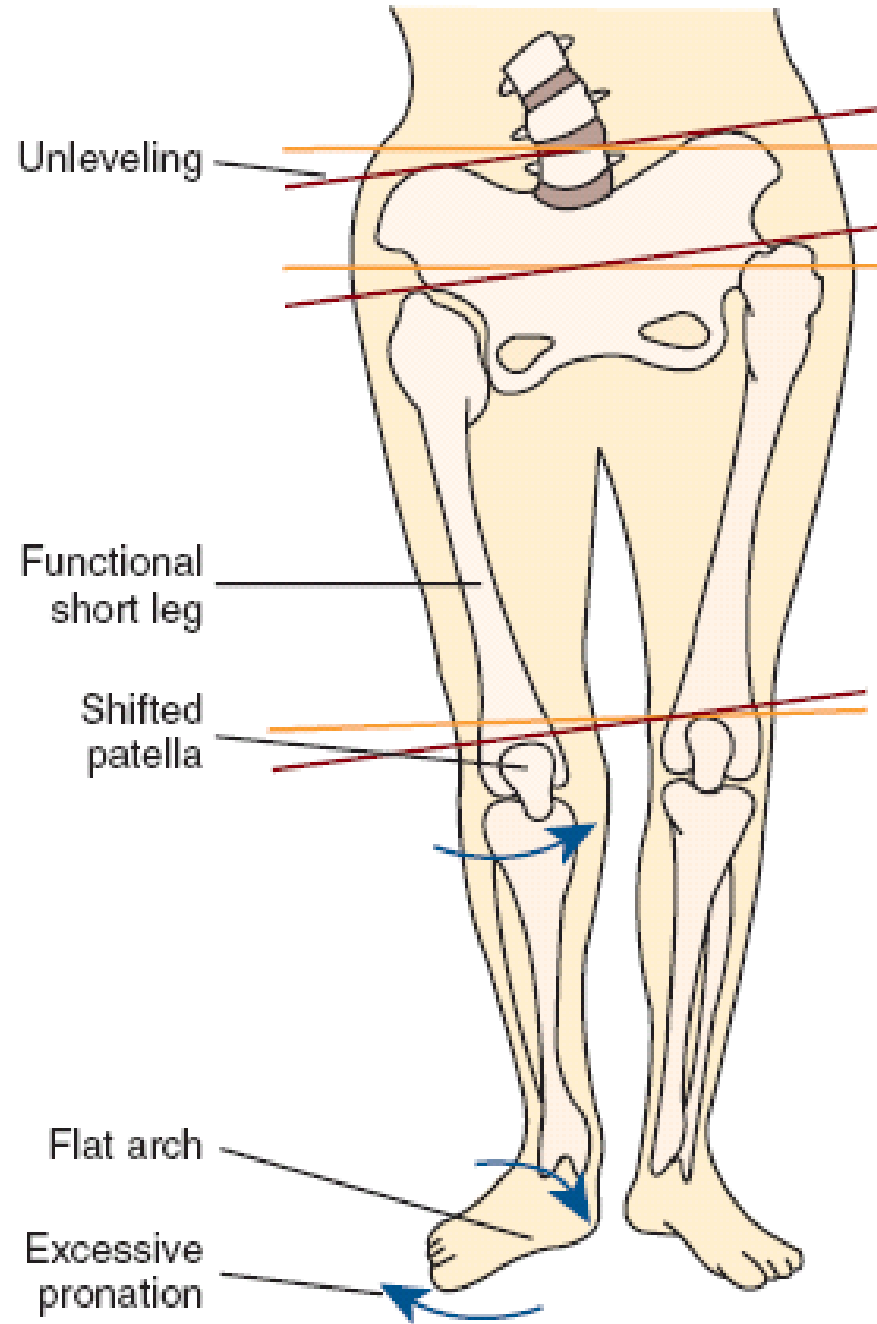


Figure 5-3 Excessive pronation consequences.

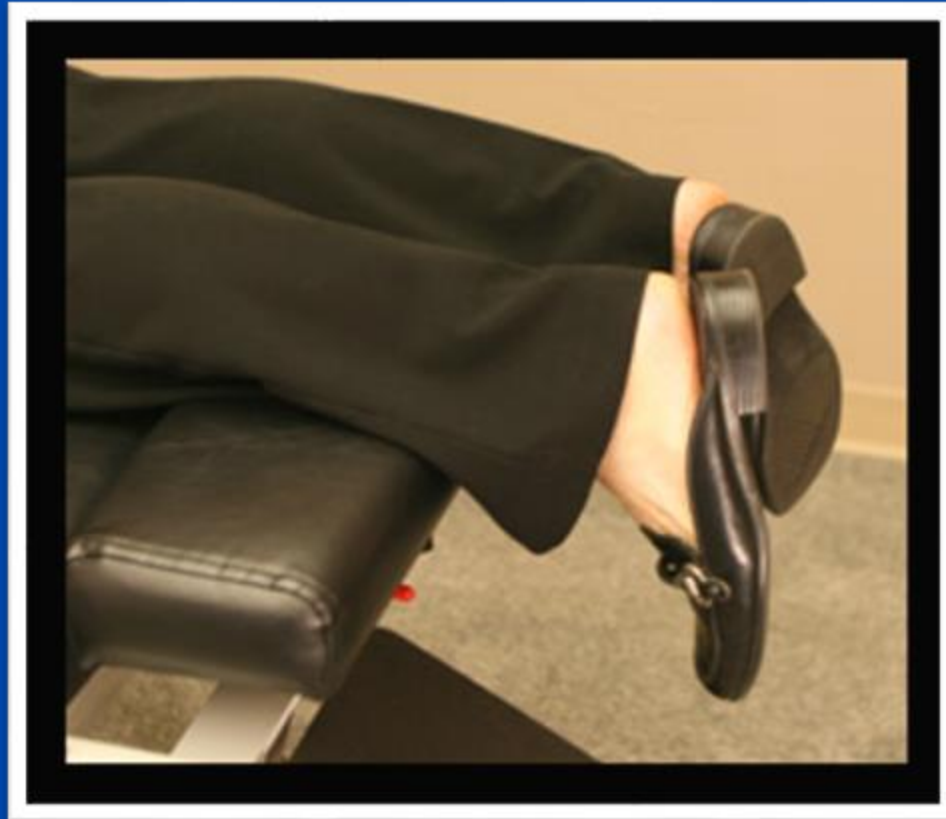
Footwear



Proper footwear should:

- ◆ Have a back or a strap that maintains contact with the heel and helps prevent gripping of the toes by the patient
- ◆ Allow access to the bones of the feet
- ◆ Fit the foot tightly, not be badly worn, and slip on and off easily when needed

Shoes should have a back or a strap that maintains contact with the heel.



Footwear should allow access to the bones of the feet.



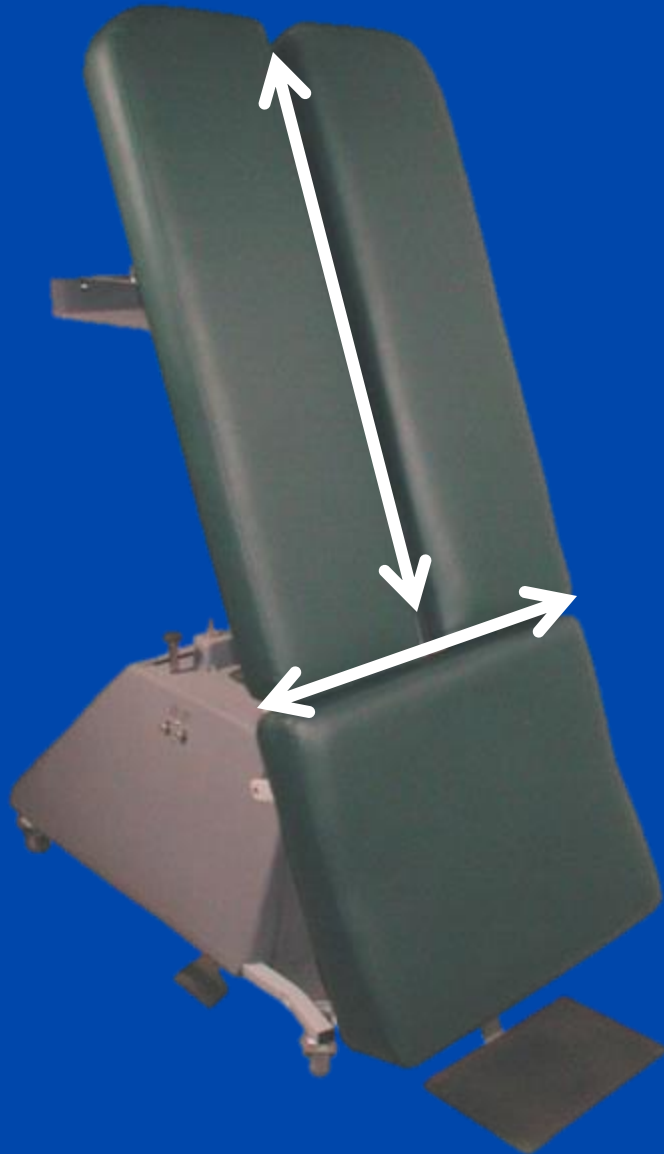
Proper footwear should fit the foot tightly.



The best shoes are low-cut, and not badly worn.



Proper Adjusting Table



Tilt table preserves and enhances weight-bearing postural distortions and compensations

Lloyd Activator[®] Hylo

Clothing and other Considerations



Proper Adjusting Table



Wide enough to support patient's arms

Bolster under patient's ankles to relax knees

Long face slot to accommodate short and tall but leave ankles in proper position

Tilt table preserves and enhances weight-bearing distortions and postural compensations

Lloyd Activator[®] Hylo

Proper Patient Placement



Instruct the patient:

- Lean into the table
- Face centered in the slot
- Arms at the sides
- Back of each hand contact-ing and resting on the table
- Do not move or adjust your weight

Place a hand firmly over patient's lower back

Lower the table

Proper Patient Placement



The patient's legs need to extend past the bottom of the table far enough to allow ankles and feet to move freely.

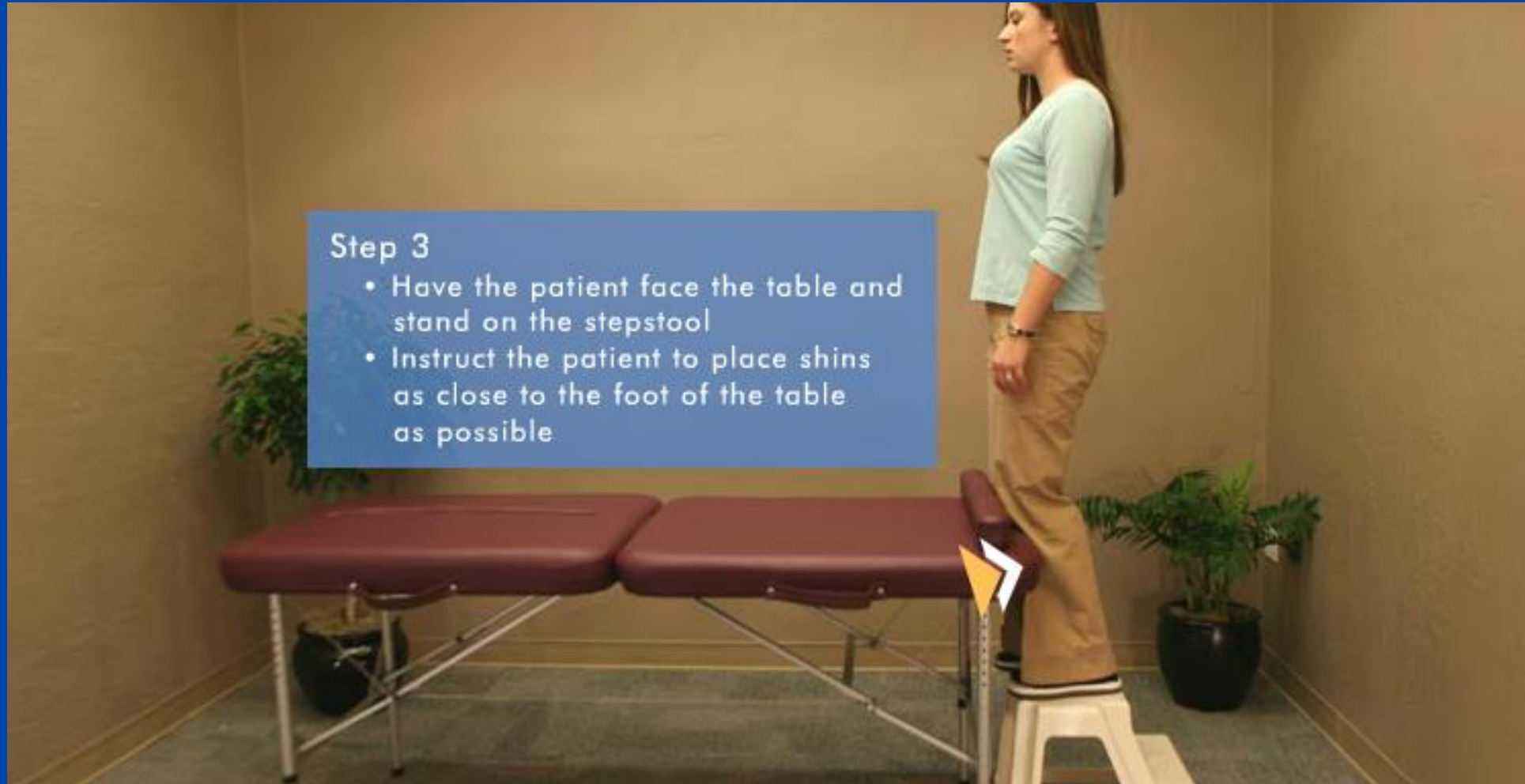
Patient Positioning: portable table



Patient Positioning: portable table



Patient Positioning: portable table



Patient Positioning: portable table

Step 4

Instruct patient to kneel on the adjusting table.

- Patient's knees come to same point on table and are parallel
- Patient's legs extend past bottom of table far enough to allow ankles and feet to move freely



Patient Positioning: portable table

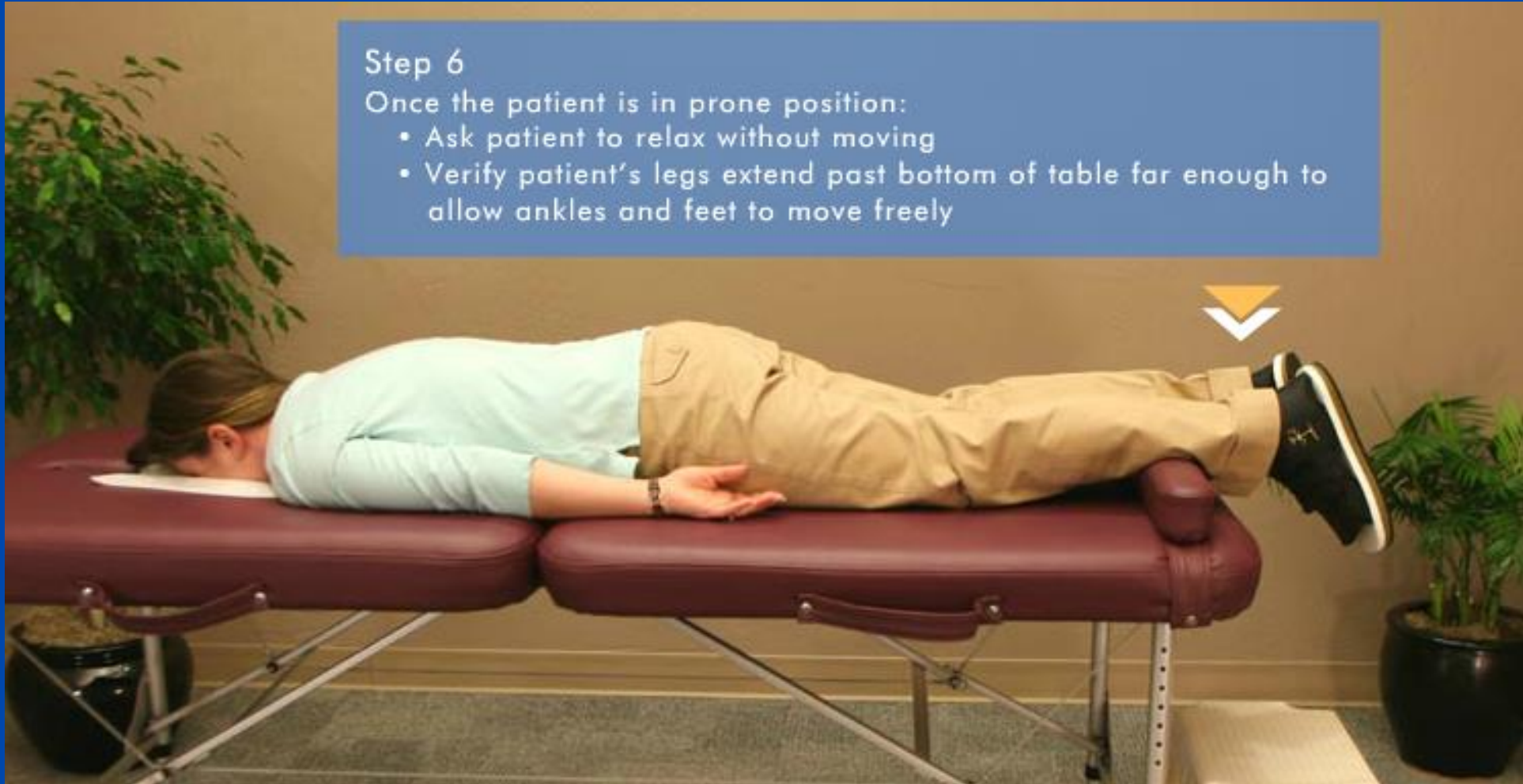


Patient Positioning: portable table

Step 6

Once the patient is in prone position:

- Ask patient to relax without moving
- Verify patient's legs extend past bottom of table far enough to allow ankles and feet to move freely



Doctor positioning: stance

The position in which you stand is also important.

- ◆ Stand at the foot of the table with a stance that permits a clear line of sight to the plantar surfaces of the patient's feet
- ◆ Place one foot forward in an in-line, or scissor stance
- ◆ Keep an upright posture



AM step-by-step procedure



Proper patient placement for conducting the initial leg check.

Leg Length Analysis: Position #1 Procedures



keypoint

Unless otherwise noted we will use a **Left PD** as our example on these slides and in the textbook.

1. Look, DON'T TOUCH!



Look for:
evidence of
asymmetrical
inversion or
eversion



Look for:
excessive
toe-out or
toe-in flare



2. Bring the legs TOGETHER



keypoint

In most cases, the short leg revealed
by visual inspection is the
Pelvic Deficient, or reactive, leg.

Step 1

Place hands in "six-point landing."



Step 2

Remove inversion/eversion.



Step 3
Gently dorsiflex the feet.





Step 4
Flare feet 10°.



Step 5
Apply gentle
headward pressure.

3. SIX-Point Landing



Remove inversion
or eversion

Gently dorsiflex the
feet

Flare feet 10°

Apply gentle
headward pressure

Look at the welt of the shoes at the heels, and observe/measure the PD (Pelvic Deficient) leg.



4. Hands OFF!



Remove hands
completely before
Position #2 hand
position

Position #1 Summary



Tips for Minimizing Error

- ◆ Use a light touch
- ◆ Do not wiggle or “play” with the feet or legs
- ◆ Keep your index finger off the Achilles tendon in Position #1
- ◆ Remove inversion (supination) and plantar flexion

keypoint

From this point on, the short leg identified in this initial leg check is considered the PD leg, or reactive leg.

Leg Check Drills

1. Look, DON'T TOUCH!
2. Bring the Legs TOGETHER
3. SIX-Point Landing
4. Hands OFF!

1. Look, DON'T TOUCH!



Before touching the feet, visually observe for asymmetrical inversion or eversion, and excessive toe-out or toe-in foot flare

2. Bring the Legs TOGETHER



Cup the palms of the hands over the lateral malleoli and bring (but do not force) the legs together until the heels approximate

3. SIX-Point Landing



Remove inversion
or eversion

Gently dorsiflex the
feet

Flare feet 10°

Apply gentle
headward pressure

The Activator Method

Basic Scan Protocol

Module 2: Interpreting the Results
of the Initial Leg Check

p 116-122

Objectives

- ◆ Position #2 Procedures *p 119*
- ◆ Minimizing Error *p 121*
- ◆ Interpreting Results of the
Check *p 121*

Initial Leg

The 4 Essential Steps of the Initial Leg Check

1. Patient Placement
2. Visual Inspection
3. Position #1 procedure
 - Identify the PD leg
4. Position #2 procedure
 - Identify the starting point for analysis

Leg Length Analysis: Position #2



Position #2 Procedure

1. Stand in an in-line, scissor stance
2. Contact the dorsal aspect of the patient's feet at the MTP junction with the middle fingers
3. Plantar flex the feet until slack is taken up, **before** lifting the legs

Position #2 Procedure

4. Slowly lift the legs by raising the feet and flexing the knees
5. At $\sim 30^\circ$ of knee flexion, slide the index fingers into the welt of the shoe, and position the thumbs on the soles near the ball of each foot

Position #2 Procedure

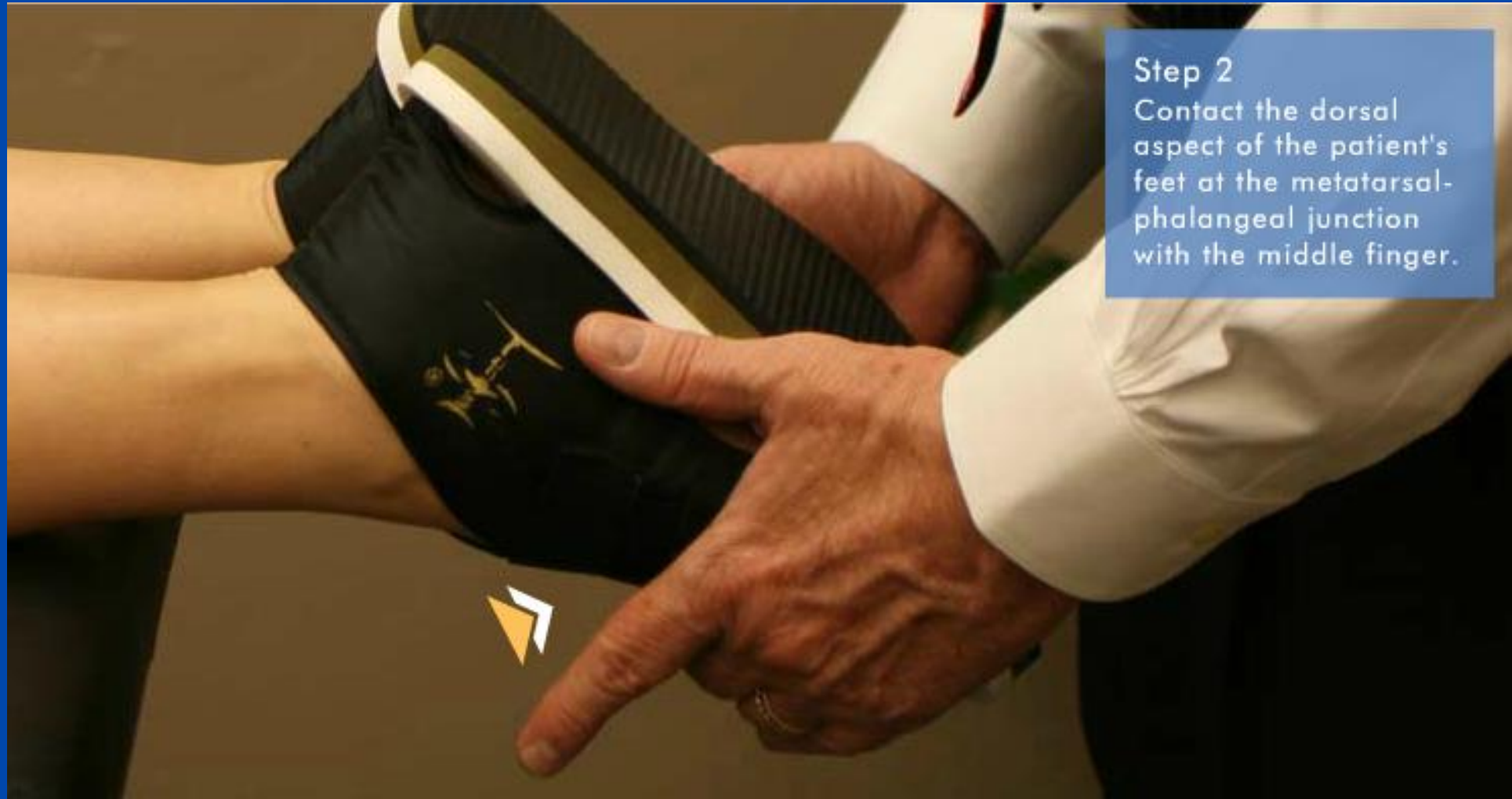
6. Continue to raise feet until knees are flexed to no more than 90°
7. Site an imaginary mid-line on the patient (*2nd sacral tubercle to EOP*)
8. At 90° , abduct the feet to a 10° toe-out foot flare



Step 1
Stand in a scissor stance.

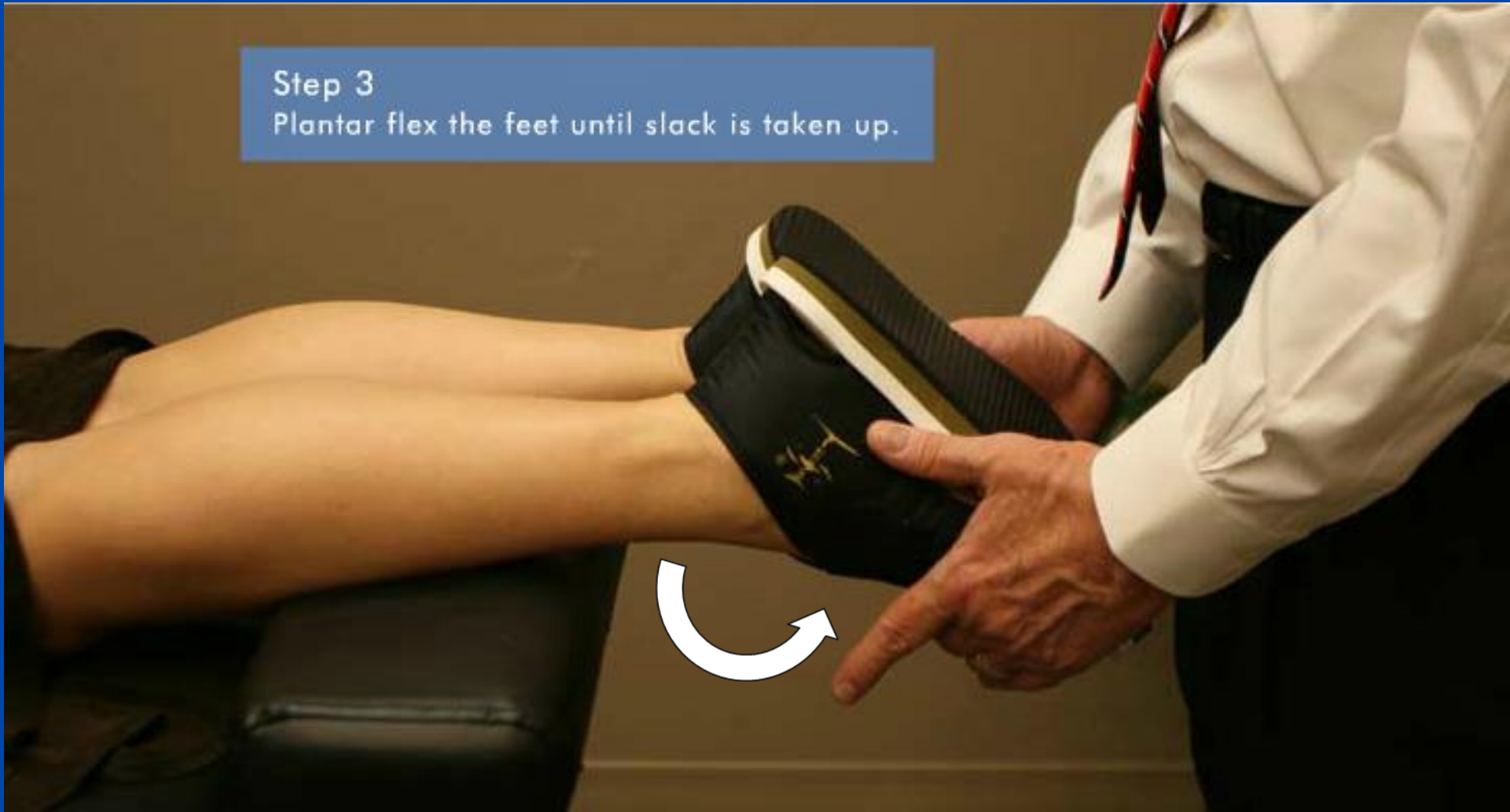
Step 2

Contact the dorsal aspect of the patient's feet at the metatarsal-phalangeal junction with the middle finger.



Step 3

Plantar flex the feet until slack is taken up.





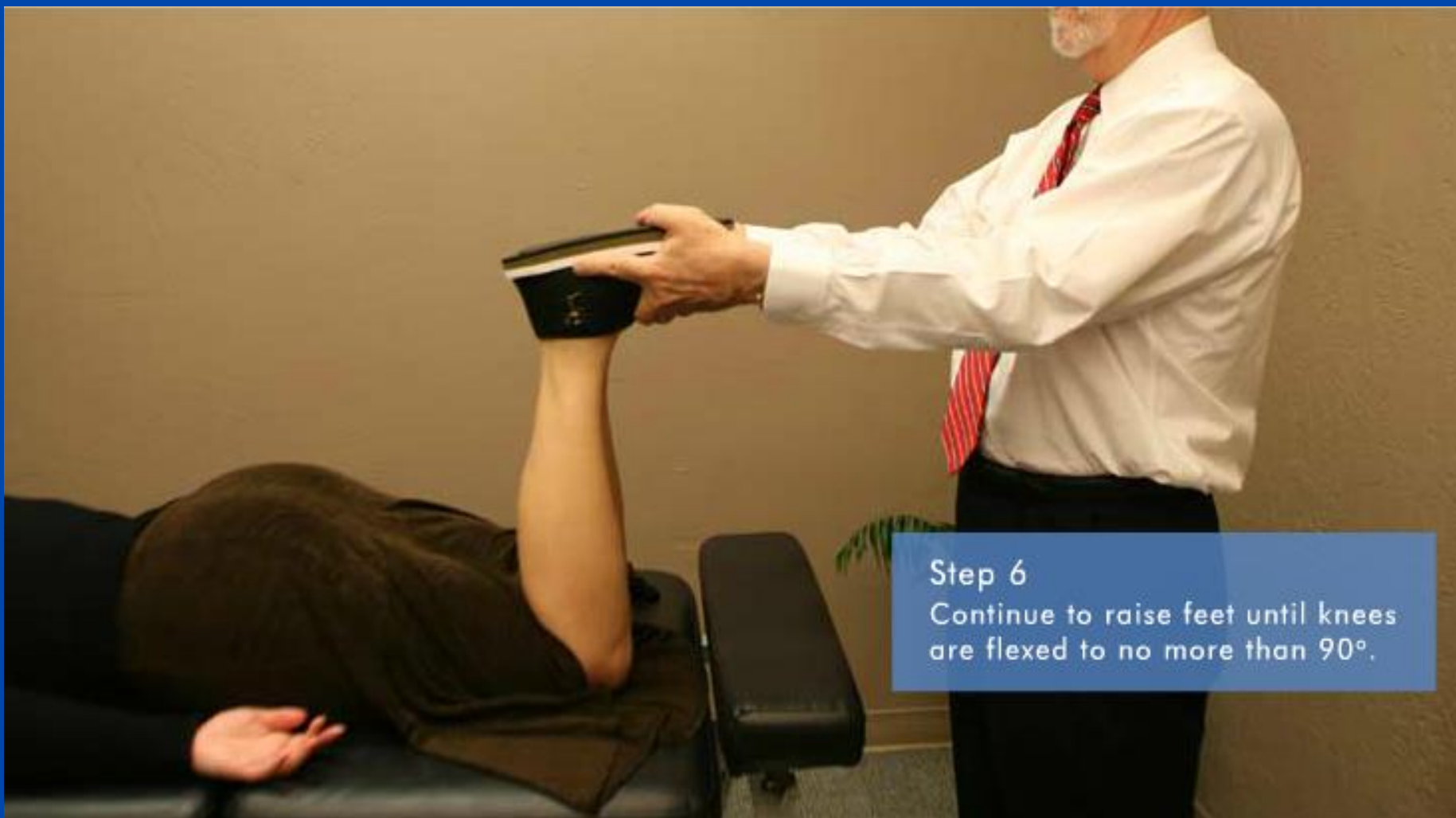
Step 4

Lift the legs by raising the feet and flexing the knees.



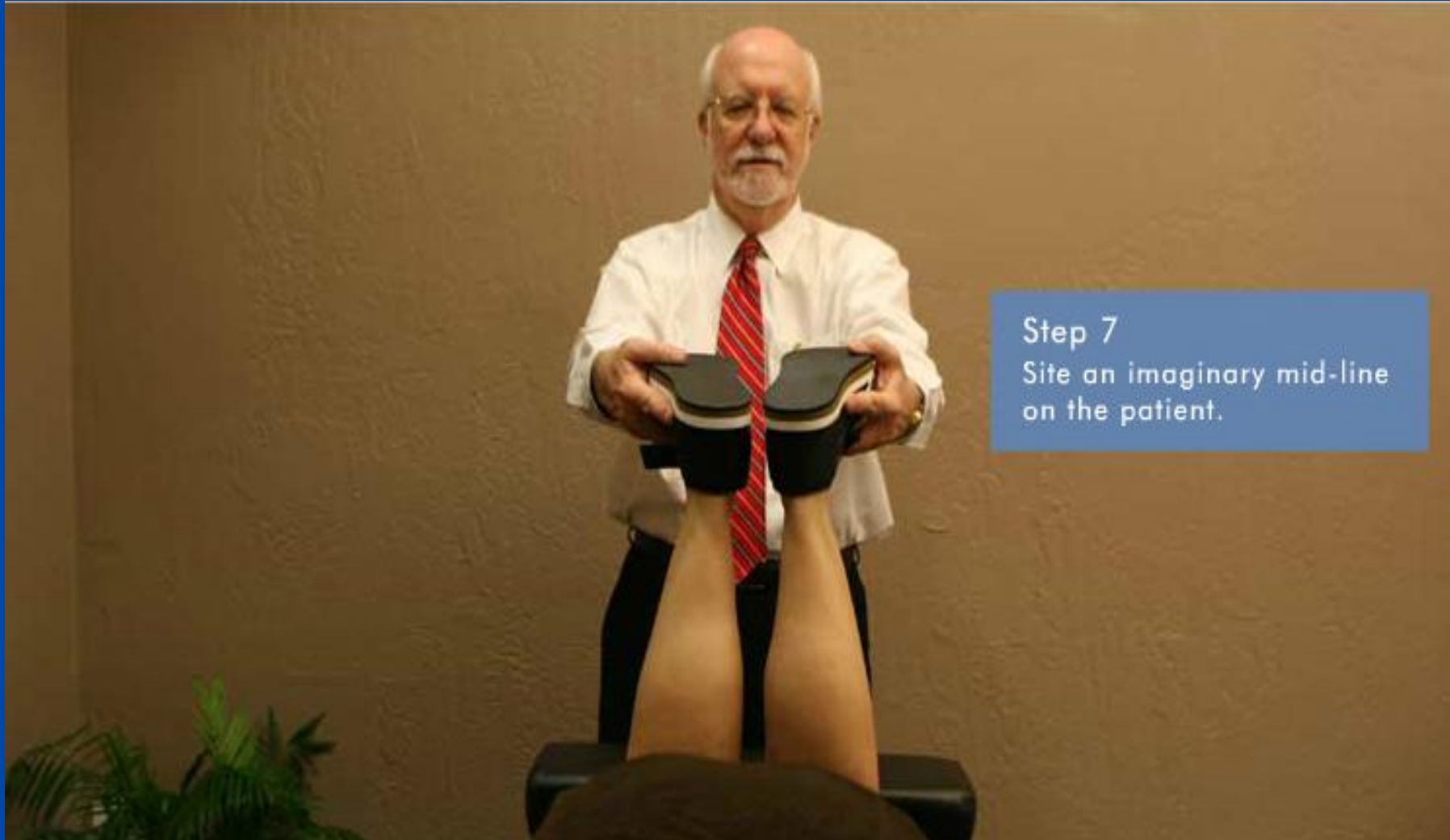
Step 5

Slide index finger into welt of shoe,
and position thumbs on soles.



Step 6

Continue to raise feet until knees are flexed to no more than 90° .



Step 7
Site an imaginary mid-line
on the patient.





Step 9
Feet should mirror each other.

Look at the welt of the shoes at the heels, and measure any change in the relative length of the PD leg.



Position #2 Summary



Tips for Minimizing Error

- ◆ Move the legs deliberately from Position #1 toward Position #2
- ◆ Keep your elbows tucked into the sides while raising the legs toward Position #2
- ◆ Lower the legs slowly from Position #2 back down to Position #1

Tips for Minimizing Error

- ◆ Let the feet form a “V” in Position #2, **keeping the heels from touching**, with the toes flared out
- ◆ **Do not force dorsiflexion** of the feet in Position #2

Interpreting the Results of the Initial Leg Check

- ◆ Raise the legs to Position #2, observe for the PD leg to lengthen or shorten relative to its length in Position #1
- ◆ Determine the starting point for AM assessment protocol based on the relative change

keypoint

The results of the initial leg check reveal the starting point for the AM assessment protocol:

1. Knees and Feet
2. Fourth Lumbar (L4)
3. Symphysis Pubis

Possibility One

PD leg appears to have **lengthened** in Position #2



Legs uneven in Position #1



AM testing procedure starts with the **knees and feet**

Possibility One Examples

Position #1	Position #2
Left leg 1" short	Left leg $\frac{1}{4}$ " short
Left leg $\frac{1}{2}$ " short	Left leg $\frac{1}{2}$ " long

Possibility Two

PD leg appears to have **stayed short** or becomes **shorter** in Position #2



Legs uneven in Position #1



AM testing protocol starts with **fourth lumbar (L4)**

Possibility Two Examples

Position #1	Position #2
Left leg $\frac{3}{4}$ " short	Left leg 1" short
Left leg $\frac{1}{4}$ " short	Left leg $\frac{1}{2}$ " short

Possibility Three

Legs **even** in Position #1 and Position #2



Legs are even in Position #1



AM testing protocol starts with the **symphysis pubis**

Possibility Three Example

Position #1	Position #2
Legs even	Legs even

NOTE: This occurs very rarely in new patients – even asymptomatic patients typically have an identifiable PD leg

keypoint

Possibility One occurs much more frequently during the initial LLA than Possibility Two and Possibility Three.

Three Possibilities Summary

Possibility	Finding	Testing/Adjustment
Possibility One	PD leg lengthens going from Position #1 to Position #2	Begin with knees and feet
Possibility Two	PD leg shortens going from Position #1 to Position #2	Skip knees and feet, and pelvis; begin with fourth lumbar vertebra (L4)
Possibility Three	Legs are even/balanced in Position #1 and Position #2	Skip knees and feet, and pelvis; begin with pubic symphysis

Leg Check Drills

1. Look, DON'T TOUCH!
2. Bring the Legs TOGETHER
3. SIX-Point Landing
4. Hands OFF!
5. Plantar FLEX
6. Lift and TAKE CONTROL
7. SLIDE Home

1. Look, DON'T TOUCH!



2. Bring the legs TOGETHER



3. SIX-Point Landing



Remove inversion
or eversion

Gently dorsiflex the
feet

Flare feet 10°

Apply gentle
headward pressure



**KEEP
CALM
AND
MAKE
THE CALL**

4. Hands OFF!



Remove hands
completely before
Position #2 hand
position

5. Plantar FLEX



6. Lift and TAKE CONTROL



7. SLIDE Home



Continue to raise the feet until change in apparent length of PD is noticeable

Gentle thumb pressure on balls of feet, dorsiflex feet to point of resistance



**KEEP
CALM
AND
MAKE
THE CALL**

Leg Check Drills

1. Look, DON'T TOUCH!
2. Bring the Legs TOGETHER
3. SIX-Point Landing
4. Hands OFF!
5. Plantar FLEX
6. Lift and TAKE CONTROL
7. SLIDE Home

The Activator Method

Basic Scan Protocol

Module 3: Pressure/Stress Testing;
Knees and Feet; Pelvis

p 142-153

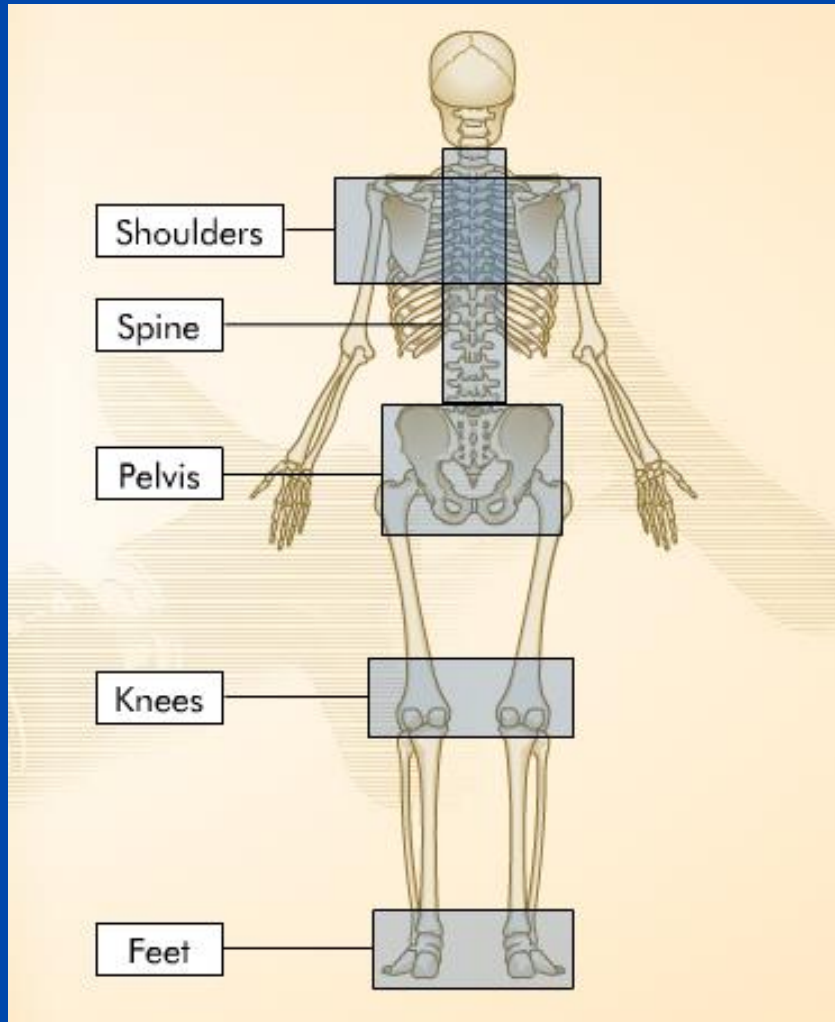
Objectives

- ◆ Describe the verification tests used to confirm involvement of an area
- ◆ Identify the appropriate testing procedures for the knee joint
- ◆ Select appropriate adjustments for:
 - the talus and medial knee
 - the cuboid and lateral knee

Basic Scan: Clinical Rationale

- ◆ A **systematic** clinical approach for identifying and treating a wide variety of common complaints
- ◆ A sequence of various tests and adjustments most frequently seen in **new and returning** patients

Basic Scan: Clinical Rationale



The majority of dysfunctions of consequence tend to occur at biomechanical stress points.

keypoint

Verification tests use LLA (leg length analysis) as part of their performance and assist in determining where and when to appropriately adjust.

Verification Tests

Three types of tests are used to confirm involvement of an area of the body:

1. Pressure Tests
2. Stress Tests
3. Isolation Tests

Verification Tests

Three types of tests are used to confirm involvement of an area of the body:

- 1. Pressure Tests**
2. Stress Tests
3. Isolation Tests

WHAT are Pressure Tests?

- ◆ **Tests performed by the doctor** to identify a specific component suspected of subluxation
- ◆ A gentle manual pressure applied at the point of suspected involvement into the **direction of adjustment**

WHY do you use Pressure Tests?

- ◆ They indicate WHERE and WHEN to appropriately adjust to improve joint neurology and biomechanics
- ◆ They confirm the **need for** and the **direction of** the adjustment of an axial or appendicular joint

keypoint

Pressure Tests are only performed when the legs are imbalanced or uneven in Position #1.

HOW do you use Pressure Tests?

- ◆ Apply a gentle manual force to a vertebral segment or extremity joint in the **direction of adjustment**
- ◆ Recheck for the legs to balance or become more even in Position #1

Verification Tests

Three types of tests are used to confirm involvement of an area of the body:

1. Pressure Tests
2. Stress Tests
3. Isolation Tests

Verification Tests

Three types of tests are used to confirm involvement of an area of the body:

1. Pressure Tests
2. Stress Tests
3. Isolation Tests

WHAT are Stress Tests?

- ◆ **Tests performed by the doctor** to isolate a specific component suspected of subluxation
- ◆ A gentle manual force applied at the point of suspected involvement in the **direction of neuroarticular dysfunction**

WHY do you use Stress Tests?

- ◆ They **help confirm** whether a joint is dysfunctional
- ◆ To identify and evaluate neuro-articular dysfunction in the spine, and the upper and lower extremities

keypoint

Stress Tests are only performed when the legs are balanced or even in Position #1.

HOW do you use Stress Tests?

- ◆ Apply a gentle manual force to a vertebral segment or extremity joint in the **direction of neuroarticular dysfunction**
- ◆ Recheck for the legs to imbalance or become less even in Position #1

Three Possibilities Summary

Possibility	Finding	Testing/Adjustment
Possibility One	PD leg lengthens going from Position #1 to Position #2	Begin with knees and feet
Possibility Two	PD leg shortens going from Position #1 to Position #2	Skip knees and feet, and pelvis; begin with fourth lumbar vertebra
Possibility Three	Legs are even/balanced in Position #1 and Position #2	Skip knees and feet, and pelvis; begin with pubic symphysis

Possibility One

PD leg appears to have **lengthened** in Position #2



Legs uneven in Position #1



AM testing procedure starts with the **knees and feet**

What does Possibility One indicate?

- ◆ The PD leg lengthening in Position #2 is more frequently associated with pelvic involvement than the knees and feet
- ◆ However, the knees and feet should be tested prior to testing the pelvis for involvement

Adjusting the Knees and Feet

- ◆ Adjustment of the knees and feet involve elements of the kinetic chain of the lower extremity
- ◆ Consequently, the Basic Scan Protocol calls for adjustment of two different elements when adjusting a Medial or Lateral knee pattern

Pressure Test of Medial Knee

- ◆ Apply a firm but gentle pressure by stroking over the medial collateral ligament
- ◆ Apply the pressure in lateral and inferior direction
- ◆ Stroke across the knee joint

Pressure Test of Medial Knee



keypoint

If the legs become even, or if the difference between them decreases following a Pressure Test, the need for correction is indicated.

Nonreactive Pressure Test of Medial Knee



Leg lengths are uneven
in Position #1

Leg lengths stay uneven
in Position #1

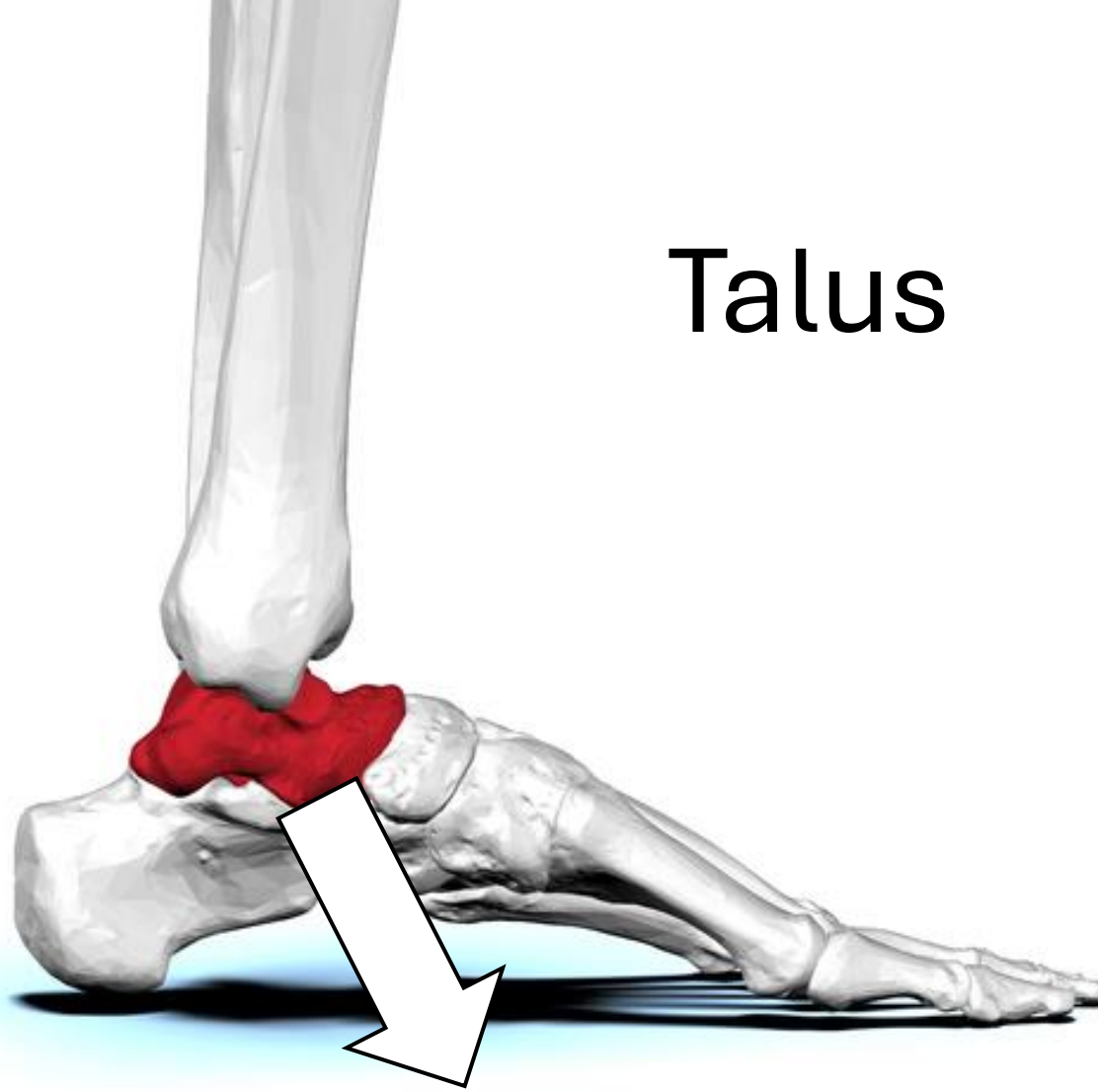
Reactive Pressure Test of Medial Knee



Leg lengths are uneven
in Position #1

Leg lengths balance or
become more even in
Position #1

Talus



Subluxates anterior, inferior and medial

Medial Knee | Step 1

Adjusting the Talus

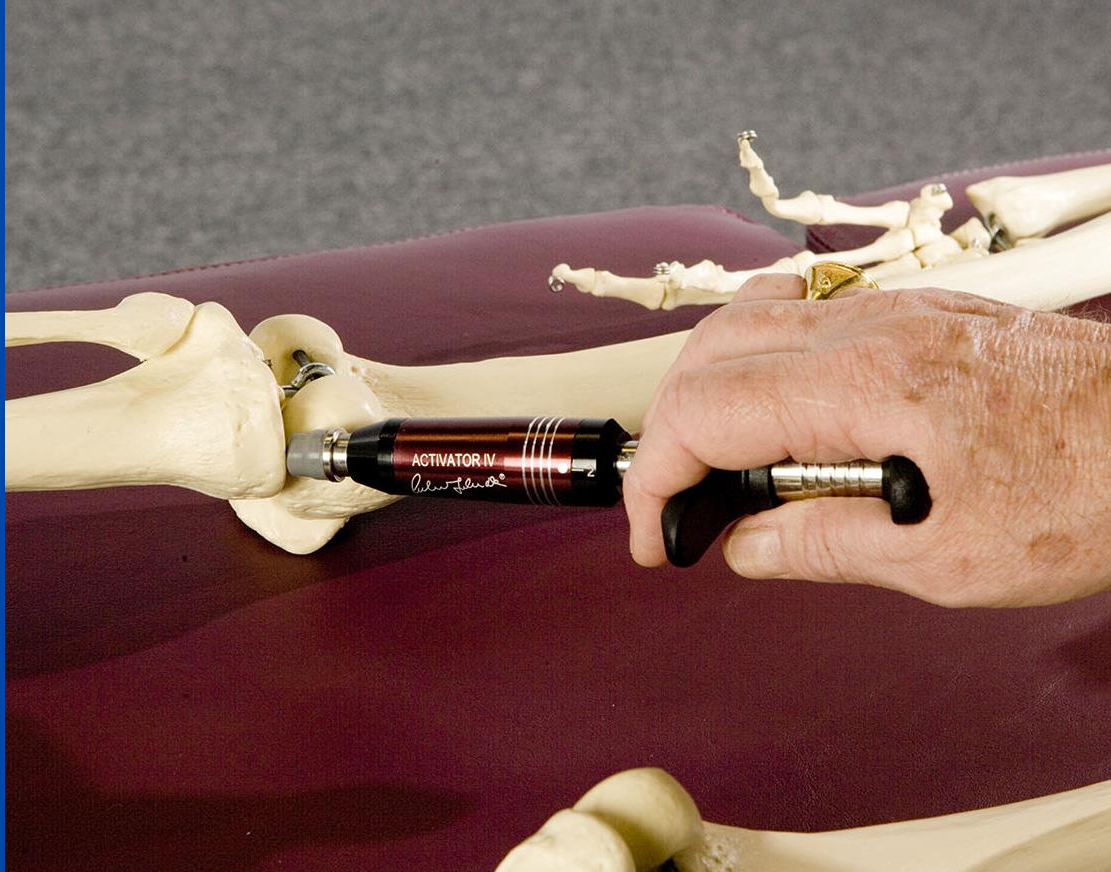


CP: Medial border of talus, anterior-inferior to the medial malleolus

LOD: Posterior, superior and lateral

Medial Knee | Step 2

Adjusting the Knee



CP: Knee above tibial plateau, on medial collateral ligament

LOD: Lateral and inferior

Knees | Clinical Tip

To ensure proper placement of the tip of the instrument, flex and extend the knee while palpating for the joint space. Locate the bony prominence of the tibial plateau. The contact is slightly above the tibial plateau.

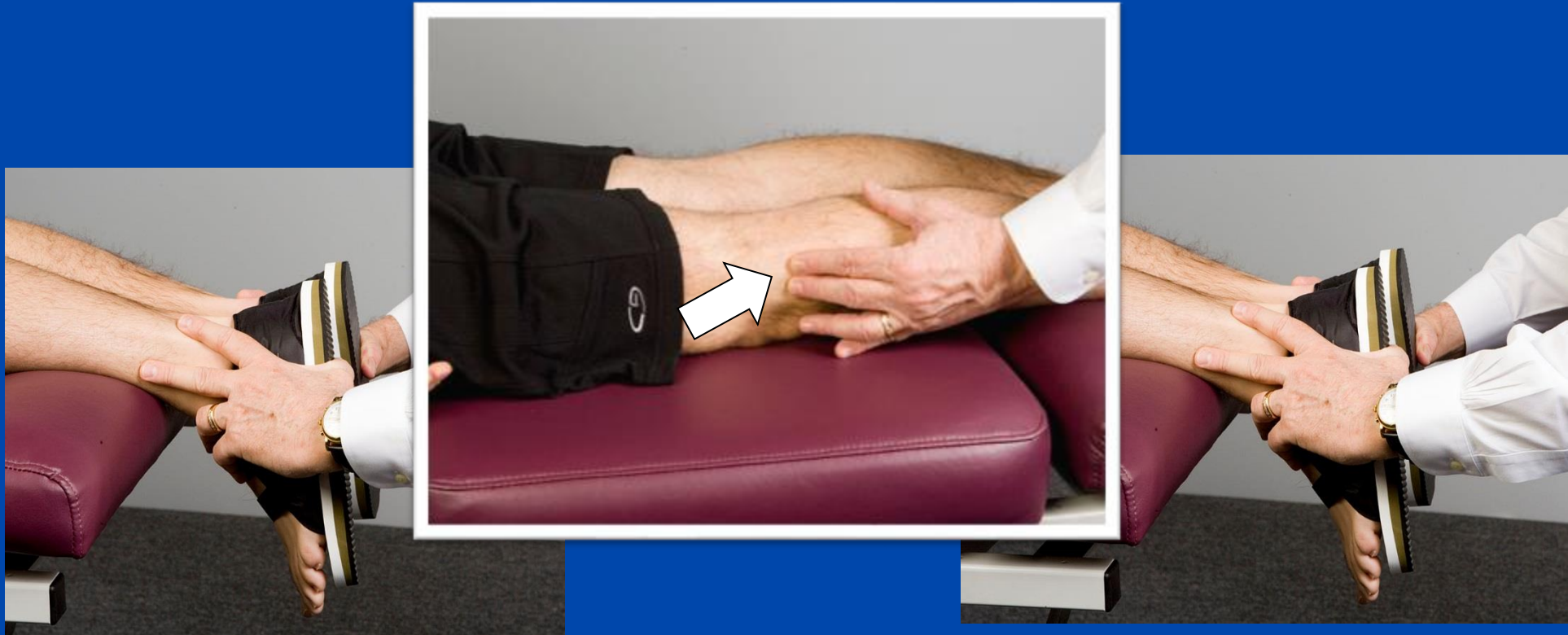
Pressure Test of Lateral Knee

- ◆ Apply a firm but gentle pressure by stroking over the lateral collateral ligament; avoid the fibula
- ◆ Apply the pressure in medial and inferior direction
- ◆ Stroke across the knee joint

Pressure Test of Lateral Knee



Nonreactive Pressure Test of Lateral Knee



Leg lengths are uneven
in Position #1

Leg lengths stay uneven
in Position #1

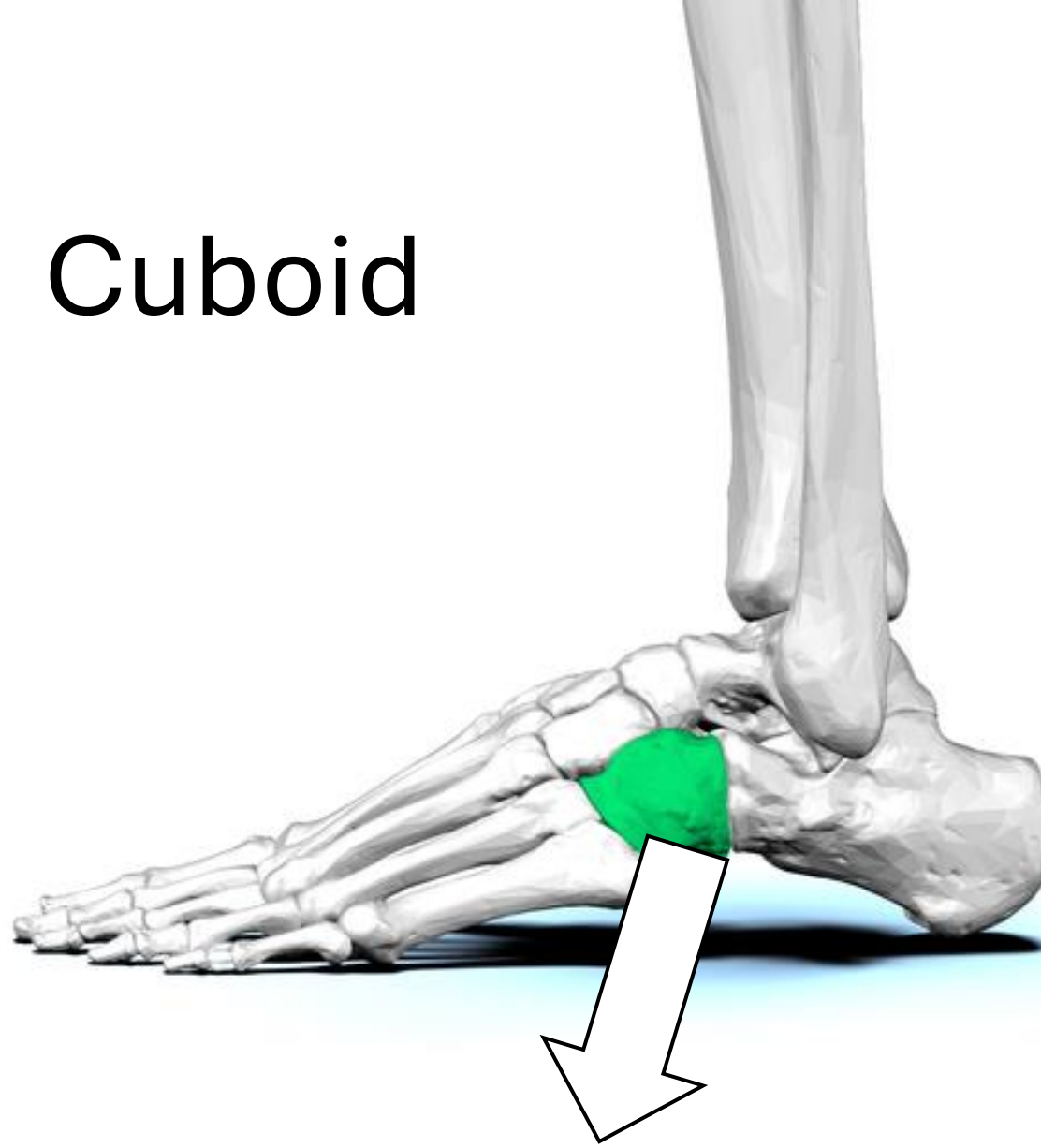
Reactive Pressure Test of Lateral Knee



Leg lengths are uneven
in Position #1

Leg lengths balance or
become more even in
Position #1

Cuboid



Subluxates anterior, inferior and lateral

Lateral Knee | Step 1

Adjusting the Cuboid



CP: Inferior and lateral aspect of the cuboid

LOD: Posterior, superior and medial

Lateral Knee | Step 2

Adjusting the Knee



CP: Knee above tibial plateau, on lateral collateral ligament

LOD: Medial and inferior

Knees | Clinical Tip

If upon the first two or three visits, you observe the knees and feet are not involved, it is not necessary to continue assessing them upon subsequent visits for that patient.

Correct order for testing and adjusting the knees and feet

Pressure Test	Adjust
Medial Knee on side of PD	Talus/Medial Knee
Medial Knee on side Opposite PD	Talus/Medial Knee
Lateral Knee on side of PD	Cuboid/Lateral Knee
Lateral Knee on side Opposite PD	Cuboid/Lateral Knee



What is the proper Activator instrument setting?

Extremities (healthy adult):

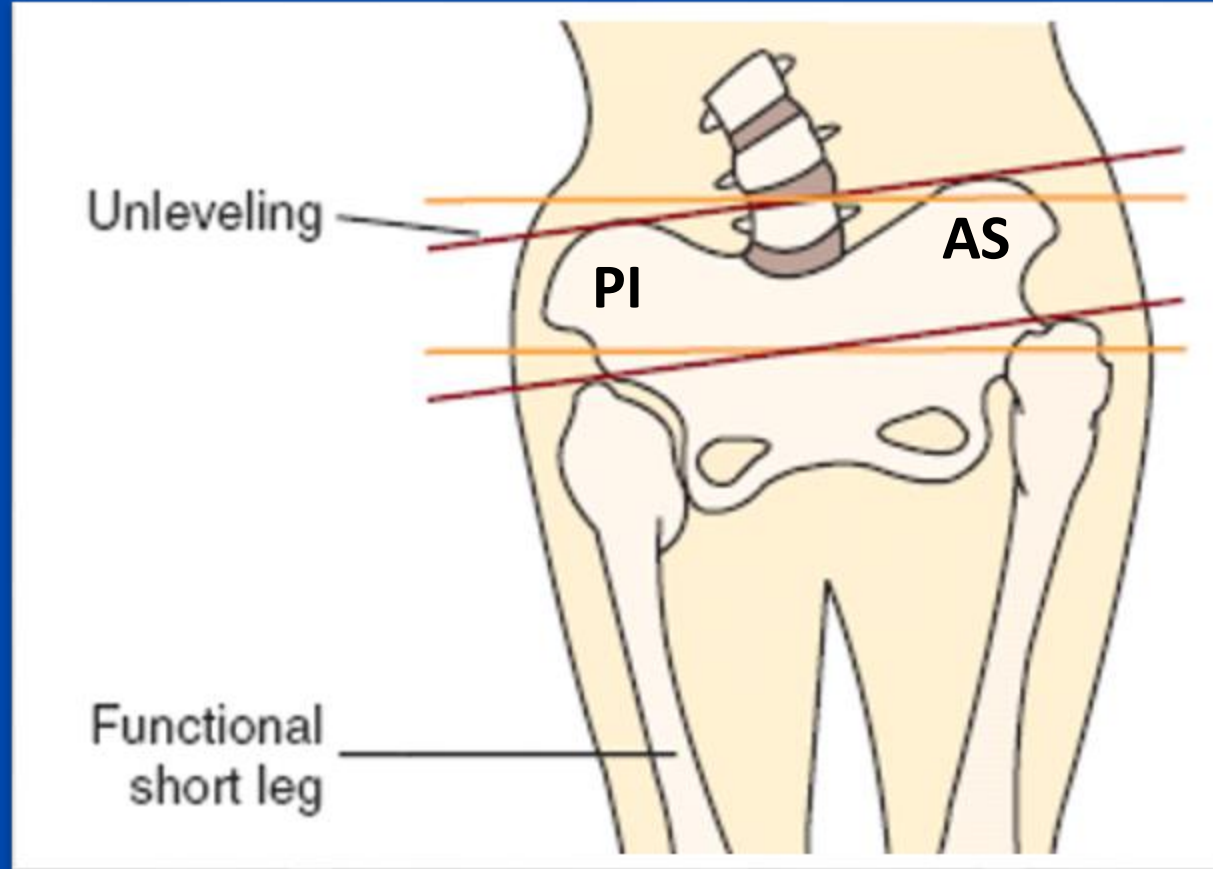
- Activator II: 3 rings
- Activator IV: setting 2
- Activator V: setting 2

Pelvic Tests

If the legs are not balanced in Position #1 and Position #2, after testing and adjusting the knees and feet, proceed to the pelvic Pressure Tests:

- AS (Anterior-Superior) ilium
- PI (Posterior-Inferior) ilium

e.g. Left Pelvic Deficiency



P-A schematic of pelvic misalignment

AS Ilium Procedure **Step 1**



Apply a gentle inferior and medial pressure to the crest of the ilium on the side opposite PD in a plane parallel to the plane line of the SI joint.

AS Ilium Procedure **Step 2**

Recheck the legs in Position #1

- ◆ If the legs balance or become more even, adjust the AS ilium
- ◆ If the legs DO NOT balance or become more even, pressure test for a PI ilium on the side of PD

AS Ilium Procedure **Step 3**

Adjustment of an AS ilium requires a single (1) thrust on each of the three (3) contact points (CP) with the Activator Adjusting Instrument as follows:

keypoint

It is advisable to **maintain a firm, steady contact** with the instrument to the patient throughout the duration of the thrust.

p 131, 142

AS Ilium Adjustment #1 of 3



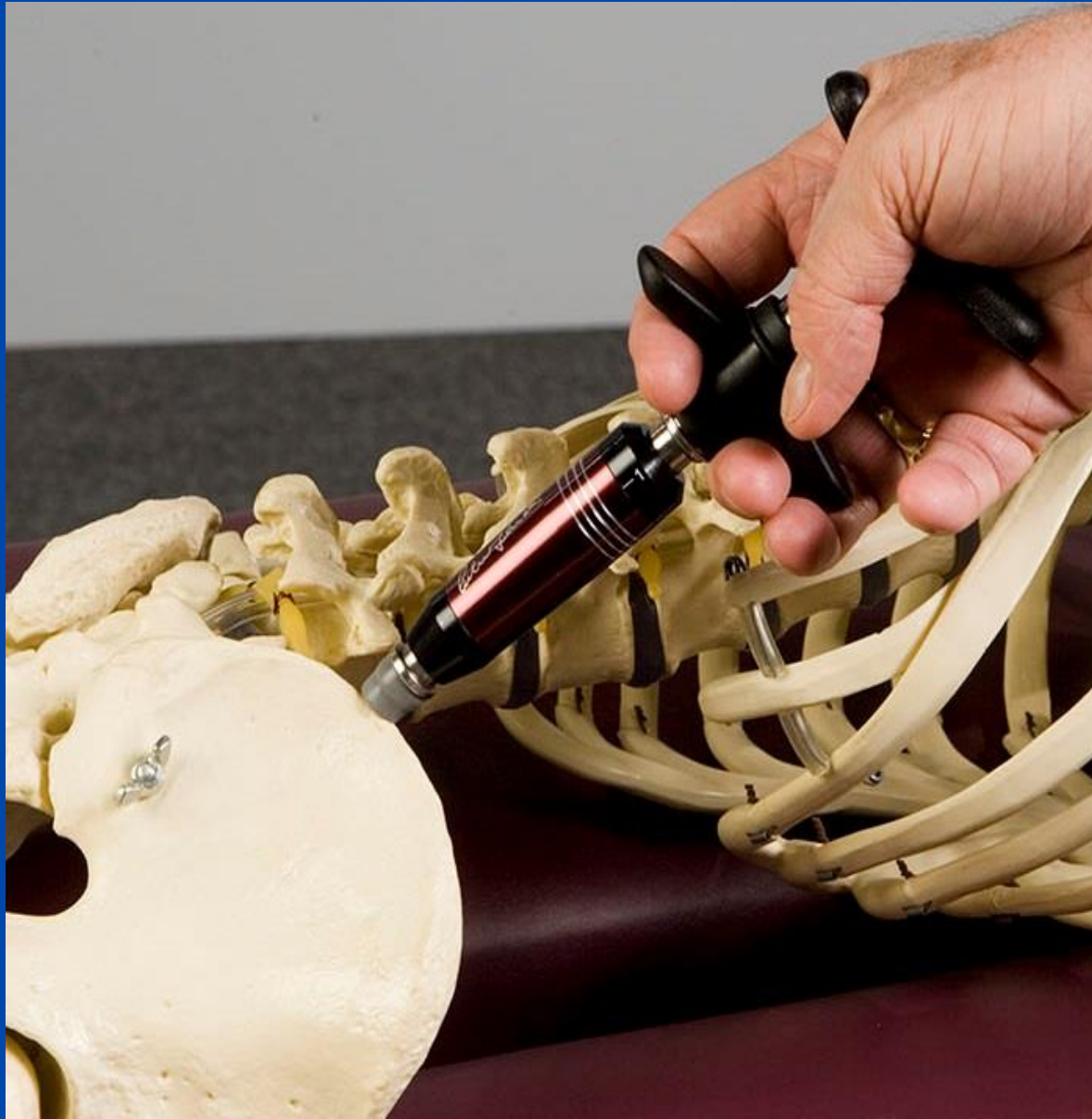
1st CP:
Base of
the sacrum
about ½ inch
lateral to the
first sacral
tubercle

AS Ilium Adjustment #1 of 3



LOD: Anterior
and inferior

AS Ilium Adjustment #2 of 3



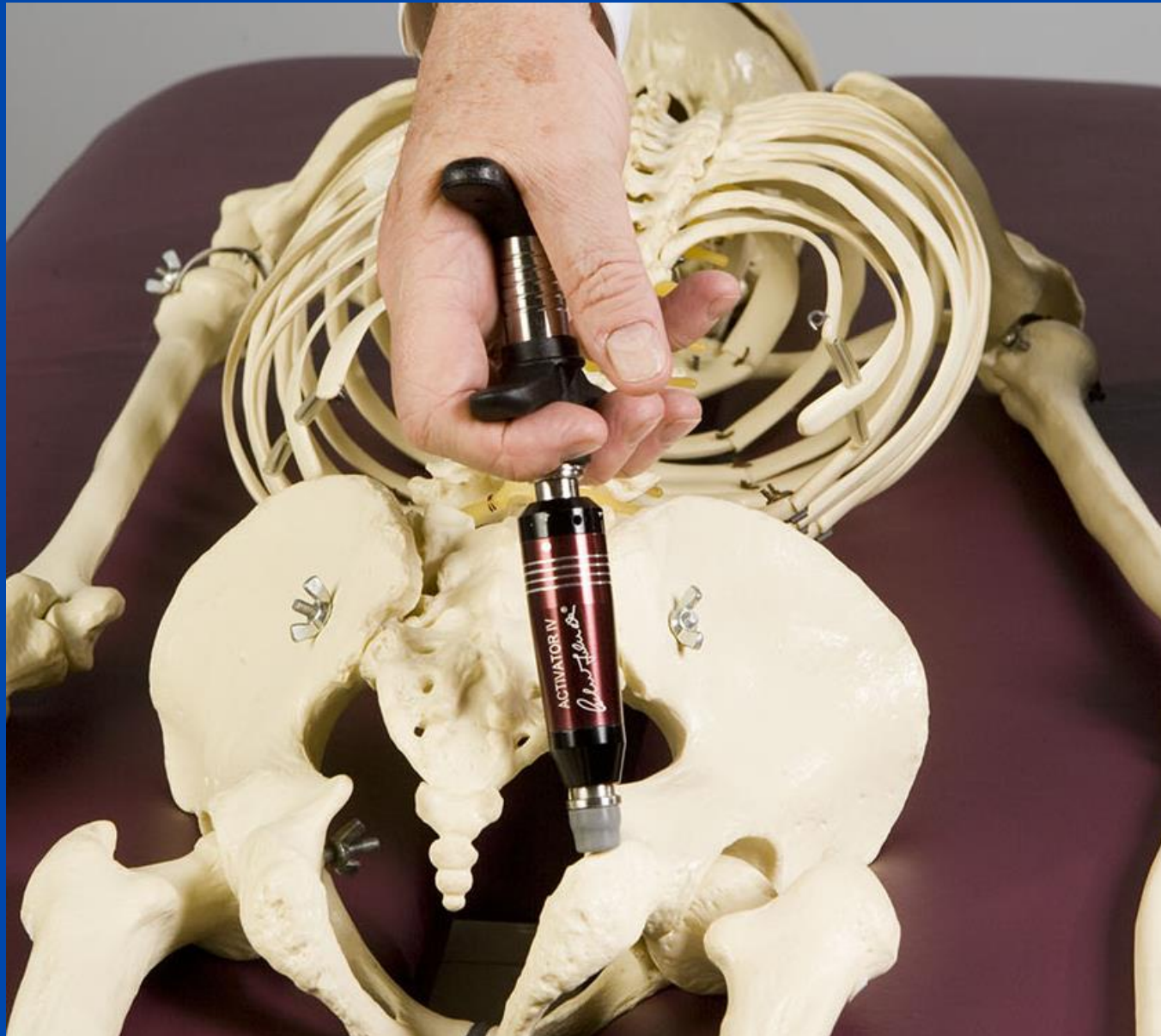
2nd CP: Crest of the ilium about 1 inch superior to the PSIS

AS Ilium Adjustment #2 of 3



LOD: Inferior
and medial
parallel to the
plane line of
the sacroiliac
articulation

AS Ilium Adjustment #3 of 3



3rd CP:
Superior
aspect of
the ischial
tuberosity

AS Ilium Adjustment #3 of 3



LOD: Anterior
and inferior

AS Ilium Procedure **Step 4**

Recheck the legs in Position #1



If the legs are still not balanced, perform Pressure Test for PI ilium on the side of PD.

PI Ilium Procedure **Step 1**



Apply a **firm** superior, lateral and posterior pressure under the sacrotuberous ligament on the side of PD in a plane parallel to the plane line of the SI joint.

PI Ilium Procedure **Step 2**

Recheck the legs in Position #1

- ◆ Look for the legs to balance; this indicates the necessity for PI ilium adjustment on the side of PD

PI Ilium Procedure **Step 3**

Adjustment of a PI ilium requires a single (1) thrust on each of the three (3) contact points (CP) with the Activator Adjusting Instrument as follows:

PI Ilium Adjustment #1 of 3



1st CP:
Spine
of the
ischium

PI Ilium Adjustment #1 of 3



Position the tip of instrument in the soft tissue of the glutueus maximus just medial to the ischial tuberosity

LOD: Posterior, superior and lateral

PI Ilium Adjustment #2 of 3



2nd CP: Under
the
sacrotuberous
ligament

PI Ilium Adjustment #2 of 3



Place the tip of the instrument under the sacrotuberous ligament in the sciatic notch

LOD: Posterior, superior and lateral

PI Ilium Adjustment #3 of 3



3rd CP:
Iliac fossa

PI Ilium Adjustment #3 of 3



Contact the
iliac fossa just
lateral to the
sacroiliac joint
in the soft
tissue of the
gluteus medius

LOD: Anterior
and superior

keypoint

The PI ilum on the side of PD
is most commonly involved.

What is the proper Activator instrument setting?

Pelvis (for most body types):

- Activator II: 6 rings
- Activator IV: setting 4
- Activator V: setting 4

Protocol for Proper Use of Activator Adjusting Instruments (AAI)

Holding the Activator IV

- ◆ Hold between 2nd and 3rd digits
 - May need 3rd and 4th digits
- ◆ Handle rests on thenar eminence
- ◆ Always **maintain a neutral wrist**

Holding the Activator IV



It is important to maintain a neutral wrist.

Incorrect Wrist Angles

i.e. not neutral



Hand may need to be turned to get the correct LOD.



Example: hand turned palm up for pelvic adjustment

Holding the Activator V

◆ Grip Styles

- The Classic Grip
- The Modified Grip
- The Inverted Grip

The Classic Grip



The Modified Grip



The Inverted Grip



Holding the Activator V

- ◆ **Trigger finger**

- 1st finger vs. 2nd finger (or thumb)

- ◆ **Grip Pressure**

- Light vs. Firm
 - Holding vs. Squeezing

The

Activator Method

*History & Protocol for
Activator Adjusting
Instruments*

Bone Movement:



140N Activator thrust on
T11, T12, L1, L2, and L3
moved L3-L4, and L4-L5



0.3 – 1.6mm

Nathan M, Lehneman JB, Keller TS. Measurement and Analysis of the in Vivo Posteroanterior Impulse Response of the Human Thoracolumbar Spine: Feasibility Study JMPT 1994; 17(7):431-44.

Bone Movement:



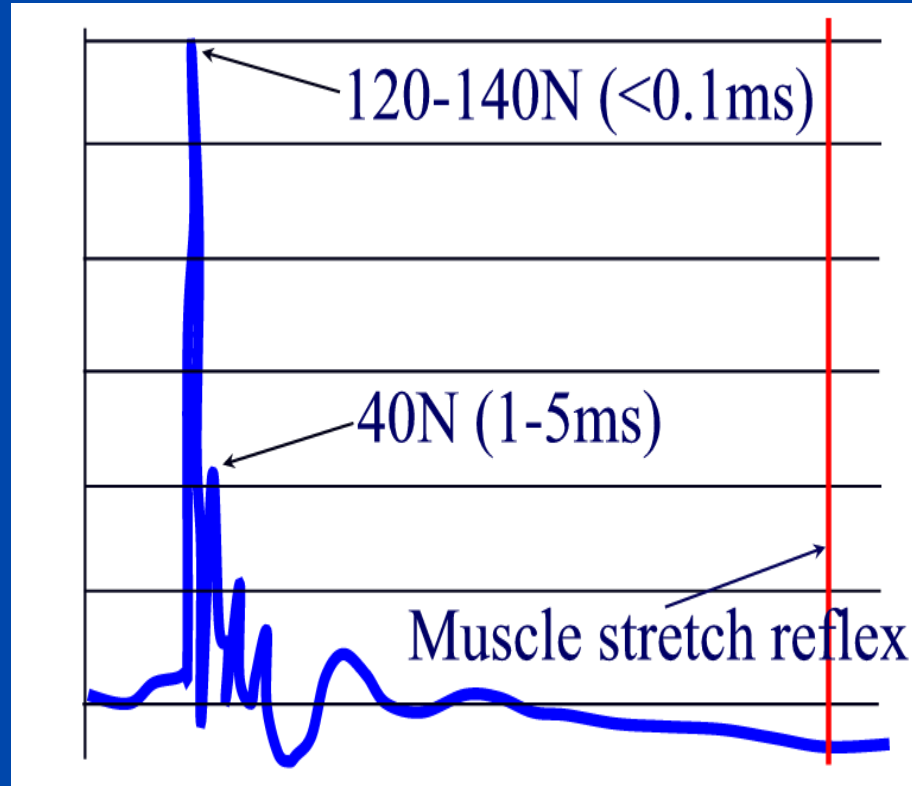
540N manual thrust
on L4 moved L4-L5



1.1mm

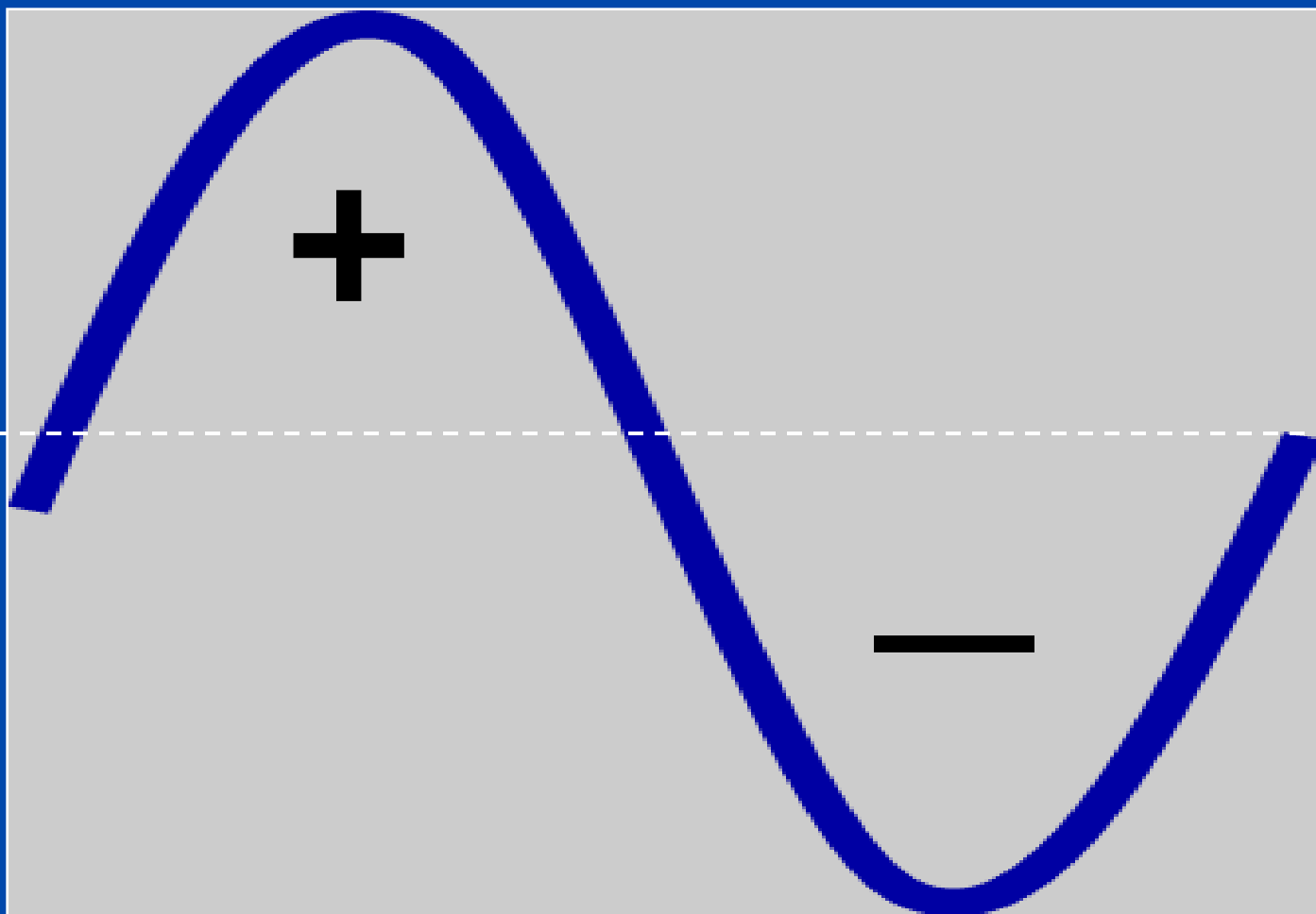
Maigne JY, Guillon F. Highlighting of Intervertebral movements & variations of intradiskal pressure during lumbar spine manipulation, JMPT 2000;23:531-36.

Ultra High Speed Thrust



“Activator delivers
an ultrafast thrust,
up to 200x faster
than a manual
adjustment.”

Keller TS, Colloca CJ, Fuhr AW. Validation of the force and frequency characteristics of the AAI: effectiveness as a mechanical impedance measurement tool. JMPT 1999; 22(2):75-86.



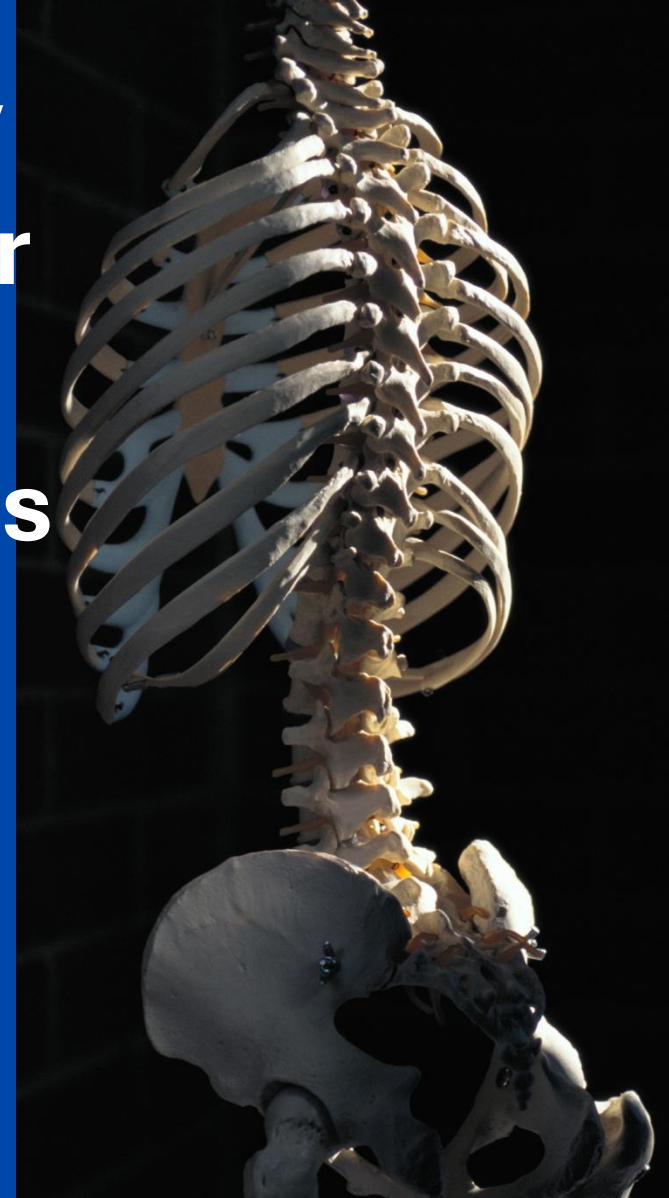
AN IDEAL WAVE FORM

Is fast enough to **stimulate**
mechanoreceptors.

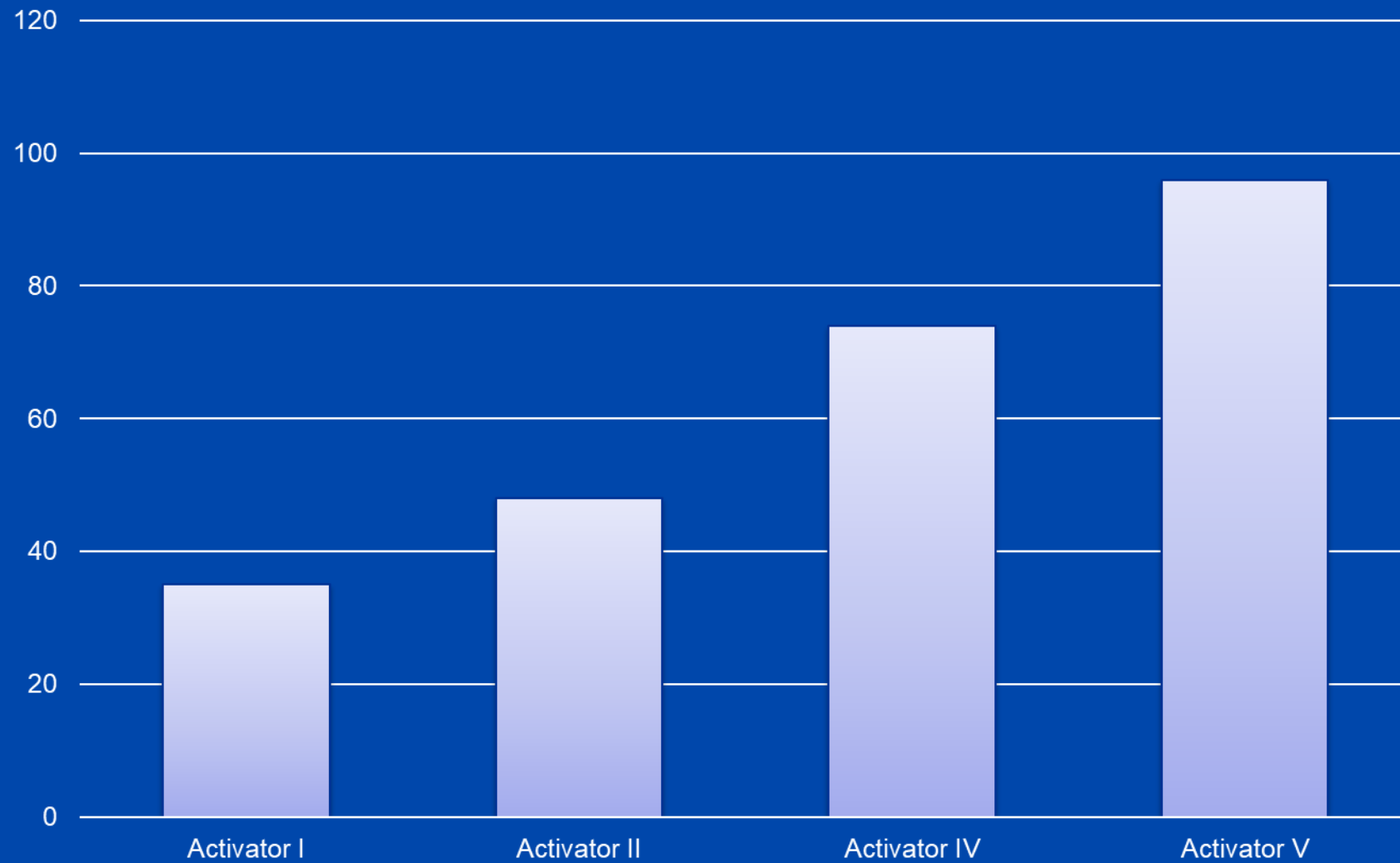
Propagates more easily
through biological tissue.

Enhancing the frequency spectrum of the Activator device toward an **IDEAL WAVE FORM** may allow us to create...

MORE bone movement
WITH LESS force.



IDEAL WAVE FORM



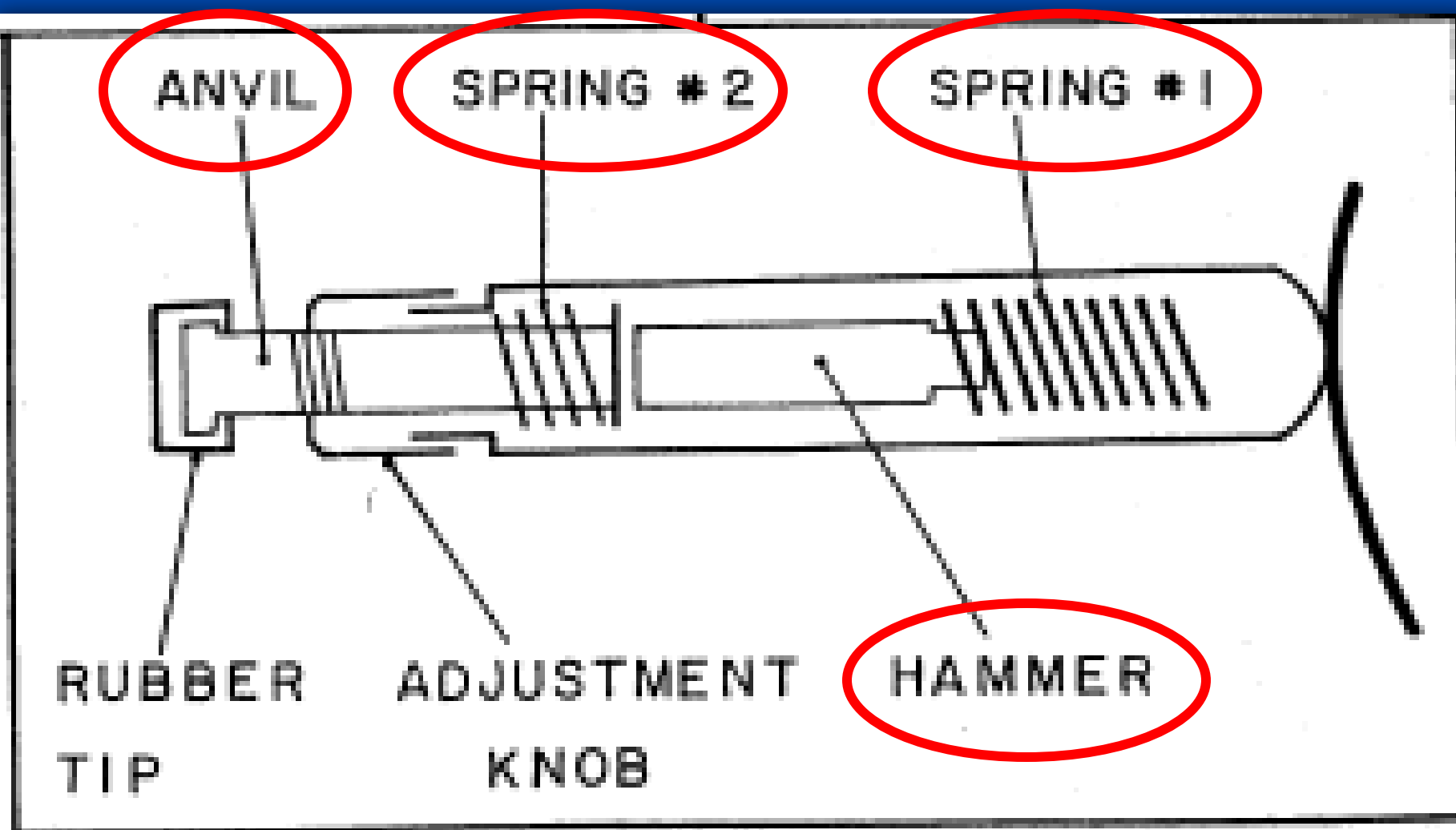
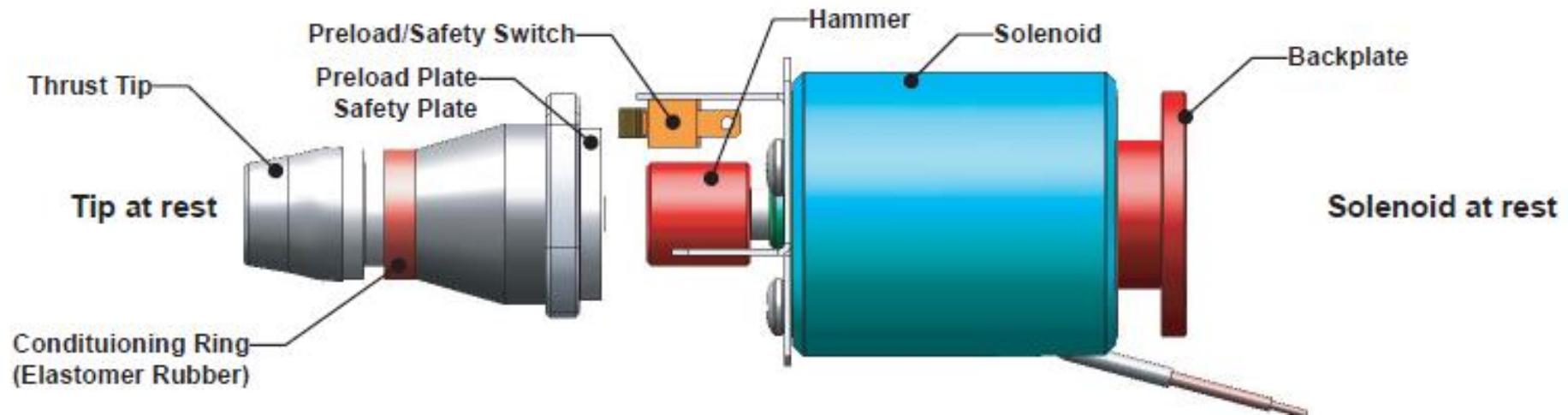
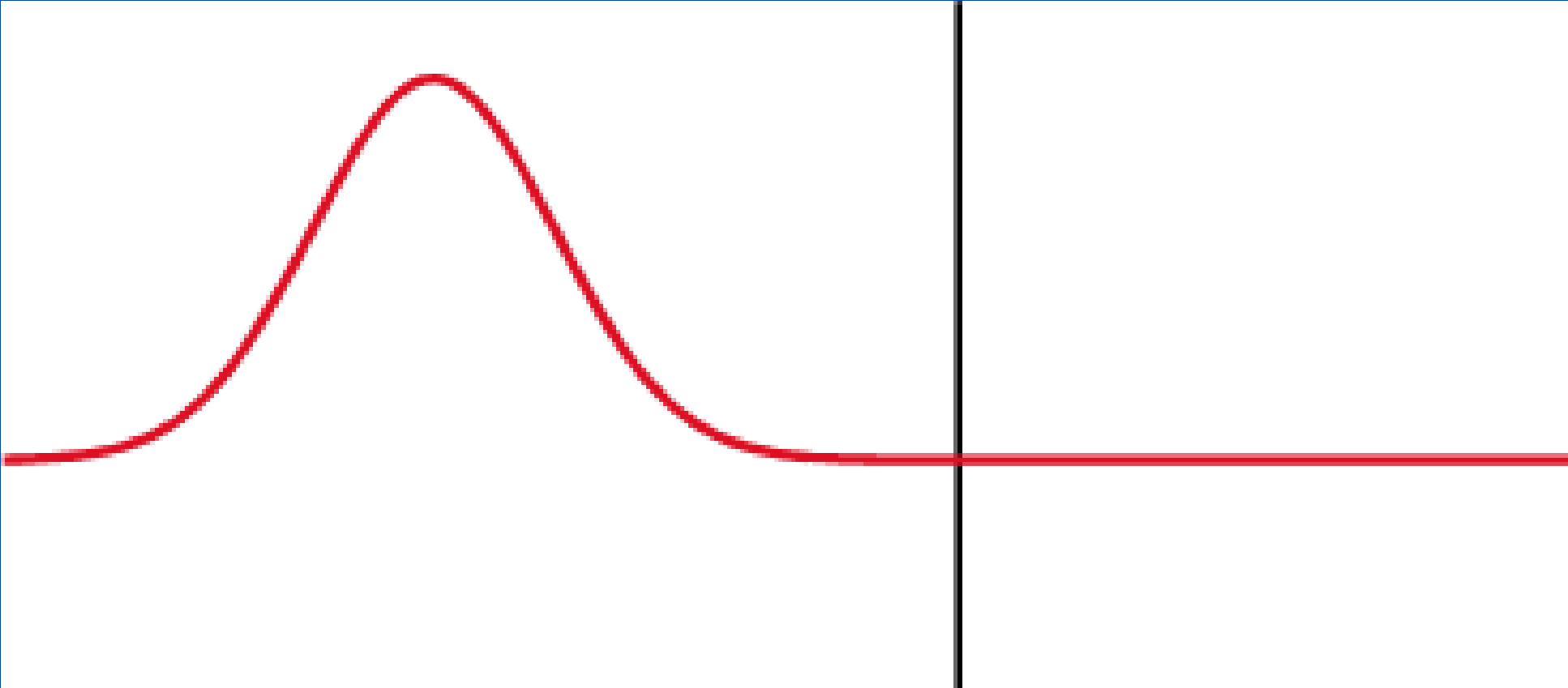


FIGURE 1. The Activator Adjusting Instrument. The drawing is schematic and only illustrates parts important to the discussion.

Linear Solenoid Schematic



Transmissibility

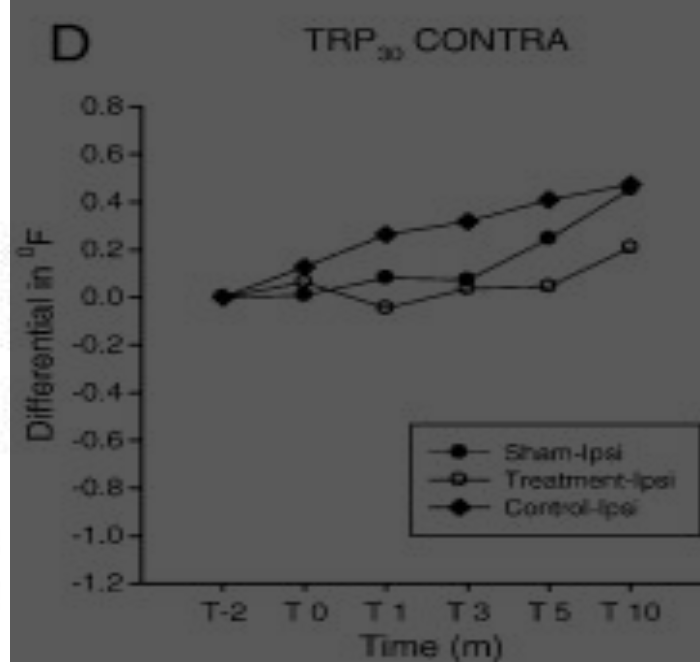
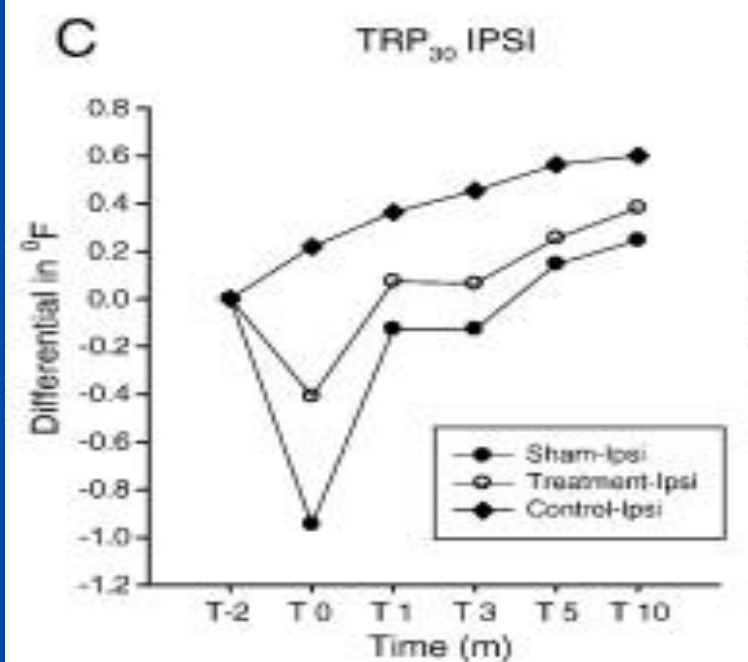
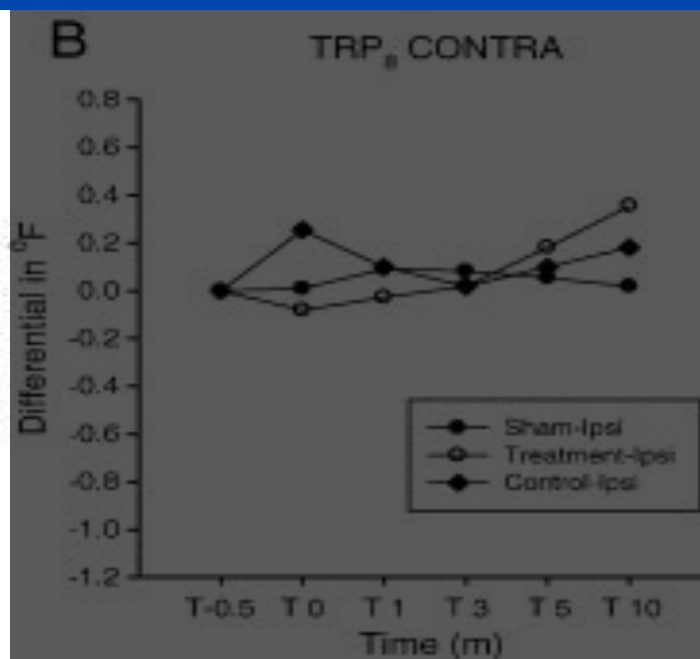
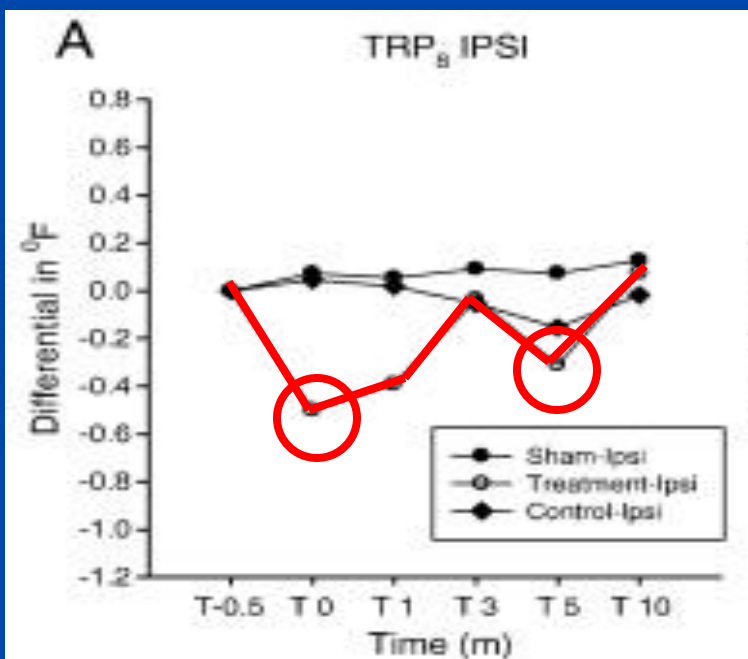


ANY QUESTIONS
OR COMMENTS?

One more thing...

EFFECTS OF A MANUALLY ASSISTED MECHANICAL FORCE ON CUTANEOUS TEMPERATURE

Richard A. Roy, DC, MSc, et. al.
JMPT 2008;31:230-236





The Activator Method

Basic Scan Protocol

Module 5: Lumbar Spine

Thoracic Spine

p 154-173

Objectives

- ◆ Review Activator Testing procedure
- ◆ Identify the appropriate testing procedures and adjustment procedures for the lumbar vertebrae
- ◆ Identify the appropriate testing and adjustment procedures for the thoracic vertebrae and ribs

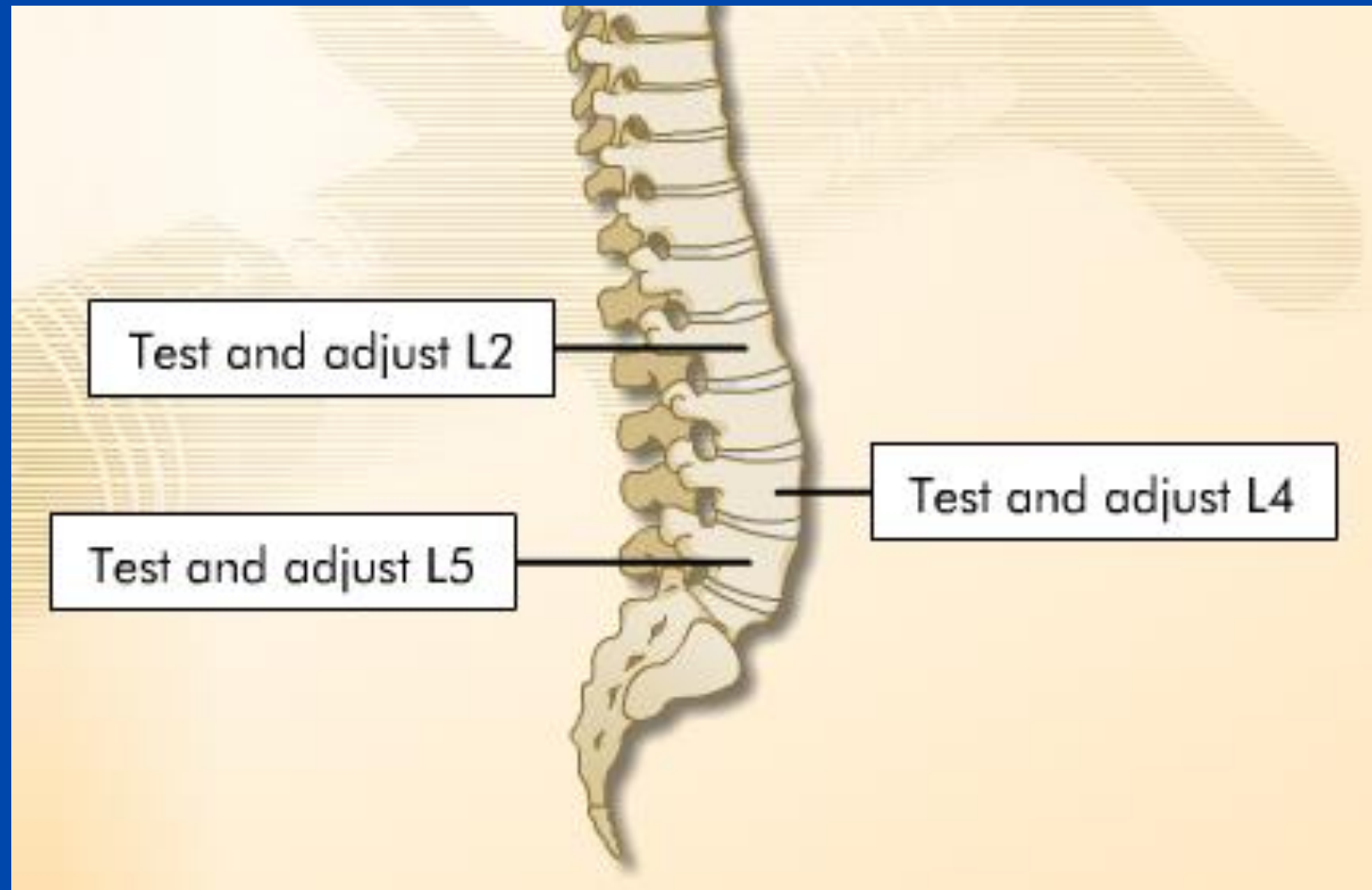
Activator Testing Procedure

1. Perform an Isolation Test.
2. Look for reactivity of the PD leg in Position #1.
3. Observe relative changes of the PD leg in Position #2.
4. Pressure Test to confirm.
5. Make necessary adjustments.

NOTE: Remember to re-perform an Isolation Test post-adjustment in order to confirm correction.

Lumbar Spine

Follows testing and adjustment of the symphysis pubis

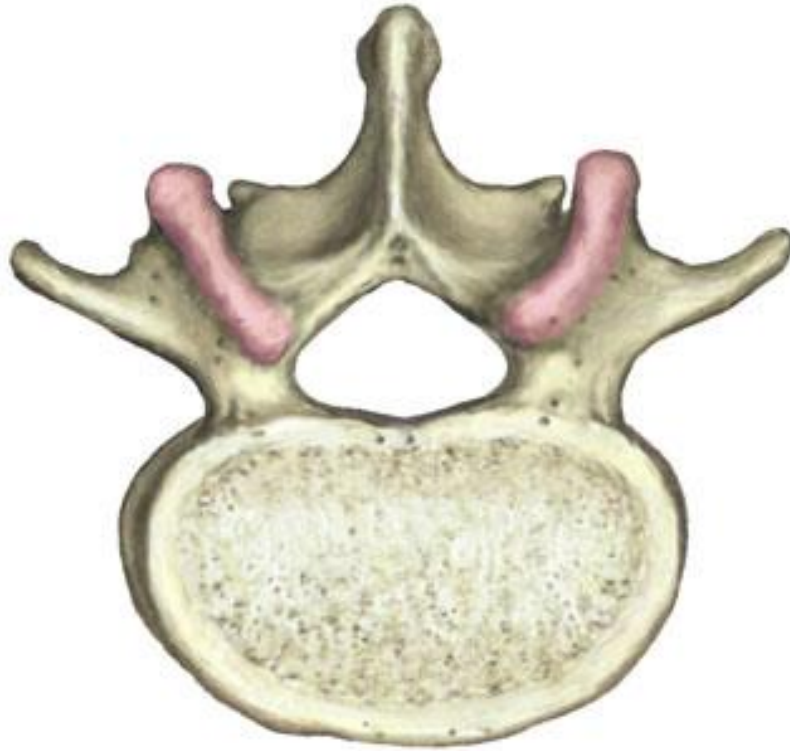


Lumbar Spine Introduction

- ◆ In the Basic Scan protocol, only L5, L4, and L2 are routinely tested
- ◆ The line of drive for all standard lumbar adjustments is anterior and superior through the plane line of the facet, i.e. not the disc

Instrument Patient Contact

- ◆ **Maintain a firm, steady contact** with the instrument to the patient.
- ◆ “It is better to hold the instrument more perpendicular to the patient in order to maintain a firm, steady contact than being as particular to the *exact* recommended LOD.”



Facet Joints

Lumbar Spine Evaluation

Isolation Tests	• Use as primary test • Use stress tests if patient cannot perform isolation test • Take legs to Position #2, and use the Short/Long Rule • Interpret results
Pressure Tests	• Use to clarify results of isolation test • Correctly applied pressure will cause legs to balance in Position #1 and Position #2 • If legs balance, adjust the involved vertebral motor unit on the side indicated by the Short/Long Rule

Testing the Lumbar Spine

- ◆ Verify that the leg lengths are even in Position #1 and Position #2
- ◆ Have patient perform Isolation Test
 - Use a Stress Test if patient is unable to properly perform Isolation Test
- ◆ Use Short/Long Rule in Position #2 to determine side of involvement

Adjusting the Lumbar Spine

- ◆ **Adjustment procedure:** same for all of the lumbar spine
- ◆ **Contact Point:** inferior articular process
- ◆ **Line of Drive:** anterior and superior through the plane line of the facet

Fifth Lumbar (L5)



Isolation Test:

Instruct the patient to place the forearm on the side of PD on the low back

Confirm



Please confirm this action

Cancel

OK

Fifth Lumbar (L5)



CP: Inferior
articular
process of L5

LOD: Anterior
and superior

p 160

Three Possibilities Summary

Possibility	Finding	Testing/Adjustment
Possibility One	PD leg lengthens going from Position #1 to Position #2	Begin with knees and feet
Possibility Two	PD leg shortens going from Position #1 to Position #2	Skip knees and feet, and pelvis; begin with fourth lumbar vertebra
Possibility Three	Legs are even/balanced in Position #1 and Position #2	Skip knees and feet, and pelvis; begin with pubic symphysis

Possibility Two

PD leg appears to have **stayed short** or becomes **shorter** in Position #2



Legs uneven in Position #1



AM testing protocol starts with **fourth lumbar (L4)**

What does Possibility Two indicate?

- ◆ The PD leg shortening in Position #2 **occurs much less frequently**
- ◆ A small percentage of patients will present as a Possibility Two, and usually, their conditions are of a chronic nature

Fourth Lumbar (L4)



Isolation Test:

Instruct the patient to place the forearm on the side Opposite PD on the low back

Confirm



Please confirm this action

Cancel

OK

Fourth Lumbar (L4)



CP: Inferior
articular
process of L4

LOD: Anterior
and superior

p 160

Second Lumbar (L2)



Isolation Test:

Instruct the patient to place the forearms of both arms on the low back

Confirm



Please confirm this action

Cancel

OK

Second Lumbar (L2)



CP: Inferior
articular
process of L2

LOD: Anterior
and superior

p 161

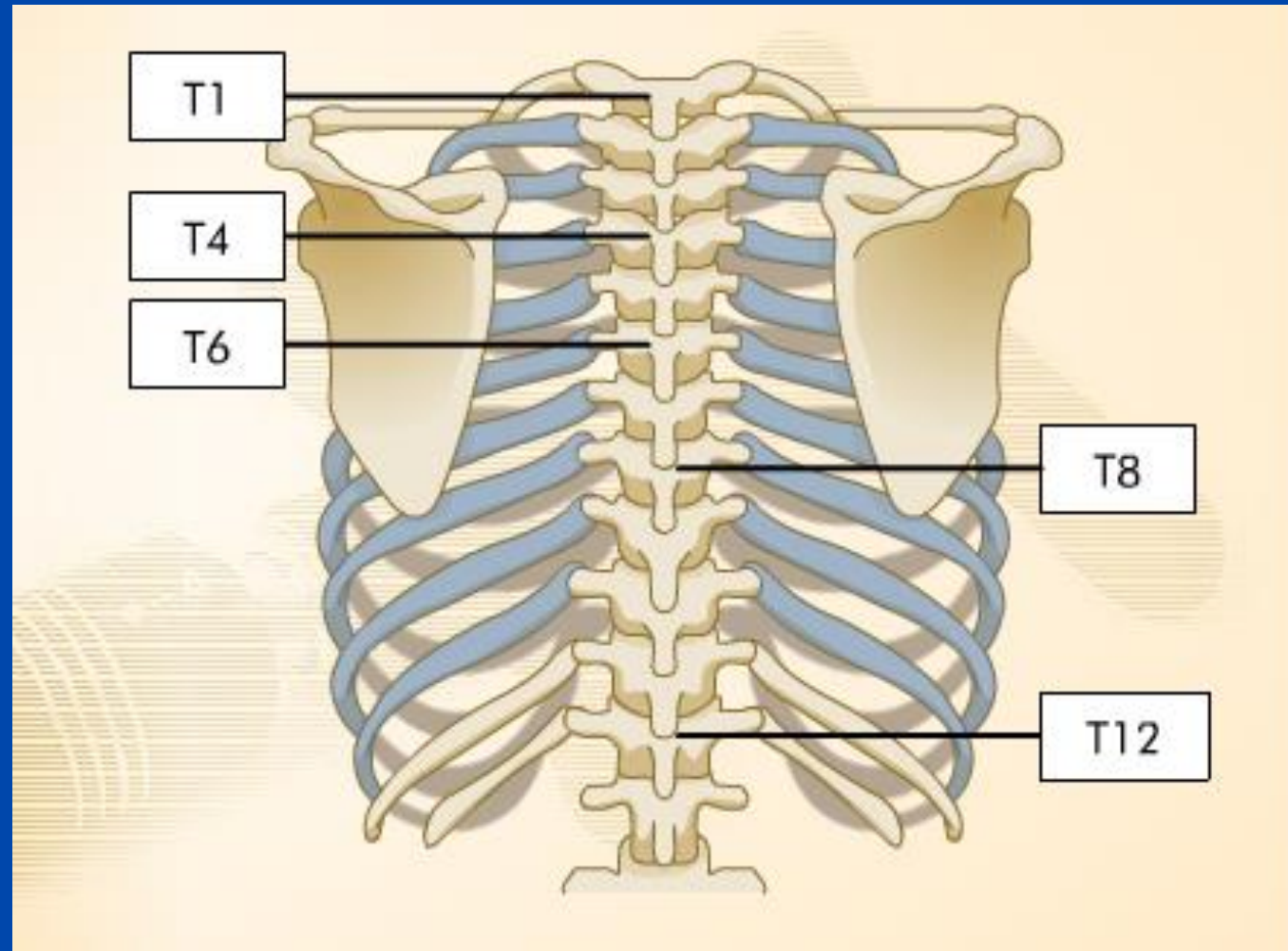
What is the proper Activator instrument setting?

Lumbar spine (most body types):

- Activator II: 6 rings
- Activator IV: setting 4
- Activator V: setting 4

Thoracic Spine

Follows testing and adjustment of the lumbar spine



Thoracic Spine Introduction

- ◆ Involves evaluation and treatment of:
 - T12 and T8 (lower thoracic spine)
 - T6, T4 and T1 (upper thoracic spine),
and first ribs
- ◆ Includes adjustment of corresponding rib for each segment from T10 – T2

Testing the Thoracic Spine

- ◆ Verify that the leg lengths are even in Position #1 and Position #2
- ◆ Have patient perform an Isolation test
 - Use a Stress test if patient is unable to properly perform isolation test
- ◆ Use Short/Long Rule in Position #2 to determine side of involvement

Adjusting the Thoracic Spine

- ◆ **Adjustment procedure:** same for all of the thoracic spine
- ◆ **Contact Point:** transverse process
- ◆ **Line of Drive:** anterior, superior and slightly medial through joint plane line of the facet

Activator Testing Procedure

1. Perform an Isolation Test.
2. Look for reactivity of the PD leg in Position #1.
3. Observe relative changes of the PD leg in Position #2.
4. Pressure Test to confirm.
5. Make necessary adjustments.

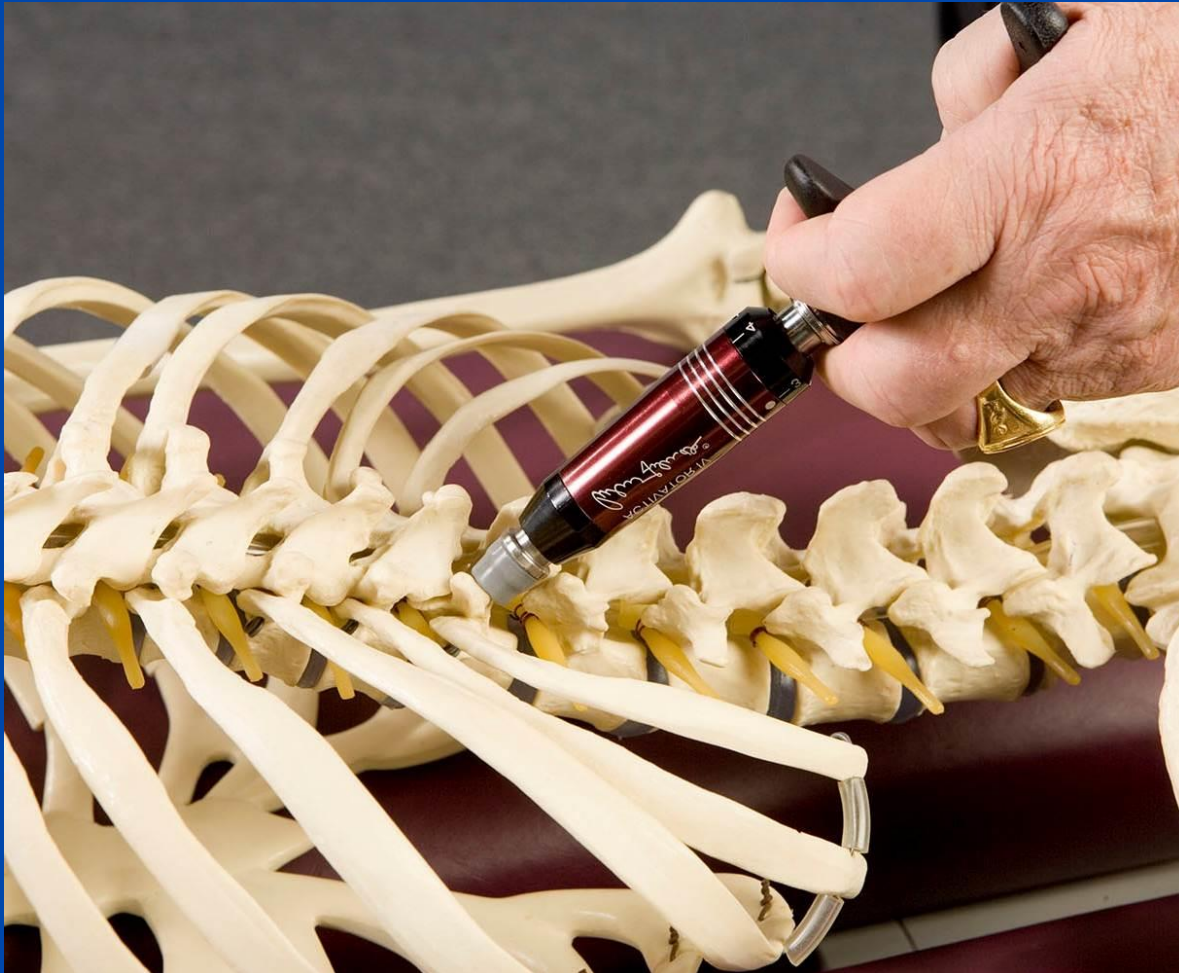
Twelfth Thoracic (T12)



Isolation Test:

Instruct the patient to abduct the shoulder on the side of PD and rest that forearm on the table superior and lateral to the head

Twelfth Thoracic (T12)



CP: Transverse
process T12

LOD: Anterior,
superior, and
slightly medial

p 164

Eighth Thoracic (T8)



Isolation Test:

Instruct the patient to abduct both shoulders and rest that forearms on the table superior and lateral to the head

Eighth Thoracic (T8)



CP: Transverse
process of T8

LOD: Anterior,
superior, and
slightly medial

keypoint

For T10 – T2 vertebral segments, the ribs are routinely adjusted on the side OPPOSITE vertebral adjustment.

Eighth Thoracic (T8) Rib



CP: Body of rib
½ inch lateral to
transverse
process of T8

LOD: Lateral and
inferior

Sixth Thoracic (T6)



Isolation Test:

Instruct the patient to turn the face to the PD side and rest the head on the table

Sixth Thoracic (T6)



CP: Transverse process of T6

LOD: Anterior, superior, and slightly medial

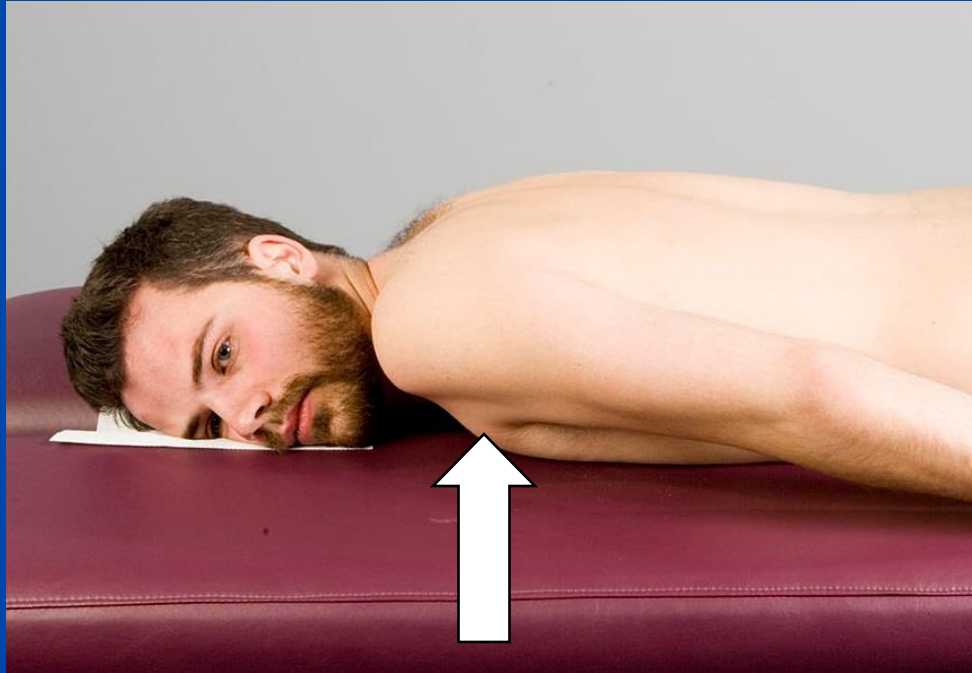
Sixth Thoracic (T6) Rib



CP: Body of rib
½ inch lateral to
transverse
process of T6

LOD: Lateral and
inferior

Fourth Thoracic (T4)



Keep the arms at the sides with the head turned to the PD side.

Isolation Test:

Instruct the patient to lift the shoulder on the side of PD off the table toward the ceiling, then put it back down

Fourth Thoracic (T4)



CP: Transverse
process of T4

LOD: Anterior,
superior, and
slightly medial

p 168

Fourth Thoracic (T4) Rib



CP: Body of rib
1/2 inch lateral to
transverse
process of T4

LOD: Lateral and
inferior

p 168

First Thoracic (T1)



Keep the arms at the sides with the head turned to the PD side.

Isolation Test:

Instruct the patient to shrug both shoulders toward the ears and then relax

First Thoracic (T1)



CP: Transverse process of T1

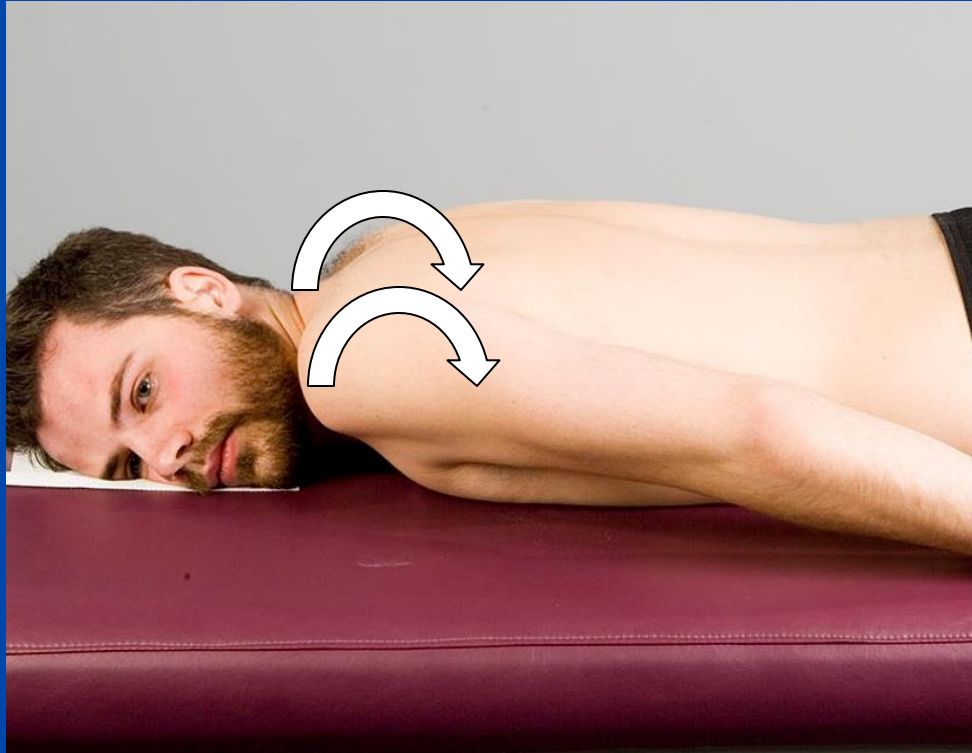
LOD: Anterior, superior, and slightly medial

p 170

keypoint

After completion of the adjustment for T1 as indicated, test for elevation involvement of the first (T1) rib.

First Thoracic (T1) Ribs



Keep the arms at the sides with the head turned to the PD side.

Isolation Test:

Instruct the patient to roll both shoulders superior, posterior, and inferior in a circular motion, and then to relax

The Short/Long Rule



Adjust
on the PD
side

If the PD leg relatively
lengthens in Position #2

First Thoracic (T1) Rib



CP: Body of rib
½ inch lateral to
transverse
process of T1

LOD: Inferior

First Thoracic (T1) Rib



NOTE: Have the patient turn the head to the neutral, face-down position. For patient comfort, use your free hand to take a posterior-inferior tissue pull.

The Short/Long Rule



Adjust
on the
OPD side

If the PD leg relatively
shortens in Position #2

Bilateral Rib Involvement

- ◆ If leg lengths are unimproved after first rib testing/adjustment, Pressure test on the side opposite PD for involvement
- ◆ If the legs balance in Position #1, bilateral rib involvement is indicated

What is the proper Activator instrument setting?

T12 – T7 (for most body types):

- Activator II: 6 rings
- Activator IV: setting 3
- Activator V: setting 3

What is the proper Activator instrument setting?

T6 – T1 (for most body types):

- Activator II: 6 rings
- Activator IV: setting 2
- Activator V: setting 2

The Activator Method

Basic Scan Protocol

Module 6: Shoulder Involvement–
Medial and Lateral Scapulae

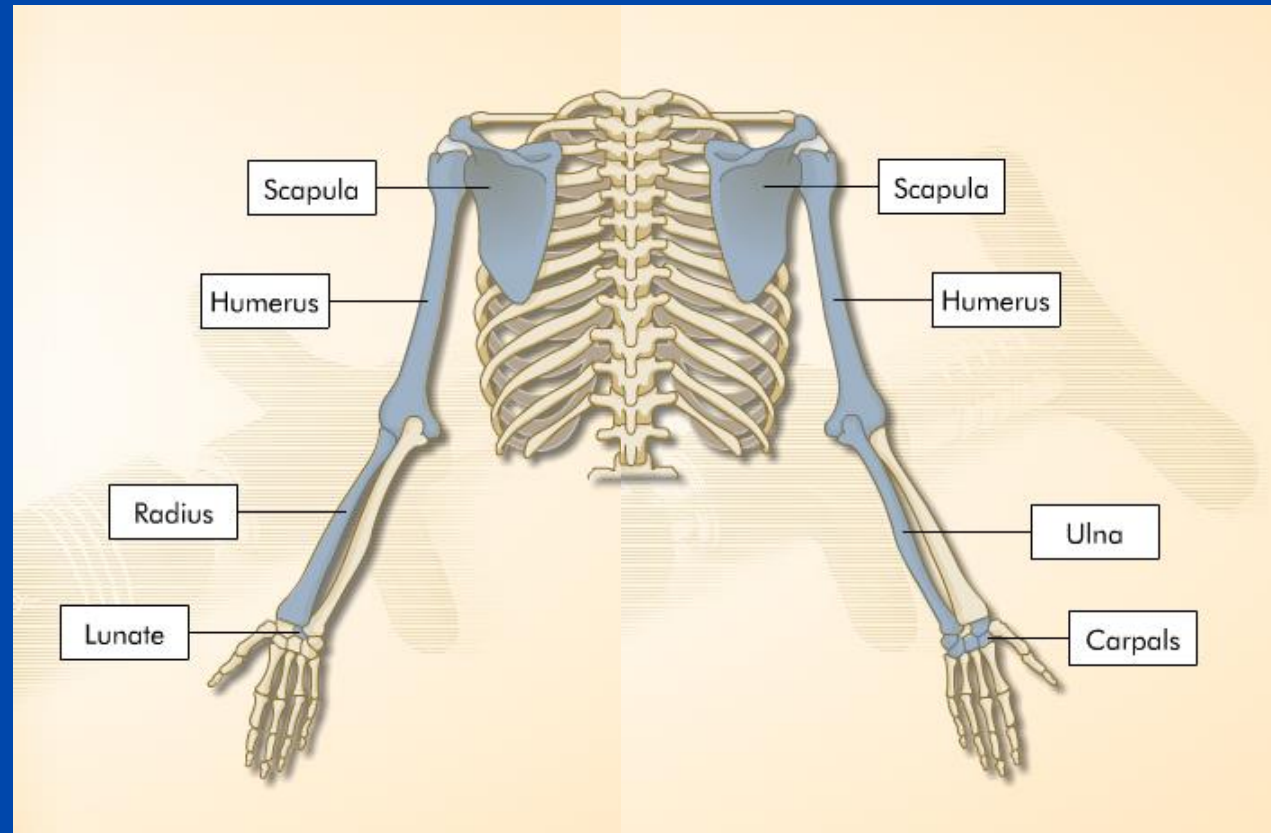
p 173-183

Objectives

- ◆ Identify the appropriate testing and adjustment procedures for:
 - Medial/Lateral scapula on the side of PD
 - Medial/Lateral scapula on the side opposite PD

Medial and Lateral Scapulae

Follows testing and adjustment of the thoracic spine



keypoint #1

Before testing the scapulae, make sure the patient's face is turned to the side of Pelvic Deficiency.

NOTE: This is the same position for testing all the upper thoracic segments from T6 and above.

keypoint #2

Test the scapula on the side of PD first and perform adjustments as indicated before testing and adjusting the scapula on the side opposite PD.

keypoint #3

The scapular Isolation test introduces a variation of the Short/Long Rule in the interpretation of Position #2: **the longest leg in Position #2 indicates the *direction* of involvement of the scapula being tested.**

Scapular Short/Long Rule



Example of RIGHT leg
longest in Position #2

The **longest** leg in
Position #2
indicates the
direction of
involvement
of the scapula
being tested

Scapular Short/Long Rule



The **longest** leg in Position #2 indicates the direction of involvement of the scapula being tested

Example of LEFT leg **longest** in Position #2

keypoint #4

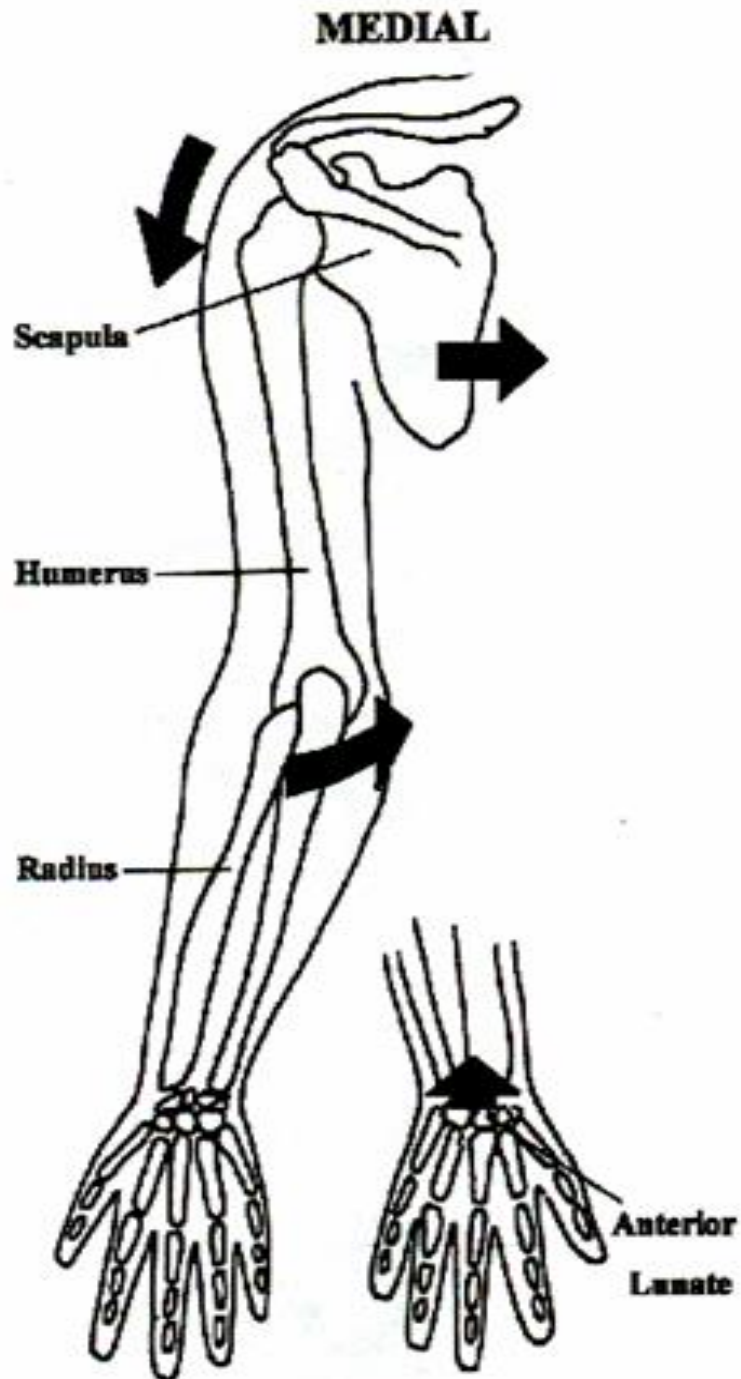
The reference point for scapular testing is the inferior angle of the scapula. The inferior angle of the scapula subluxates toward the longest leg side in Position #2.

Testing the Scapulae

- ◆ Verify that the leg lengths are even in Position #1 and Position #2
- ◆ Have patient perform Isolation Test
 - Use a Stress Test if patient is unable to properly perform Isolation Test
- ◆ Use variation of the Short/Long Rule to determine direction of involvement

Adjusting the Scapulae

- ◆ Adjustment of the scapulae involve elements of the kinetic chain of the whole upper extremity
- ◆ Consequently, the Basic Scan Protocol calls for adjustment of four different elements when adjusting a Medial or Lateral scapular pattern



Medial Rotation:

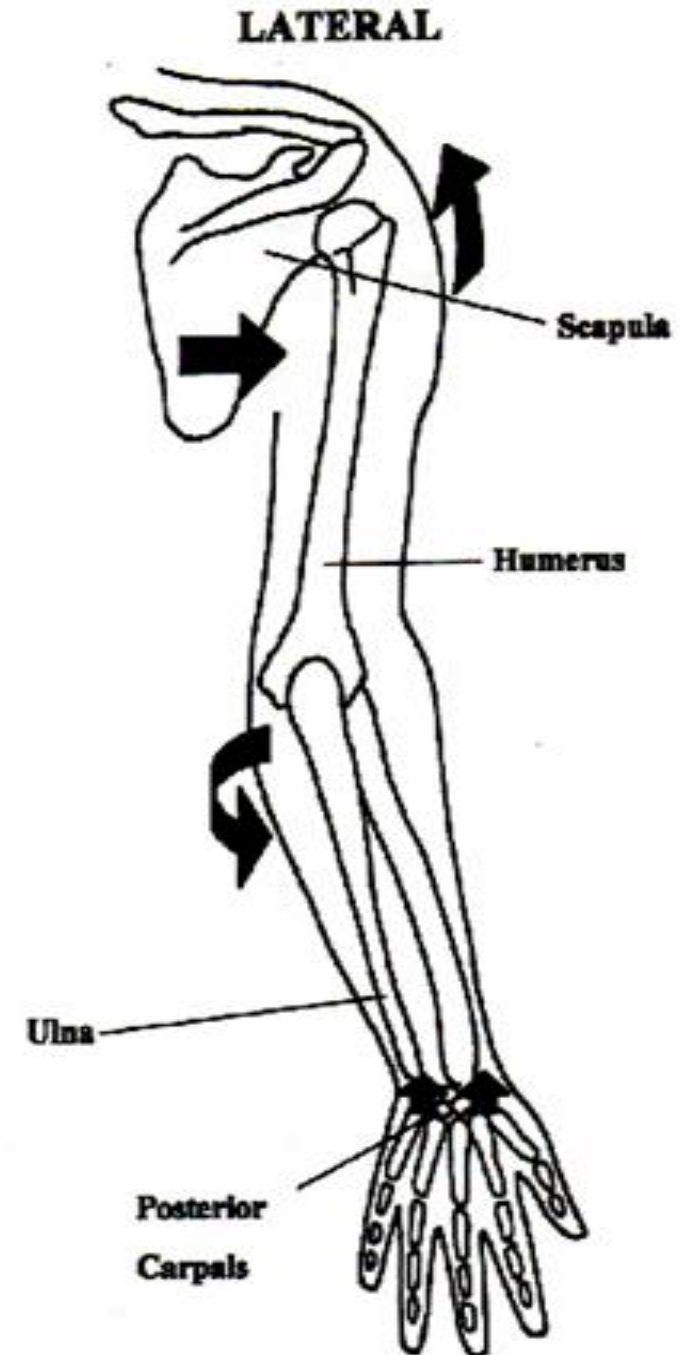
Direction of subluxation

- ◆ Medial ala of the scapula
- ◆ Inferior humerus
- ◆ Posterior-superior radius
- ◆ Anterior lunate

Lateral Rotation:

Direction of subluxation

- ◆ Lateral ala of the scapula
- ◆ Superior humerus
- ◆ Inferior-lateral ulna
- ◆ Posterior distal carpals



Confirm



Please confirm this action

Cancel

OK

Scapula Test (Left)



Isolation Test:

Instruct the patient to squeeze the elbow of the arm on the PD side against the body; this stresses the shoulder girdle

Medial Scapula | Step 1

Adjusting the Scapula



CP #1: Lower
third of the ala
of the scapula

LOD: Straight
lateral

p 177

Medial Scapula | Step 2

Adjusting the Humerus



CP #2: Lateral aspect of the shaft of the humerus, just distal to the deltoid tubercle

LOD: Superior

Medial Scapula | Step 3

Adjusting the Radius



Swing the patient's arm up along side the head and rest the forearm –palm down– on the table.

CP #3: Posterior, superior aspect of the head of the radius

LOD: Anterior and inferior

Medial Scapula | Step 4

Adjusting the Lunate



CP #4: anterior
(volar) aspect of
the lunate

LOD: Straight
posterior

Shoulders | Clinical Tip

The shoulders seem to fall into a pattern:

- ◆ The Medial scapula is usually found on the side of PD
- ◆ The Lateral scapula is usually found on the side opposite PD

NOTE: When deviation to this pattern occurs, trauma is usually involved.

Scapula Test (Right)



Isolation Test:

Instruct the patient to squeeze the elbow of the arm on the side opposite PD against the body; to stress the shoulder girdle

Lateral Scapula | Step 1

Adjusting the Scapula



CP #1: Lower
third of the ala
of the scapula

LOD: Straight
medial

Lateral Scapula | Step 2

Adjusting the Humerus



CP #2: Proximal third, lateral aspect of the humerus on the deltoid muscle

LOD: Inferior

Lateral Scapula | Step 3

Adjusting the Ulna



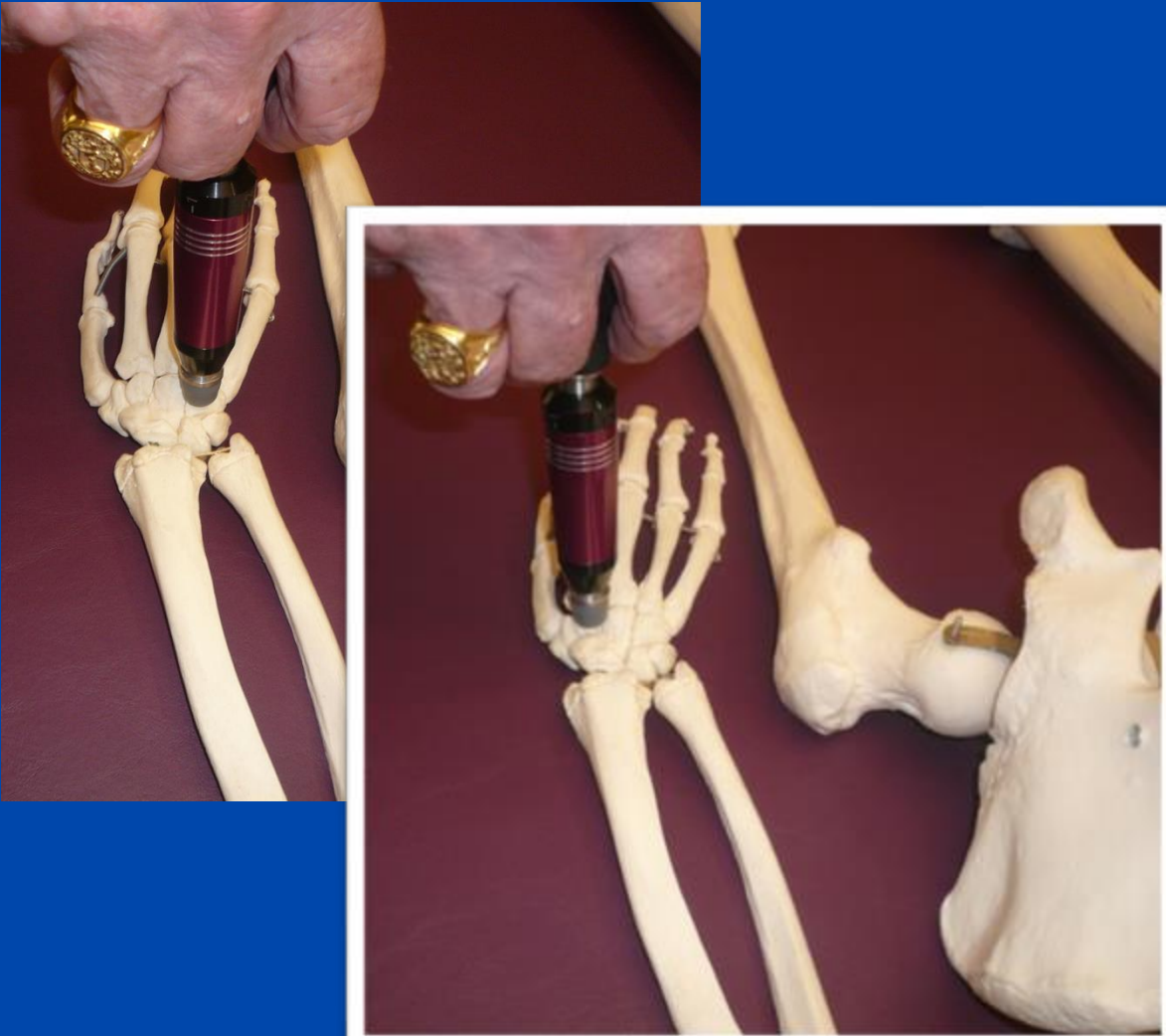
CP #3: Anterior aspect proximal head of the ulna

LOD: Superior and medial

Direct the thrust in a superior to lateral direction toward the olecranon process.

Lateral Scapula | Step 4

Adjusting the Carpals



CP #4 and #5:
Posterior distal
carpal row

LOD: Straight
anterior

Articular Dysfunction	Test	Adjustment	
		Contact Point	Line of Drive
1. Medial Scapula	Isolation Test	1. Scapula ala	1. Lateral
	Patient keeps face turned toward the side of PD and squeezes elbow on side of PD against the body	2. Humerus	2. Superior
		3. Proximal radius	3. Anterior-Inferior
		4. Anterior lunate	4. Posterior
2. Lateral Scapula	Isolation Test	1. Scapula ala	1. Medial
	Patient keeps face toward the side of PD and squeezes elbow on the side opposite PD against the body	2. Humerus	2. Inferior
		3. Proximal ulna	3. Medial-Superior
		4. Posterior carpals	4. Anterior

What is the proper Activator instrument setting?

Extremities (for most body types):

- Activator II: 3 rings
- Activator IV: setting 2
- Activator V: setting 2

The Activator Method

Basic Scan Protocol

Module 7: Cervical Vertebrae
and Occiput

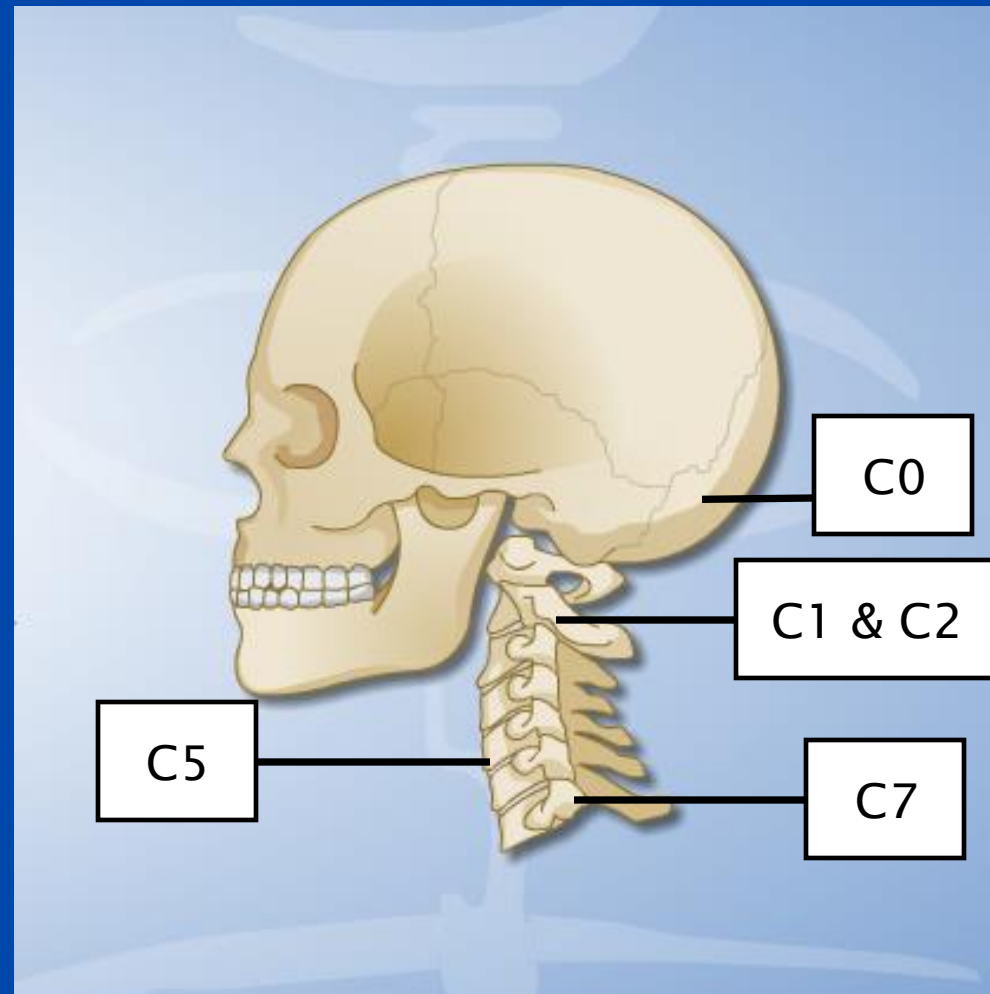
p 185-190

Objectives

- ◆ Identify the appropriate testing and adjustment procedures for the cervical vertebrae
- ◆ Identify the appropriate testing and adjustment procedures for the occiput

Cervical Spine

Follows testing and adjustment of the scapulae



Cervical Spine Introduction

Involves evaluation and treatment of:

- Seventh cervical (C7)
- Fifth cervical (C5)
- Axis (C2)
- Atlas (C1)
- Posterior occiput (C0)

Testing the Cervical Spine

- ◆ Verify that the leg lengths are even in Position #1 and Position #2
- ◆ Have patient perform Isolation Test
 - Use a Stress Test if patient is unable to properly perform Isolation Test
- ◆ Use Short/Long Rule in Position #2 to determine side of involvement

Adjusting the Cervical Spine

- ◆ **Adjustment procedure:** essentially the same for C7 – C2
- ◆ **Contact Point:** pedicle-lamina junction on side of involvement
- ◆ **Line of Drive:** anterior, superior and slightly medial through joint plane line of the facets at 45°

keypoint



Recall that during the testing of the upper thoracic spine and scapulae, the head is turned to the side of PD

Seventh Cervical (C7)



Isolation Test:

Instruct the patient to turn the head back to a face-down, neutral position

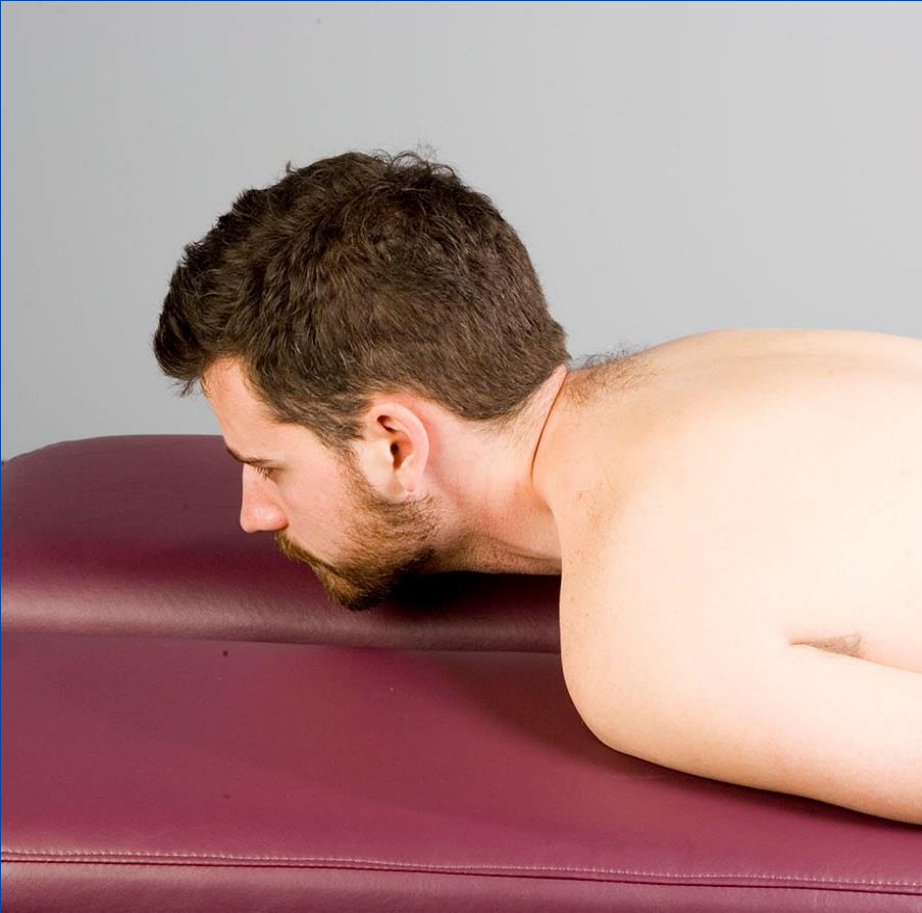
Seventh Cervical (C7)



CP: Pedicle-lamina junction of C7

LOD: Anterior, superior, and slightly medial

Fifth Cervical (C5)



Isolation Test:

Instruct the patient to extend the neck slightly by raising the head from the table, and then relax

Fifth Cervical (C5)



CP: Pedicle-lamina junction of C5

LOD: Anterior, superior, and slightly medial

Upper Cervical (C2-C1)



Isolation Test:

Instruct the patient to slightly tuck the chin toward the chest, and then relax

keypoint

Axis-Atlas (C2-C1) testing involves a variation of the Short/Long Rule:

- If the PD leg **shortens** in Position #2, proceed to C2 on the side opposite PD
- If the PD leg **lengthens** in Position #2, proceed to C1 on the side of PD

The Short/Long Rule



Adjust C2
on the
OPD side

If the PD leg relatively
shortens in Position #2

Second Cervical (C2)



CP: Pedicle-lamina junction of C2

LOD: Anterior, superior, and slightly medial

Upper Cervical (C2-C1)



Isolation Test:

Instruct the patient to slightly tuck the chin toward the chest and then relax

The Short/Long Rule



Adjust C1
on the PD
side

If the PD leg relatively
lengthens in Position #2

First Cervical (C1)



CP: Lateral
aspect of the
transverse
process of C1

LOD: Straight
medial

p 187

USE CAUTION!

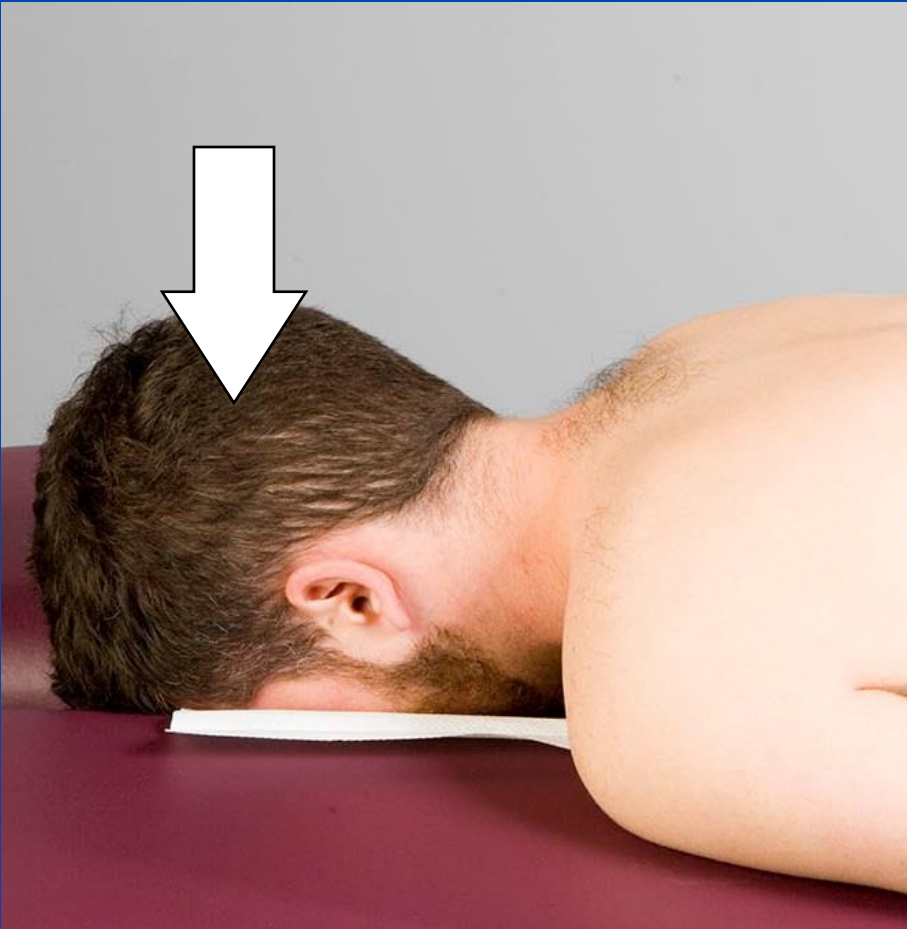
Do NOT contact the transverse process of the atlas (C1) too anterior. It creates discomfort for the patient, with the possibility of adjusting the stylus of the mastoid.

C1/C2 | Clinical Tip

Post-adjustment of C1 or C2, instruct the patient to re-perform the Isolation Test. If there is PD leg reactivity in Position #1, it may indicate both C1 and C2 are involved.

Pressure Test to confirm.

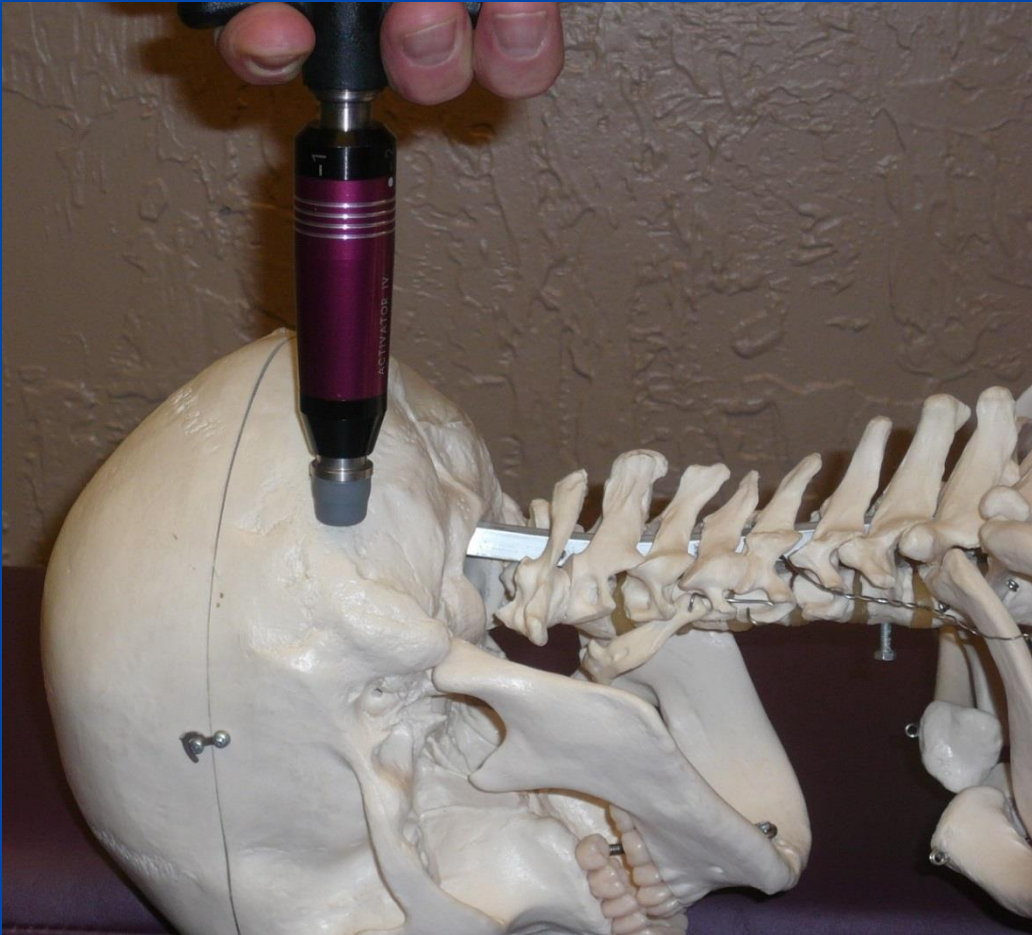
Occiput (C0)



Isolation Test:

Instruct the patient to gently push the face into the table, and then relax

Occiput (C0)



CP: Inferior
nuchal line of
the occiput

LOD: Anterior

Occiput (C0)



NOTE: Stabilize
the tip of the
instrument with
the thumb

LOD: Anterior

What is the proper Activator instrument setting?

C7-C2 (for most body types):

- Activator II: 2-3 rings
- Activator IV: setting 2
- Activator V: setting 2

What is the proper Activator instrument setting?

C1-C0 (for most body types):

- Activator II: 1 ring
- Activator IV: setting 1
- Activator V: setting 1

Activator | Technique Workshop



Thank you for attending!

We look forward to seeing you at a
future Activator Methods[®] seminar.