



The Thirteenth Annual NUCCA Convention

The Annual NUCCA Convention and Educational Conference is held for the purpose of giving attending doctors and students the practical NUCCA research findings regarding the subluxation and its bodily effects conducted during the previous year. NUCCA research is a continuous process, conducted for the benefit of the profession and the public. The subluxation and its correction (adjustment) is the essential tool of the chiropractor; it is his reason for existence.

Past NUCCA research has proved that every C1 subluxated patient has a distorted or misaligned spinal column—a column that is malpositioned in its relationship to the “normal” or to the vertical axis of the body; and NUCCA research has demonstrated that this malpositioning of the spine and pelvis requires restoration to the vertical axis from a corrective C1 adjustment before the spinal segments and pelvis can be released from all rotatory forces of an abnormal nature that have caused them to misalign and, perhaps, subluxate. In other words, rotation of a spinal segment is a result of a spinal column that has deviated from the body’s vertical axis. C1 correction is essential to spinal column restoration to its normal position; therefore, C1 correction is imperative to vertebral subluxation reductions to normal.

NUCCA has also shown that not only does a C1 subluxation mechanically distort the spine and pelvis, but it is the cause of a neurological over-innervation throughout the spinal motor
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A Model for the Supine Leg Check

ERRORS

Too frequently a correct measurement of the short leg in the supine position is not accurately obtained. Supine leg checking requires that the practitioner knows the reference points, and is capable of visualizing them. Unless mental images are formed by the practitioner of the points of reference, he can commit errors that render his efforts ineffectual. Checking for leg length deficiency is a highly subjective process, and too often ends as a matter of opinion, not of fact.

The orientation planes of the patient and the practitioner provide the most accurate guide. If correctly used, these planes determine the required degree of accuracy essential in making a correct determination of the amount of leg deficiency. The patient’s head, shoulders, spine, pelvis, knees, and feet can, for example, be aligned directly to the patient’s midsagittal plane, which can be depicted by drawing a line, or it can be visualized.

ANOMALIES

The short leg, caused from a pathological, congenital, or other anomalous reason will be measured differently. The amount of leg deficiency may be recorded in these cases with considerable accuracy if the C1 subluxation is first corrected to normal and verified by post-x-rays and ANATOMETER recordings of previously registered bodily distortions. Corrections, or normalization of the misalignment factors of the C1 subluxation, removes the subluxation-induced shortness, leaving only the shortness caused by anomaly. Shoe lifts may then be used as body-balancing devices to correct

the deficiency caused by anomaly. The subluxation-induced deficiency should be corrected only by the adjustment.

The difference will have to be established between the two causes of leg disparity, because the body is precisely balanced in the normal state and quite subject to structural adaptation to the short leg. The use of shoe-lifts to equalize the subluxation-induced short leg is an erroneous procedure because they interfere with normal structural adaptation of the spinal column which results from the correction of the subluxation.

IMPORTANCE OF LEG-CHECKING

The existence of a leg deficiency in the absence of anomalous reasons is a positive indicator of imbalance in the central nervous system (CNS), and of spastic contracture of the extensor, or anti-gravity, musculature, and is caused by the C1 subluxation. The C1 subluxation, detrimentally affects the CNS, the reticular formation of the brain stem, and causes the muscular contracture. Bodily distortions, pelvic obliquity, and the short leg result. Thus, the presence of the short leg is symptomatic of a subluxation of C1. A C1 subluxation, therefore, is a stress-producer of the body.

Not only does the short-leg indicate the presence of nervous imbalance in the CNS, but the amount of shortness can indicate the degree of neurological imbalance. The shorter the leg, the greater the degree of detriment, generally speaking. It does not, however, indicate the severity of the excursions of the subluxation into the planes of mo-
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Convention

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neurons. Each motor neuron, consequently, cannot be normalized until and unless C1 is maximally reduced toward normal. Since the neurological over-innervation of the spinal cord results from a C1 subluxation, and is the pathology of the subluxation, C1 correction is compulsory to proper chiropractic care. Neurological over-innervation can not be normalized from any vertebral segment other than C1, neither will adjustment of the pelvis normalize over-innervation.

A basic course in upper cervical film analysis and corrective adjustment is part of the NUCCA educational program, because of the importance of the C1 subluxation effects on the body. While NUCCA does not distinguish among chiropractic techniques, it does emphasize its research-proved principles and practices because of their importance to all chiropractors, regardless of systems of practice. NUCCA is concerned with the type of chiropractic service that the public receives as well as the benefits that the chiropractor obtains from NUCCA research. It is for this reason, and because of limited space, that applicants to its conventions and educational programs should be sincerely interested before applying.

The NUCCA Convention schedule is printed on page 8. An application form is attached for those who wish to apply. A motel card will be sent upon receipt of the application form. All applications must be received by March 15, 1979.

Addendum

In the article, **C1 Subluxations, Short Leg and Pelvic Distortions**, (Vol. 2, No. 5) it was incorrectly stated on page 2, column 2, paragraph 4, that "The forces of gravity on the spinal cord in the supine position are approximately 30 lbs. per sq. in. whereas..." The sentence should have read: "The forces of gravity on the spinal column in the supine position are approximately 30 lbs. per sq. in. whereas..."

Leg Check

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tion. Of importance to the practitioner is that the variance in leg length seen on different office visits suggests different things and may be of aid to him in charting his course of action on that visit: how much to adjust, if his patient is making progress, and so on.

Leg length varies for several reasons, and careful records of the amount of leg shortness should be recorded on each visit. If, of course, the legs are equal, no nerve imbalance is indicated; therefore, no adjustment is required. This fact should also be recorded. Increased detriment to the CNS often results from unreported accidents, falls, and the like, not thought important by the patient. Because these accidents may change the misalignment factors of the subluxation, thereby changing the adjustment vectors, they should become known to the practitioner and recorded. An increased shortness of a leg should be viewed with suspicion, and the patient questioned regarding its cause. Occasionally, following trauma, the opposite leg will shorten. This always indicates a change in the adjustment vectors; another misalignment factor of the subluxation has become, because of the trauma, the misalignment that is producing the greatest contracture, affecting the patient's opposite side. Trauma, in other words, can easily change the subluxation's misalignment factors, causing a former and previously minor subluxation factor to become predominant in its effects on the reticular formation of the brain stem, causing a loss of the neurological inhibitory influences to the extensor musculature on the patient's opposite side. Such an occurrence signals a red-light to the practitioner, warning him that re-x-ray is imperative, a new adjustic vector required. If he fails to heed the red-light and continues on adjusting the patient can relapse, and may develop new symptoms.

Agreement of all methods and devices used to determine imbalance in nervous conduction should be the rule. The leg length check should agree with the thermoscope, and, if it

does not, the reason should be determined. For every point "break" on the thermoscribe graph, approximately 1/8 inch shortness of the leg should show. Whatever method of measurement is utilized, agreement with the leg-check should occur before a C1 adjustment is given. An adjustment of C1, no matter how perfectly delivered, constitutes trauma if no neurological imbalance is present. This trauma will express itself within a few days in the patient in terms of the short leg, increased symptoms, and neurological detriment.

Not the least value accruing from accurate leg-checking is that it indicates patient progress. Because C1 is a stresser in the body when it is subluxated, it does not contribute to a healthy body; bodily distortions are not signs of health. The proper use and correct understanding of the significance of the leg-check provides a simple and reliable index for the practitioner.

EQUIPMENT

Leg-checking is a more exact process if the proper table is used. Recommended is the Utterback adjusting table. The body piece is about twelve inches in height, which is the best height for the average practitioner. This height allows the practitioner better control of his gravity center when checking legs. The body piece is upholstered for leg-checking—neither too hard nor too soft. The table is of sufficient weight and structure to insure safety for the patient.

PATIENT ALIGNMENT to the MID-SAGITTAL PLANE

The patient is instructed to remove all impediments, such as a man's pocketbook, from the back pockets of pants, slacks, etc. These articles may cause a false shorting of the leg because they may turn the patient's pelvic girdle into the transverse plane when he lies on them. He is then asked to sit at the body piece end of the table, facing away from the head-piece. The practitioner guides the pa-

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Leg Check

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tient onto his back, aligning the patient's spinal column and head to an imaginary line which divides the adjusting table into two equal halves. (Figure 1)

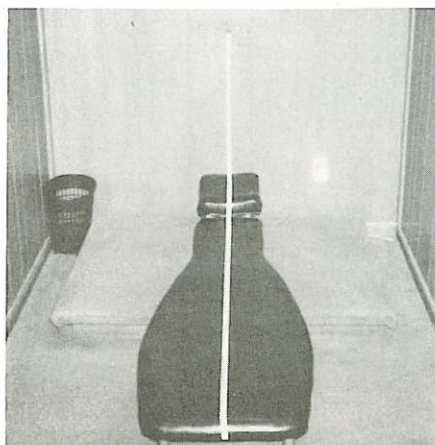


Figure 1

The better practice, especially for practitioners who lack experience in leg-checking, is to establish a permanent line midway through the length of the adjusting table (Figure 1). Another line is placed vertically on the wall at the headpiece end of the table. The adjusting table line is then exactly aligned to the vertical line by moving the adjusting table, insuring greater accuracy in sighting the centers of the patient's head, shoulders, and pelvis to the vertical line and the table center line. (Figure 2)



Figure 2

If the patient is tall, his legs may extend beyond the end of the body piece to the extent that his knees may bend. If this occurs, an additional support of the same height as the table's body piece should be used. The patient's feet and ankles, however, should extend beyond the

body piece, providing additional support to permit grasping the shoes and performing the leg-check. (Fig. 2)

The practitioner checks the patient's position on the table. The glabella, the center of the chin, episternal notch, and pubic center should lie directly above the table center line. This procedure insures that the patient is centered to the mid-sagittal plane. (Fig. 2)

Figure 3 shows an incorrect placement of the patient on the table. The head is turned in the transverse plane, and neither the glabella nor the center of the chin align to the mid-sagittal plane. A comparison of the legs to the table's center line quickly shows that the patient's legs do not parallel the line. This error in placement could cause a false leg shortening.



Figure 3

After checking the patient's position in relation to the table's center line, the practitioner slightly raises each of the patient's legs, one at a time, and places them in parallel alignment to the table's center line. The legs are not dragged across the table top as this error will falsely shorten a leg. Dragging a leg against the table top pulls the musculature on the posterior surface of the patient's leg, producing the error.

ALIGNMENT TO THE PATIENT'S SAGITTAL PLANE

The practitioner aligns his sagittal plane to the patient's sagittal plane. This procedure assures that lateral displacement of the practitioner's body will not cause error in leg-checking by producing greater shoe pressure from one side of his body. A continuation on the floor of the mid-center line of the adjusting table aids

alignment of the two sagittal planes. (Fig. 4)

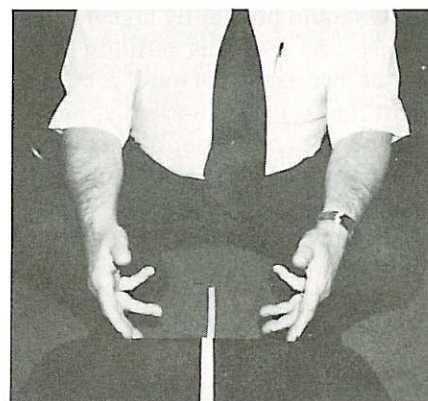


Figure 4

Positioning himself so that his vertical mid-sagittal plane is at right angles to the patient's horizontal mid-sagittal plane, the practitioner places his feet laterally and equidistant from the extended mid-center line between his feet. His feet are turned out at an approximate 45° angle. The width between the feet is approximately equal to the width of his pelvis.

Bending his knees, the practitioner settles down his thighs along the same plane as described by his feet. He keeps his lumbar spine fairly straight. In bending down, the knees flex more rapidly than the joints of the hips; they "lead the way", so to speak. The practitioner should not "squat" down with the center of his gravity back so far that he will tend to produce a pulling action when checking the patient's feet. His body weight should be sufficiently forward so that there is a slight pushing action against the patient's feet, so that he cannot maintain his position without holding the table for balance. His hip



Figure 5

(Continued on page 4)

Leg Check

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sockets should be slightly higher than his knee sockets. This position permits the necessary forward pressure against the patient's shoes of approximately 5 lbs. per shoe, and control of the pressure by the practitioner by pushing downward with his knees. This downward pressure brings his body forward. Figure 5 illustrates the correct position from the lateral view, and Figure 6 shows the incorrect posture.



Figure 6

A triangle is formed by the practitioner when he is in the checking position. The apex of the triangle is at the practitioner's pelvic center of gravity, and the sides of the triangle are formed by the practitioner's thighs. A line just above the practitioner's knees represents the base line. This triangle serves the purpose of aligning the practitioner, the base line of the triangle paralleling a line across the heels and shoes of the patient which is at right angles to the patient's mid-sagittal plane. The triangle, with its apex directly over the mid-center line and its base parallel to the line at right angles to

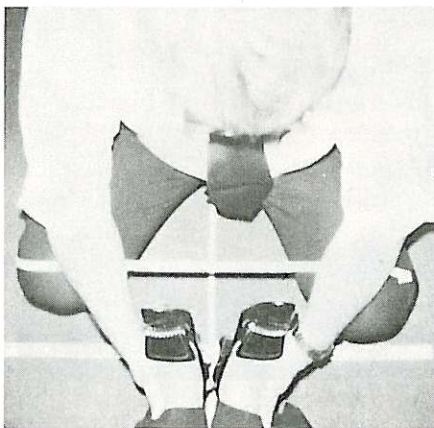


Figure 7

the patient's sagittal plane line, alerts the practitioner if his body is rotated in the transverse plane (Fig. 7)

Figure 7 shows that there is a slight rotation of the practitioner's body. The right knee is farther back of the rule bisecting the mid-center line, or patient's mid-sagittal plane, than the left knee. A body rotation of this nature would probably cause some shortening of the patient's right leg because slightly more pressure against the right leg would result. The base line of the triangle and an imaginary line across the patient's feet would not parallel.

The practitioner should position himself neither too close nor too far from the patient's feet, as either wrong position can cause error. The base line of the triangle is used as a guide, and the patient's feet should closely approximate or even touch the base line during the checking process, neither breaking through the triangle's base line nor being more than two or three inches in front of it.

The distance from the center of each of the practitioner's knees to the imaginary line across the soles and heels of the patient's feet should be equal, thereby indicating that the practitioner's body is not rotated.

THE ARCIFORM

The practitioner forms his hands in a curved position as illustrated (Figure 8), called the arciform. It is a bow-like shape, and required for holding the patient's shoes properly. The backstay of the shoe (part of shoe above the heel) rests in the palm of the hand, supporting the foot. The little finger is placed under the heel of the shoe so that sufficient pressure is exerted to keep the heel of the shoe against the patient's heel. The thumb rests gently along the outside of the shoe, paralleling the patient's leg.

This method of holding the patient's shoes allows control of the feet of the patient, and they can be squared to a line bisecting the patient's mid-sagittal plane at right angles, or parallel to the base line of the triangle. Care must be taken that no downward pressure is placed on the patient's legs; neither should they be lifted from the table except suffi-

ciently to obtain full extension of the legs.

It is a better procedure to take one of the patient's shoes at a time and align it to the line bisecting the mid-sagittal plane of the patient.

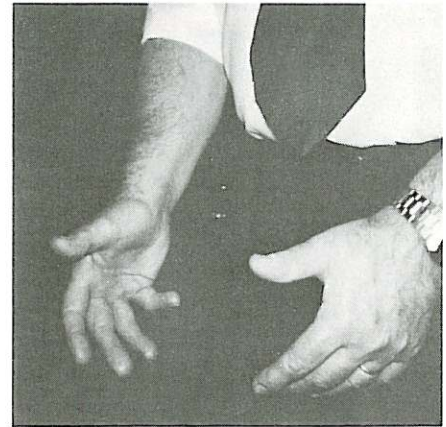


Figure 8

The patient's legs should lie on the table in a relaxed position. The tendency of some patients to assist by tightening their ankle joints or bringing their feet together should be discouraged. If a patient cannot relax either or both of his legs, it may indicate that a subluxation is forming at C1, which may not yet be apparent in a deficiency of leg length.

Positioned in the checking posture, the practitioner checks his mid-sagittal plane for alignment at right angles to the patient's mid-sagittal plane, verifies that the base line of the triangle is parallel to a line across the patient's soles and heels, confirms that equal distance exists from the center of each knee to the line across the patient's soles and heels, and that he can control his weight forward by pressing down with his knees in order to bring about a 5 pound pressure against the patient's heels. He then places his fore-arms, elbows slightly outward, across his thighs, somewhat at a 45° angle. (Figure 9) Forming his hands into the arciform position, he secures the patient's shoes, squares them as previously described, pushes downward with his knees to exert the required pressure against the patient's extensor musculature, rocking slightly forward on the balls of his feet which permits his knees to come downward. If it is necessary to close

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Leg Check

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any little distance between the patient's feet, the practitioner does so by bringing his knees equally toward each other.

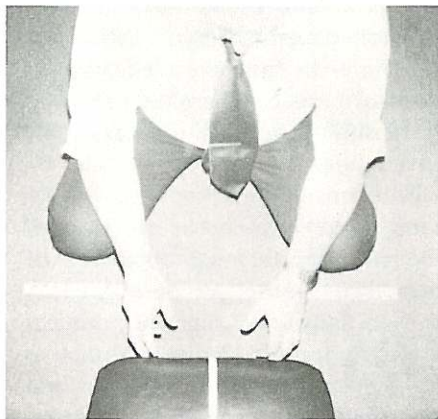


Figure 9

The patient's shoes are compared in establishing leg deficiency by judging one shoe against the other at that point where the heel of the shoe attaches to the backstay. Shoe heels and soles are often unequally worn and frequently shoes are warped from wear. This is especially true if the patient has been walking in them with a short leg. The unconscious tendency to splay, or turn out, the foot of the short leg causes a twisting motion in walking which increases damage to the shoe on the affected side. Circular markings are often seen on the leather soles of the shoes of patients with a short leg.

EFFECTS of the DURA METER on the SHORT LEG

There are many factors involved in a leg deficiency that are usually reflected in the C1 subluxation. A subluxation, for example, may be just forming, or loss of equilibrium may be occurring at the time of the leg-checking process. Rigidity or tenseness may indicate either of these factors; the patient cannot relax. Sometimes a loss of resistance can be felt by the practitioner if he pushes toward the patient's body on the tense leg as compared with the opposite leg. These signs are indicative of an on-coming subluxation at C1.

A more dramatic indication of an on-coming subluxation is observed when the patient's head is turned

either to the right or left while checking for the short-leg. Rotation of the patient's head may cause one leg to shorten. If so, the disparity is due to a corkscrewing of the dura mater narrowing the cervical canal. Caillet (1964) states: In rotation of the head, the length of the canal is not influenced, but the cervical canal narrows, not from bony closure but from spiral motion of the dura."⁽¹⁾

The dura mater is attached to the circumference of the foramen magnum and to the posterior surfaces of the second and third cervical vertebrae.⁽²⁾ It is clear, therefore, how rotation of the head will produce a narrowing of the cervical canal. The narrowing of the canal from the twisting of the dura produces an imbalance to the CNS similar to that of a misalignment of C1. Both can cause leg disparity. **It is highly significant that when C1 is not subluxated, and is still balanced, that turning the head will not cause a leg deficiency.** The ANATOMETER, despite the greatly increased gravity stress on the spinal column in the erect position, will also show increased readings when the twisted dura increases the narrowing of the cervical canal in cases where an impending subluxation of C1 is forming.

It should be noted further that it is frequently observed when turning the **subluxated** patient's head to one side that a lengthening of the short leg occurs. Turning the head to the opposite side may shorten the leg more than in the straight head position. Apparently, in the first instance, the dura effect temporarily relieves the C1 subluxation. In the second instance, it increases the C1 subluxation.

CONCLUSION

The supine leg-check, properly executed, is one of the conclusive tools in determining the presence or absence of C1 neurological insult. It also has a predictable value in ascertaining if a C1 subluxation is forming. By its precise use, the practitioner protects the patient against indiscriminate and needless adjusting, thus preventing relapses in the progress of the patient and future problems for the practitioner. The

supine leg-check alerts the practitioner of un-reported injuries, protecting both the patient and the practitioner against serious changes in the misalignment factors of the C1 subluxation that would cause changes in the adjustic vectors. It must, however, be borne in mind that it is only one means of determining the presence of a C1 subluxation, a subjective one at that; and should be used in conjunction and in agreement with other subluxation determining devices.

REFERENCES:

- Caillet, R. **Neck and Arm Pain**. F.A. Davis Co. Philadelphia. (p. 27).
Gray's Anatomy, 35th British Ed., W.B. Saunders Co., Philadelphia (1975) (p. 989)

Announcement

Jet-port limo service every hour from the Detroit Metropolitan Airport to Howard Johnson's Motel and the Holiday Motel in Monroe became effective on December 18, 1978. The transport service is conducted by Shortway Lines, Inc., 1 Keeshin Drive, Toledo, Ohio 43612. Tickets and information are available at all stops and at most travel agencies. The fare from Metropolitan to Monroe is \$8.00 one way; round trip is \$14.00. On arriving at the Detroit Metropolitan, contact the Greyhound ticket counters, North and South Terminals.

Change of Address

MONOGRAPHS, booklets, pamphlets, and other NUCCA and NUCCRA materials, sent in answer to requests by mail, are too frequently returned because of lack of notification by the subscriber of change of address, or ineligible addresses. Return address corrections add considerably to the NUCCA postage costs as the U.S. Post Office charges twenty-five cents for each correction. Please notify the NUCCA Editor, 217 West Second Street, Monroe, Michigan 48161 of any change of address. PLEASE CLEARLY PRINT OR TYPE YOUR ADDRESS.

A Need for Practical Chiropractic Research

Many chiropractors still sit in judgment on the value of chiropractic research, believing as they seemingly do that all has been said that needs to be said and all has been done that requires doing concerning the subluxation. For them, the chiropractic package is completely and neatly wrapped; the truth of chiropractic securely rests on its traditional principles and practices. There is little need for further investigation. In this mystical world, the subluxation problems of patients neither exist nor would they be recognized as problems when they do exist. Unfortunate as this state of affairs is, there is a growing interest in chiropractic research among younger practitioners and students. Interest is also increasing among patients. Despite, however, this growing interest, little valid and practical research of the essential nature of chiropractic—the production and reduction of the vertebral subluxation and the associated problems—is apparently being done.

No one, certainly, would deny that much valuable research is being done. Little of it, however, is of a practical and immediate help to the practitioner as it does not relate directly to the problems of subluxation production and reduction and their reciprocal relationships to body functions. Yet, the subluxation is a mechanical entity, and is, therefore, a natural field for investigation and measurement, as are its bodily stress factors. Other than clinical research conducted by the National Upper Cervical Chiropractic Research Association, Inc. (NUCCRA), no practical research, based on measurement procedures of the subluxation and its stress effects on the body, is apparently being done.

It is in the application of relevant, known, and proved mechanical principles to the subluxation and its problems that chiropractic will stand or fall as a separate and distinct science. If it does not do its own research, it will never obtain more than a prescriptive status. Another healing

art will develop the science and art of the subluxation and its correction, and expand its still unexplored potential. The future of the profession rests firmly on research, and the more practical and basic that research is the better it is for the growth of chiropractic, for its survival.

The schism between so-called straights and mixers—a bitter disagreement over scope of practice that has torn us apart—has its solution to a great extent in valid research of the subluxation and its detrimental effects on the body. Such a type of research could be a healing force—a balm applied to the profession's wounds. The research that has been done so far by NUCCRA has shown the superiority of subluxation-correction over modality practices.

The so-called mixer may reply, and apparently believes, that he has not found the subluxation concept and its strict practice sufficient to satisfy the needs of his patients. This is no doubt true of him (and others) because he has not been trained in college and elsewhere in a validly researched technique or system of subluxation-correction. So far as the subluxation and its correction is concerned, what he was exposed to is better left unsaid. Thus it is not difficult to understand why doctors run from one technique course to another in their attempts to practice subluxation reduction. A vast difference exists between correcting a subluxation and trying to with techniques that are too mechanically inept to be in accordance with reason. As a matter of fact, such techniques as the mechanically incompetent rotaries, where the head is used to attempt to lever a misplaced cervical vertebra into position, can increase subluxations. This is the paradox of chiropractic practice: that too many systems fail to maximally reduce or correct subluxations when the great objective of chiropractic is to remove the subluxation. It is for the accomplishment of this objective that the chiropractor holds himself out to

the public. So subluxation-correction escapes us and the subluxation, the common denominator of chiropractic, eludes us, and we seek a larger scope of practice where the problems of the subluxation will not have to be solved.

Problems seldom ever require solutions if they cannot be recognized. The practitioner must be aware of them, train himself or be trained, if he is to daily solve them in practice. Searching for and testing solutions to the problems of the production and reduction of the vertebral subluxation will, however, expand his scope of practice. Furthermore, problem solving develops the practitioner. His practice of his art becomes a highly organized skill, and a discipline. No one in such matters can be a law unto himself; he must participate in a pattern of controlled behavior, designed for his growth, the profession's growth, and last but not least, the public safety. Such a pattern evolves from knowledge gained from bona fide research.

NUCCRA statistics show that the subluxation reduction that is less than 70% is ineffective in benefitting the patient. In the range of reduction level of 80% to 100%, the patient is helped. Skill, then, is a determining factor, and the degree of success for the patient, the doctor, and the profession can be weighed on the scale of the acquired ability of the practitioner. His know-how determines his efficiency; his knowledge makes for an ethical practice.

Knowledge of the subluxation, its production and reduction, is as vital to the researcher as it is to the practitioner. The researcher, first and foremost, must be a consistent and skillful subluxation-reducer. Without this skill, he cannot successfully investigate and test the effects of the correction of the subluxation. A subluxation that cannot be maximally reduced so that the effects of reduction can be measured hardly provides good research data.

New NUCCA Policy

For several years, NUCCA has sent the MONOGRAPH and other materials, including booklets and pamphlets, to non-member doctors and students enrolled in chiropractic colleges throughout the world without charge upon receiving requests. Up to now, NUCCA wrote off the publishing, handling, and postage costs to public relations. Because of the increased costs, NUCCA can no longer offer this free service to non-members.

A yearly subscription of ten (\$10.00) dollars, therefore, to non-members will be charged for the MONOGRAPH. Booklets and pamphlets of a technical nature will be priced according to cost of printing and handling. NUCCA members will, of course, receive the MONOGRAPH and other publications, without charge as part of their membership privileges.

Many requests are received from doctors and students for past issues

of the MONOGRAPH, because of the NUCCA research and academic articles. There are 15 past issues which can be obtained from NUCCA for a cost of ten (\$10.00) dollars by ordering them from the NUCCA Editor, 217 West Second Street, Monroe, Michigan 48161. Single issues of the MONOGRAPH can be obtained for one (\$1.00) dollar.

This offer holds as long as past issues are available.

NUCCA Scholarship Awards

At its October 22, 1977 meeting, the NUCCA Board received with thanks the \$500.00 donation sent by Mrs. Upton X. Furman of Neenah, Wisconsin in memory of her late husband, Dr. Upton X. Furman, who died April 22, 1977. Dr. Furman was a supporter and long time member of NUCCA. The NUCCA Board voted to use the donation to help fund the Scholarship Awards as Dr. Furman often expressed his interest in college students and their financial problems. This is also in accordance with Mrs. Furman's wishes.

The NUCCA Board approved a continuation of the \$250.00 scholarship grant-in-aid for the next three years, and that this sum be paid to any chiropractic student currently enrolled in a chartered college of chiropractic who submits to the **Monograph** editor an acceptable article pertaining to the upper cervical spine.

Submitted articles may deal with any aspect of the Occipital-atlanto-axial area of the cervical spine: mechanics, neurological manifestations, analyses of cervical subluxations, corrective techniques for cervical subluxations, detrimental effects of upper cervical subluxations on the human organism, and the like.

All entries will be judged by the NUCCA Directive Board and by Professor Seemann. Their judgment will be final. Accepted articles become the property of the National Upper

Cervical Chiropractic Association, Inc. Winners will be announced at the following NUCCA Convention.

NUCCA will attempt to return all manuscripts that are accompanied by a self-addressed, stamped envelope. NUCCA will not be responsible for lost or mislaid material. Further information is available by writing the **Monograph** Editor, 221 West Second Street, Monroe, Michigan 48161

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(PLEASE PRINT OR TYPE FORM)



The Thirteenth Annual NUCCA Convention

Dates: April 28, 29, 30 & May 1, 1979

Days: Saturday through Tuesday

Place: Howard Johnson Motor Lodge
1440 N. Dixie Highway
Monroe, Michigan 48161

Theme: "Understanding, The Key to the
Adjustment."

Convention Chairman:
Dr. Steven Goodman

Educational Program Supervised By:
Professor Daniel C. Seemann
University of Toledo

Designed to satisfy license-renewal requirements

★ ★ ★

NUCCA Monday, April 30, 1979
Banquet: THE COLONIAL HOUSE
Guest Speaker: Mr. Bert Kizer

Saturday, April 28, 1979

8:00 - 8:45
Registration

8:45 - 9:00
Invocation
Rev. H.B. Fehner
Pastor Emeritus
Trinity Lutheran Church, Monroe

9:00 - 10:00
Opening Address
Dr. Steven Goodman
Convention Chairman

10:00 - 12:00
Upper Cervical Biomechanics
Dr. Ralph R. Gregory

12:00 - 2:00
LUNCH

2:00 - 6:00
Chiropractic Research
Prof. D.C. Seemann

Sunday, April 29, 1979

9:00 - 11:00
Biomechanics (con't)

11:00 - 12:00
Film Analysis
Dr. Ralph R. Gregory

12:00 - 1:30
LUNCH

1:30 - 4:00
**The Phenomenon
of Self-Healing**

Eileen Metress, Ph.D.
Assistant Professor
University of Toledo

4:00 - 6:00
Film Analysis
Dr. Ralph R. Gregory

Monday, April 30, 1979

9:00 - 11:00
Adjusting Technique
Dr. R.R. Gregory

11:00 - 12:00
Film Analysis

12:00 - 1:30
LUNCH

1:30 - 4:00
**Current Trends in
Chiropractic Education**
Dr. Leon R. Coelho
President: Pacific States
Chiropractic College

4:00 - 6:00
**NUCCA Annual
Business Meeting**
★ ★ ★

Tuesday, May 1, 1979

9:00 - 12:00
**Practical Work in
Film Analysis and
Adjusting Technique**

12:00 - 1:30
LUNCH

1:30 - 4:00
General Review