



(Super Healthy Pty Ltd ABN 61 007 341 479)

Dr Nick Hodgson, B.App.Sc. (Chiropractic)

89 Shannon Ave. Manifold Heights, Vic. 3218

Ph: 0419 104 076

E-Mail: drnick@superhealthy.com.au

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To: Whom it may concern

Re: Torque Release Technique Online Theoretical Program, Hands on Workshop, Advanced Hands on Workshop and Advanced Online Education Course Outline.

Overview of Torque Release Technique

1) Developed by Dr Jay Holder whose credentials include but are not limited to: The 1993 United States Senate compared Dr Holder's Success in research to Michael Jordan's performance in basketball. Dr Holder's work has been featured on a Discovery Health Channel documentary. First American Physician to receive the Albert Schweitzer Prize in Medicine which was given to him during the 23rd World Medical Congress in Malaga, Spain; 1992 Florida Chiropractic Association Chiropractor of the Year; 1995 Florida Chiropractic Society Chiropractic Researcher of the Year. Adjunct Professor, St. Martin's College, Milwaukee; held appointment to the faculty at the University of Miami, Centre for Addiction Studies and Education, and held appointment as post graduate faculty at numerous chiropractic colleges including National College, Life College, Life West and Parker College. Executive Board Member and Treasurer of the Council on Chiropractic Practice. Author of two books, edited in several others, author of many scientific papers and research studies, and inventor of medical, acupuncture and chiropractic devices.

2) The original research project during which the technique was developed was co-designed and statistically analysed by Robert C Duncan Biostatistician and Professor of Epidemiology at the University of Miami School of Medicine.

3) TRT includes procedures from Upper Cervical (Palmer), Directional Non-Force Technique (Van Rump), Sacro Occipital Technique (DeJarnette), Toftness, Thompson, Gonstead, Logan, Pierce, and Network Spinal Analysis (Epstein). The procedures from each technique included were literature searched extensively by Dr Jay Holder and reviewed for evidence appropriateness and inclusion by Robert C Duncan PhD during the research design.

4) The research involved longitudinal, randomised, placebo-controlled, three-armed (active care plus standard care, placebo care plus standard care, standard care) research design providing the highest statistical outcomes on a range of gold-standard health outcomes possible (Becks Depression, Spielbergers Anxiety, retention in a residential program, Nursing Station Visits).

5) The Integrator adjusting instrument was designed during the research design to overcome the statistical and research problem of chiropractic intervention via hands, the lack of reproducibility

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provided by pre-existing adjusting instruments and is patented for the correction of subluxations, has FDA, CE & TGA accreditation.

6) The Integrator was the first Chiropractic Adjusting Instrument to provide true reproducibility of correctional vectors due to the preloading mechanism and includes recoil and torque not supplied by other instruments. It includes specific factors for force, speed, frequency and amplitude.

7) The TRT research project findings were published in the Journal of Psychoactive Drugs and Molecular Psychiatry, and featured in a wide range of chiropractic, addiction medicine and psychology publications as well as being featured in a Discovery Health Channel Documentary (Lifeline – “Wiped Out”).

8) The leg length analysis taught has 87% inter-examiner reliability published in the research literature.

9) A significant segment of the TRT program is hands on demonstration and workshop providing professional interaction between professionals and their trainer to dramatically augment the acquisition of clinical experience and technical mastery.

10) The TRT protocol provides the chiropractor with a methodology to improve their differential diagnostic skills to determine where to adjust a patient and the most appropriate correctional vectors to utilize.

11) The TRT program includes extensive scientific literature review of advanced spinal anatomy, neurophysiology and pathology not taught at an undergraduate level.

12) We recommend, teach and demonstrate the use of objective functional and quality of life assessment tools to assist the practitioner to monitor and modify their care plans.

13) TRT includes methodology to minimise clinical intervention and to provide contraindications to unnecessary or incorrect adjustment interventions and scheduling efficacy – as such to minimise public and professional risk from care.

14) The online training modules include video teaching content from some highly credentialed scientific experts: Jay Holder; Neuroscientist and pharmacologist Candace Pert PhD; Cell Biologist Bruce Lipton PhD; Professor of Theoretical Physics Leonard Susskind PhD; Professor of Psychology Karl Pribram PhD; Biochemist and Cell Biologist Rupert Sheldrake PhD; Cell Biologist and Bioengineer Donald Ingber MD, PhD; Physician Ben Goldacre MB, BS, MA; Biologist and Biophysicist James Oschman PhD.

15) Torque Release Technique is taught as an in the classroom elective at both Life University and Sherman College. It is also taught in the clinic and allowed in the clinic and provided in the clinics at both Life & Sherman. Of course both life and Sherman have full CCE accreditation. It is a required course in the core curriculum at McTimoney College, Oxford England: McTimoney has been doing so for 15 years.

16) Torque Release Technique has always been approved for continuing education in every jurisdiction it has ever been held in and/or applied for. Internationally it has received post grad accreditation in every state in the United States, Australia, England, Germany, Italy, Jerusalem, Puerto Rico, New Zealand, South Africa, Mexico, Japan and Canada.

17) The majority of the continuing education credits in the USA are maintained by and run through the postgraduate education department of Life University except for the majority of the foreign locations which are done separately on a one-to-one basis.

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18) Torque Release Technique is the only ICA sponsored/accredited Chiropractic technique by their Council on Applied Chiropractic Sciences.

Course Structure:

There are four parts to the Australian Torque Release Technique curriculum.

Part 1: 8 hours online distance education theoretical training.

Part 2: 8 hours hands-on face to face workshop training. Prerequisite to attending this training is completion of Part 1 or previous attendance to the former Australian TRT training programs.

Part 3: 8 hours hands-on face to face seminar workshop advanced training. Prerequisite to attending this training is completion of Parts 1 and 2 or previous attendance to the former Australian TRT training programs.

Part 4: 8 hours online distance or DVD based education advanced theoretical training.

Course Summary:

History and Research of Torque Release Technique = 1.0 Hours

The background and history leading to the research project: Dr Jay Holder's experience in Miami Vice and addiction's recovery programs and observations that penal and psychosocial management of addictive disorders was often unsuccessful; Research concept proposal to Florida Chiropractic Associations and approval of small grant by Florida Chiropractic Society; Early discussion of what techniques and protocols should be included in the research project and compromise to include a mix of evidence-based established and commonly used chiropractic protocols.

Review of the literature and selection criteria of technique protocols as overseen by University of Miami School of Medicine Biostatistician Bob Duncan in conjunction with the Holder Research Institute: Literature searches were conducted on the chosen technique models to ensure that correct and documented application of each method was carried out during the research project.

Research design and methods: Design of research protocols and statistical methods by Bob Duncan, inclusion and exclusion of assessment and adjustment methods, inclusion and exclusion criteria for clients.

Client selection, randomisation and health research outcomes: Randomised client selection; Three arms – normal care, normal care plus placebo adjustment, normal care plus chiropractic adjustment; Client retention rates; Spielberger Anxiety inventory; Becks Depression Scale; Nursing station visits. Three groups were randomized: Active treatment comprising daily adjustments to correct vertebral subluxations using the Integrator adjusting instrument to deliver a set amount of force and direction with an audible click; a placebo treatment utilizing the same instrument but set to deliver zero force with no direction while maintaining the audible click; and a usual care group who followed the general policies of the residential program. The chiropractic and usual care groups each had 33 subjects while the placebo group had 32 subjects.

Technique system development: Compilation and integration of the accepted assessment methods into a technique system and clinical process.

Adjusting instrument (Integrator) research, design and development: Review and exclusion of pre-existing adjusting instruments due to documented flaws; Literature review of specifications of Toggle Recoil; Design and development; Adaptation to a placebo instrument; FDA 510K approval.

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Review of the study results and conclusions: All of the Active group completed the 28-day program, while only 24 (75%) of the Placebo group and 19 (56%) of the Usual Care group completed 28 days. These completion rates are significantly different than that for the Active group ($p < 0.05$). A Kaplan-Meier survival analysis showed that the probability of retention in the Placebo and Usual Care groups was less than that for the Active treatment group (Log Rank Test, $p < 0.001$). At four weeks the Spielberger State Anxiety scores were 32.0 ± 1.6 for the Active group, 42.5 ± 3.0 for Placebo group, and 33.1 ± 3.7 for the Usual Care group. The Active and Placebo groups were significantly different at four weeks ($p < 0.05$), with the Active group showing a significant decrease in anxiety (19.0 ± 2.2 , $p < 0.001$) while the Placebo group showed no decrease in anxiety (2.3 ± 2.9 , ns). Among the Active treatment group only 9% made one or more visits to the Nurse, while 56% of the Placebo groups ($p < 0.001$ compared to Active) and 48% ($p < 0.002$ compared to Active) made such visits.

Publication in the major medical journals: Journal of Psychoactive Drugs (Vol 32 Supplement, November 2000. (Pg 59-60)) and Journal of Molecular Psychiatry (Vol. 6, Supplement 1 - February, 2001, part 2, abstracts, Published by Nature. (Pg S8))

Publications in Chiropractic and other journals and publications: Canadian Chiropractor; Journal Vertebral Subluxation Research; Handbook Of Abusable Drugs; Alternative Medicine Digest; Chiropractic Pediatrics; Psychology Today Online.

Filming and production of the TV documentary by Discovery Health Channel: "Wiped Out" feature on Lifeline series.

Overview on clinical relevance of the research demonstrating the Chiropractic Adjustment's role in improving addiction recovery outcomes: Discussion of relevance of research on addicted population to general and chiropractic client population

Subluxation detection and correction, and "state of wellbeing" outcome measures: Summary of Reward Deficiency Syndrome and how addicted population presents ideal study group to research state of wellbeing, and how research demonstrates that improving state of wellbeing can be applied to all chiropractic clients.

The Diagnostic Indicators of Subluxation = 3 Hours

Exhaustive review of the archival publications and literature of the tonal chiropractic techniques by Dr Jay Holder, collating the "best of the best" Subluxation indicators to make the chiropractic assessment process much more outcomes based.

Review of the evidence-based process to synthesize diagnostic methods from:

- Thompson Terminal Point
- Van Rumpt Directional Non-Force
- DeJarnette Sacro-Occipital
- Logan Basic
- Toftness
- Palmer Upper Cervical
- Network Spinal Analysis technique systems

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This symbiosis of assessment criteria to take the Chiropractor's clinical decision making to new levels of confidence, reliability and reproducibility: Standardisation and documentation of correct application and implementation of each method:

- 1) POSTURAL FAULTS (Standing, Sitting, Prone) – low-tech and high tech objective means of recording and measuring; the neurological differences between standing, sitting and prone postural assessments; Clinical Relevance.
- 2) ABNORMAL BREATHING PATTERNS: Classification and differentiation of breathing movements from segmented to wave-form; Clinical Relevance.
- 3) PALPATION: – Scanning – superficial to skin
 - Tissue – superficial to muscle
 - Inter-segmental – muscle and soft-tissue
 - Motion – motor unit motion and play
- 4) ABNORMAL HEAT/ENERGY RADIATION FROM BODY: Thermography or Scanning Palpation; Clinical Relevance.
- 5) CONGESTIVE TISSUE TONE: Tissue palpation in strategic regions; Clinical Relevance.
- 6) INAPPROPRIATE SUSTAINED PATTERNS OF PARASPINAL CONTRACTIONS: Inter-segmental Palpation or surface EMG; Clinical Relevance.
- 7) FUNCTIONAL LEG LENGTH INEQUALITY: Description and demonstration as a neurological reflex test; Differentiation to anatomical leg difference and biomechanical assessment; Clinical Relevance.
- 8) HEEL TENSION: Description and demonstration as a neurological indicator of dural tension; Differentiation to other heel tension tests; Clinical Relevance.
- 9) ABDUCTOR TENDENCY/ADDUCTOR RESISTANCE: Description and demonstration as a neurological indicator of dural tension; Clinical Relevance.
- 10) FOOT FLARE: Description and demonstration as a neurological indicator of dural torsion; Clinical Relevance.
- 11) FOOT PRONATION/SUPINATION: Description and demonstration as a neurological indicator of pelvic torsion; Differentiation and comparison to foot flare; Clinical Relevance.
- 12) CERVICAL SYNDROME TEST: Description and demonstration as a neurological screening test of C1 or C5 dural tension; Description of flaws, false positives and false negatives, specificity and reliability; Clinical Relevance.
- 13) BILATERAL CERVICAL SYNDROME TEST: Description and demonstration as a neurological screening test of “bilateral” dural tension; Description of flaws, false positives and false negatives, specificity and reliability; Clinical Relevance.
- 14) DEREFIELD TEST: Description and demonstration as a neurological screening test of Pelvic dural tension; Description of flaws, false positives and false negatives, specificity and reliability; Clinical Relevance.

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The Protocol of the Torque Release Technique Model = 1.5 Hours

Review of the historical Chiropractic literature to glean underlying principles behind Chiropractic assessment and adjusting: Writings of DD and BJ Palmer and RW Stephenson and discussion of relevance to current practice and knowledge.

“Non-linear timing”: Utilising physical examination indicators to dictate the order in which adjustments are delivered as opposed to a habitual top to bottom or bottom to top adjusting protocol; Using a system which asks a person’s body for permission to adjust a particular segment as opposed to imposing our will on their system.

“Primary” and “secondary” subluxations: Differential diagnosis of the neurological impact of co-existing subluxations; Discussion of difference between “live” primary subluxation which shifts with time and the reactions to life stressors as opposed to traditional chiropractic model of a primary being a permanent pattern.

Non-linear adjusting: Clinical decision making system to determine how to adjust a primary subluxation; Utilising a model which allows adjustment protocols to evolve as person’s nervous system adapts to higher levels of organisation or regresses due to abnormal reaction to stressors.

“Less is more”: Outcome-based findings to minimise clinical intervention while maximising therapeutic response; Discussion of common error for Chiropractors to do too much for their patients as opposed to utilising a system which focuses treatment on a clinical needs basis.

“Low force adjusting”: Specifications and benefits of Integrator instrument adjusting; Flaws and risks of manual adjusting.

Leg testing and pressure testing for correctional vectors: Overview of the differential diagnostic method for determining primary subluxation.

Three-dimensional subluxation listings including torque: Overview of the differential diagnostic method for determining three-dimensional vectors of correction and subluxation.

Rechecking for outcomes of each adjustment: Clinical safeguards built in to the TRT system to cross-check findings and to determine efficacy of each adjustment.

How to maximise processing of each adjustment: Review of research and practices from BJ Palmer Clinic; Development of short-cut during TRT research to increase speed of primary subluxation correctional processing.

Nervous System Tonal Model = 1.5 Hours

Anatomy: Review of Cranio-Spinal Meningeal Functional Unit (C-SMFU); Dural attachments to bone; Dural attachments to ligament and muscle; Dural attachments to spinal cord.

Biomechanics: Review of effects of flexion, extension, lateral flexion and rotation on dural attachments and spinal cord tension.

Physiology: Comparison of models of neural tension versus neural compression; Neurological, Biochemical and Circulatory changes.

Neurobiology of the spine and central nervous system: Neuropeptides and their concentrations in different neural tissues.

The importance of spinal tonal integrity: Comparison of Cerebro Spinal Fluid flow models versus neural tension models; Review of neurosurgical research on dural tension in pathological states.

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Review of historical Chiropractic literature and more recent scientific literature relevant to the concepts of adverse mechanical spinal cord tension.

The role of dural attachments in Subluxation models.

Tensegrity: Review of tensegrity models and application to neurological function and dysfunction.

Neuroplasticity: Discussion of current models on neural plasticity and how this relates to the need for a dynamic and responsive assessment and adjustment protocol.

To gain an appreciation for and new found understanding of, the intimate relationship between body and mind, and the pivotal role the spine plays in this connection.

Principles of the Torque Release Technique Model = 1.5 Hours

Review the fundamental principles beginning from the original chiropractic concepts as proposed by the Palmers and Stephenson: Intelligence, force and matter; Mental impulse; Subluxation; Intent.

Progressing/evolving through to cutting edge quantum physics science: Body-mind hologram: Holographic Brain Theory; Fields of intelligence; Conscious intention

Definition of the Cranio-Spinal Meningeal Functional Unit (C-SMFU).

Definitions of Subluxation.

Non-linear timing: Randomised versus non-randomised events; Comparison to linear being defined as a pre-determined order of adjustment; Explanation of variability and non-linear nature of biological mechanisms.

Non-mechanistic: Upgrading from a purely mechanical model of subluxation, analysis, and adjusting to a vitalistic “live” model of subluxation, analysis, and adjusting.

Neurological: Differentiation of orthopaedic and mechanistic analysis versus neurological assessment and interpretation of findings.

Correction and healing vs relief and maintenance: Discussion of different healing models of allopathic and mechanistic versus vitalistic and naturalistic.

Flux between ease and dis-ease: Discussion of states of being well or being ill, versus being healthy or sick.

Gain a clear focus of the driving values behind the delivery of each and every adjustment: Discussion of models of chiropractic care; models of correction and maintenance versus ongoing functional optimisation.

The Flaws of Advanced Leg Testing = 1.0 Hours

If you think that functional leg testing is a waste of time you need to attend TRT to discover why you are wrong.

If you do utilise leg testing you need to attend TRT to expose and correct all the mistakes you have been making – till now!

Review of:

- Practitioner errors; errors of application and doctor’s state.
- Patient anomalies; Congenital and developmental.
- Patient positioning.

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- Clinical application; Contact points and vectors.
- Consistency; Self awareness and review of technique.
- Reproducibility
- Physical environment: Clothing; Alignment of table
- Chiropractic equipment flaws; Table design and build factors.

The Non-Linear Testing Priorities = 3.0 Hours

Review and comparison of Network and Torque Release research demonstrating the non-linear probabilities of each primary subluxation.

Differential diagnosis and triage of assessment and adjustment; How to determine a non-linear manifestation using a linear assessment process.

Application to any technique adjusting model to upgrade the assessment and clinical decision making skills: How the TRT assessment system can be utilised to upgrade any adjusting model or method.

Evolving and upgrading from a linear and non-randomised assessment and adjustment progression (e.g. start at the top of the spine and work down, or vice versa).

Non-linear and randomised system and protocol to determine where you should adjust first, second, third etc: Repetition, demonstration and rehearsal of the practical application of the non-linear testing priorities combined with the indicators of subluxation, and differential diagnostic tests.

Prioritising where to deliver an adjustment, at any given moment in time based on neurological indicators and examination.

Pressure Testing = 2.5 Hours

Differential diagnostic tests for Correction, Subluxation and Torque.

Objective detection of the site of primary subluxation and its three-dimensional vectors for correction.

Using the priorities of segmental subluxation testing based on data analysis of probabilities from the TRT research project and its correlation with the Network Spinal Analysis Phasing system.

Demonstration and multimedia presentation of vertebral contact points and vectors utilised during TRT assessment protocols.

Coccyx/Sphenoid Testing and Correction = 0.5 Hours

Why did the original text on upper cervical adjusting include a chapter on the coccyx: Review of anatomy, biomechanics and neurological implications of Coccyx subluxation; Assessment and Adjustment.

What features does the Sphenoid bone share with a vertebra, and can this segment be adjusted: Review of anatomy, biomechanics and neurological implications of Sphenoid subluxation; Assessment and adjustment.

Demonstration of how to test and correct these key neurological attachment points.

The Brain Reward Cascade and Reward Deficiency Syndrome in Subluxation Centred Chiropractic = 1.5 Hours

The Journal of Psychoactive Drugs dedicated an entire edition to this mind-expanding paradigm shift in mind/body medicine.

Mainstream science discovering and discussing the chemicals of emotion and their intimate relationship to neurological integrity.

Chiropractic as one of the major therapeutic modalities discussed and Subluxation as a model for exacerbation of RDS.

Psycho-neuro-immunological evidence supporting century-old chiropractic theories.

Genetic variants and anomalies predisposing to Reward Deficiency Syndrome (RDS): A1 Allele of the D2 Dopamine Receptor Defect and similar variants; Review of research and relevance.

Clinical manifestations of RDS: Explanation of terms; use, experimentation, self-medication, abuse, denial and addiction.

Genetic and lab testing for signs of RDS.

Neuropeptides and neurochemistry involved in the Brain Reward Cascade and RDS: Explanation of biochemistry and manifestations of Dopamine, Serotonin, GABA, Norepinephrine, Endorphins and other Opioids

The chemical and neurological connection between vertebrate spinal anatomy and Brain Reward Cascade: Discussion of the role of Dorsal horns in spinal, biochemical and neurological integrity.

Subluxation correction in treatment of RDS: Model for how subluxation interferes with brain reward cascade and exacerbate states of RDS.

Complementary recovery strategies for RDS: Auriculotherapy, Biofeedback, Nutraceuticals, Brain-wave therapies, psychosocial therapies, diet, exercise etc.

Implementation of TRT = 2.0 Hours

Vitalistic principles for adjustment delivery: Review of early literature and recommendations for application of each adjustment.

Visualisation and intent and seeing whole for testing and corrections.

How to implement TRT into daily practice: Patient education and communication; Explanation of assessment and adjusting methods; Graduated implementation and mastery of the use of the indicators.

Forms and paperwork: Patient entry and history forms; Recording, quantifying and comparing assessments and reassessments.

Listings and notation: Discussion of methods to annotate the three-dimensional vectors.

Patient education resources, props and scripts.

Utilising the indicators of subluxation to determine response to adjustment: Use of the indicators to assess state of wellbeing within an adjusting session and between adjusting sessions.

Scheduling: Scheduling model utilised in research project; Implementing a schedule in practice; Determining if schedule regularity is working or not; Adapting schedule based on indicators and patterns of subluxation.

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Care program: Managing appointments based on clinical findings versus recipe book scheduling.

Integrator Instrument adjusting protocols and tips: Contraindications; Selection of rubber tips; Utilising the pre-loading mechanism; Correct grip on the instrument; Setting up and controlling vectors; Minimising interference with instruments inbuilt vectors; Care and Maintenance.

Hands-On Workshop = 5 Hours

Interactive supervised hands-on training is provided throughout the Hands on Workshop and Advanced Hands on Workshop to maximise learning and quantum leap technical development

Personal tuition and coaching in the use of everything learnt during the program and in the use of the Integrator Instrument.

Advanced Technical considerations = 2.0 Hours

- Adjusting Extremities.
- Adjusting the other Cranials including TMJ.
- Myofascial connections to the Primary Subluxation.
- Emotional relationships to the Primary Subluxation.
- Increasing respiratory responses to each adjustment.
- Paediatric assessment and adjusting.
- Unusual presentations – amputees, torticollis, stenosis, acute symptoms, the fixed non-responsive functional short leg.

NeuTone and Therapeutic Fasciculation = 2.0 Hours

Melzack and Wall's Neural Gate Theory.

Melzack's Neural Matrix Theory.

Central Pattern Generators.

Introduction to the concept of Therapeutic Fasciculation (TF) and the isotonic contraction required to initiate this phenomenon.

Discussion, demonstration and practice of the NeuTone Postural Exercises.

Demonstration of how to integrate TF into a chiropractic adjustment to facilitate deeper neurological response.

Comparison of the Quantum Physics Theorems with Stephenson's 33 Principles = 4.0 Hours

Overview of the Quantum Physics Theorems – Einstein's Theory of Special Relativity, Waves and Particles, Observer Effect, Entanglement, Information and Black Holes, Heisenberg's Uncertainty Principle, Intelligent Design, Quantum Biology, Holograms, Holographic Universe, Holographic Brain Model, Tensegrity, Piezoelectricity, The Matrix, Morphic Resonance, Psychoneuroimmunology.

Review of Stephenson's 33 Principles in context of all the above...

TOTAL 32 HOURS.

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Dr Nick Hodgson Bio

Dr Nick Hodgson has a B.App.Sc.(Chiropractic), undergraduate Chiropractic Science Academic Excellence Award, has received outstanding service awards from both the Chiropractors' Association of Australia and RMIT University Alumni office for his role as President of the Chiropractic Alumni Association for a decade, was named the Victorian Chiropractor of the Year in 2005, and is a fellow of the Holder Research Institute. Nick has received Torque Release Technique Training from the Holder Research Institute and has been personally mentored by Dr Jay Holder of the Holder Research Institute, and has utilised TRT in private practice since 2003, and has been responsible for organising and teaching hundreds of hours of continuing professional development.

- “The Health and Wellness Coach” – developer of the “Super Healthy” programs
- 1990 Chiropractic graduate of the Phillip Institute of Technology (now RMIT University) – B.App.Sc.(Chiropractic)
- 1990 recipient of the CAAPIT academic award for Chiropractic Science
- Practised full-time as a Chiropractor in Ocean Grove for eighteen years (1989 to 2007)
- Practiced in, directed and managed the longest established and largest natural health care practice on the Bellarine Peninsula 1989 to 2007
- Currently in private practice in Geelong since 2008
- Small Business Director continuously since 1989 and has employed, trained and lead numerous Chiropractic Assistants
- Has mentored 6 chiropractic associates
- President of the RMIT University Chiropractic Alumni Association (CARPP) from 1996 to 2005 (Responsible for organising numerous “Homecoming” and professional development events, assisting RMIT Alumni to connect with their past graduates directly and indirectly leading to large monetary donations to the University)
- Recognised by the Chiropractors' Association of Australia (Vic) in 2002 for his outstanding contributions and service to the chiropractic profession
- Recognised by RMIT University Alumni in 2003, 2004 and 2005 for his contributions and service to the past and present graduates of the University
- CAA(Vic) VICTORIAN CHIROPRACTOR OF THE YEAR 2005
- Responsible for introducing cutting-edge treatments such as Torque Release Technique, Auriculotherapy and Addictionology to the Australian Chiropractic profession
- Responsible for organising professional development programs featuring some of the most famous chiropractic presenters: Tedd Koren, Patrick Gentempo, Lindsay Rowe, Chris Kent, Jay Holder, Dave Jackson, Stuart and Therese Warner and Richard Barwell
- Speaker at numerous chiropractic seminars including Dynamic Growth Congresses and Workshops, CARPP seminars, and MC for numerous CARPP seminars and RMIT graduation and awards ceremonies

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- Has two published peer reviewed research papers – Improvement in Signs and Symptoms of ADHD and Functional Outcomes in Four Children Receiving Torque Release Chiropractic: A Case Series, and Improvement in Signs and Symptoms of ADHD, Migraines and Functional Outcomes While Receiving Subluxation Based Torque Release Chiropractic and Cranial Nerve Auriculotherapy: A Case Study.
(<http://www.torquerelease.com.au/AVSR-Hodgson-Vaden.pdf> and <http://www.torquerelease.com.au/AVSR-Hodgson-Fox.pdf>)
- Author, speaker and developer of the “Super Healthy – The Wellness Coaching Manual”, “Super Posture – The Postural Correction Program” manual, “Super Behaviour – ADHD To Drug Or Not To Drug” DVD and Manual, “Super Fertility – Guidelines For Maximising Chances Of A Successful Conception And Pregnancy” manual, “Super Brain – The Ten Natural Steps To Maximising Brain Health And Mental Function” program, and “Super Recovery – Controlling Addiction Naturally” manual
- Fellow of the Holder Research Institute (F.H.R.I.)
- Australasian provider of Torque Release Technique training as accredited by the Holder Research Institute and has taught post-graduate chiropractic technique programs in Australia, New Zealand, South Africa, Sweden and Hungary.
- Has taught numerous Torque Release Technique training programs, one day Auriculotherapy, and ½ day “Super Posture” postural correction and analysis seminars
- Author of the Australasian Torque Release Technique Training Manual
- Australian distributor of Posture Pro Digital Postural assessment software as developed by Dr Joseph Ventura of Ventura Designs USA for more than twenty years
- Has completed five of the ten modules of the Certified Addictionologist (CAAd) program offered by the American College of Addictionology and Compulsive Disorders (ACACD)
- Nick is proud to have inspired 6 practice members to commence undergraduate chiropractic training
- Previously actively involved in leadership roles at the Ocean Grove Baptist Church; leading small study groups including Alpha and S.H.A.P.E., singing and leading in the worship team, and coordinating the church-wide “40 Days of Purpose” spiritual growth campaign
- Nick was a top ten nationally ranked Triple Jumper in the 1980s competing at several Australian Championships, winning minor medals at open level in the Victorian Championships, an ACT Championships Gold Medal, was Australian Universities Champion and twice Australian Intercollegiate Champion. His PBs were 15.22m for TJ and 6.90m for LJ
- Was privileged for many years to be part of the John Boas training squad training alongside elite athletes like Gary Honey, David Culbert and a young Andrew Murphy. Growing as an elite athlete and person in this environment still shapes a lot of his current training and life philosophies
- Is now the number one ranked Masters 55-59 year old Triple Jumper in Australia and has been ranked in the top five in the world for the last six years and has won Gold Medals at Geelong, Victorian Country, Victorian, Australian, Pan Pacific and World Masters Games

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45-50 years Men's Triple Jump Champion, and Silver Medallist at the World Masters Championships.

- He is the Victorian Triple Jump Record holder from 45 to 59 and Australian Indoor and Outdoor Record holder for 50-54. Nick is also former Victorian Record holder in the Men's 50-54 Long Jump. Nick was the first Australian 50-54 man to Triple Jump 13m and Victorian man to Long Jump 6m.
- Nick is a Level 3 AA Horizontal Jumps Coach and Level 2 Advanced AA Sprints, Relays and Hurdles Coach and has coached numerous state champions and national medallists
- Level 1 AA Long Jump and Triple Jump Official
- Has been coaching on average 15 hours per week for the last seven athletics seasons which has included developing a highly successfully squad of talented young jumpers and also formerly for two years assisting Geelong College with their Athletic Training Program. Nick's squad usually includes about 35 athletes each season and he coaches on average 11 months of the year.
- Was married to Gill for 25 years, with two children; Meg 22 and Noah 20. Now divorced

Rationale outlining why the activity is proposed:

To teach and train participants the Science, Art and Philosophy of Torque Release Technique – a low-force tonal chiropractic technique developed through a randomised clinical trial design and not currently available as an undergraduate program in Australia. The four part training process takes the registrant through basic to advanced training completion.

Learning objectives and outcomes:

To teach, train, test and observe practical competency in the research, development, models, indicators, protocols, principles, non-linear testing priorities, differential diagnosis and adjustment methods of TRT.

100% attendance during Hands on Training, observation of practical proficiency during workshops, 75% pass mark for online assessment tasks.

Activity materials:

- Online video lectures.
- Downloadable course notes.
- TRT Instruction Manual e-book.
- Lloyd Integrator Portable Adjusting Tables.
- Integra Integrator Adjusting Instruments.
- Workshop printed training manuals.
- Powerpoint presentations.
- Additional educational and practice resources available for purchase.
- Web site with links to all supporting research papers.

Follow up process for participants, should they encounter any problems/questions:

Ongoing email and phone support, periodical email and print newsletters, web-site updated with any new research and professional publications, web-site blog updates.

Advanced hands-on workshops are provided.

CCEA competencies:

Public Health & Community Interaction = 1.5 Hours

1.2: Explanation of the Biogenetic Model of Reward Deficiency Syndrome (RDS) and how it relates to depression, anxiety, ADHD, addictive and compulsive disorders. Discussion of the causes, prevalence, effects on mortality and morbidity of the five addictions. Explanation of links between RDS and the other significant causes of mortality and morbidity.

Health care system interaction = 0.5 Hours

2.2: Discuss the issues of over and under servicing and provide a technical and clinical framework to determine and modify frequency of care.

Patient Assessment = 7.0 Hours

6.1: Discussion of the three causes of Subluxation and the relative prevalence of each and how the interview process and intake paperwork can be used to begin to form clinical impressions.

Demonstrate the use of self-rated health questionnaires including for the most common mental health and psychological disorders.

6.3 A: The indicators of Subluxation are taught, demonstrated and practiced

- 1) POSTURAL FAULTS (Standing, Sitting, Prone);
- 2) ABNORMAL BREATHING PATTERNS,
- 3) PALPATION (Scanning, Tissue, Inter-segmental, Motion);
- 4) ABNORMAL HEAT/ENERGY RADIATION FROM BODY (Thermography or Scanning Palpation);
- 5) CONGESTIVE TISSUE TONE (Tissue Palpation);
- 6) INAPPROPRIATE SUSTAINED PATTERNS OF PARASPINAL CONTRACTIONS (Inter-segmental Palpation or surface EMG);
- 7) FUNCTIONAL LEG LENGTH INEQUALITY (Basic and Advanced Leg Testing Procedures);
- 8) HEEL TENSION (Palpation);
- 9) ABDUCTOR TENDENCY/ ADDUCTOR RESISTANCE (Observation and Palpation);
- 10) FOOT FLARE (Observation and Palpation);
- 11) FOOT PRONATION/ SUPINATION (Observation and Palpation);
- 12) CERVICAL SYNDROME TEST;
- 13) BILATERAL CERVICAL SYNDROME TEST;
- 14) DEREFIELD TEST.

Scoring and annotation of all findings is explained.

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The differential diagnosis of the Primary Subluxation is taught, demonstrated and practiced:

- 1) NON-LINEAR TESTING PRIORITIES.
- 2) LEG AND PRESSURE TESTING (for Correction, Subluxation and Torque).
- 3) DETERMINATION OF PRIMARY SUBLUXATION AND VECTORS.

Annotation (listings) of relevant Subluxation findings.

The flaws of leg checking and methods to increase specificity, reliability and reproducibility of this examination procedure are discussed and demonstrated.

6.3 B: Discussion of the indicators of subluxation in relation to mental state. Use of self-rated questionnaires to screen for severity of mental disorder is discussed and demonstrated.

6.4: Use of extreme or non-changing indicators to trigger need for further imaging is discussed.

6.5: Use of indicators to suggest chemical cause of subluxation and clues to direct further assessment.

6.6: Discussion, presentation and comparison of high-tech and low-tech methods to assess the indicators of Subluxation:

Digital postural analysis, digital range of motion analysis, inclinometry, paraspinal infrared thermography, paraspinal surface electromyography, electroencephelography.

Using indicators to determine need for further imaging: Xray, CT, MRI or bone scanning.

Diagnostic decision making = 7.0 Hours

7.1: Explanation of the non-linear testing priorities as determined during the TRT research project – illustration of the probabilities of each segment being a primary subluxation, and how this directs the spinal examination process.

Discussion, demonstration and application of the differential diagnosis of the primary subluxation, using advanced leg checking, pressure testing for correction, pressure testing for subluxation, and pressure testing for torque. Criteria for determination of primary subluxation and corrective vectors.

Explanation of the concept of the primary subluxation and the need to be impartial during examination, and to rely on the responses and findings of the patients neuro-physiological reaction to each diagnostic test on each visit, as opposed to some pre-determined decision about the treatment needs of the patient.

Explanation of the neurophysiological model of subluxation and methods and props to illustrate and explain the positive findings to the patient.

Use of the indicators of subluxation to suggest other underlying causes of the patients presenting subluxations, and hence to suggest other lines of investigation if indicated.

Use of the indicators and differential diagnosis of subluxation to assess response to each adjustment and to a course of adjustments.

Using a subluxation indicator severity rating/scoring system to monitor response and progress to care.

Discussion of tips to improve self-appraisal and quality assurance in the diagnostic procedures taught.

Presentation of some models of communicating and demonstrating findings and diagnosis to patients, and how to quantify and present changes in findings through time.

Planning of patient care = 4.0 Hours

8.1: Use of the indicators of subluxation, non-linear testing priorities, ranking of primary subluxations and differential diagnosis of primary subluxation to determine the indications and corrective vectors required for each adjustment – discussion, demonstration and application.

Discussion of the above findings in relation to symptomatology and possible underlying pathology and how to use the above to minimise unnecessary adjustments.

8.2: Explanation of the initial scheduling plan used in the TRT Research Project and discussion of how to modify this to individual patient needs.

8.3: Discussion of the scheduling model used in the TRT research project.

Discussion of the use of the indicators and responses to adjustments to determine appropriateness of treatment intervals.

8.4: Discuss the benefits and limitations of manual adjusting, and benefits and limitations of instrument adjusting and how to best minimise risk to the patient.

Implementation of care = 8.0 Hours

9.1: Discuss translating the neurophysiological model of subluxation and the TRT examination findings to plain English

9.2: Present arguments for and against open plan versus closed plan office styles and make recommendations for maximising privacy and comfort.

Present samples of paperwork and clinical notes.

Using changes in indicators to initiate communication with patient regarding possible underlying risk factors.

9.5: Discuss intent, verbal and non-verbal communication to bolster patient comfort and confidence.

9.6: Discussion of patient positioning, table design and ergonomics, and use of a chiropractic adjusting instrument to minimise patient discomfort and maximise safety.

9.7: Use of the indicators of subluxation and differential diagnosis of primary subluxation to assist decision making and adjustment delivery in crisis cases.

Discuss most common crisis presentations (disc, antalgia, torticollis, acute arthritic attack, rib or vertebral fracture) and how care can be modified in crisis cases.

Discussion of using the indicators and differential diagnosis to rule out treating a symptomatic region.

9.8: Discussion of the tonal model of subluxation, anatomy of spinal dural attachments, anatomical and clinical implications of the mechanical cord tension model, neurophysiological research in regards to mechanical cord tension.

Research and development of the Integrator Adjusting Instrument is taught, and the Physics principles behind manual adjustments, toggle recoil and instrument adjusting are compared.

The TRT protocol for determining the preferred segment and vectors for adjustment is taught, demonstrated and applied.

The history, components and relevance of the included techniques in the TRT research project are discussed: Palmer Upper Cervical (Toggle Recoil), Thompson Terminal Point, Van Rumpft Directional Non-Force, DeJarnette Sacro-Occipital, Logan Basic, Toftness and Network Spinal Analysis.

The biomechanical and neurophysiological difference between subluxations with dural attachments and those without dural attachments are discussed.

Use of the subluxation indicators, non-linear testing priorities and differential diagnosis of the primary subluxation are taught, demonstrated and applied to teach prioritising adjustment order, vectors, preferred technique and outcome of each adjustment.

The research findings from the TRT research project are discussed in terms of addiction recovery retention rates, depression and anxiety inventories and need for palliative care – and these findings are discussed in terms of general chiropractic practice, crisis care and state of wellbeing management.

The contact points and vectors for all differential diagnostic tests and as a result all adjustments are discussed, illustrated, demonstrated and applied.

Contraindications for the use of the Integrator Adjusting Instrument are taught.

Patient variables (eg anatomical short eg, congenital anomalies, degenerative conditions, acute antalgic presentations, amputees and wheelchair bound, infants and paediatric) are discussed.

Discussion of listing systems and how to record findings and adjustments.

9.10: Use of the subluxation indicators to monitor patient progress within a visit and between visits, to detect need for further questioning or investigation in cases of dramatic shifts in indicators.

Use of assessment technologies and self-rated health questionnaires to quantify and track progress under care.

Demonstration of some methods to score and explain changes in functional assessments through time.

Professional scientific development = 3.0 Hours

11.1: All the supporting scientific literature and statistics from the TRT research project and subsequent studies is discussed and the sources provided.

Strategies and resources for further technical and professional development is discussed.

Samples of TRT case studies are presented and participants encouraged to consider these as an attainable scientific endeavour in private practice.

Comparison of the Quantum Physics and Quantum Mechanics theorems with the 33 Principles of Chiropractic as published by RW Stephenson

Disease Prevention/Health Management = 1.0 Hours

10.1: Discussion, demonstration and practice range of specialised spinal exercises designed to tone and stretch core spinal regions to assist practice members with self-care.

Discussion, demonstration and practice specialised breathing exercises designed to reduce tension, assist sleep quality, and improve respiratory efficiency to assist practice members with self-care.

How the program promotes participant interaction and participation and how the content relates to the chiropractors' professional practice:

- The online modules include online assessment tasks which must be completed for accreditation.
- The seminar is presented in an interactive fashion and questions are encouraged throughout the program.
- Seminar notes are provided with spaces for participant notes to be added.
- Demonstrations are conducted in an interactive fashion.
- Hands-on workshop with close supervision are regularly conducted throughout the program.
- The entire program is directed towards everyday and every patient improved encounters and outcomes. The TRT system is designed to fit underneath the techniques that the chiropractor currently utilises on every single patient, and is described as an “upgrade” to everyday practice.

Standard of achievement:

- 1) Successful completion of online assessment tasks (75% pass mark).
- 2) 100% attendance in all training sessions at the workshop programs.
- 3) Presenter observing practitioner proficiency in the practical components of the teaching during the workshop sessions.

Be Well,



Dr Nick Hodgson,

HEALTH AND WELLNESS COACH

VICTORIAN CHIROPRACTOR OF THE YEAR 2005, B.App.Sc.(Chiropractic) 1990, Phillip Institute of Technology Chiropractic Science Award 1990, Private chiropractic practice for 33 years, Director Super Healthy Pty Ltd, President Chiropractic Alumni Association RMIT University (CARPP) 1996-2005, Fellow Holder Research Institute (F.H.R.I.), Australasian Provider Torque Release Technique Training, Outstanding Service Award CAA(Vic) 2002, Outstanding Contribution Award RMIT Alumni Relations 2003, 2004 and 2005.

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