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Patient Name:_____Date:_____

Primary Dx:_____Secondary Dx:_____

Treatment Freq. _____X per Week / Month ☐ Evaluate & treat as necessary

Duration of treatment _____ Weeks / Months Send evaluation after _____ visits.

INSTRUCTIONS:

MODALITIES:

ACUPUNCTURE___ CUPPING___ MOXIBUSTION___ ELECTRIC STIM___

MASSAGE___ HERBS___

Physicians Signature: