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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 ___

GUA SHA ___ HERBS _____

Physicians Signature: