

# ACUPUNCTURE REFERRAL

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Follow up date:** \_\_\_\_\_

**Diagnosis**

<p><b>Pain Management &amp; Rehabilitation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Back</li> <li><input type="checkbox"/> Shoulder (R / L)</li> <li><input type="checkbox"/> Elbow (R / L)</li> <li><input type="checkbox"/> Wrist (R / L)</li> <li><input type="checkbox"/> Hand (R / L)</li> <li><input type="checkbox"/> Hip (R / L)</li> <li><input type="checkbox"/> SI Joint</li> <li><input type="checkbox"/> Knee (R / L)</li> <li><input type="checkbox"/> Ankle (R / L)</li> <li><input type="checkbox"/> Foot (R / L)</li> <li><input type="checkbox"/> TMJ (R / L)</li> <li><input type="checkbox"/> Facial Paralysis (R / L)</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Sports Injury</li> <li><input type="checkbox"/> Neuropathy</li> <li><input type="checkbox"/> Failed Back Surgery Syndrome</li> <li><input type="checkbox"/> Manage Chronic Pain</li> <li><input type="checkbox"/> Postural Instability Pain</li> <li><input type="checkbox"/> Other ( _____ )</li> </ul>	<p><b>Holistic Approach to Health Management</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Addiction – smoking, alcohol, overeating</li> <li><input type="checkbox"/> Allergy</li> <li><input type="checkbox"/> Anxiety and Depression and Stress</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Common Cold and Flu.</li> <li><input type="checkbox"/> Constipation and Diarrhea</li> <li><input type="checkbox"/> Ear Ringing</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Headache and Migraine</li> <li><input type="checkbox"/> Impotency</li> <li><input type="checkbox"/> Insomnia / Sleep Disturbances</li> <li><input type="checkbox"/> Palpitation</li> <li><input type="checkbox"/> Sinus Problem</li> <li><input type="checkbox"/> Skin problem</li> <li><input type="checkbox"/> Stomach Problem</li> <li><input type="checkbox"/> Vertigo and Dizziness</li> </ul> <p><b>Woman’s Health</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Menstruation Problem</li> <li><input type="checkbox"/> Menopause Syndrome</li> <li><input type="checkbox"/> Infertility</li> <li><input type="checkbox"/> Urinary Dysfunction and UTIs</li> </ul>
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**Modalities**

<ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncture</li> <li><input type="checkbox"/> Electro-Acupuncture</li> <li><input type="checkbox"/> Electro-Acupuncture (Needle Free)</li> <li><input type="checkbox"/> Manual Therapy</li> <li><input type="checkbox"/> Cupping</li> <li><input type="checkbox"/> Moxa</li> <li><input type="checkbox"/> Ear-Seeds</li> <li><input type="checkbox"/> Reflexology</li> <li><input type="checkbox"/> Neuromuscular Reeducation</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Therapeutic Exercise                         <ul style="list-style-type: none"> <li><input type="checkbox"/> ROM</li> <li><input type="checkbox"/> Strengthening</li> <li><input type="checkbox"/> Stretching</li> </ul> </li> <li><input type="checkbox"/> Postural Instruction</li> <li><input type="checkbox"/> Paraffin</li> <li><input type="checkbox"/> Kinesio Taping Method</li> <li><input type="checkbox"/> Medical Pilates</li> </ul>
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**Frequency and Duration**

Standard Treatment Plan – 3 days a week    4    6    8 weeks  
 Other frequency of treatment \_\_\_\_\_ day a week

**Comment:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**FAX to: 1-559-439-2720**