



CORNERSTONE
ACUPUNCTURE INSTITUTE, INC.

650 Roosevelt 2F-B, Irvine, CA 92620

T: (949) 424-6430 F: (949) 612-0010

WWW.CORNERSTONEIRVINE.COM

THERAPY ORDERS

- ACUPUNCTURE
- THERAPEUTIC MASSAGE
- PHYSIOTHERAPY

Patient Name: _____ Date: _____

Primary Diagnosis: _____

Referring Physician: _____

EVALUTE AND TREAT

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stress / Anxiety |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Facial Paralysis |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Allergic Rhinitis |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Other Joints | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Other _____ | | |

Duration: 4 WKS 6 WKS 8 WKS

Frequency 2 per week 3 per week

Additional Comments or Special Requests:

Referring Physician's Signature _____