

Intern's Name: _____ ID# _____ Phase: LEVEL 2 LEVEL 3

Intern's Treatment Protocol

Supervisor's Assessment

Patient's File# _____ BP: _____ / _____ HR: _____ /m M/F AGE: _____ Date: _____ WT: _____

Chief Complaint: _____ C/C: _____

Present Illness & Physical Exam: _____ P/I & PE: _____

Tongue: _____ T: _____

Pulse: Lt: _____ P: Lt: _____

Pulse: Rt: _____ P: Rt: _____

Dx: _____ Dx: _____

Tx. Plan: _____ Tx. Plan: _____

Acup. Rx: _____ Acup. Rx: _____

_____ Moxa Cupping Ear Seed Tuina Other

Herb Rx: _____ Herb Rx: _____

Remarks & Comments: _____ Approval Signature: _____

Patient's File# _____ BP: _____ / _____ HR: _____ /m M/F AGE: _____ Date: _____ WT: _____

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