



**Treatment Form**

Patient Name: \_\_\_\_\_ Handedness: \_\_\_\_\_

Date: _____			Visit # _____
Type	√	Name Point Treated (R or L, G or S)	Post Treatment Assessment
Oscillation			
Inversion			
MaO			
Histamine			
Endoxan			
Prostaglandin			
Vit. C			
Ginseng			
Other:			
Date: _____			Visit # _____
Type	√	Name Point Treated (R or L, G or S)	Post Treatment Assessment
Oscillation			
Inversion			
MaO			
Histamine			
Endoxan			
Prostaglandin			
Vit. C			
Ginseng			
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Vit. C			
Ginseng			
Other:			

