



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Your clinician has prescribed the following clip numbers:**

My Clips									
1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SETS									
REPETITIONS									
HOLD FOR (seconds)									
FREQUENCY (times/day)									

Other Instructions: \_\_\_\_\_

Next appointment: \_\_\_\_\_

Clinician: \_\_\_\_\_



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