PRESCRIPTION FOR TREATMENT

Please bring this completed form and insurance information with you to your appointment!

CLIENT:____ **DATE:**________________

PHYSICIAN INFORMATION:

Name:___________________________________ **Tel:**____________ **Fax:**____________

Address:____

***NOTE TO PHYSICIAN:** Please circle all related diagnoses to maximize the effectiveness of your patient's care.*

Dx	Diagnosis – Condition	Dx	Diagnosis - Condition
	CERVICAL		**LOWER EXTREMITIES**
723.1	Cervicalgia (neck pain)	844	Strain/Sprain – Knee, Leg (R) (L)
847.0	Strain/Sprain (cervical whiplash)	845.00	Strain/Sprain – Ankle (R) (L)
848.1	Strain/Sprain – TMJ, Jaw	845.1	Strain/Sprain – Foot (R) (L)
	THORACIC		
847.1	Sprain/Strain - Thoracic		**OTHER**
	LUMBOSACRAL	715.9	Arthritis - Osteo
724.2	Low Back Syndrome	726.1	Bursitis *(Specify)*
724.3	Sciatica	729.1	Fibromyositis, Myofascial Pain
846.0	Strain/Sprain - Lumbosacral	784.0	Headache, Common
847.2	Strain Sprain - Lumbar	346.9	Headache, Migraine
848.5	Strain/Sprain - Pelvic	728.85	Muscle Spasms *(Specify)*
847.3	Strain/Sprain - Sacrum	724.4	Neuritis, Radiculitis *(Specify)*
	UPPER EXTREMITIES	719.4	Pain in Joint *(Specify)*
354.0	Carpal Tunnel Syndrome (R) (L)	719.5	Stiffness in Joint *(Specify)*
726.0	Frozen Shoulder (R) (L)	726.9	Tendonitis *(Specify)*
840.4	Strain/Sprain – Rotator Cuff (R) (L)	524.6	TMJ Dysfunction
841.9	Strain/Sprain – Elbow/Forearm (R) (L)		
842.00	Strain/Sprain – Wrist (R) (L)		
842.10	Strain/Sprain – Hand (R) (L)		

Physician will re-evaluate progress and treatment plan for continuation, modification or termination. Massage Therapist will provide prescribed treatment in an effective, timely manner for Dx.

Massage techniques, defined as massage and other physical modalities within approved scope of practice, to include: physical / muscle evaluation, myofascial release, neuromuscular, craniosacral, therapeutic massage.

TREATMENT FREQUENCY	TREATMENT DURATION
Times per week:	Number of weeks:

Physician Signature:____