

Prescription for Massage Therapy

Patient: _____

Date: _____

Diagnosis (with codes): _____

Areas Concerned:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> cervical | <input type="checkbox"/> upper limb | <input type="checkbox"/> viscera - thoracic |
| <input type="checkbox"/> thoracic | <input type="checkbox"/> lower limb | <input type="checkbox"/> viscera - abdominal |
| <input type="checkbox"/> lumbar/lumbosacral | <input type="checkbox"/> cranium | <input type="checkbox"/> viscera - pelvic |
| <input type="checkbox"/> pelvic girdle | <input type="checkbox"/> jaw/TMJ | <input type="checkbox"/> CNS/ANS |

This condition is related to: injury/trauma auto accident work
other: _____

Treatment Plan:

total visits: _____

frequency: 1x/wk 1x/2wks 1x/3wks

duration: over a period of _____ months

Additional comments: _____

Physician's Signature: _____

Printed name: _____

Contact number: _____

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