HI-MED Therapeutic
Massage & Wellness Clinic

☐ Workers Compensation

☐ No Fault

☐ Other

Massage Prescription Form

PATIENT NAME: ______________________________ ***DATE:*** ____________________

PHONE: ________________ **CELL:** ____________________

DOI: ______________________________ **DOB:** ____________________

INSURANCE Co.: ____________________________________

CLAIM : ____ **ADJUSTER:** ______________________

DIAGNOSIS: ____

NUMBER OF VISITS PER WEEK: __________________ **NUMBER OF WEEKS:** ________________

FROM: _____ / _____ / _______ **TO:** _____ / _____ / _______

OBJECTIVES & GOALS: ____

____

____

PHYSICIAN NAME: ____________________________________

PHYSICIAN SIGNATURE: ____ **DATE:** _______________

THERAPIST NAME: ____

THERAPIST SIGNATURE: ____ **DATE:** ______________

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