PRESCRIPTION FOR MASSAGE THERAPY

ATHLETIC EDGE, 107 Main Street, Los Altos, CA 94022
(650) 815-6552 / www.athleticedge.biz

From:_____ Patient Name:_____ Address:_____ _____ Insurance Company:_____ Policy Number:_____ Claim Numer:_____ Billing Address:_____ _____ Date of Injury:_____ Diagnosis:_____ _____ ICD- 9 code (s):_____ _____	Condition is related to ___MVA___work injury ___Other injury ___Stress ___other medical condition Number of sessions to be done: (frequency and duration)_____ Send progress report: ____ every week ____every two weeks ____at the completion of prescribed treatments ____other_____ Special directions/Comments:_____ _____ _____ _____

Areas to be worked on: (circle all that apply, add comments)

Cranial: Temporalis, Masseter, Frontalis_____
_____

Cervical: E.S, Levator, Scalenes, SCM, Spenius Cervicus/Capitis, Trapezius, Sub-occipitals_____
_____

Thoracic: E.S, Rhomboid, Serratus Anterior, Trapezius, Serratus posterior superior_____
_____

Shoulder: Infraspinatus, Supraspinatus, Subscapularis, Teres , Deltoid, PecMj, PecMn_____
_____

Lumbar: E.S, Quadratus, Iliacus, Psoas_____
Sacral: Gluteus Max, Min, Med, Rotators, IT Band, Quads, Hamstrings, TFL_____
_____

Other:_____
_____

Hydrotherapy: None, Heat, Cold Location:_____

Physicians Signature_____Date:_____

Physicians Name printed:_____
Address_____
Phone_____