

Massage Therapy Prescription

Patient: _____

Physician: _____ Address: _____

Dr.'s I.D. # _____

Phone: _____ Fax: _____

Donna Rowell L.M.T.
Lic. MA19512 & MM8760
Licensed Massage Therapist
615 S.W. St. Lucie Crescent # 102
Stuart, FL 34994
(772) 781-5444 ~ Fax (772) 597-3660

PROCEDURES and MODALITIES

97140 Manual Therapy Techniques

PHYSICIAN'S DIAGNOSIS

- | | |
|--|---|
| 346.90 <input type="checkbox"/> MIGRAINES | 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain |
| 784.0 <input type="checkbox"/> HEADACHES | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain |
| 847.0 <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain / Strain R__ L__ | 846.9 <input type="checkbox"/> SACROILIAC REGION (unspecified site) Spr/Str |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in neck) | 847.3 <input type="checkbox"/> SACRUM Sprain / Strain |
| 840.3 <input type="checkbox"/> INFRASPINATUS Sprain / Strain R__ L__ | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R__ L__ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain / Strain (muscle) R__ L__ | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R__ L__ |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) R__ L__ | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain R__ L__ |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R__ L__ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R__ L__ |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R__ L__ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R__ L__ |
| 842.00 <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) R__ L__ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME R__ L__ | 728.85 <input type="checkbox"/> SPASM OF MUSCLE _____ |
| 842.10 <input type="checkbox"/> HAND Sprain / Strain (unspecified site) R__ L__ | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis) |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE | 728.9 <input type="checkbox"/> Unspecified Disorder of Muscle, Ligament, Fascia |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain | Other <input type="checkbox"/> _____ |

Frequency _____ per week

Duration ___ 3 months ___ 6 months ___ 1 year

Special Notes:

Dr. Signature: _____ Date: _____