Prescription for Medical Massage Therapy

Prescribing provider:_____

Practice Name:_____

Address:_____

Phone #:_____ Fax # :_____

To: Vital Qi Acupuncture P.C.

Patient Name:_____ DOB:_____/_____/_____

Diagnoses 1:_____ Dx Code 1:_____

Diagnoses 2:_____ Dx Code 2:_____

Frequency of Treatment: Medical massage, 1-3/week,18-20 Treatment.

Treatment of Goals

☐Decrease pain

☐Decrease inflammation

☐Decrease tension / spasm

☐Increase ROM / flexibility

Physician Signature:_____ Date :_____

NPI:_____

Vital Qi Acupuncture P.C.
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