Physician/Health-Care Provider's Statement of Medical Necessity

Patient Information

Patient Name: _____ Date of Birth: _____

This patient has a medical condition in which massage therapy would be of benefit in the improvement of symptoms.

Medical condition:

_____ Back Pain _____ Arthritis _____Carpal Tunnel Syndrome

_____ Depression _____ Stress _____ Anxiety

_____ Chronic Fatigue _____ Fibromyalgia _____ Hypertension

_____ Diabetes _____ Pain Management

_____ Other: _____

Recommended Frequency:

_____ Weekly _____ Biweekly _____ Monthly _____ Other: _____

Duration of Treatment:

_____

This statement is valid for 12 months unless otherwise indicated.

Physician/Health-Care Provider Name: _____

Signature: _____

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