Prescription for Massage Therapy

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Office: (614) 472-0992 Fax: (614) 472-0994

Patient:_____

DOB:_____

Massage Therapy:

_____As needed for stress reduction or relief of: _____

_____As needed for wellness and/or illness or injury prevention

_____As specified below:

DX:_____

Region:_____

_____

Doctor Signature and Date