Jacob Caldwell, LMP
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# Prescription for Massage Therapy

From Doctor:_____ Phone:_____

Patient:_____ Date of Birth:_____

Identification ID:

- ☐ 97124 Massage
- ☐ 97140 Massage
- ☐ 97010 Hot or Cold Packs
- ☐ 97250 Myofascial Release
- ☐ 97032 Electrical Stimulus
- ☐ 97036 Hydrotherapy

- ☐ 354.0 Carpal Tunnel Syndrome
- ☐ 723.1 Cervicalgia
- ☐ 723.4 Upper Extremities: Brachial Neuritis/ Radiculitis
- ☐ 724.3 Sciatica
- ☐ 784.0 Headache
- ☐ 724.4 Lumbosacral/ Thoracic Neuritis or Radiculitis (Lower Extremities)
- ☐ 729.1 Fibromyalgia/ Myalgia/ Mysositis
- ☐ 840.9 Shoulders-Upper Arms Sprain/ Strain
- ☐ 846.0 Lumbosacral Sprain/ Strain
- ☐ 847.0 Cervical Sprain/ Strain
- ☐ 847.1 Thoracic Sprain/ Strain
- ☐ 847.2 Lumbar Sprain/ Strain
- ☐ 847.3 Sacral Sprain/ Strain
- ☐ 847.4 Coccyx Sprain/ Strain
- ☐ 848.1 TMJ Sprain/ Strain
- ☐ _____ Other
- ☐ _____ Other

Number of Visits:_____

Number of times a Week: _____ or Number of Times a Month_____

Start Date :_____ End Date: _____

Physician Signature: _____