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Ma age Medical Clea a ce F

Patient Name: _____

DOB: ___/____/_____ Email address: _____

Phone Number: _____

Name of Physician (print/type): _____

Date: _____

Signature of Physician: _____

Address:_____

Phone Number: _____

I, the above-signed Physician, give clearance for my patient, named above to receive the following types of Massage Therapy:

☐ Swedish massage ☐ Thai Massage ☐ Tui Na

☐ Deep Tissue massage ☐ Shiatsu ☐Reflexology

☐ The patient is not cleared for massage at this time.

Reason:

_____

_____

_____

Recommendations/Restrictions:

_____

_____

_____