My Somatic Bodywork
619.990.4255
www.mysomaticbodywork.com

Physician/Health-Care Permission

Integrative Bodywork and Massage Therapy

Client Name: ___________________________________ Date: ____________

Practitioner/Clinic Name: ____________________

Contact Information: ________________________

Patient Information

Patient Name: _________________________________ Date of Birth: ______________

Permission Granted to:

Provider Name: **My Somatic Bodywork** Specialty/Type of Treatment: **THEREPUTIC MASSAGE**

Reason for Permission: There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note the following considerations:

Description of condition:

Possible interactions with medications:

Special instructions:

Permission Granted by Physician/Health-Care Provider Name:

Phone: ________________________ Fax: ________________________ Email: __________________________

Signature: ___________________________________ Date: __________________

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, any update at the conclusion of care would be appreciated.