

Hands to Help NFP Medical Clearance Form

Client: _____ DOB: _____

Client Address: _____

Client Phone Number: _____

Signature of Client: _____ Date: _____

Massage Therapist: _____

Type of Massage Therapy used will consist of any one or combination of the following:

Swedish, PROM, Trigger Point, Myofascial Release, Deep Tissue, Reflexology

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- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

Not Cleared for: _____ Reason: _____

Recommendations/Restrictions: _____

Name of Physician (print/type): _____ Date: _____

Address: _____

Phone Number: _____ Fax: _____

Signature of Physician: _____