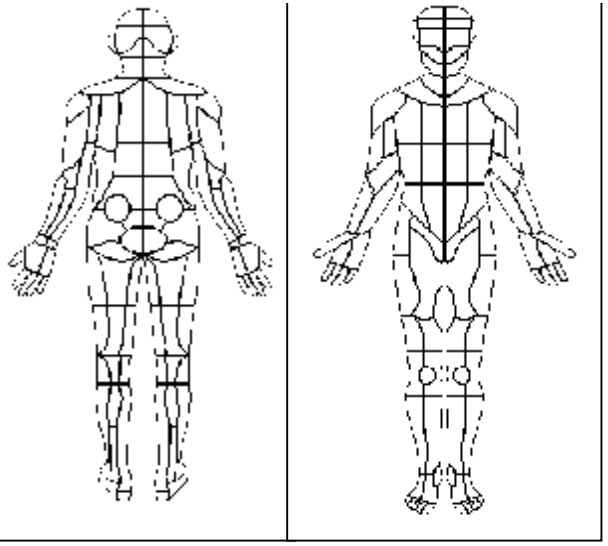
Patient Name_____ Form # ___

Number_____

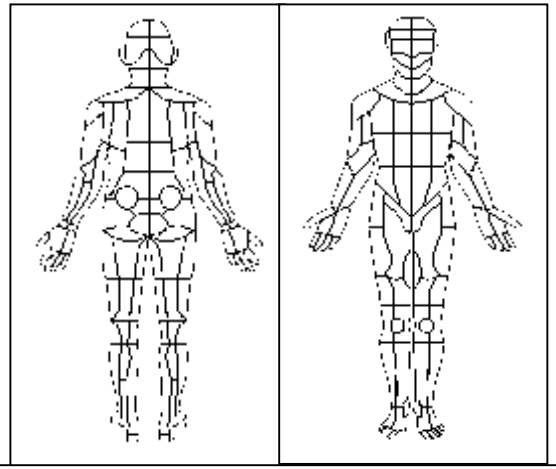
Provider Name _____

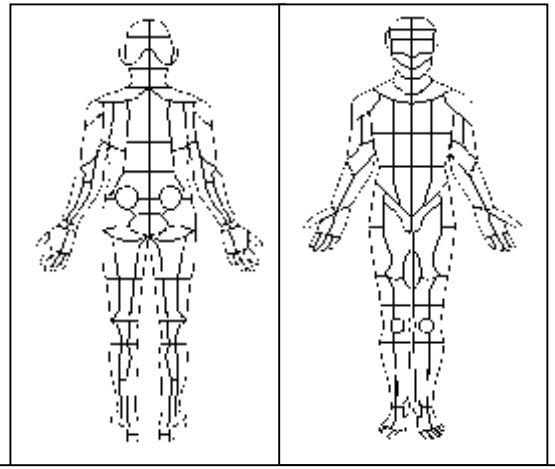
MASSAGE THERAPY TREATMENTS

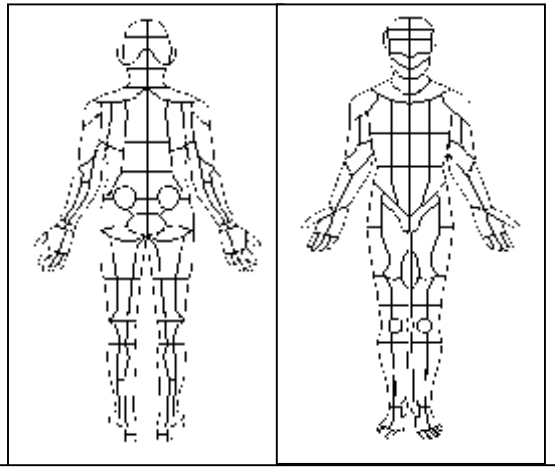
[] (MASS)	Massage (per 15 minute unit)	97124	35
[] (MAST)	Relaxation Full Body	97124	65
[] (MASST)	Relaxation Full Body - Stone	97124	75
[] (ULTRA)	Ultrasound	97035	25
[] (HOT)	Hydrocollator Packs	97010	20
[] (EMS)	Electrical Muscle Stimulation	97014	22
[] (INTER)	Traction, Mech Interseg Mobil.	97012	25
[] (COLD)	Cold Packs	97010	20
[] (97016)	Vibromassage vasopuematic	97016	22



Main Complaints







Date: _____ Time Start_____ Stop_____

Subjective: _____

Objective: _____

Assessment: _____

Plan: _____

Date: _____ Time Start_____ Stop_____

Subjective: _____

Objective: _____

Assessment: _____

Plan: _____

Date: _____ Time Start_____ Stop_____

Subjective: _____

Objective: _____

Assessment: _____

Plan: _____