Associated Bodywork & Massage Professionals MEMBER

Practitioner/Clinic Name: _____

Contact Information: _____

Parents/Health-Care Provider's Permission

Patient Information

Patient Name: _____ Date of Birth: _____

Permission Granted to

Provider Name: _____ Specialty/Type of Treatment: _____

Reason for Permission

_____

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.