Oregon Massage and Wellness Clinic
415 17th St Suite 8 Oregon City, OR 97045
Chelle Mitchell, BA, LMT, OR License # 5172
503-467-1561
Chelle@ccgmail.net

Patient Name: ___________________________________Date of Birth:_______________

Referring Physician Name:____

Any of the following procedures that are within the therapist's scope of practice and training may be used as therapist deems necessary during treatment. Normally there are 4 units per visit. A unit = 15 minutes.

____ 346.0 Migraine
____ 723.1 Cervicalgia
____ 724.3 Sciatica
____ 728.1 Myofibrosis
____ 729.1 Myalgia
____ 840.3 Infraspinatus Sprain/Strain
____ 840.6 Supraspinatus Sprain/Strain
____ 841.0 Elbow/Forearm Sprain/Strain
____ 843.9 Hip/Thigh Sprain/Strain
____ 845.0 Ankle Sprain/Strain
____ 846.9 Sacroiliac Sprain/Strain
____ 847.1 Thoracic Sprain/Strain
____ 847.3 Sacrum Sprain/Strain
____ 848.9 Pelvis Sprain/Strain
____ 354.0 Carpal Tunnel
____ 724.1 Thoracic Pain
____ 724.4 Lumbosacral Ridiculistis
____ 728.0 Unspecified Disorder
____ 784.0 Headaches
____ 840.5 Subscapularis Sprain/Strain
____ 840.9 Shoulder/Arm Sprain/Strain
____ 842.0 Wrist Sprain/Strain
____ 844.0 Knee/Leg Sprain/Strain
____ 845.1 Foot Sprain/Strain
____ 847.0 Cervical Sprain/Strain Whiplash
____ 847.2 Lumbar Sprain/Strain
____ 848.1 Jaw Sprain/Strain TMJ Ligaments
____ Other

Frequency:_______ times per week or _______total visits.
Additional Comments: -
____
____
____

Physicians Signature: ____

Date:______________________________ Phone:_________________________________