

# PHYSICIAN'S PERMISSION

Confidential Form

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

I have been treating this patient \_\_\_\_\_ since \_\_\_\_\_

for the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

There is no reason to believe that massage therapy, craniosacral therapy, or other bodywork treatments will harm this patient's progress. However, please note that the following considerations or medication warrant special concern:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Should you notice any changes and/or additional considerations or medications that warrant special concern in the treatment or progress of this patient in regards to receiving bodywork, please notify my office immediately.

Thank-you.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Bethany Bachmann LLC**  
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Licensed Massage Therapist  
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