MULTICARE HEALTH CENTER MASSAGE FORM

3842-44 S. HARLEM AVENUE LYONS, IL 60534
PHONE 708-442-3050 FAX 708-442-3058

Please Fill Out Completely!

Name ____________________________________

Referred by ______________________________

Address _________________________________

City ____________________ Zip____________

Phone ___________________________________

Age ______ Birthday ____________________

Place of Work ____________________________

E-Mail ___________________________________

Insurance

Health Insurance ☐ Yes ☐ No

Name of Insurance ______________________

Please Circle One

HMO PPO Other

Accidents

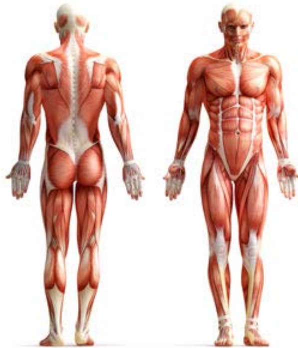
Auto Month/Year _______________

Work Month/Year ________________

I understand that massage therapy given here today is for relief of stress and muscular tension or spasm. I understand that the massage therapy is not substitute for medical examination and/or diagnosis. I have stated all my physical and medical conditions and taken it upon myself to keep the therapist updated on my health. I am aware that I will be properly draped at all times. I understand that I have given up substantial rights by signing this release and that it represents an agreement between myself and Multicare Health Center. I agree that my participation in treatment(s) is voluntary and I accept the inherent risks. I hereby release Multicare Health Center, its agents, owners, employees, successors, and suppliers from any and all damage or injury that may result from the treatment I receive. I represent that all information provided by me and is true and correct. I am over the age of 18 years old. I hereby authorize the therapist to perform massages and treatments. Initial ____________

Symptoms

Headache	Low Back Pain	Neck Pain
Shoulder Pain	Arm Pain	Leg Pain
Knee Pain	Hip Pain	Numbness
Pain with Activity	Tingling	None



Please circle your areas of pain on figure

Do you have skin problems or allergies? Yes or No
If so, please explain _______________________
Have you had surgery before? Yes or No
If so, please explain _______________________
Are you pregnant? Yes or No
Is there anything else we should be aware before your treatment? ____________________________
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Visit us on the web…
www.multicarehealthcenter.com

I fully understand all of the above information and authorize Multicare Health Center to treat me. I agree to all the terms and conditions.

Print Name________________________________ Signature _________________________________ Date ____________________