Downtown Omaha Massage
1216 Howard Street Omaha, NE 68102

Name:_____ Phone #:_____ h/c/w

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Occupation:_____ E-mail:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Anniversary:_____ How did you hear about us?_____

Would you like to receive promotional e-mails and/or appointment reminders? Yes No
Would you like to receive text reminders? Yes No Cell Provider:_____
(All information is strictly confidential and is not shared with any other parties.)

Please review the following conditions and circle those that apply to you:

(Please be advised that certain conditions may be contraindicated for therapeutic massage, and your session may need to be adjusted, discontinued, or rescheduled if receiving therapeutic massage would put your health or the health of the therapist at risk.)

HIV/AIDS	Carpel Tunnel Syndrome	Gout
Cancer	Arthritis	Cold/Flu
Heart Disease	TMJ	Anxiety/Depression
Epilepsy	Fibromyalgia	Skin Conditions
High/Low BP	Varicose Veins	Pregnancy # of weeks:_____
Diabetes	Joint Pain	Allergies:_____
Headaches/Migraines	Muscle Pain	Other:_____

Please explain any of the conditions you circled:_____

_____

Please list any recent injuries or surgeries:_____

Please list any medications you are currently taking:_____

Do you have your physician's permission to receive therapeutic massage?: Yes No N/A

Are you bothered by incense or aromatherapy? Yes No

Have you received massage therapy in the past?: Yes No

What is your goal/focus for today's treatment?:_____

Massage Therapy is not intended to substitute proper medical care, nor is it used for sexual purposes. This health information may only be utilized by Downtown Omaha Massage to provide you with the best care. All information given is true to the best of my knowledge. I release Downtown Omaha Massage from any unforeseen liability that may occur from receiving massage therapy. Downtown Omaha Massage reserves the right to refuse service to anyone, at any time, for any reason.

Signature:_____ Date:_____