

**DOWNTOWN OMAHA MASSAGE**  
1216 Howard Street Omaha, NE 68102 402-706-7398

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**Health Questionnaire**

Please Print

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_

OCCUPATION \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_ Referral \_\_\_ Om Center  
\_\_\_ Web Site \_\_\_ Walk-In

**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. Please review the following conditions and check those that apply to you:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Tension Headaches/ Migraines | <input type="checkbox"/> Joint Pain              | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Carpel Tunnel Syndrome       | <input type="checkbox"/> Muscle Pain             | <input type="checkbox"/> Skin Conditions    |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> TMJ                          | <input type="checkbox"/> Cold/Flu                |   |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Pregnancy # weeks _____ |   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Varicose Veins               | <input type="checkbox"/> Allergies _____         |   |

Please explain any of the conditions you checked above: \_\_\_\_\_

\_\_\_\_\_

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  not necessary

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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 \_\_\_\_\_