Taylor'd Living Wellness

Name_____ DOB_____ Phone Number_____

Email _____ Address_____

Emergency Contact_____ Phone_____

Massage Medical History Form

Please Indicate any existing or recent conditions:

____ Arthritis

____ Disc Problems (list below)

____ Osteoarthritis

____ Allergies

____ Headaches/ Migraines

____ Pregnant(list below)

____ Asthma

____ Heart problems

____ Rheumatoid Arthritis

____ Back Problems

____ High Blood Pressure

____ Skin Conditions

____ Blood Disorders

____ Insomnia

____ Sprains/Strains

____ Broken Bones/Pins

____ Low blood Pressure

_____ Spinal Problem

____ Cancer

_____ Muscle Spasms/ Cramps

____ Strokes

____ Carpal Tunnel

____ Neck problems

____ Surgeries (list below)

____ Diabetes

____ Numbness

____ TMJ/ Jaw Pain

Please Explain Checked boxes:

_____

_____

_____

Have you received professional massage therapy? ___ Yes ___ NO

Last massage date? _____

Desired Pressure: ___ Light ___ Medium ___ Deep

Goal for today sessions: _____

_____