Dr.Ratka Mira Popovic, DACM
www.nectarhealth.net/ 510-967-7563

Date_____________

Name____

Address____

City___________________ State________ Zip code_____________

Phone(c)_______________________ (h)____________________________________

Email____

DOB________________ Occupation____

Height_______________ Weight______________

Who may I thank for this referral? _______________________________________

Have you had a professional Massage before? ______________________________

Why are you here today? ____

Are you under any type of stress?

Do you make time daily to relax? If so what form of relaxation?

List all surgeries you have had to date:

Are you HIV positive?   Y   N   or do you have any active viral infections?
Are you currently pregnant?   Y   N   Due date: _______________

Do you exercise regularly? What form of exercise and frequency?

What pharmaceutical or herbal medications are you currently taking?

Please list any further conditions not described on this form that I should know about.
Symptoms:

____

Massage Therapy is an adjunct in your healthcare, it is not meant to replace medical diagnosis or treatment. If any symptoms persist or become severe please contact your Primary Care Physician.

I clearly understand that payment in full is to be paid after the treatment.
Please give 24-hours notice for an appointment cancellation, or you will be charged in full.

I have read the above and understand your policies.

Signature________________________________ Date _________________________