David S. Rosenthal center for wellness and health promotion
Harvard University Health Services

Registration Form

Please read & agree to the information below and complete both sides of this form.

Name _____ _____ HUID _____
First *Last*

Phone _____ Phone (work) _____

Email _____

☐ Faculty/Staff
☐ Graduate Student
☐ Undergraduate Student
☐ Family Member
☐ Postdoc
☐ Other: _____
☐ Retiree
☐ Alumnus

Those with affiliations in this box must pay for their appointment when scheduling.

Health Plan (if applicable) ☐ HUGHP (staff) ☐ Student Health Fee School/Unit _____

When scheduling your appointment, please notify us if you are pregnant, have a serious injury or illness, or any other significant relevant condition. Hands-on time will vary; for a one-hour appointment you should expect 50+ minutes. We do not accept gratuities. If you intend to use Payroll Deduction or Term Bill as payment, providing your signature below authorizes a charge for the initial appointment and future payroll deductions or term bill charges.

***Cancellation Policy**: Cancelling or rescheduling an appointment must be done with at least 24 hours' notice. Otherwise, you will be held responsible for the full cost of the appointment. Please call 617-495-9629 at least 24 hours before the appointment time if you need to cancel or reschedule.* Signing below indicates that you have read and agree to this policy.

Signature _____ Date _____

Health History

Age _____

Recreational activities/exercise _____

What medications are you currently taking? _____

On a scale of 1-10 (1=least), what is the amount of stress/tension in your life? _____

Please check off any of the following symptoms or medical conditions that apply to you, and provide a comment if desired:

☐ Swelling _____
☐ Pain or tenderness _____
☐ Numbness _____
☐ Infection _____
☐ Skin conditions _____
☐ Allergies _____
☐ Cardiovascular conditions _____
☐ Liver/kidney conditions _____
☐ Respiratory/lung conditions _____
☐ Cancers or tumors _____
☐ Diabetes _____
☐ Arthritis _____

☐ Pregnancy/gyn _____

☐ Injuries _____

☐ Headaches _____

☐ Recreational drugs _____

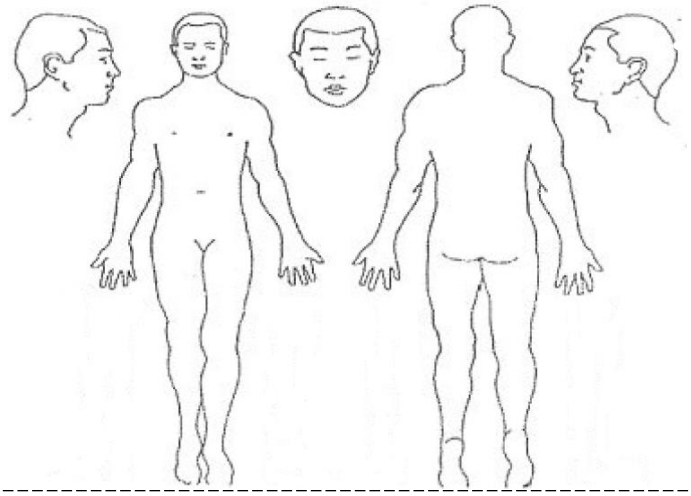
☐ Bloodborne pathogens _____

☐ Other medical condition: _____

_____

_____

What are your specific areas of tension/pain? List below or indicate on the diagram at right.



_____

_____

_____

_____

_____

Complete the massage and/or acupuncture sections below to register for that service.

Massage

Our licensed massage therapists can work with mild, moderate, or firm pressure, and rely on your feedback to ensure that they are using the appropriate technique and pressure for you. If you do not like what the therapist is doing or how it feels at any point during your treatment, you should let them know immediately.

Have you had massage before? ☐ Yes ☐ No If so, how long ago? _____

What did you particularly like or dislike? _____

Any other info that would be helpful to the massage therapist? _____

_____

Acupuncture

I have reviewed the information below regarding some of the possible contraindications of acupuncture:

- severe coagulopathy, including anticoagulation out of control
- severe abdominal pain (especially lower)
- hemophiliacs, certain points in visible areas are avoided
- under influence of drugs and alcohol
- women pregnant under 3 months, lower abdomen & lower back
- severe psychotic conditions
- very chronic & late stage diabetics may need to be careful about infections of the extremities

Signature _____ Date _____

Were you referred by a clinician? ☐ Yes ☐ No Name of referring clinician _____

Have you been treated with Oriental medicine or alternative therapy (acupuncture, massage, chiropractic, etc.) before? ☐ Yes ☐ No If so, where and when? _____

What are your goals of your acupuncture treatment? _____

_____

_____

_____