CENTER FOR WELLNESS AND HEALTH PROMOTION REGISTRATION FORM

Center for Wellness and Health Promotion
Harvard University Health Services

Name: _____ **HUID #:** _____
(8 digits)

Email: _____ **Phone #:** _____

Affiliation: ☐ **Faculty/Staff** ☐ **Graduate Student** ☐ **Postdoc** ☐ **Undergraduate Student**
☐ **Alum** ☐ **Retiree** ☐ **Spouse/Child of a Harvard affiliate**
(please complete the additional section at the bottom of this page)
☐ **Other:** _____

Please sign below to indicate that you have read & agree to our policies:

- If you have symptoms like fever, cough, or chills, stay home and isolate to avoid spreading illness.
- Our clinic is a fragrance-free environment. For the health and consideration of our employees and customers, please refrain from wearing perfume, aftershave, and other scented products when coming for appointments.
- Hands-on time may vary. For a one-hour appointment, you should expect about 50 minutes of massage.
- Our practitioners rely on your feedback to ensure that they are using the appropriate technique for you. If you do not like what the practitioner is doing or how it feels at any point during your treatment, please let them know immediately.
- For massage, if you have discomfort with disrobing or are seeking a specific pressure level or type of massage, please call the office before scheduling. We recommend against scheduling a longer appointment if this is your first time at our office.
- For acupuncture appointments, please be sure to arrive on time. If you are more than 15 minutes late, we will consider it a no-show and charge you accordingly.
- Please inform us if you have an illness or have a significant health condition.
- Signing below authorizes us to deduct from your payroll (staff) or add charges to your term bill (students). You always have the option of paying by credit card.
- ***Cancellation Policy:*** When you schedule an appointment with the Center for Wellness, that time is set aside special for you. We have this policy in place to be fair to all clients, out of consideration for our providers, and to support the overall sustainability of our clinic. We require **24-hours' notice** when cancelling an appointment. If you do not show up to an appointment or cancel without sufficient notice, you remain responsible for the full payment unless we are able to fill your timeslot with a different patient.

Signature : _____ **Date:** _____
(MM/DD/YYYY)

Please continue to the other side of this form

If your only affiliation is through a family member, please complete these additional fields. We will need to add you to Harvard's system before you can schedule an appointment.

Your Date of Birth: _____ **Harvard Affiliate's HUID #:** _____
(8 digits)

Harvard Affiliate's Name: _____

Your Relationship to the Harvard Affiliate: _____

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HEALTH HISTORY

What medications are you currently taking?

Is this your first massage treatment? ☐ **Yes** ☐ **No**

Is this your first acupuncture treatment? ☐ **Yes** ☐ **No**

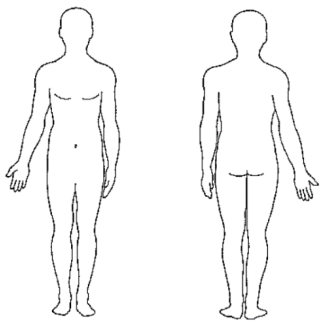
Please check off any of the following symptoms or medical conditions that apply to you, and provide a comment below if desired:

☐ Active Skin Infection
☐ Blood Clots or DVT
☐ Cancer
☐ Fever or Contagious Disease
☐ Hemophilia
☐ High Risk Pregnancy
☐ Osteoporosis
☐ Pacemaker/Medical Implant
☐ Recent Surgery

☐ Allergies
☐ Arthritis
☐ Blood Disorder
☐ Bloodborne Pathogens
☐ Cardiovascular Conditions
☐ Diabetes
☐ Elevated Stress/Anxiety
☐ Headaches
☐ Liver/Kidney Conditions
☐ Long Covid
☐ Numbness
☐ Pain/Tenderness
☐ Pregnancy/gyn
☐ Recent Injury
☐ Respiratory/Lung Conditions
☐ Skin Conditions
☐ Swelling/Lymphedema

☐ Other Medical Conditions: _____

What are your concerns and/or areas you wish to be treated? List below or indicate on the diagram at right.



Do you have any preferences or issues that you think would be important for the practitioner to know about?

Any other info that would be helpful for the practitioner?

INFORMED CONSENT FOR MASSAGE AND ACUPUNCTURE SERVICES

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NATURE OF TREATMENT

Massage therapy is the manual manipulation of the body's soft tissues—such as muscles, tendons, ligaments, fascia, and skin—to reduce pain and tension, relieve stress, and improve circulation, mobility, and overall well-being. With roots in ancient healing traditions, it is now widely used to support relaxation, recovery from injury, and overall health.

Acupuncture is a traditional Chinese medical practice in which thin, sterile needles are inserted into specific points on the body to relieve pain, manage health conditions, improve physiological functioning, and promote energy (Qi) balance along the meridians of the body. It is typically used as a complementary therapy alongside conventional medicine.

POTENTIAL BENEFITS

I understand that the goal of massage and acupuncture treatments is to help reduce pain, improve function, and support overall health and well-being. I understand that these services may provide benefits for certain conditions, but results cannot be guaranteed.

POTENTIAL RISKS AND SIDE EFFECTS

I understand that massage treatment may produce short-term side effects such as muscle soreness, minor superficial bruising, increased awareness of areas of pain, aggravation of an unknown or pre-existing injury, or lightheadedness, among other possible temporary side effects.

I understand that acupuncture treatment may produce short-term side effects such as minor bleeding and bruising, aggravation of presenting symptoms, soreness or pain at the needle sites, skin irritation or burns, and very rare but serious risks, including infection, nerve injury, or pneumothorax, among other possible temporary side effects.

MEDICAL INFORMATION AND COMMUNICATION

I understand that treatment may be contraindicated for certain medical conditions or symptoms. Massage contraindications may include fever, contagious disease, blood clots (DVT), high risk pregnancy, recent surgeries, and severe medical conditions such as cancer and osteoporosis. Acupuncture contraindications may include active skin infection, hemophilia, and pacemakers.

To the best of my knowledge, I do not have any injuries or conditions that would prevent me from safely receiving massage therapy or acupuncture services. I agree to inform my massage therapist or acupuncturist (hereinafter referred to as 'provider') of all known medical conditions and/or medications, and I acknowledge that additional risks may be associated with my physical condition.

If I experience pain or discomfort during treatment, I will immediately inform my provider so that treatment can be adjusted to my level of comfort.

INFORMED CONSENT FOR MASSAGE AND ACUPUNCTURE SERVICES

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I understand that massage and acupuncture services are not a substitute for medical care and that my providers are not qualified to diagnose, prescribe, treat physical or mental illness, or make physical adjustments of the spine or its immediate articulations.

I understand that my health and treatment information will be kept confidential and will not be shared without my written permission, except when required or permitted by law (i.e., when there is a concern about safety or when reporting is legally required). The Center for Wellness and Health Promotion complies with all applicable HUHS confidentiality and privacy policies.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW

I understand that either I or the provider may end the session at any time for any reason. I understand that any remarks or actions of a sexual or personal nature will result in immediate termination of treatment and that no future appointments will be allowed.

By signing below, I confirm that I understand the information above regarding acupuncture and massage therapy services and I voluntarily consent to treatment.

I understand that I may withdraw my consent at any time, except for the services already provided.

Signature : _____ **Date:** _____
(MM/DD/YYYY)