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* *8 digits*

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

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

- Hands-on time may vary – for a one-hour appointment, you should expect about 50 minutes.
- 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.
- Please inform us if you have an illness or have a significant health condition.
- When arriving for your appointment, please refrain from having any excess sweat, body odors, or heavy perfumes.
- 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, you should 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.
- ***Cancellation Policy:*** *24 hours' notice is required to cancel an appointment without incurring a charge. 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.* Our services are in high demand and we want to make sure they are available to everyone at Harvard.

Signature _____ Date _____

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.

Date of birth _____ Email _____

Name of Harvard affiliate _____ Harvard affiliate's HUID _____

Your relationship to the Harvard affiliate _____

Health History

What medications are you currently taking? _____

On a scale of 1-10 (1=least), what is your current pain level? _____

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

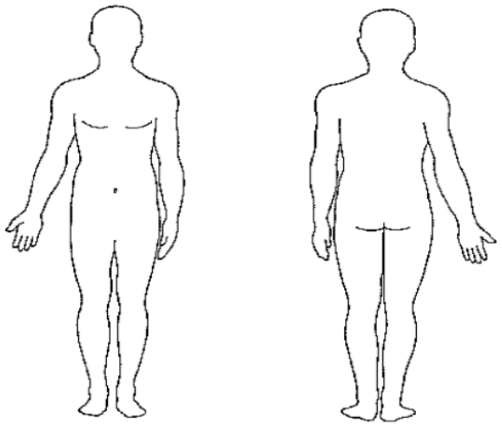
- ☐ Pregnancy/gyn
- ☐ Active infection
- ☐ Allergies
- ☐ Arthritis
- ☐ Bloodborne pathogens
- ☐ Blood disorder/taking clotting medication
- ☐ Cancers or tumors
- ☐ Cardiovascular conditions
- ☐ Diabetes
- ☐ Elevated stress/anxiety
- ☐ Headaches
- ☐ Liver/kidney conditions
- ☐ Long covid
- ☐ Numbness
- ☐ Pacemaker/medical implant
- ☐ Pacemaker/medical implant
- ☐ Pain/tenderness
- ☐ Recent injury
- ☐ Recent surgery
- ☐ Respiratory/lung conditions
- ☐ Skin condition
- ☐ Swelling/lymphedema
- ☐ Other medical condition

_____

_____

_____

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



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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?

_____

_____