

# INSTRUCTIONS FOR SCHEDULING AN ACUPUNCTURE APPOINTMENT

AT HARVARD UNIVERSITY HEALTH SERVICES (HUHS), HOLYOKE CENTER

Thank you for your interest in scheduling an acupuncture appointment through Harvard Wellness Programs. We want your appointment to be as enjoyable as possible. As part of our ongoing efforts in this regard, we have developed a quick guide to the process.

## BEFORE SCHEDULING YOUR APPOINTMENT (FIRST TIME CLIENTS ONLY):

- Print out and fax or send the Clearance Letter to your Primary Care Clinician
- Print out and complete Introductory Appointment Paperwork
- Submit Introductory Appointment Paperwork and Clearance Letter to:  
Center for Wellness & Health Communication (CWHC)  
Harvard University Health Services (HUHS)  
75 Mount Auburn Street, 2<sup>nd</sup> Floor  
Cambridge, MA 02138  
Phone: 617.495.9629  
Fax: 617.495.1135

NOTE: Introductory Appointment Paperwork and Clearance Letter must be received by the CWHC before the first appointment can be scheduled.

- Print out and complete Health History Form (to bring to your first appointment)

## TO SCHEDULE YOUR APPOINTMENT:

- For all appointment scheduling, call 617.495.9629 or stop by the Center for Wellness & Health Communication (CWHC), Harvard University Health Services (HUHS), 75 Mount Auburn St, 2<sup>nd</sup> floor, Cambridge MA
- A staff member will help you choose from available dates and times that are most convenient for you.
- If you are pregnant, have a serious injury or illness, or any other condition you feel we should be aware of, please inform the staff member when scheduling your appointment. We must have your Clearance Letter on file before an appointment can be scheduled.
- Submit payment via Visa, Mastercard, check, term-bill or payroll deduction at the time your appointment is made.
- If you need to reschedule or cancel your appointment a 24-hour notice is required, otherwise you will be held responsible for payment. We do understand that scheduling changes happen; however, our time slots are limited and we would like to be able to accommodate other participants if you cannot make your appointment. Please call 617.495.9629 as soon as possible and leave a message with the staff or on voice mail.

## ARRIVING FOR YOUR APPOINTMENT:

- Arrive at HUHS, 75 Mount Auburn St at least 5 minutes before your appointment. Metered parking is available on side streets. Garage parking is available in the Holyoke Center Garage. The CWHC cannot validate parking for any type of appointment.
- Enter HUHS through the Urgent Care Entrance. The entrance can be found by going down the parking ramp beneath HUHS, off of either Holyoke or Dunster St.

- ❑ Proceed to the 2nd floor of HUHS where your appointment will take place.
- ❑ Take a seat outside the CWHC and the acupuncturist will come out to greet you.
- ❑ If you are a first time client, please be sure that you have your Health History Form with you to review with the acupuncturist.

#### YOUR APPOINTMENT:

- ❑ Your one-hour appointment is held in a private room and begins with a brief interview in which the therapist will review your Health History Form with you.
- ❑ Your session of acupuncture, which is a practice based on Traditional Oriental Theories, primarily involves the insertion of needles through the skin at certain points on the body in an attempt to relieve pain or improve body function.
- ❑ Once your treatment is complete, you will be provided with an opportunity to offer feedback and discuss your treatment with the acupuncturist.

#### TO SCHEDULE ADDITIONAL APPOINTMENTS:

- ❑ Call 617.495.9629 or stop by the CWHC to make additional appointments. After your first appointment, you will not be required to complete any further paperwork. Payment is always due at the time an appointment is made.

#### OTHER HELPFUL INFORMATION:

- ❑ The acupuncturists have a valid, active Massachusetts State Acupuncture License, have extensive training in diverse areas, and are certified in the Clean Needle Technique. To find out more about the acupuncturists, review biographies.
- ❑ Bring or wear **comfortable clothes, like sweats, yoga wear, shorts, T-shirts or tank tops.** Constrictive clothing, e.g. tight jeans, tights, wire bras, etc. should not be worn during treatments. Tight or constrictive jewelry should be removed during your appointment.
- ❑ **It is recommended that you not have an overly full stomach or bladder during treatment.**
- ❑ Although gratuities are not accepted, your feedback is always appreciated.
- ❑ Gift certificates are available by calling 617.495.9629 or by stopping by the CWHC on the 2<sup>nd</sup> floor of HUHS.
- ❑ Please feel free to contact us at 617.495.9629 if we can provide further information that can be helpful to you.

Please fax or send this form before scheduling an appointment

Harvard Wellness Program  
75 Mt Auburn Street, 2E  
Cambridge, MA 02138  
Phone: 617.495.9629  
Fax: 617.495.1135

Client #: \_\_\_\_\_  
Entry #: \_\_\_\_\_

# INTRODUCTORY APPOINTMENT PAPERWORK

## A. PERSONAL INFORMATION:

Name: \_\_\_\_\_ Harvard ID: \_\_\_\_\_  
Campus/Work Address: \_\_\_\_\_  
*(if no campus address, please use home address)*  
Telephone (W): \_\_\_\_\_ (H): \_\_\_\_\_  
Email Address: \_\_\_\_\_

## B. UNIVERSITY AFFILIATION:

Faculty, HUGHP?  Y  N     Staff, HUGHP?  Y  N     Family Member, HUGHP?  Y  N  
 Retiree             Alumni             Graduate Student             Undergraduate Student             Other

## C. HARVARD SCHOOL OR DEPARTMENT:

Business School             FAS             HMS             VP Administration  
 Central Administration     GSD             HSPH             VP Alumni Affairs  
 College Libraries             GSE             Radcliffe             VP Financial  
 Dental School             HKS             Retiree             VP General Counsel  
 Divinity School             HLS             UHS             Other

## D. PAYMENT INFORMATION:

Acupuncture Appointment:        \$75 (\$40.00/HUGHPmembers)  
Payment Methods                     Visa or MC # \_\_\_\_\_ Exp. \_\_\_\_\_  
Accepted:                             Check *(payable to CWHC, due when appointment is scheduled)*  
     Term Bill *(current Harvard students only)*  
     Payroll Deduction *(current Harvard employees only, Fellows & temporary staff N/A)*  
     Gift Certificate # \_\_\_\_\_  
Signature (for MC, Visa, PD, or TB) \_\_\_\_\_

## E. ACKNOWLEDGEMENT OF 24-HOUR CANCELLATION POLICY

While we do understand that scheduling changes happen, a 24-hour notice is required if the need to cancel or reschedule an appointment arises. Our time slots are limited and we would like to be able to accommodate other participants if you cannot make your appointment. For this reason, we ask that you call **495-9629** at least 24 hours before the time of the appointment if you need to cancel or reschedule the appointment. During non-business hours, you can leave a message on voice mail and the time of your cancellation can be accurately confirmed through this system.

**Without 24-hour notice of cancellation, you will be responsible for payment of the appointment.**

I, \_\_\_\_\_ *(Name)* have read and understand that I am responsible for payment of an acupuncture appointment without at least a 24-hour notice of cancellation.

Signed \_\_\_\_\_ Date \_\_\_\_\_

THANK YOU FOR YOUR INTEREST IN THE HARVARD WELLNESS PROGRAM!

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## ACUPUNCTURE CLIENT INFORMATION FORM

Name: \_\_\_\_\_

Harvard ID# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

- A. I give my permission for the acupuncturist to provide treatment in compliance with all applicable statues and regulations. I am aware that my clinician has given clearance for me to receive this treatment, but has not ordered it. I understand that my clinician has reviewed the frequent uses and possible contraindications of acupuncture and if any cautions or restrictions are suggested, they have been described on the clinician clearance form. I am electing to receive this treatment on my own accord and accept any risks associated with this treatment.
- B. I give permission for my primary care clinician to release information about my medical condition only as it pertains to providing me safe, effective acupuncture. I understand that only information about those medical conditions or treatments that might be affected by acupuncture will be released.
- C. I am aware that my primary care clinician and the acupuncturist may need to communicate in order to provide me with the most beneficial, coordinated care. Appointment notes will be entered into my medical record by the acupuncturist after each appointment.
- D. I have reviewed the information below regarding frequent uses, conditions recommended for acupuncture by the World Health Organization, and some of the possible contraindications of acupuncture.

### FREQUENT USES

- Pain management (including arthritis, back pain, and headaches)
- Neurological conditions
- Asthma
- Drug Abuse and Alcoholism
- Nausea related to Chemotherapy
- Weight Control
- Smoking
- Stroke
- Gastrointestinal Disorders
- Gynecological and Obstetric Problems
- Sexual Problems

### CONTRAINDICATIONS

- Severe coagulopathy, including anticoagulation out of control
- Hemophiliacs, for cosmetic reasons, certain points in visible areas may need to be avoided
- Very chronic and late stage diabetics, may need to be careful about infections of the extremities
- Severe abdominal pain (especially lower)
- Severe psychotic conditions
- Under influence of drugs or alcohol
- For pregnant women under three months, points on the lower abdomen and lumbosacral region are contraindicated

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**CLEARANCE FORM**  
**FOR ACUPUNCTURE**  
(TO BE COMPLETED BY PATIENT'S CLINICIAN)

- I give clearance for my patient, (name) \_\_\_\_\_ (huid#) \_\_\_\_\_, to receive acupuncture treatments at the Center for Wellness and Health Communication, Harvard University Health Services.
- I have reviewed the information below regarding frequent uses and some of the possible contraindications of acupuncture.

**FREQUENT USES**

- Pain management (including arthritis, back pain, and headaches)
- Neurological conditions
- Asthma
- Drug Abuse and Alcoholism
- Nausea related to Chemotherapy
- Weight Control
- Smoking
- Stroke
- Gastrointestinal Disorders
- Gynecological and Obstetric Problems
- Sexual Problems

**CONTRAINDICATIONS**

- Severe coagulopathy, including anticoagulation out of control
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- I have reviewed this patient's records and have found no conditions or treatments that would contraindicate this patient receiving acupuncture at this time. If I suggest any cautions or restrictions, I describe them below.

\_\_\_\_\_  
*Name of Clinician*

\_\_\_\_\_  
*Signature of Clinician*

\_\_\_\_\_  
*Date*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Please bring this form with you to the appointment**

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# HEALTH HISTORY FORM

Please complete both pages of this form. This information will help the acupuncturist assess your needs before any hands-on work is done in order to provide you with the highest quality of care.

**Any information that is provided will be kept confidential.**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Campus/Work Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Harvard ID: \_\_\_\_\_

Name of referring Clinician: \_\_\_\_\_ Reason? \_\_\_\_\_

Health Plan:  HUGHP  Student Health Plan / HUHS

Are you currently under the care of a health practitioner not listed above?  Yes  No

Name and Specialty of Health Practitioner: \_\_\_\_\_

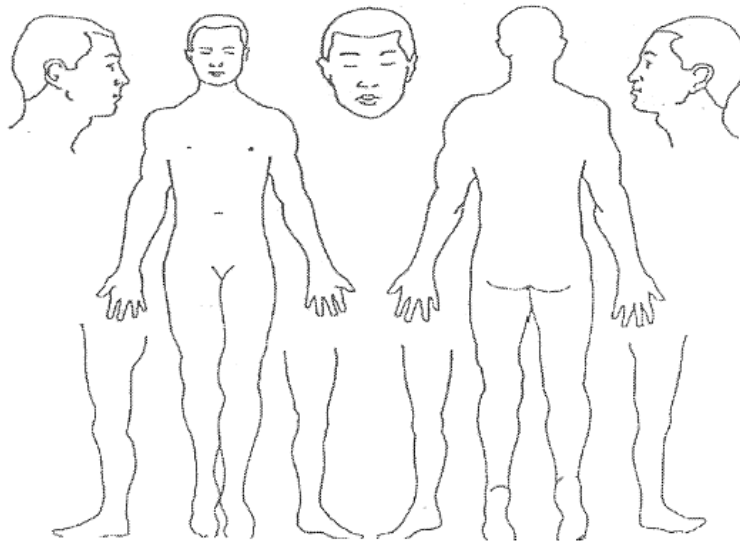
Have you ever been treated with Acupuncture or Oriental Medicine before? If so, where and when?

\_\_\_\_\_

Occupation and occupational activity (e.g. heavy lifting): \_\_\_\_\_

\_\_\_\_\_

What are your specific areas of pain or distress? \_\_\_\_\_



*(Please Continue on Next Page)*

What medications are you currently taking? \_\_\_\_\_

Do you wear contact lenses? Yes No Do you wear dentures? Yes No  
On a scale of 1 to 10 (1 = least) what is the amount of stress/tension in your life? \_\_\_\_\_

Do you have a regular exercise program? Yes No If yes, please describe \_\_\_\_\_

Other recreational activities: \_\_\_\_\_

Have you ever had any type of alternative therapy in the last year (Chiropractic, Massage, etc.) Yes No

If so, where and when? \_\_\_\_\_

Was there anything that you particularly liked or didn't like about it? \_\_\_\_\_

Is there anything else that you feel would be helpful for the acupuncturist to know? \_\_\_\_\_

### GENERAL SYMPTOMS

Please mark whether or not you are experiencing any of the following general symptoms at the present time and add any comments that might further clarify (i.e. locations on the body, names of conditions, clinician-specific advice about the condition).

		<u>COMMENTS</u>
Any swelling or tendency to swell	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Any sites of pain or tenderness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Any sites of numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Any sites of infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

### SPECIFIC MEDICAL CONDITIONS

If you have ever had any of the following conditions, please mark whether it was past or current and add any comments that might further clarify.

		<u>COMMENTS</u>
Skin Conditions (e.g. rashes, infections, itching)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Known Allergies	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Cardiovascular Conditions (e.g. high blood pressure, heart condition, angina, phlebitis, blood condition, hardened arteries, etc.)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Liver or Kidney Conditions	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Respiratory/Lung Conditions	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Cancers or Tumors (either malignant or benign)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Pregnancy	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Injuries (e.g. disc problems, fractures, knee problems, tendonitis)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Headaches (e.g. chronic, severe, etc.)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____
Other medical conditions not mentioned above	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	_____

**PLEASE REMEMBER TO BRING THIS FORM  
WITH YOU TO YOUR APPOINTMENT!**