

INSTRUCTIONS FOR SCHEDULING A MESSAGE APPOINTMENT

BEFORE SCHEDULING YOUR FIRST APPOINTMENT:

- ❑ Complete the Introductory Appointment Paperwork form and submit it via fax, campus mail, email, or in person to:

The Center for Wellness and Health Communication (CWHC)
Harvard University Health Services (HUHS), 75 Mount Auburn Street, 2nd Floor
Cambridge, MA 02138
Phone: 617.495.9629
Fax: 617.495.1135
Email: cwhc@uhs.harvard.edu

- ❑ Complete the Health History Form and bring it to your first appointment.

TO SCHEDULE YOUR FIRST APPOINTMENT:

- ❑ Call or visit the Center for Wellness.
- ❑ Choose from available dates and times that are most convenient for you. (Therapist biographies are available at cw.huhs.harvard.edu.)
 - At HUHS, Holyoke Center:
Monday 9am - 9pm, Tuesday 3pm - 8:30pm, Wednesday 9am - 8pm, Thursday 8:15am - 7:45pm, Friday 4:00 - 8pm, Saturday 8am - 7pm, or Sunday 11am - 4:30pm
 - At Harvard Business School, Cumnock Hall (HBS affiliates *only*):
Friday 12:30pm, 1:30pm, 3:00pm, & 4:00pm.
- ❑ *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 at this time.
- ❑ Payment is always due at the time an appointment is made.

ARRIVING FOR YOUR APPOINTMENT:

AT HUHS, HOLYOKE CENTER:

- ❑ Arrive at HUHS at least 5 minutes before your appointment.
- ❑ Metered parking is available on side streets. Garage parking is available in the Holyoke Center Garage.
- ❑ Enter HUHS through the main entrance during business hours (Monday - Friday, 8am - 5:30pm) or through the Urgent Care Entrance after-hours (down the ramps from Dunster and Holyoke Streets that lead to the Parking Garage).
- ❑ Proceed to the Center for Wellness.

AT HBS, CUMNOCK HALL:

- ❑ Arrive at HBS, Cumnock Hall at least 5 minutes before your appointment. Parking is available on side streets.
- ❑ Enter Cumnock Hall and proceed to the Health Services waiting room.

DURING YOUR APPOINTMENT:

- ❑ Every appointment will begin with a confidential discussion about the information you provided on the Health History form as well as your motivation for scheduling the appointment (pain, stress, injury, etc.), your preference for massage style (relaxation, deep tissue,

sports, energy work, etc.), your preference for pressure (light, moderate, firm, deep), and the areas which you do or do not want massaged. If you request a full-body massage, the session may include massage of the scalp, face, neck, upper chest, shoulders, arms, hands, back, hips, legs, and feet.

- ❑ If you are pregnant, have a serious injury or illness, or any other condition, please mention it at this time. A few extra minutes may be required before the start of a pre-natal treatment (and others that require special preparation and caution).
- ❑ Once the intake discussion is complete, the therapist will leave the room so that you may undress in private. Rest assured, your therapist will always use a top sheet for warmth and modesty, only exposing the area on which he/she is currently working. Please, disrobe down to *your own* personal comfort level, removing some or all of your clothing. However, please be aware that the therapist may not be able to work on certain areas if clothing obstructs them. The therapist will never ask you to remove clothing and will do his/her best to work around it. Once you have disrobed, lie on the massage table either face up, face down, or on your side as your therapist instructed. After a few minutes, your therapist will knock on the door and ask if he/she can re-enter the treatment room for the hands-on portion of the appointment.
- ❑ Throughout the treatment, if you are uncomfortable for any reason (temperature, pressure, pain, etc.), communicate this to your therapist openly. It is your right. Our therapists have been trained to modify their work accordingly and rely on your honest feedback to deliver the most effective treatment.
- ❑ Once the hands-on treatment is complete (hands-on time will vary according to the length and complexity of the intake discussion and other factors), the therapist will again leave the room, giving you privacy to redress. Please, open the treatment room door as soon as you are done.
- ❑ Each appointment will end with a confidential exit discussion after the therapist has re-entered the room to discuss any changes you feel, recommended self-care, and a treatment plan.

OTHER HELPFUL INFORMATION:

- ❑ Gratuities are never accepted. Your feedback is always appreciated, however.
- ❑ The Center for Wellness does not validate parking.
- ❑ Appointment cancellations must be done with at least 24-hours notice. Otherwise, you will be held responsible for the full cost of the appointment.
- ❑ Gift certificates are available for purchase.

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

INTRODUCTORY APPOINTMENT PAPERWORK

for office use only
Client # _____
Entry # _____

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:

- | | | | |
|---|------------------------------|---|--|
| <input type="checkbox"/> Business School | <input type="checkbox"/> FAS | <input type="checkbox"/> HMS | <input type="checkbox"/> VP Administration |
| <input type="checkbox"/> Central Administration | <input type="checkbox"/> GSD | <input type="checkbox"/> HSPH | <input type="checkbox"/> VP Alumni Affairs |
| <input type="checkbox"/> College Libraries | <input type="checkbox"/> GSE | <input type="checkbox"/> Radcliffe | <input type="checkbox"/> VP Financial |
| <input type="checkbox"/> Dental School | <input type="checkbox"/> HKS | <input type="checkbox"/> HUHS | <input type="checkbox"/> Other |
| <input type="checkbox"/> Divinity School | <input type="checkbox"/> HLS | <input type="checkbox"/> VP General Counsel | |

D. PAYMENT INFORMATION:

Massage Therapy Appointment: 1 hr appt \$60(\$40/HUGHP members) half-hour appt \$37 (\$25/HUGHP)

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 employess 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 a massage therapy appointment without at least a 24-hour notice of cancellation.

Signed by _____ Date _____

THANK YOU FOR YOUR INTEREST IN THE HARVARD WELLNESS PROGRAM!

Please bring this form with you to the appointment

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

**HEALTH
HISTORY
FORM**

Please complete both pages of this form. This information will help the massage therapist 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: _____

Were you referred by a clinician? Yes No Reason? _____

Name of Clinician: _____ Health Plan: _____

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

Name and Specialty of Health Practitioner: _____

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

What are your specific areas of tension? _____

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 exercise? Yes No How often? _____ What type? _____

Other recreational activities: _____

Have you ever had a massage before? Yes No If yes, how long ago? _____

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 massage therapist to know? _____

(Please Continue on Next Page)

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).

COMMENTS

- | | | | |
|-----------------------------------|------------------------------|-----------------------------|-------|
| 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.

COMMENTS

- | | | | | |
|--|----------------------------------|-------------------------------|-----------------------------|-------|
| Skin Conditions
(e.g. rashes, infections including oral Herpes or Shingles, itching, etc.) | <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, 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 | _____ |

Our licensed, certified massage therapists will work on areas of tension, pain, or limited motion using various techniques, including stroking, kneading, friction, and/or percussion. These massage techniques increase circulation, improve mobility, and induce deep relaxation. All of the therapists at the CWHC are able to work with mild, moderate, firm, or deep pressure. Some of the therapists are trained in additional fields (such as cranio-sacral and energy work) and may use that training to further enhance your massage experience, with your consent. Our therapists will check-in with you periodically throughout your massage to insure that they are using the appropriate technique and pressure for you, as you agreed upon at the beginning of the appointment. This is the perfect time to give honest feedback to your therapist. Changes can and will be made to fit your needs. 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.

I have read the Instructions for Scheduling a Massage Appointment and the paragraph above and will let my therapist know if I am not comfortable with his or her technique, pressure level, or any other aspect of the massage.

Signed: _____

Date: _____