

# MASSAGE THERAPY STRESS REDUCTION CLINIC: REGISTRATION FORM FALL 2008

Please PRINT and use ink when filling out the form. Thank you.

Return this completed Registration Form along with a check or money order for \$150, payable to the Swedish Institute, to Swedish Institute, 226 W. 26th Street, Stress Reduction Clinic, New York, NY 10001.

OFFICE USE ONLY				
	E	W	C	N/S
1				
2				
3				
4				
5				
6				

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

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

## EMERGENCY CONTACT

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

Phone: \_\_\_\_\_

## CLINIC DATES AND TIMES

Appointments are available on Saturdays and Sundays, from 9:45 a.m. to 4:00 p.m.

■ Saturdays: Oct. 4, 11, 18, 25, Nov. 1, 8

■ Sundays: Oct. 5, 12, 19, 26, Nov. 2, 9

Appointment times for both Saturday and Sunday are:

■ 9:45 a.m. 11:00 a.m. 12:15 p.m.  
1:30 p.m. 2:45 p.m. 4:00 p.m.

My preference is for the following days and times:

First choice: Day \_\_\_\_\_ Time \_\_\_\_\_

Second choice: Day \_\_\_\_\_ Time \_\_\_\_\_

Once your appointment has been confirmed the fee is non-refundable.

Have you ever had a professional Swedish session? \_\_\_\_\_ Shiatsu session? \_\_\_\_\_

Do you have a history of or are you currently suffering from any of the following:

- |                                                                  |                                                               |
|------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Skin Conditions/Athlete's Foot          | <input type="checkbox"/> Varicose Veins/Blood Clots/Phlebitis |
| <input type="checkbox"/> Allergies                               | <input type="checkbox"/> Hypertension/Cardiovascular Disease  |
| <input type="checkbox"/> Osteoarthritis                          | <input type="checkbox"/> Ongoing Fever                        |
| <input type="checkbox"/> Rheumatoid Arthritis                    | <input type="checkbox"/> Chronic Heart or Kidney Failure      |
| <input type="checkbox"/> Gout                                    | <input type="checkbox"/> Cancer Type _____                    |
| <input type="checkbox"/> Bone Breaks or Dislocations             | <input type="checkbox"/> Lymphedema                           |
| <input type="checkbox"/> Osteoporosis/Osteopenia                 | <input type="checkbox"/> Diabetes                             |
| <input type="checkbox"/> Disc Injuries/Spinal Problems/Scoliosis | <input type="checkbox"/> Surgery/Recent Surgery               |
| <input type="checkbox"/> Epilepsy/Seizure Disorder               | <input type="checkbox"/> Acute Trauma                         |

For any items checked above please describe and give dates of diagnosis or occurrence:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(continued on next page)**

Are you pregnant?

If so, number of weeks : \_\_\_\_\_

Do you have any current infectious or contagious diseases?

Please describe: \_\_\_\_\_

Do you have any other medical conditions, or injuries?

Please describe: \_\_\_\_\_

Do you have a prosthesis, implants, shunts or pacemaker?

Please describe: \_\_\_\_\_

I understand that massage will be provided by students as part of their educational internship and is not for the treatment of medical conditions. I understand that this clinic is not suitable for clients with the following conditions: contagious disease, ongoing fever, chronic heart or kidney failure, diabetes, phlebitis, thrombosis, acute trauma, recent surgery, active or history of cancer, any other medical condition or pregnancy. Massage practitioners do not diagnose illness, disease, or other physical or mental disorders. By completing this form, I assert that I have informed the clinic of all of my known medical conditions, and understand that it is my responsibility to notify the clinic PRIOR to treatment concerning ANY changes in my physical health. Failure to comply with any of the above may result in removal from the clinic.

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

_____	5.
_____	4.
_____	3.
_____	2.
_____	1.

**SUPERVISOR NOTES**

FOR ADMINISTRATIVE USE ONLY