Client intake COVID-19 Addendum

NAME: _____ DATE:_____

To best protect your health and the health of others, please fill out this form before each massage and bodywork session. Thank you!

1› Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days? __ YES __ NO

2› Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)? __ YES __ NO

3› Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flulike symptoms within the last 14 days? __ YES __ NO

4› Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test?

What were the results?

5› Have you been in places with a high infection rate within the last two weeks (e.g., statedesignated “hotspots”)? __ YES __ NO If yes, please explain.

6› Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever __ Chills __ Cough __ Sore throat __ Diarrhea, digestive upset

__ Nasal, sinus congestion __ Loss of sense of taste or smell __ Fatigue

__ Shortness of breath __ Sudden onset of muscle soreness (not due to a specific activity)

__ Rash or skin lesions (especially on the feet) __ Eye Irritation or Secretion

7› Do you have any new discomfort with exertion or exercise? __ YES __ NO

8› Do you have any discomfort holding your breath for up to 10 seconds? __ YES __ NO

9› Please enter your temperature as read today by our staff _____

I declare that the information provided above is true and accurate to the best of my knowledge.

SIGN: _____ DATE:_____

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am informed of office hygiene procedures, I am aware of the risks involved and give consent to receive massage from this practitioner.

Furthermore, I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health dept.

SIGN: _____ DATE:_____

NAME: _____