Intake Form Addendum

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

NAME: DATE:

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

When was your test?

What were the results?

Have you been in places with a high infection rate within the last two weeks (e.g., state-designated "hotspots")? If yes, please explain.

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 related to a specific activity)
__ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise?

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

(print name) (signature) (date)