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COVID SCREENING QUESTIONNAIRE

	YES	NO
Do you have a fever, or have you felt feverish recently?		
Do you have a cough?		
Are you having shortness of breath or any difficulty breathing?		
Do you have chills or repeated shaking with chills?		
Do you have any muscle pain?		
Do you have any recent onset of headache or sore throat?		
Do you have any other flu-like symptoms?		
Do you have any recent loss of taste or smell?		
Have you experienced any recent GI upset or diarrhea?		
Are you in contact with anyone who has been confirmed to be Covid-19 positive?		
Have you traveled in the past 14 days to any regions affected by Covid-19?		
Have you been tested for Covid-19? If yes, what was the result?		
Have you been diagnosed with Covid-19? If yes, when?		
Are you over the age of 65?		
Do you have: Heart Disease Lung Disease Kidney Disease Autoimmune Disorders		

While information is still limited, the CDC indicates that these underlying conditions place people at higher risk for severe illness from Covid-19:

- People 65 years or older
- Chronic Lung Disease
- Moderate to Severe Asthma
- Heart Conditions
- Compromised or suppressed immunity
- Severe Obesity (BMI of 40 or higher)
- Diabetes
- Chronic Kidney Disease
- Liver Disease

Continued on other side

Unless otherwise directed by the client's primary healthcare provider, clients are higher risk of severe illness from Covid-19 should forgo massage while the virus is still present in their community.

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

Signature_____
Printed Name_____ Date _____

"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 department."

Signature_____
Printed Name_____ Date_____