MASSAGE RESCUE

Covid-19 Patient Screening Form

As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure, please complete and submit this questionnaire truthfully and to the best of your ability prior to your appointment.

Name: ___________________________________

Upcoming Appointment Date: ________________

	YES	NO	
Have you experienced any recent flu-like symptoms (fever, chills, body aches, fatigue)	☐	☐	
Do you have a cough?	☐	☐	
Are you having shortness of breath or any difficulty breathing?	☐	☐	
Do you have any recent onset of headache, runny nose or sore throat?	☐	☐	
Do you have any unexplained muscle pain	☐	☐	
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 attended any gatherings in the past 14 days of 3 or more people that do not include your immediate family?	☐	☐	
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 and the members of your household sheltering at home?	☐	☐	
Do you have any of the following: Heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorder?	☐	☐	

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: ___________________________ Date: ___________________________