

COVID-19 Client Health-Screening Form

Client Name (Printed): _____

Date: _____

Question	Yes / No
Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days?	
Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)?	
Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?	

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner.

Client Signature: _____

Date: _____

Internal Use Only:

Does the Client have a temperature reading of 100.4 degrees or higher?

- ☐ Yes
☐ No

LMT Confirming Form: _____ Date: _____