



Covid - 19 Client Declaration

Full Name:

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Address:

.....

Mobile:

.....

& Email:

GP Name & Address:

Date of Birth:

.....

Please ring or underline answer

Do you have symptoms of Coronavirus? Yes / No?

Have you had symptoms of Coronavirus in the last 7 days? Yes / No?

Has someone you live with had symptoms of Coronavirus in the last 14 days? Yes / No?

Have you been declared as high risk by a medical professional? who has told you to self-isolate to avoid Contracting the virus? (As it is more likely to pose a threat to life) Yes / No?

Please do not book your appointment 2 weeks prior and 3 weeks post covid19 vaccine.

No treatment can go ahead without Id or proof of age.

I declare to the best of my knowledge the answers given above are accurate and that I have not omitted any information.

I confirm that I fully understand and agree to comply with the Covid - 19 rules and guidelines regarding track & trace.

Client Signature:

Date:

Id Provided:

Therapist Name: