COVID-19 PRESCREENING

To ensure the safety of all our clients and practitioners, we require everyone to arrive wearing masks, remove shoes, wash hands and have their temperature taken. We ask that you arrive alone and no earlier than 5 minutes before your scheduled appointment. At Manhattan Healing Center, we are making every effort to ensure a sanitary, safe space. All beds are sanitized after each client; linens are replenished after each use; bathroom is disinfected after each use.

Name:

Address:

Email Address:

Cell Phone:

For your safety and the safety of all our clients and practitioners, thank you for taking the time to answer all questions honestly and to the best of your knowledge. An answer of YES does not exclude you from treatment. Please answer YES or NO to each of the following questions: *

QUESTION	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States, by air, bus or train within the past 14 days?	☐	☐
Do you have a weakened immune system?	☐	☐
Are you currently undergoing treatment for cancer, such as chemo or radiation therapy?	☐	☐
Do you take steroids for any conditions? Examples of common steroids are Cortisone, Prednisone, Methylprednisone. Contact your physician or our office if not sure. Also, answer YES if unsure.	☐	☐
Do you have an autoimmune disease such as Lupus, rheumatoid arthritis, multiple sclerosis, or psoriasis?	☐	☐
Do you have diabetes?	☐	☐
If so, do you have to take insulin injections?	☐	☐
Do you have asthma or COPD?	☐	☐

Explain any YES answers in the box below:

Signature: By typing your name in the box below, you acknowledge that your answers you provided are true and accurate to the best of your knowledge and with the full understanding and disclosure of the risks associated with receiving care during the Covid-19 pandemic.You agree not to hold any entities of this office responsible for any future conditions that you may acquire related to Covid-19*

Self Empowered Beauty
420 East 81st Street, Suite #1, NY NY 10028
917-658-1660

PROFILE SHEET (For internal records Only)

NAME OF CLIENT_____ TODAY'S DATE_____

ADDRESS_____

CITY, STATE & ZIP_____

OCCUPATION_____ DATE OF BIRTH_____ SEX M☐ F☐

CELL_____E-MAIL_____

FULL NAME AT BIRTH(requested for Biofeedback): _____

PLACE OF BIRTH (requested for Biofeedback): CITY/STATE_____ COUNTRY _____

To be completed by all Clients:

				If you answered YES to anything in this column, Microcurrent/Biofeedback should NOT be performed	
Number of cigarettes smoked per day		Number of alcohol drinks per day		Are you pregnant or possibly pregnant?	
Number of exercise sessions per week		Amount of sugar per day (1- minimal, 2- moderate, 3- excessive)		Do you have Epilepsy?	
Amount of toxic exposure such as radiation, chemicals, etc. (1- minimal, 2- moderate, 3- excessive)		Sensitivity to toxic exposure (1- minimal, 2- moderate, 3- excessive)		Do you have a pacemaker or heart condition?	
Stress Level (1- mild, 2- moderate, 3- severe)		Allergies (1- mild, 2- moderate, 3- severe)		Have you had fillers, botox or a chemical peel within the last 2 weeks?	

I understand that the attending practitioners are not allopathic doctors (MDs) and do not portray themselves to be but are providing biofeedback/micro-current/microchanneling/microneedling and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioners do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, we do not diagnose, treat or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending practitioners' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do biofeedback testing, wellness consultation and other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

_____ (initials)

CANCELLATION/RESCHEDULE POLICY (this information must be completed for the cancellation policy)
Cancellations/Rescheduling less than 1 day of the appointment will be charged the full appointment fee.

******For best results, drink 18oz of water before your session. If you wish to have numbing cream applied for MicroNeedling or MicroChanneling treatments, 20 additional minutes is needed. Make sure to book online or call the office in advance to schedule the time. There is a $20 charge for numbing cream.***

Thank You in advance for tipping your skin care specialist.

Signature: _____ Print Name _____Date _____

Relationship to Client: ☐Self ☐Other _____ Would you like to receive relevant articles occasionally? ☐Yes ☐No

Is Client specified above a minor, under 18 years of age? ☐Yes ☐No Would you like to receive promotions occasionally? ☐Yes ☐No

Note: Self Empowered Beauty agrees to keep all client information including history, discussions, procedures and results obtained from the above services strictly confidential and may not be shared with anybody unless authorized in writing by the client.

PHOTO CONSENT & RELEASE FORM

I the undersigned do hereby agree to the following. I am allowing Self Empowered Beauty or a staff member to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress.

In addition:

I give permission for my photos to be used for education._____ (please initial)

I give permission for my photos to be used for advertising._____ (please initial)

I give permission for my photos to be used for advertising with blurred eyes and my identity will

remain anonymous. _____ (please initial)

At my request, my photos will only be used for my chart. _____ (please initial)

I do not give permission for my photo to be used for any of the above. _____(please inital)

Print Name: _____

Signature: _____ Date: _____