



# Client Screening Form

In the current environment in which we work and play we have had to introduce this additional screening form to be completed. This is to ensure the health and wellbeing of all our clients we require every client to complete this form at every session until the COVID-19 situation ends. We apologise for the inconvenience and thank you for your co-operation.

## Personal Details

Date of visit: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Mobile: \_\_\_\_\_

Primary Doctor: **Name:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

## COVID-19 Screening Questions

Please indicate if you have experienced any of the following in the past 14 days:

- Fever
- Excessive tiredness
- Dry Cough
- Shortness of breath
- Sore Throat
- Anosmia (loss of smell)

Have any of your close contacts experience any of the above symptoms in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any of your close contacts had contact with any confirmed cases of COVID-19 in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any of your close contacts travelled interstate / overseas or to an identified COVID-19 "hotspot" in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any of your close contacts had contact with any confirmed cases of COVID-19 in the last days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Additional Information

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## Agreement

*I understand that, because massage 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 a massage from this practitioner. I understand that my contact details may be provided to the appropriate authorities for the purpose of contact tracing if required.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_