Covid-19 Specific Health Questionnaire

To best protect your health and the health of others, please fill out this form before your chiropractic session. Thank you!

Name: _____ Date: _____

Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test?

What were the results?

Have you been in places with a high infection rate within the last two weeks (e.g. state-designated "hotpots")? If yes, please explain.

Do you have any discomfort with exertion or exercise?

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

____ Fever

____ Chills

____ Cough

____ Sore throat

____ Diarrhea, digestive upset

____ Nasal, sinus congestion

____ Loss of sense of taste of smell

____ Fatigue

____ Shortness of breath

____ Sudden onset of muscle soreness (not related to a specific activity)

____ Rash, discoloration or skin lesions (especially on the feet)

Covid-19 Acknowledgment and Consent Form

Please initial beside each statement

_____ *I understand that close contact with people increases the risk of infection from COVID-19. By initialing here and signing this form, I acknowledge that I am aware of the risks involved and give consent to receive chiropractic treatment from Coastline Health and Chiropractic.*

_____ *I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.*

I declare that the information provided above is true and accurate to the best of the knowledge.

Signature: _____ Date: _____