COVID-19 screening

PERSONAL DETAILS

Date of visit:

Name:

Address:

Postcode:

Phone (home):

Mobile:

DOB:

Emergency contact:

Emergency number:

Please indicate if you are currently experiencing any of the following symptoms:

Fever	◯ Yes	◯ No	Excessive tiredness	◯ Yes	◯ No
Dry cough or sore throat	◯ Yes	◯ No	Shortness of breath	◯ Yes	◯ No
Runny nose	◯ Yes	◯ No	Loss of smell/taste	◯ Yes	◯ No
Unexplained muscle or joint pain	◯ Yes	◯ No	Upset stomach/diarrhoea	◯ Yes	◯ No
Headache	◯ Yes	◯ No	Loss of appetite	◯ Yes	◯ No

Have you or any of your close contacts experienced any of the above symptoms in the last 14 days?

◯ Yes ◯ No

Have you or any of your close contacts been near anyone diagnosed positive for COVID-19 in the last 14 days?

◯ Yes ◯ No

Have you or any of your close contacts travelled interstate, overseas or regionally to an identified COVID-19 "hotspot" in the last 14 days?

◯ Yes ◯ No

I understand that because massage involves touch and close physical proximity over an extended period of time there may be an elevated risk of disease transmission, including COVID-19. The therapist has explained the risks to me and I consent to receive massage. I also consent to having my contact information shared with the relevant government authorities in the event that contact tracing is required.

Signature *Date*

Therapist to complete:

Was any PPE used during the treatment session? ◯ Yes ◯ No

Surgical mask for therapist? ◯ Yes ◯ No Surgical mask for client? ◯ Yes ◯ No

Other adjustments (e.g. temperature check):

Signature *Date*