COVID-19 Health Information & Informed Consent

Client Name: ______________________________________
Date: ____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

1.) Since your infection, have you talked to your doctor about returning to massage therapy?

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2.) Do you have any **new** (that is, since your infection) skin marks, lesions, or rashes, especially on the toes, but anywhere on the body?

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3.) Do you have any **new** (that is, since your infection) experience of ***severe*** deep muscle or joint pain—unrelated to recent physical activity?___________________

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4.)Do you have any **new** (that is, since your infection) discomfort with exertion?

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5.)Are you taking any drugs to manage blood clotting?__________________________

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Client Signature:____

Date:_______________________________________