**COVID-19 Client Pre-Consultation Form**

**(Please read, you will be asked to sign on arrival for your appointment.)**

To help prevent the spread of COVID-19 in the clinic and local community, I am asking each client to complete and sign this form before their treatment. This form has already been sent to you by text, email or verbally over the phone.  These are extra measures to safeguard my clients prior to arrival. I kindly ask you to complete this declaration for the safety of you, my clients and me.

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| **Client Name:**    | **Therapist Name:**   Pre-screening questionnaire received: **Yes/No**  |

**QUESTIONS**

Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness, or flu like symptoms now or in the past 14 days? **Yes/No**

Have you been diagnosed with confirmed or suspected COVID-19 infection in

the last 14 days? **Yes/No**

Are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2 meters for more than 15 minutes                             **Yes/No**

Have you been advised by a doctor to self-isolate at this time? **Yes/No**

Have you been advised by a doctor to cocoon at this time? **Yes/No**

Do you consider yourself to be in the category of people at higher risk from

Covid 19? **Yes/No**

**If your situation changes after you complete and submit this form you agree to inform me before attending for you appointment.**

Please enter any other information you feel is relevant.

**Clients Signature……………………………………………….       Date…………………………**