Body Wisdom Therapeutic Massage & Wellness

COVID-19 Intake Questionnaire, Waiver & Consent

Name:_____ Date:_____

Address:_____

Cell Phone Number: _____ Home Phone Number:_____

E-Mail Adddress: _____

1. Can you exercise to get your heart rate and respiratory rate up without any problem? ____
2. Have you had a new onset of muscle aches and pain since the emergence of the virus?____
3. Have you seen any new marks, rashes, spots, bumps or other lesions on your skin? ____
4. Do you now have or have you had in the past 14-21 days a fever? ____
5. Do you now have shortness of breath or difficulty breathing? ____
6. Do you have persistent pain or pressure in the chest? _____
7. Have you had new confusion? ___
8. Do you have a cough? ____
9. Do you have gastrointestinal upset? ___
10. Do you have general muscle aches for unknown reasons? ____
11. Do you have a headache? ____
12. Do you feel fatigued?____ Do you have difficulty waking up or staying awake?___
13. Have you had bluish lips or face? ___
14. Have you had a loss of sense of smell or taste? ____
15. Have you noticed a change in the circulation of your fingers or toes? ___
16. Have you tested positive for COVID-19 within the past 14 days? ____
17. Has someone you have been in close contact with been confirmed to be COVID-19 positive within the past 14 days? ____

18. Have you been in close contact with someone suspected to be suffering from COVID-19 in the past 14 days? ____
19. Have you traveled by air, train or bus in the past 14 days?
20. Have you traveled out of New York State or the northern tier of Pennsylvania in the past 14 days?
21. In the past 14 days have you traveled to an area with spiking COVID-19 cases, including, but not limited to Alabama, Arkansas, Arizona, North Carolina, South Carolina, Texas, Florida, Utah or Washington?
22. Are you over the age of 60? ____
23. Do you have heart disease, lung disease, kidney disease, diabetes or any autoimmune disorders? _____

I,_____, confirm that I am free of symptoms of COVID-19, that I have not had a positive test for COVID-19 in the past 14 days, that, to my knowledge, I have not been in contact with a someone confirmed or suspected of having COVID-19 within the past 14 days. I further acknowledge that all of the long and short-term effects of COVID-19 are unknown at this time, but which are known, in some cases, to include coagulopathy (clotting disorders) which could result in stroke, and I affirm that my responses to the foregoing questions are true to the best of my knowledge. I understand that close contact with people in confined spaces increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved in receiving massage and consent to receive massage from Donna M. Hutchison, LMT.

_____ Date: _____

I understand that my name and contact information might be shared with the State and local Health Department in the event that a client or practitioner in this studio tests positive for COVID-19. I consent to the disclosure of my contact details with the Health Department or other appropriate entity in the event that they are relevant based on suspected exposure date.

_____ Date: _____