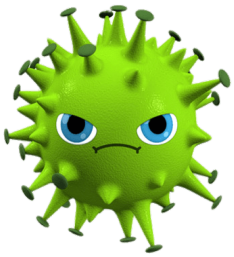

COVID-19 SCREENING QUESTIONARE

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

Have you been tested for Covid-19? ***Yes No***

Have you tested positive for Covid-19? ***Yes No***

In the last 14 days, have you traveled or had contact with persons who have traveled to places with a high infectious rate or to a country outside of the US? ***Yes No***

If yes, please explain.

In the last 14 days have you been in close contact with someone who has tested positive for Covid-19? ***Yes No***

Please circle any of the following that you have experienced in the last 72 hours.

FEVER or ABOVE NORMAL TEMPERATURE *CHILLS*

COUGH *SORE THROAT* *DIARRHEA/DIGESTIVE UPSET*

SHORTNESS OF BREATH/TROUBLE BREATHING *FATIGUE*

LOSS OF SENSE OF SMELL OR TASTE *RUNNY NOSE*

RASH OR SKIN LESION (especially on the feet)

By signing this document, I declare that the information provided above is true and accurate to the best of my knowledge.

Print name: ***Signature:*** ***Date:***