COVID-19 Symptom Questionnaire/ Waiver for Emily Klik LMT, CST CranioSacral Therapy

Client first Name_____Client last Name _____

Name of guardian/ parent if visit is for a minor client:_____

In the past 2 weeks, have you experienced any of the following (circle any that apply):

Fever
Cough
Sore throat
Shortness of breath
Fatigue
Chills
Sores on toes
Sudden loss of taste or smell
Nasal or sinus congestion
Sudden onset body aches
New rash or other changes to your skin
Loose/ runny stool
New digestive GI/ upset

Have you had COVID-19 ? Yes / No When? _____

If you have had a recent test for covid-19, what was the date of your most recent test?_____

Outcome of most recent test? Positive / Negative

Are you aware of any potential exposure to COVID-19 in the past week, direct or indirect? Yes / No

Have you been vaccinated against the COVID-19 virus? Yes / No

Which vaccine? Pfizer / Moderna / J & J **Date/s: _____ & _____**

Date of booster if applicable_____

_____ There have been no changes since last appointment on _____

Liability waiver: I understand that, because therapeutic bodywork like craniosacral therapy and massage involve maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved with receiving treatment / bodywork / manual therapy at this time, I voluntarily agree to assume responsibility for those risks in full, and I release and hold harmless Emily Klik from any present and future claims related thereto. I give my consent to receive craniosacral therapy and/or massage therapy from Emily Klik, LMT, CST.

Client/ Guardian signature: _____

Temperature:_____ Date: _____