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

Due to the COVID-19 pandemic, please fill this intake form at the start of each session.

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

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 and Jill Wolf 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: _______________________________