



kristina koestler

## CLIENT COVID-19 CONSENT FORM

Client Name	
Address	
Mobile	
Email address	

### COVID-19 Screening information

Have you had a fever in the last 7 days? (feeling hot to touch on your chest and back)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you now, or have you recently had a persistent dry cough? (coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you been told to stay home, self-isolate or self-quarantine?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any other symptoms such as loss of taste and smell, unusual fatigue, shortness of breath?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you tested positive or had treatment for COVID-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a Covid-19 test ? Antigen or Antibody test? <b>Antigen</b> - tests for Covid-19 on day of testing. <b>Antibody</b> - possible immunity	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you or anyone that you live with fall into the 'clinically vulnerable' or 'clinically extremely vulnerable' categories and therefore advised to shield at home by the government?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

### Client Consent for treatment

I understand that, because my treatment may involve close contact with my practitioner, there may be an elevated risk of disease transmission, including Covid-19.

I give my consent to receive treatment from this practitioner and am satisfied with COVID hygiene protocols put in place. **Yes/No** Signed \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_