CORONAVIRUS SELF –ASSESSMENT FORM

NAME _____

PERSONAL EMAIL _____

ADDRESS _____

HAVE YOU BEEN TO ONE OF THE COVID-19 AFFECTED COUNTRIES OR STATES

IN THE LAST 14 DAYS

YES_____ NO _____

WHICH STATES OR COUNTRIES _____

ARE YOU CURRENTLY EXPERIENCING SYMPTOMS, COUGH, SHORTNESS OF BREATH, FEVER, MUSCLE ACHES, FATIGUE, DRY COUGH, CHILLS

YES_____ NO _____

SYMPTONS_____

IF YOU ARE EXPERIENCING SYMPTONS YOUR SESSIONS WILL BE RESCHEDULED AFTER YOU HAVE QUARANTINE FOR 14 DAYS.

TEMP CHECK

READING _____

MASK REQUIREMENT DURING SESSION. NO TALKING DURING SESSION DUE TO CLOSE CONTACT BETWEEN PRACTITIONER AND CLIENT.