COVID-19 Health Information

Client Name: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health pandemic. Please read and fill out this form and let me know if you have any questions.

Have you been tested for COVID-19? ☐ Yes ☐ No

If yes, what type of test did you have? _____

Date of last test: _____ Result: _____

Have you had a fever in the last 24 hours of 100° F or above? ☐ Yes ☐ No

Have you been in places with a high infection rate within the last two weeks (e.g., state-designated "hotspots")? ☐ Yes ☐ No *If yes, please explain / location:*

_____

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus symptoms? ☐ Yes ☐ No

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

☐ Fever ☐ Nasal, sinus congestion ☐ Shortness of Breath

☐ Chills ☐ Loss of sense of taste or smell ☐ Fatigue

☐ Cough ☐ Sore Throat ☐ Diarrhea, digestive upset

☐ Sudden onset of muscle soreness *(not related to a specific activity)*

☐ Rash or skin lesions (especially on the feet)

Do you have any discomfort with exertion or exercise? ☐ Yes ☐ No

I declare that the information provided above is true and accurate to the best of my knowledge.

_____ _____ _____

(print name) (signature) (date)

At your next appointment, please review this questionnaire and sign and date on the back of this form.

COVID-19 Health Information Questionnaire

Client Name: _____

Have any of your responses to the questionnaire changed? □ Yes □ No
If no please sign and date below.
If yes, please fill out a new questionnaire.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____