Intake Form Addendum

Active Health Massage Therapy & Fitness

To best protect your health and the health of others, please fill out this form before each massage and bodywork session. *Thank you!*

NAME: _____ DATE:_____

Have you been tested for COVID-19? If yes, what type of test did you have? _____

*When was your test?*_____

*What were the results?*_____

Have you been in places with a high infection rate within the last two weeks (e.g., state designated "hotspots")? If yes, please explain.

_____
_____

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

____ Fever
____ Chills
____ Cough
____ Sore throat
____ Diarrhea, digestive upset
____ Nasal, sinus congestion
____ Loss of sense of taste or smell
____ Fatigue
____ Shortness of breath
____ Sudden onset of muscle soreness (not related to a specific activity)
____ Rash or skin lesions (especially on the feet)
____ New discomfort with exertion or exercise

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

_____
(print name)

_____
_____
(signature)
(date)