**COVID-19 Health Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 Information**

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, headache, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐
4. Have you traveled anywhere outside of the state or been in close contact with someone who has been out of the state in the last two weeks? Yes ☐ No ☐

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

***The following questions are specific to a new aspect of COVID-19 involving blood coagulation.***

1. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐
2. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐
3. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

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