Chiropractic Family Wellness Center

COVID-19 Massage Questionnaire

Patient Name: _____

Due to the COVID-19 pandemic we kindly ask that our massage patients complete this brief survey and sign below to ensure the safety of our patients and therapists. Our therapists are taking every precaution necessary to limit the spread of this disease including but not limited to: taking therapist temperatures daily, taking patient temperatures before each massage, mask wearing, sanitizing room and linens thoroughly between appointments, and frequent hand washing before and after each patient.

Please answer the questions below:

1. Are you ill or have you been caring for anyone who is ill in the last 15 days?

   □ Yes □ No

2. Have you experienced any coughing, fever, chills, shortness of breath, or lost of taste or smell?

   □ Yes □ No

3. Have you recently traveled to any of the COVID-19 hotspots within the last 15 days?

   □ Yes □ No

4. Have you been in contact with anyone that has tested positive for COVID-19 within the past 15 days?

   □ Yes □ No

In signing this survey you acknowledge that you are answering truthfully and understand that COVID-19 is an infectious disease that is still being studied on how it is spread and you are receiving this massage at your own risk.

I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner

Patient Signature**:** _____

For Office Use Only

Patient Temperature: _____

Therapist Signature:_____ Date:_____