COVID-19 Intake Form

Be sure to give complete and accurate information to the best of your knowledge. Please seek immediate medical attention if you have any of the severe COVID-19 signs listed below.

Name: Phone:

Have you had a fever in the past 24 hours above 100 degrees F? Yes or No

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 or No

In the past 14 days, have you experienced: (place a check mark if YES)

Unexplained body aches or pain?

Coughing?

Sore throat?

Shortness of breath?

Chills with or without body aches?

Recent loss of taste or smell?

Unexplained sores on the soles of the feet?

Unusual fatigue?

Non allergy-related runny nose?

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from Good Karma Massage Studio.

Signature: Date: