COVID-19 screening

PERSONAL DETAILS

Date of visit:

Name:

Address:

Postcode:

Phone (home):

Mobile:

DOB:

Emergency contact:

Emergency number:

Have you, any of your close contacts or any household members experienced any of the following symptoms of COVID-19 in the past 14 days

Fever	Yes	No		Excessive tiredness	Yes	No	
Dry cough or sore throat	Yes	No		Shortness of breath	Yes	No	
Runny nose	Yes	No		Loss of smell/taste	Yes	No	
Unexplained muscle or joint pain	Yes	No		Vomiting/diarrhoea	Yes	No	
Headache	Yes	No		Loss of appetite	Yes	No	

Are you or any of your close contacts and household members awaiting results of a COVID-19 test or been confirmed positive for COVID-19?

Yes No

Have you been identified as a close contact or do you live with someone who has been advised to self isolate?

Yes No

Have you or any of your close contacts travelled interstate, overseas or regionally to an identified COVID-19 "hotspot" in the last 14 days?

Yes No

I understand that because massage involves touch and close physical proximity over an extended period of time there may be an elevated risk of disease transmission, including COVID-19. I also understand that even if an individual has received a vaccination against COVID-19 that they may still contract and transmit the virus to other individuals. The therapist has explained the risks to me and I consent to receive massage. I consent to having my contact information shared with the relevant government authorities in the event that contact tracing is required.

Signature *Date*

Therapist to complete:

Mask worn by therapist	N95	Surgical	None	
Mask worn by client	N95	Surgical	Cloth	None
Target CO_2 ppm for treatment room		Maximum CO_2 ppm achieved during treatment session		
Ventilation strategies used	HEPA filtration	Window	Door	