COVID-19 Health Information & Informed Consent

Client Name: ____
Date: ______________________

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read & fill out this form carefully & let me know if you have any questions.

COVID-19 Related Health Information

1. Have you had a fever in the last 24 hours? *Yes* *No*
2. Do you now, or have you recently had, any respiratory or flu symptoms (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 in the last two weeks?

   Yes *No* *Location:* __________________________
5. Have you had a new loss of sense of taste or smell?

   Yes *No*

The following questions are specific to blood coagulation as it refers to COVID-19

6. Can you exercise to get your heart rate & respiratory rate up without any problem? *Yes* *No*
7. Have you seen any new marks, rashes, spots, bumps or other lesions on your skin? *Yes* *No*