

# COVID-19 INTAKE FORM

This form is to be filled out for every client, every time that they come for an appointment.

**Client Name** \_\_\_\_\_

**Date** \_\_\_\_\_ **Phone** \_\_\_\_\_.

I consent to having my temperature taken and recorded in this intake form, which will become part of my treatment record.

Client Signature: \_\_\_\_\_

**\*\*\* THIS PORTION IS NOT REQUIRED BUT IS STRONGLY RECOMMENDED\*\*\***

**Current temperature?** \_\_\_\_\_

**Signs of a fever:**

- in adults: 38°C (100.4°F) and above,
- in older adults: 37.8°C (100°F) and above,
- in children: 38°C (100.4°F) and above
- or 1.1°C above the person's usual value

**Is the temperature above 38°C (100.4°F)?**

☐ YES    NO    ☐

Therapist Read the following Statement aloud:

- In order to protect yourself, your therapist, honest disclosure about your health and other activities is essential. Please answer the following questions with a yes or a no answer

**Are you experiencing any of the following?**

- severe difficulty breathing (e.g., struggling for each breath, speaking in single words)
- severe chest pain
- having an extremely hard time waking up
- feeling confused
- lost consciousness

☐ YES    NO    ☐

**Are you experiencing any of the following?**

- shortness of breath at rest
- inability to lie down because of difficulty breathing
- chronic health conditions that you are having difficulty managing because of your current respiratory illness

☐ YES    NO    ☐

**Do you have any of the following?**

- fever
- new onset of cough or worsening of chronic cough
- new or worsening shortness of breath
- new or worsening difficulty breathing
- sore throat
- runny nose

☐ YES    NO    ☐

**Do you have any of the following?**

- chills
- painful swallowing
- stuffy nose
- headache
- muscle or joint ache
- feeling unwell, fatigue or severe exhaustion
- nausea, vomiting, diarrhea, or unexplained loss of appetite
- loss of sense of smell or taste
- conjunctivitis (pink eye)

☐ YES    NO    ☐

**In the past 14 days, did you return from travel outside of Canada, or did you have close contact with someone who is confirmed as having COVID-19?**

☐ YES    NO    ☐

**If the client answered yes to any of these questions they are absolutely contraindicated for massage or manual osteopathic treatment. TREATMENT UNDER THESE CONDITIONS CANNOT PROCEED! They need to be instructed to self-isolate and contact the local health authority about their symptoms.**

You have a responsibility to help prevent the spread of COVID-19. There are steps you can take to protect yourself and others.

- Practice **physical distancing**. This is not the same as **self-isolation**. You do not need to remain indoors, but you do need to avoid being in close contact with people.
- Practice good hygiene: wash hands often, cover coughs and sneezes, and avoid touching your face.
- Monitor for COVID-19 symptoms: fever, cough, shortness of breath, sore throat, or runny nose.

**If you do develop any COVID-19 symptoms, stay home, and take this self-assessment again.**

**Form Completed By:\_\_\_\_\_Date:\_\_\_\_\_**