**COVID-19 QUESTIONNAIRE AND DISCLAIMER** N.B. Every question **must** be answered.

|  |  |
| --- | --- |
| CLIENT Name:  | CLINIC HEALING HANDS  |
|   |
| Question  | Yes / No  |
| 1. Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the past 14 days any bruises or rashes?  |   |
| 2. Have you been diagnosed with confirmed or suspected COVID19 infection in the last 14 days?  |   |
| 3. Are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2 metres for more than 15 minutes accumulative in 1 day)?  |   |
| 4. Have you been advised by a doctor to self-isolate at this time?  |   |
| 5. Have you been advised by a doctor to cocoon at this time?  |   |
| 6. Please provide details below of any other circumstances relating to COVID-19, not included in the above, which may need to be considered to allow your TREATMENT.  |
|  7. Have you returned from another country in the last 14 days, and have you self isolated? \_\_\_\_\_\_\_\_\_\_\_\_   |

**TEMPERATURE CHECK DATED; (Taken in clinic)**

**HAVE YOU ANY ALLERGIES TO CLEANING PRODUCTS, LATEX OR**

**POWDER?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU ANY UNDERLYING MEDICAL CONDITIONS YOU ARE**

**WORRIED ABOUT? OR ANY MEDICAL ISSUES SINCE YOU WERE LAST IN THE CLINIC? IF SO PLEASE DISCUSS WITH ME ASAP.**

**I AM KEEPING A TRACK AND TRACE RECORD. DUE TO GDPR**

**REGULATIONS, PLEASE CONFIRM THAT YOU AGREE TO BE**

**CONTACTED AND YOUR CONTACT DETAILS PASSED ON TO THE APPROPRIATE PERSONS SHOULD THE NEED ARISE. I WILL INFORM YOU IN ADVANCE IF THESE MEASURES NEED TO BE TAKEN.**

**IT IS VITAL THAT IF YOU EXPERIENCE ANY OF THE COVID-19 SYMPTOMS UP TO THE MORNING OF YOUR APPOINTMENT, CONTACT THE CLINIC IMMEDIATELY.**

**Have you read the regulations/protocol and agree to same?\_\_\_\_\_\_\_\_\_ SIGNED :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\* If your situation changes after you complete and submit this form, PLEASE PHONE ME

STRAIGHT AWAY. NEW CLIENTS TO THE CLINIC, WILL HAVE TO PRE-SCHEDULE A

WHATSAPP/ZOOM CHAT BEFOREHAND. A DETAILED CONSULTATION WILL BE DISCUSSED.

PLEASE NOTE, A 48 HOUR CANCELLATION POLICY IS IN PLACE, FAILURE TO CANCEL YOUR APPOINTMENT WITHIN THE 48 HOURS, WILL RESULT IN PAYMENT OF FEE FOR TREATMENT SCHEDULED.

Print

Name:……………………………………………….Signature……………………………………………Date:……………

# Please update your email address here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISCLAIMER;** **I BERNADETTE DOYLE, AM CURRENTLY**

**FREE OF COVID-19 SYMPTOMS, HAVE NOT BEEN IN CONTACT WITH ANYONE CURRENTLY SUFFERING COVID19 OR WHO IS SELF ISOLATING.**

**I HAVE TAKEN AND RECORDED MY TEMPERATURE EACH MORNING.**

**SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**