A Matter of Muscles

THERAPEUTIC MASSAGE

Restoring balance to relieve discomfort

COVID-19 Supplemental Intake & Waiver

Name: ____ Date of Birth: __________________

Phone: (______) ______ - __________ Email: _____________________________________

Have you been tested for COVID-19? ◯ Yes ◯ No

If yes, what type of test did you have? ◯ Nasal ◯ Blood ◯ Antibody ◯ Other _______________

Date of Test (Approximate): _______________________ Test Results: ◯ Positive ◯ Negative

Have you experienced any of the following as a NEW PATTERN since the start of the pandemic?
◯ Yes ◯ No

__ Fever
__ Chills
__ Cough
__ Fatigue
__ Sore Throat
__ Diarrhea, digestive upset
__ Nasal, sinus congestion
__ Sudden onset of muscle soreness (not related to a specific activity)
__ Loss of sense of taste or smell
__ Shortness of breath
__ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise? ◯ Yes ◯ No If yes, please explain:

____

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Have you been asked to self-isolate or quarantine in the last 14 days? ◯ Yes ◯ No

Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flu-like symptoms within the last 14 days? ◯ Yes ◯ No

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from Caite Craddock, LMT of A Matter of Muscles, LLC.

I further understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Name: ______________________________________

Client Signature: ______________________________________ Date: _______________

Official Use Only

Date of Vaccination$_1$: ____/____/______

Temperature(°F) __________

Date of Vaccination$_2$: ____/____/______