



Coronavirus Pre-Treatment Questionnaire & Declaration

Client Full Name.....

DateTimeTemperature

Contact Number: Email:

Section 1: COVID-19 Questionnaire (To be completed upon arrival)

	Yes	No
Have you or anyone you reside with or care for suffered from any of the below recognised symptoms of, or tested positive for coronavirus within the last 14 days? <ul style="list-style-type: none">• A high temperature• A new, continuous cough• Loss or change to your sense of smell or taste		
• Have you have been in contact with a person suffering with any of the above recognised symptoms, or who has tested positive for coronavirus within the last 14 days?		
• Do you have a health condition outlined by public health England which may leave you more vulnerable to contracting or more susceptible to the effects of coronavirus?		
• Have you, or anyone you live with/care for been told to shield for any reason in relation to coronavirus?		

Section 2: Declaration

- I solemnly and sincerely declare that I have provided true and correct information to all questions asked of me within this document and the consultation conducted as part of this booking.
- I understand that any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.
- I understand it is my duty to inform my therapist of the following immediately if:
 - I or anyone I reside with or care for develops any of the symptoms outlined in section 1 or is tested positive for coronavirus in the 14 days following my treatment.
 - I subsequently learn that someone I reside with, care for or came into close contact with was suffering with the symptoms outlined in section 1 or was tested positive for coronavirus in the 14 days preceding my treatment.

I consent to my details being passed to the NHS Test & Trace service if required.

Client Signature.....Date

Therapist SignatureDate.....