

COVID-19 CLIENT PRE-APPOINTMENT CONSULTATION FORM

It is required under some State Government Regulations to complete this form and email it back to us prior to your appointment. When you come to your appointment please follow these general rules:

- Wash your hands or use hand sanitiser provided upon arrival
 - Please come alone to your treatment
 - Please wait outside if you arrive early
 - Please bring your own blanket should you get cold during treatment
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FULL NAME:

PHONE NUMBER:

ADDRESS:

EMAIL ADDRESS:

DATE & TIME OF APPOINTMENT:

PLEASE CIRCLE AN ANSWER TO THE FOLLOWING QUESTIONS:

1. Have you been in contact with anyone with a confirmed case of COVID-19? Yes/No

2. Have you had any of the following symptoms in the past 14 days?

Fever? Yes/No

Dry Cough? Yes/No

Extreme tiredness Yes/No

Difficulty breathing or shortness of breath? Yes/No

Chest pain or pressure on chest? Yes/No

Loss of speech or movement? Yes/No

3. Have you been in contact with anyone with any of the following symptoms?

Fever? Yes/No

Dry Cough? Yes/No

Extreme tiredness Yes/No

Difficulty breathing or shortness of breath? Yes/No

Chest pain or pressure on chest? Yes/No

Loss of speech or movement? Yes/No

4. Have you travelled overseas in the last 14 days? Yes/No

5. Have you been in contact with any persons who have travelled from overseas in the past 14 days? Yes/No

6. Have you been in contact with any persons who cares for and/or treats COVID-19 related cases? Yes/No

When completing this form, you have acknowledged your responsibilities in managing your own personal health in relation to COVID-19 and confirm the information you have provided is correct.

Signed (Full name):

Date:

Note: If you answered yes to any of these questions, we will not be able to treat you, and suggest you seek medical advice.