# COVID-19 Intake Form:

If you have been to a COVID-19-impacted area or have been in close contact with a person infected with COVID-19, I ask that you please reschedule your appointment for at least 14 days past the date of contact.

Please note, InSync Massage Therapy (Anja Wuerminghausen) is requesting that you wear a face mask when you arrive for your appointment. I will wear one as well throughout the session. The mask protocol is consistent with the CDC's recommendation to the general public, Ohio State Medical Board, AMTA and ABMP recommendations for offices of health care providers.

**Please mark the following health questions with "yes" or "no":**

Have you had a fever in the last 24 hours of 100°F or above?
Yes☐ No☐

Do you now, or have you recently had, any respiratory or flu symptoms, a fever, sore throat, shortness of breath, loss of smell or taste, Covid-19 toes (lesions/purple toes), nausea, diarrhea, extreme fatigue, unusual headaches?
Yes☐ No☐

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus type symptoms?
Yes☐ No☐

Do you have any serious underlying medical condition, such as heart or lung disease, moderate or severe asthma, COPD, diabetes or a suppressed immune system (liver or kidney disease with dialysis, cancer treatments, etc.)?
Yes☐ No☐

Have you traveled anywhere outside of the state in the last two weeks?
Yes ☐ No ☐ Location: _____

***The following questions are specific to a new aspect of COVID-19 involving blood coagulation:***

Can you exercise to get your heart rate and respiratory rate up without any problem?
Yes ☐ No ☐

Have you had a new onset of muscle aches and pain since the emergence of the virus?
Yes ☐ No ☐

Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?
Yes ☐ No ☐

For contact tracing and to avoid infection to others, you agree that you will call InSync Massage Therapy LLC (330 412 2059) if you start showing any apparent COVID-19 symptoms within the next 14 days after a treatment. _____

**Consent for Treatment to Proceed with receiving care:**

I confirm and understand the following (*Please initial in all places provided*): I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding

recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____