Pre-Screen Assessment Questionnaire / Waiver
Inspired Touch Therapeutic Massage, PLLC

Name _____ Date of Birth_____

Phone _____ Email _____

Address _____

City _____ State _____ Zip _____

Temperature upon arrival for today's appointment

Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days?

Yes No

Have you experienced any cold or flu-like symptoms (fever, cough, shortness of breath or other respiratory issues) 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

Have you been in places with a high infection rate within the last 2 weeks (e.g., state designated “hotspots”)? If yes, please explain below.

Yes No

Please circle if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

Fever Chills Cough Sore throat Shortness of breath Nasal, sinus congestion

Loss of sense of taste or smell Rash or skin lesions (especially on feet) Fatigue

Sudden onset of muscle soreness (not related to a specific activity) Diarrhea, digestive upset

Have you been tested for COVID-19? Yes No

If yes, at what location?

What type of test did you have? Viral Antibody Both

What were your test results? Negative Positive

I understand that close contact with people increases the risk of infection from COVID-19 and that the very nature of massage therapy poses that possibility to exposure and or its transmission.

To help mitigate the possible transmission of COVID-19 both Client and Therapist agree to wear protective face masks or coverings while on the premises of Inspired Touch.

I understand that my name and contact information might be shared with the state health department for contact tracing, in the unlikely 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.

I declare that the information provided above is true and accurate to the best of my knowledge and that by signing this form I acknowledge that I am aware of the risks involved. The practitioner providing today's service and Inspired Touch Therapeutic Massage, pllc will not be held liable or responsible if I become ill following my appointment. If you do become ill, you must let us know immediately.

I give my consent to receiving massage / bodywork.

Signature _____ Date _____