Full Circle Massage Therapy
COVID-19 SCREENING FORM

•Client Name:_____
•As per the CDC every client must be screened for possible COVID19 exposure. Following the CDC guidelines, If “yes” is answered to any of these questions your appointment will be rescheduled 14 days from its original date.

1. Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?
YES_____ NO_____

2. Have you or anyone in your household been tested for COVID-19 and been found positive?
YES_____ NO_____

3. Have you or anyone in your household visited or received treatment in a nursing home, long-term care, or other long term health care facility in the past 30 days?
YES_____ NO_____

4. Do you have any reason to believe anyone in your household has been exposed to or acquired COVID-19?

YES_____ NO_____

5. Have you been in close proximity to any individual who tested positive for COVID-19?
YES_____ NO_____

X_____
Client Signature