TBW Covid-19 Pre & Post Session Health Questionnaire

Client Name-

Date of Invoice- DOS-

- Have you experienced any cold or flu-like symptoms in the last 14 days? Yes / No
- Has a health professional asked you to self-isolate or quarantine in the last 14 days? Yes / No
- Have you been in close contact with someone experiencing a cold or flu-like symptoms in the last 14 days? Yes / No
- Have you cared for someone who has tested (+) for Covid-19 in the last 14 days? Yes / No
- Have you been tested for Covid-19 in the last 14 days?

  Yes- result- No

- Any symptoms coming on of illness?

  Yes- No
- Any other new or unusual symptoms?

  Yes- No

What brings you in for massage today / areas of focus?

Client sig. / Date_____