**COVID-19 Client Pre-Entry Consultation Form**

* When you come to your appointment please ensure you arrive on time and alone and use the hand sanitiser at the front door upon arrival.

Have you been in contact with a person with a confirmed case of COVID-19? ▢ Yes ▢ No

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

Fever ▢ Yes ▢ No

Dry cough ▢ Yes ▢ No

Extreme fatigue ▢ Yes ▢ No

Difficulty breathing or shortness of breath ▢ Yes ▢ No

Chest pain or pressure? ▢ Yes ▢ No

Have you been in contact with anyone with any of the above symptoms? ▢ Yes ▢ No

Have you travelled overseas in the past 14 days? ▢ Yes ▢ No

Have you been in contact any persons who have travelled form overseas
in the past 14 day? ▢ Yes ▢ No

**If you have answered YES to any of the above, unfortunately I am unable to provide you my service at this time. I recommend you seek medical treatment and advice and encourage you to reschedule your booking.**

**By signing and submitting this consultation form you acknowledge your responsibilities in managing your own personal health in relation to COVID-19 and confirm all the above information is true and correct at the time of submission.**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_