Covid-19 Pandemic Client Disclosure

During the past 14 days have you had, or currently have:

Fever or chills	Yes	No
Dry cough	Yes	No
Sore throat	Yes	No
Shortness of breath or trouble breathing	Yes	No
Loss of taste or smell	Yes	No
Nasal congestion or a runny nose	Yes	No
Diarrhea	Yes	No
Been exposed to someone with COVID19	Yes	No
Traveled by airplane, train, bus, or out of state	Yes	No
Have you had COVID-19 or have had a positive antigen test?	Yes	No

Consent for Treatment

I have received and read the new protocols for receiving treatments with Monique Gaboury L.Ac., CST I understand that, because the treatments involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time. I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Print Name _____

Date _____

Signature _____