CORE
fitness + physical therapy

2940 West 95th Street
Evergreen Park, IL 60805
708.422.0990
Fax 708.422.7130
www.corefitnesspt.com

COVID-19 Client Health-Screening Form

Client Name_____ Date_____

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 in the last 14 days (fever, cough, shortness of breath or other respiratory problem)?	❑ Yes	❑ No
Have you had close contact with or cared for sorreone diagnosed with COVID-19 within the last 14 days?	❑ Yes	❑ No

I understand.that, because massage therapy work invo/ve -maintained 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 and give consent to receive massage and bodywork from this practitioner.

Client Name_____ Date_____

Internal Use Only:

Does the Client have a temperature reading of 100.4 degrees or higher? ❑ Yes ❑ No

Staff Member Confirming Form _____ Date_____

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Massage Therapy Client Health Intake Form

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone (home)_____ (work / cell)_____

E-mail_____

Occupation_____ Date of Birth_____

Emergency Contact Person_____ Phone_____

Are you currently under a physicians care for an acute or chronic illness? ❑ Yes ❑ No

If yes please explain: _____

If yes, who is your health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? ❑ Yes ❑ No

If yes please explain: _____

Have you received a massage before? ❑ Yes ❑ No

If yes, when: _____

How did you hear about me?_____

What are your goals for this session?_____

Please list areas of tension, stress and/or pain you wish to be addressed_____

Health Information

Please mark an (**X**) by all current conditions and a (**P**) for all past conditions

____Abdominal/digestive problems	____Diabetes	____Pregnancy
____Allergies	____Fatigue	____Rash/fungus
____Anxiety	____Headaches, migraine	____Sinus problems
____Arthritis/tendonitis	____Hearing problems	____Sleep difficulties
____Asthma or lung condition	____Hernia	____Spinal disorders
____Athletles foot	____High blood pressure	____Sprain/strain
____Blood clots	____Jaw pain/TMJ pain	____Tension/stress
____Chronic pain	____Low blood pressure	____Vision problems
____Circulatory/heart problems	____Muscle/bone injuries	____Varicose veins
____Constipation/diarrhea	____Muscle/joint pain	____Other
____Depression	____Numbness/tingling	_____

Health Information. . . continued

Elaborate on noted areas on the previous page_____

_____

Please list any recent injuries or surgeries within the past 5 years_____

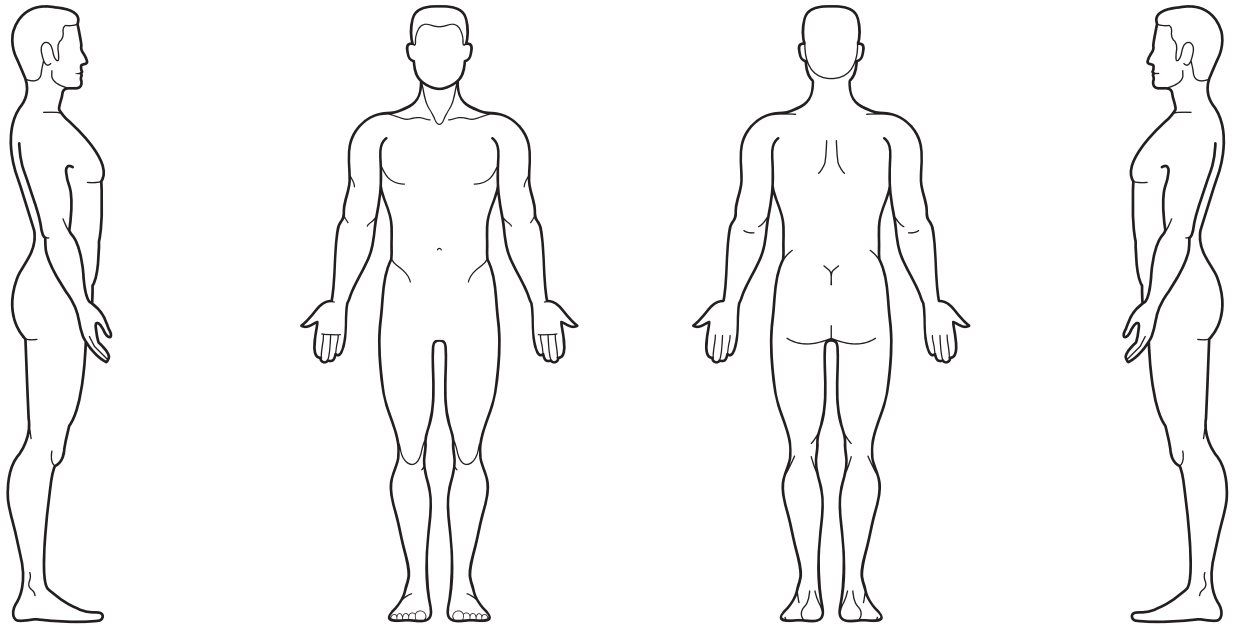
_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation_____

_____

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



RIGHT FRONT BACK LEFT

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or method, can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulation, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policy. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature_____ Date_____

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Massage Cancellation Policy

If you cannot attend your massage appointment, kindly provide 24 hours notice.

I understand if I do not provide at least 4 hours notice, my card will be charged a $25 fee.

Signature_____ Date_____