HARMONIOUS TOUCH
TAWNY MORENO, LMT

Practitioner: _____

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below;

1. Have you had a fever in the last 24 hours of 100 degrees F temp or above? Yes ___No___
2. Do you now, or have you recently had, any respiratory or flu symptoms, including but not limited to: fever, chills, sore throat, cough, shortness of breath, muscle aches or pain, nausea, vomiting, or diarrhea? Yes _____No_____
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes _____No_____
4. Have you traveled anywhere outside of the state in the last two weeks? Yes____No____
5. Have you had a new loss of sense of taste or smell? Yes _____No_____

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes _____No_____
7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes_____ No_____
8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes _____No_____

FILL THIS PART OUT AT YOUR APPOINTMENT *ONLY.*

Date: _____Temperature Reading: _____

Has any of your answers changed on this form since you first filled it out? Yes ____No____

Signature of Client (or parent/guardian of minor):_____