**Massage Intake Form Supplement**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a fever in the last 24 hours of 100º F or above? \_\_\_\_\_YES \_\_\_\_\_NO

Do you now, or have you recently had, a respiratory or flu symptoms, cough, fever, sore throat, chills, headache, shortness of breath, or new loss of taste or smell? \_\_\_\_\_YES \_\_\_\_\_NO

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

I understand that, because massage therapy work involves 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.