



COVID-19 Client Pre-Screening Questionnaire

It is mandated by the Nevada State Massage Board in compliance with the CDC and OSHA that these questions be answered truthfully and that Client temperature must be taken by the therapist and recorded prior to entrance of this establishment. If this document is not filled out, or Client refuses temperature to be taken, the appointment will be considered cancelled **AND** Client will be charged **FULL** session price. If the Client response is "Yes" to any questions, the Client will be asked to seek medical help **AND** Client will be charged **FULL** session price. Appointment availability has been affected.

Client Name: _____ Date: ___/___/___

1. Do you give consent for your temperature to be taken?

- Yes
- No

Body Temp: _____°F

Taken By: _____

Brigitte Papp, LMT (BCTMB)

2. Will you answer the following questions regarding potential COVID-19 exposure truthfully?

- Yes
- No

3. During the past 14 days have you experienced respiratory or flu symptoms, fever, dry cough, sore throat, shortness of breath, fatigue, or systemic muscle aches or pain?

- Yes
- No

4. During the past 14 days have you or anyone in your home experienced experienced respiratory or flu symptoms, fever, dry cough, sore throat, shortness of breath, fatigue, or systemic muscle aches or pain?

- Yes
- No



5. During the past 14 days have you been around anyone who has experienced respiratory or flu symptoms, fever, dry cough, sore throat, shortness of breath, fatigue, or systemic muscle aches or pain?

- Yes
- No

6. Are you currently residing with anyone who has tested positive for COVID-19 or is being quarantined for possible exposure to COVID-19 or any other pathogen?

- Yes
- No

7. Have you taken any medication in the past 6 hours that could have lowered your body temperature such as aspirin, Tylenol, or Ibuprofen?

- Yes
- No

8. Have you travelled outside the state of Nevada in the past 14 days?

- Yes
- No

COVID-19 Disclaimer and Consent for Treatment

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 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.

Client Signature: _____ Date: _____