SoCo Reflexology Intake Form

To best protect your health and the health of others, please fill out this form before each massage and bodywork session. Thank you!

"I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from SoCo Reflexology."

"I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department."

Have you been tested for COVID-19? If yes, what type of test did you have?

- When was your test? _____
- What were the results? _____

*Please circle either **Y** (yes) or **N** (no) for each of the following three questions.*

Have you been in places with a high infection rate within the last two weeks (e.g., state-designated "hotspots")? **Y N**
If yes, please explain.

Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days? **Y N**

Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flulike symptoms within the last 14 days? **Y N**

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever
__ Chills
__ Cough
__ Sore throat
__ Diarrhea, digestive upset
__ Nasal, sinus congestion
__ Loss of sense of taste or smell
__ Fatigue
__ Shortness of breath
__ Sudden onset of muscle soreness (not related to a specific activity)
__ Rash or skin lesions (especially on the feet)

I declare that the information provided above is true and accurate to the best of my knowledge.

Date: _____

_____ _____

(print name) (signature)

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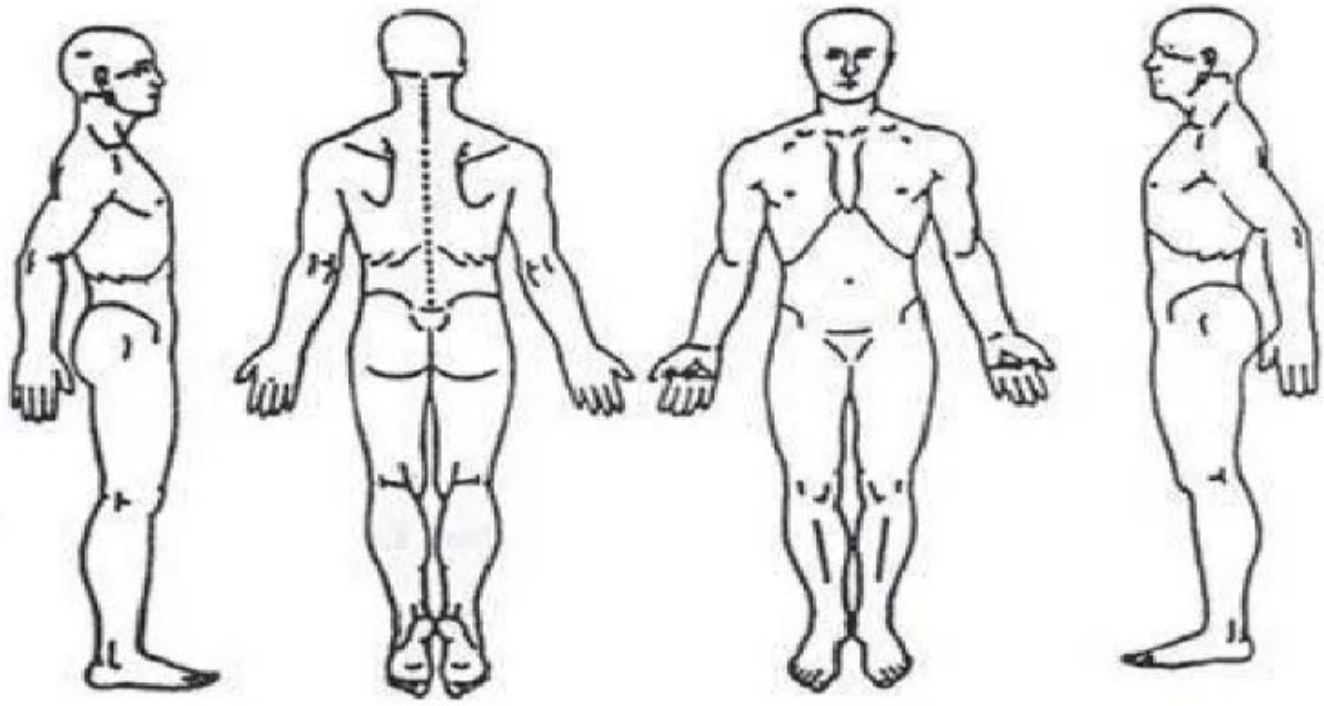
Please circle any areas of discomfort



Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep Tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no Please explain _____