Leixlip Sports Massage Clinic Client Pre-treatment Screening form

Client name: Phone:

Have you experienced any of the following symptoms in the last 14 days?	Yes	No
○ Cough		
○ Fever		
○ High temperature		
○ Sore throat		
○ Runny nose		
○ Breathlessness		
○ Flu-like symptoms		
Have you been tested for COVID-19 in the last 14 days?		
If yes, what was the result?		
Has a health professional asked you to self-isolate in the last 14 days?		
Have you been in close contact with someone experiencing COVID-19 symptoms or someone testing positive for COVID-19 in the last 14 days?		
Do you have any underlying conditions considered to be a higher risk of severity to a COVID-19 infection?		
If yes, give details:		

If you have any reason to believe you are not in good health, please contact me to postpone your treatment session.

Consent for contact tracing

I ask for your consent to contact you on the day of your appointment to remind you of the new arrival procedures and your consent to share your contact details with the HSE in the event of a possible outbreak.

I ask that you remember to bring a facemask for your safety.

Client Signature:	Date:
Therapist Signature:	Date: