Phoenix Rising Massage - COVID Intake Form

Have you experienced any cold or flu-like in the last 14 days (fever, cough, shortness of breath or other respiratory problems)? YES NO

Additional info _____

Have you had any close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flulike symptoms in the last 14 days? YES NO

Additional info _____

Have you been asked to self-isolate or quarantine by a doctor or public health official in the last 14 days? YES NO

Have you been tested for COVID-19? YES NO

Type of test: _____

Date tested: _____

Result: _____

Have you received the COVID-19 vaccine? YES NO

Type of Vaccine: _____

Date(s) of Vaccine: _____

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 at Phoenix Rising.

I understand that my name and contact information might be shared with state health department in the event that a client or practitioner at this practice 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.

I acknowledge that all the information on this form is complete and accurate. By signing below, I hereby waive and release Phoenix Rising Massage Therapy from all liability.

Print Name _____

Signature: _____ Date: _____