The safety of myself, clients, families, and visitors are my overriding priority. As the COVID-19 outbreak continues to develop we will be continually monitoring the situation and will make changes and updates based on the current recommendations from and guidance from the government and our professional organisations. To prevent the spread of COVID0-19 and to reduce the potential risk of exposure to myself, clients, and visitors, we will require a simple screening questionnaire to be completed before we are able to treat you, this will be emailed prior to each treatment session that you attend. Your participation is important to enable us to take precautionary measures to protect you and everyone in the clinic. Thank you for your cooperation.

**Date:** ………………………………… **Name: ………………………………………………………………**

Have you had a persistent cough for the last 14 days? ……………………………………………………………………Yes No

Have you had a fever in the last 14 days? ……………………………………………………………………………………….Yes No

Have you lost your sense of taste and/or smell in the last 14 days? ………………………………………………..Yes No

Have you returned from abroad in the last 14 days? ……………………………………………………………………….Yes No

Have you been in contact with anyone who has returned from abroad in the last 14 days? ……………Yes No

Have you been in close contact with, or cared for someone diagnosed with COVID-19 within the last 14 days? ……………………………………………………………………………………………………………………………………………….Yes No

Has anyone in your household shown any of the above symptoms in the last 7 days? .......................Yes No

Have you noticed any new rashes on your body or feet? …………………………………………………………………Yes No

If the answer is “yes” to any of the above questions unfortunately we will be unable to treat you and will advise you to contact theNHS.

*Additional information*

Do you promise to contact your therapist immediately if you or anyone in your household develops symptoms associated with covid-19 within 7 days of your treatment? ……………………………………………..Yes No

If anything changes between now and your next appointment time, please inform the therapist before your appointment date or asap.

Have you been advised by the NHS as being clinically vulnerable and been required to shield and self-isolate? ……………………………………………………………………………………………………………………………………………Yes No if yes please contact us directly to discuss.

Please check the list below and let us know if any of the following apply to yourself.

\_ Have had an organ transplant
\_ Having chemotherapy or antibody treatment for cancer, including immunotherapy
\_ Having an intense course of radiotherapy (radical radiotherapy) for lung cancer
\_ Having targeted cancer treatments that can affect the immune system
\_ Have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma)
\_ Have had a bone marrow or stem cell transplant in the past six months or are still taking immunosuppressant medicine.
\_ Severe lung condition such as cystic fibrosis, severe asthma, or severe Chronic Obstructive Pulmonary Disease (COPD)

\_ Have a condition that means very high risk of getting infections such as Severe Combined Immunodeficiency (SCID) or sickle cell;
\_ Medication that makes them much more likely to get infections (such as high doses of steroids)

\_ Lung condition less severity (such as asthma, COPD, emphysema or
bronchitis);
\_ Heart disease (such as heart failure)
\_ Diabetes
\_ Chronic kidney disease;
\_ Liver disease (such as hepatitis)
\_ Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy
\_ Have a condition that means you have a high risk of getting infections
\_ Taking medicine that can affect the immune system (such as low doses of steroids)
\_ Obesity (a BMI of 40 or above).

Signature: …………………………………………….. Date: …………………..