CONFIDENTIAL - CLIENT CONSULTATION & CONSENT DOCUMENT – SPECIFIC COVID-19 SCREENING

CLIENT NAME: MOBILE/TEL:

ADDRESS/POSTCODE: EMAIL:

Due to the infectious nature of Covid-19, this must be completed before EACH session enabling us both to make an informed decision regarding treatment and risk, whilst accepting there is no way to fully protect ourselves as people can be asymptomatic and contagious. A thorough risk assessment and new working procedures are in place to reduce transmission risk (copy available on website or request).

Please answer the following questions truthfully and follow guidance so we can do our best to protect each other. Thank you!

			Dates/verbal consent given by client each time				
COVID TESTING		* Date:					
Have you had Covid-19? Date tested positive?	Y/N						
Is the self isolation period over? When?	Y/N						
Have you had Covid test/antibody test? If yes, when? Was it positive/negative?	Y/N Pos/ Neg	*					
Are you registered on a trace/track app?	Y/N						
Have you been in contact with anyone with Covid-19 symptoms? When?	Y/N	*					
COVID SYMPTOMS - *Are you experiencing any of the following?*							
Severe breathing difficulties or chest pain	Y/N						
Difficulty in waking, or confusion	Y/N						
If yes to any of the above, please call 999 - postpone treatment							
Fever or temperature >37.8°C or 100°F	Y/N						
Previous symptoms getting worse: cough	Y/N						
Sore throat or runny nose	Y/N						
Chills or headache	Y/N						
Painful swallowing	Y/N						
Change/Loss of taste or smell	Y/N						
Unexplained muscle & joint ache	Y/N						
Fatigue or exhaustion	Y/N						
If any of the above, please self isolate for 7 days, family 14 days. Test required - Call 119 - postpone treatment							
Shortness of breath or difficulty lying down due to chest issues	Y/N						
Contact your GP or call 111 – postpone treatment							
Agreeing treatment for those in situations or with other health issues such as below, needs further discussion with your therapist as you are considered more at risk from Covid-19 and its effects. Consultant or GP permission may be required.							
If you've had Covid-19, are you still experiencing symptoms/complications?	Y/N						
Have you been hospitalised recently?	Y/N	*					
Heart & Circulatory disorders e.g. DVT, CVA/Stroke, high BP, heart attack?	Y/N	*					
Lung or respiratory condition	Y/N						
Cancer or immune-suppressing condition	Y/N	*					
Diabetes – type 1 or 2, insulin inject?	Y/N	*					

If yes to any of above, or if being treated for, or diagnosed with another condition, please detail below.

☐ Carer – home / care home	☐ NHS Frontline worker	☐ Recently arrived in UK from abroad
☐ Shielding a vulnerable person	☐ Aged 70+	☐ Allergic to cleaning products/ latex gloves
☐ BMI over 39	☐ Pregnant (no.weeks?) ____	_____

For completion by therapist

Treatment agreed: Y/N Medical consent required: Y/N Refer to: GP/Consultant/111/119	NOTES/REASON FOR DECISION

I solemnly & sincerely declare that the information I have provided is true and correct and I make this declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, I am aware I can be prosecuted for making a false declaration. If I, or someone I have been in contact with develops symptoms, tests positive for Covid-19, or I am contacted by test & trace, I will inform you immediately.

Signed/Date: _____ **Signed/Date:** _____

Full Client Name: **Therapist Name:**

Therapy / Reason for Visit: *Client Name/ref:*

GP Name/Address: *Therapist: Sharon Bull*

GP Consent Required: Y /N Permission given: Y / N Date Received: *First Visit Date:*

Restrictions/Adaptations:

PPE required: *Visor / IIR mask / Gloves / Apron / Client IIR Mask (Own/supply)* *Own Towels/chair/clock Y/N*

NOTES:

Do you manage, or have ever had, any of the following ? (circle as appropriate)

Epilepsy	Y/N	Metal/plastic implants	Y/N	IBS / digestive issues	Y/N	Varicose veins	Y/N
Sinusitis	Y/N	Osteoporosis	Y/N	Genito-urinary condition	Y/N	Skin lesions, scars, cuts	Y/N
Headaches/migraines	Y/N	Arthritis	Y/N	Chronic fatigue	Y/N	Anxiety, depression	Y/N
Insomnia	Y/N	Broken bones	Y/N	Fybromyalgia	Y/N	Mental health issue	Y/N
Sciatica/nerve pain	Y/N	Accidents or injury	Y/N	Mobility issues	Y/N	Are you in pain?	Y/N

If YES to any of the above, or you think there is anything else I should know, please give details. This information informs decisions on treatment suitability, restrictions or adaptation.

Are you currently being treated by GP/Medical/Complementary health practitioner? What for?

Medication details/side effects:

Current Stress levels 1-10 _____ Carer /General/specific ? How does this affect you?

Diet/Exercise/Relaxation Details:

What do you want from this/these treatment/s?

AGREED TREATMENT PLAN/FOCUS/ADAPTATIONS/RESTRICTIONS (*to be completed by therapist):*

INFORMED CONSENT DECLARATION

I declare that the information I have given is correct and take responsibility for informing my therapist of any health changes or feedback before, during or after treatment. We have discussed and agreed an appropriate treatment plan detailed above, including any contraindications or risks discussed and I understand what to expect from this treatment. By signing this I confirm I am fit to receive this/these treatment/s and hereby give my informed consent to proceed. I assume responsibility to speak to my GP/medical practitioner/consultant directly regards health concerns.

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

OTHER NOTES/COMMENTS/REVIEWS: