INTAKE FORM ADDENDUM - COVID-19

NAME:_____ DATE: _____

Have you been tested for Covid-19 recently? If yes, what type of test did you have? TYPE: _____

When was your test?

_____

Have you been in places with a high infection rate within the last two (2) weeks (e.g. state designated "hotspots")? If yes, please explain:

<u>Please check if you are experiencing any of the following as a NEW PATTERN within the past 14 days:</u>

___Fever	___Nasal, sinus congestion	___Fatigue	___Sore throat
___Chills	___Loss of sense of smell or taste	___Sudden onset muscle soreness (not related to a specific activity)	___Have been around anyone with confirmed COVID within the past 14 days
___Shortness of breath	___Diarrhea, digestive upset	___Cough	

ASSUMPTION OF RISKS

I understand that while Service Provider has undertaken reasonable steps to lessen the risk of transmission of COVID-19 in connection with the Services, Service Provider is not responsible in any manner for any risks related to COVID-19 in connection with the Services. BY signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this practitioner. I understand that despite adhering to all precautions, there is still a possibility that I will be exposed to or contract COVID-19. Persons with underlying health conditions may be particularly susceptible to illness and death from COVID-19. Such conditions include but are not limited to heart disease, chronic lung disease, suppressed immunity system, severe obesity, diabetes, chronic kidney disease and liver disease. I have been advised and choose to visit, understanding my own health condition(s). I have read the above and understand it is not inclusive of all risks and safety measures related to COVID-19. By signing this agreement, I waive any and all liability to me.
I declare that the information provided above is true and accurate to the best of my knowledge.

_____

Signature

Circle which one: Pfizer/Moderna/Johnson & Johnson

1ST Dose _____ 2ND Dose_____

Booster _____