KATE MACPHEE
BCSI, KMI Structural Integration
603 986 4964 | www.transformationalbodytherapy.com

COVID-19 Questionnaire

(required for all visits – please circle yes or no and sign)

1. **Have you been in close contact with a confirmed case of COVID-19?**
   Yes No

2. **Have you had a fever or felt feverish in the last 72 hours?**
   Yes No

3. **Are you experiencing any respiratory symptoms including a runny nose, sore throat, cough, or shortness of breath?**
   Yes No

4. **Are you experiencing any new muscle aches or chills?**
   Yes No

5. **Have you experienced any new change in your sense of taste or smell ?**
   Yes No

Printed Name Date

Signature