ADVANCED THERAPEUTIC MASSAGE - CASE HISTORY UPDATE

In order for us to adhere to the Center for Disease Control (CDC) guidelines in reference to the COVID-19 pandemic so that we may bring your original case history up to date, please provide us with following information.

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Date of last physical: _____

Have you been tested for COVID-19? **Yes** **No** If so, what were the results? **+** **-** Date of test: _____

NOTE: If you have tested positive, you will be required to provide written notification for our records from your medical provider before receiving services.

Have you traveled out of the country or the state of Colorado in the past six months? _____

_____

_____

Are you currently taking any medications? _____

_____

_____

What is your primary physical or emotional concern at this time: _____

_____

_____

I certify that the above information is accurate:

_____ _____

Print Name **Signature**

Office Use Only: