Client COVID- 19 Health Questionnaire

Please complete the following questions honestly for the safety of all clients Without this form, you cannot receive a service. IT IS A REQUIREMENT FOR ALL COSTUMERS WITHOUT EXCEPTION!!!

*Required

Name *

First Name Last Name

Email *

example@example.com

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Do you have any allergy symptoms at this time? *

If yes, please explain:

Do you have symptoms of cough, sore throat, headache or body aches? *

If yes, please explain:

Have you had a fever in the last 24 hours? *

Have you been in direct contact with someone sick with COVID- 19? *

Do you have family member of your family who works in healthcare and has been in contact with you? *

Have you been out of the country or in New York in the last 3 months? *

If yes, please explain:

Have you been in quarantine? *

If yes, please explain:

Have you been tested for COVID- 19?

Date:

Result:

Explain:

Do you have any conditions such as diabetes, hypertension, cancer, COPD or asthma?

If yes, please explain:

THANKS FOR COLLABORATING TO BE ABLE TO GUARANTEE A SAFE AND SECURE SERVICE!!!

The Organic Glow

305-308-9262