BODYWORKS

Revised 04/21/2021

CONSULTATION

To help us assist you, please provide us with the information requested below

Name:____Date:______________________

Regarding your visit today,

1.What health issue(s) are you being seen for today? Please provide a brief description below.

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2.Have you undergone any testing for the problem for which you are being seen for today? (X-ray, MRI, EMG, CT Scan, etc.) or treatments? Circle: **Yes / No**. If you answered yes, please provide a brief description.

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3.Are you currently taking any medications? Circle: **Yes / No**. If you answered yes, please list them or provide a list.

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4.Do you have any other medical conditions for which you are currently being treated? Circle: **Yes / No**. If you answered yes, please provide a brief description.

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5.Please indicate any other pertinent information or difficulties you feel are relevant to your visit today.

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With regard to COVID 19, please provide an explanation for a *YES* response.

In the past 7 days ?

1. Has anyone in your household had a fever or been ill, a cough or shortness of breath, experienced a new loss of the sense of taste or smell?

Yes / No

2. To the best of your knowledge, have you been in contact with someone who has COVID-19?

Yes / No

Please provide an explanation for a Yes response/s.

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3. Have you been fully vaccinated against Covid-19 ?

Yes: Date of final vaccination ____________________ / No

Staff Use Reviewed By/Date: ____