LIBBY EASON, LLC
COVID-19 Questionnaire Intake/Consent Form

Please note the questions below are meant to help determine your appropriateness for Rolfing Structural Integration during the time of COVID-19. Depending on your answers, additional questions may be asked. Also, please note if you have any questions regarding the process of Rolfing Structural Integration, how COVID-19 is affecting my practice, or any questions regarding this intake/consent form, please let me know. I will be happy to answer your questions to the best of my ability and/or to refer you to an appropriate source for additional information.

1. Name: ________________________________ Date of Birth: ____________ Cell Phone: _______________
2. Have you been tested for COVID-19? Yes/No. Date: ___________. Positive/Negative. If you tested positive, official medical clearance will be needed for you to be seen for treatment.
3. In the last 14 days have you been exposed to anyone who tested positive for COVID-19? Yes/No.
4. Have you travelled by airplane in the past 14 days? Yes/No
5. Do you observe social distancing in public? Always/Usually/Occasionally/Never
6. Do you wear a mask/face covering while in public? Always/Usually/Occasionally/Never
7. Do you work from home? Always/Usually/Occasionally/Never
8. Do you practice social distance at work? Always/Whenever Possible/Occasionally/Never
9. Do you wear a mask/face covering at work? Always/Usually/Occasionally/Never
10. Are there other people in your household? Yes/No
11. Do the people in your household practice social distancing while in public? Always/Usually/Occasionally/Never
12. Do the people you live with wear a mask while in public? Always/Usually/Occasionally/Never
13. Are you currently experiencing any of the following symptoms outlined by the CDC as being associated with COVID-19:
    Cough - Yes/No // Shortness of Breath - Yes/No // Fever - Yes/No // Chills - Yes/No
    Muscle Pain - Yes/No // Sore Throat - Yes/No // New loss of Taste or Smell - Yes/No
    Nausea - Yes/No // Vomiting - Yes/No // Diarrhea - Yes/No
14. Please answer the following health questions as outlined by the CDC as High Risk Conditions associated with COVID-19:
    1. Do you live in/work at or visit individuals at assisted living, nursing home, or long-term care facility? Yes/No
    2. Do you work in a medical facility (clinic or hospital)? Yes/No
    3. Do you have chronic lung disease (asthma, COPD, other)? Yes/No
    4. Do you have moderate to severe asthma? Yes/No
    5. Do you have any history of cardiovascular disease (hypertension, heart attack, stroke, heart failure)? Yes/No
    6. Are you immunocompromised in any way (autoimmune disease, chemo, etc)? Yes/No
    7. Do you have chronic kidney disease? Yes/No
       If you have chronic kidney disease are you undergoing dialysis? Yes/No
    8. Do you have liver disease? Yes/No
       Body Mass Index > 40 = Increased Risk. Height and weight are needed to calculate BMI:
       Formula: weight (lb) / [height (in)]^2 x 703 = %BMI _______
       (Or check with your healthcare provider for most recent measurement)

I ____ give Libby Eason, who is employed by Libby Eason LLC, permission to evaluate and treat me as outlined by the scope of practice as a Certified Advanced Rolfer. I understand that, because Rolfing Structural Integration involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form I acknowledge that I am aware of the risks involved and give my consent to receive Rolfing Structural Integration from Libby Eason.

Signed: ____ Date: ________________________

Temperature: Oxygen Saturation: Date: