



Covid-19 Pre-Treatment Form

FULL NAME:

DATE OF BIRTH:

ADDRESS:

Please answer the following questions

Question	YES	NO
Have you come into close contact with someone who has Coronavirus (Covid-19) in the last 14 days?		
Have you come into close contact with someone who has displayed any of the following symptoms: Fever, Chills, Cough, Sore Throat?		
Within the last 14 days, have you experienced any of the following symptoms: Fever, Chills, Cough, Sore Throat, Shortness of Breath, Chest Pains, High Temperature, Loss of Taste or Smell?		
Have you or a household member been told to, or are self-isolating within the last 14 days?		
Have you been tested for Coronavirus (Covid-19)?		
Have you been diagnosed as having Coronavirus (Covid-19)?		

I understand and I have answered the questions above truthfully.

I have been asked by Ambience to sanitise my hands upon arrival at the salon and remove any gloves that have been worn outside.

I understand that Ambience are taking all the necessary precautions and wearing the appropriate PPE in order to carry out my treatment.

I understand that this form will be held with my confidential client card. To assist the NHS Test and Trace, details may be requested to be shared for this purpose only.

SIGNED:

DATE:

THERAPIST:

Thank you, and we look forward to see you!

Sunflower Studios