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|  |  |
| --- | --- |
| **Full Name** |  |
| **Full Address** |  |
| **Date of Birth** |  |
| **Email Address** |  |
| **Mobile Number** |  |

**Testing**

|  |  |
| --- | --- |
| Have you had a Covid-19 test? If yes, when? Antigen or antibody test? **Antigen** – tests for Covid-19 on day of testing. **Antibody** – possible immunity. | **Yes/No****Date:**  |
| If it was a positive result, has the isolation period expired? | **Yes/No** |
| Do you still have symptoms? | **Yes/No** |
| Are you registered with the NHS Test & Trace app | **Yes/No** |
| **Details may be released to NHS Test & Trace for contact tracing if necessary.** |  |

**Symptoms – Are you experiencing any of the following?**

|  |  |
| --- | --- |
| Severe breathing difficulties or chest pain | **Yes/No** |
| Difficulty in waking or confusion | **Yes/No** |
| If YES to the above | **call 999 (cannot be treated)** |

|  |  |
| --- | --- |
| Fever | **Yes/No** |
| Onset, or worsening of a cough | **Yes/No** |
| Sore throat or running nose | **Yes/No** |
| Chills or headache | **Yes/No** |
| Pain swallowing | **Yes/No** |
| Muscle & joint ache | **Yes/No** |
| Fatigue or exhaustion | **Yes/No** |
| Loss of taste or smell | **Yes/No** |

**If any of the above, the advice is to self-isolate for 7 days. A covid-19 test may be necessary, call 119**

|  |  |
| --- | --- |
| Shortness of breath or difficulty lying down due to chest issues | **Yes/No** |

**If any of the above, call 111**

|  |  |
| --- | --- |
| Have you been in contact with anyone with Covid-19 symptoms? | **Yes/No** |
| Have you recently been hospitalised? | **Yes/No** |
| If so, why? |  |

**Do you have any of the following health issues:**

|  |  |
| --- | --- |
| High blood pressure or other heart condition | **Yes/No** |
| Diabetes Type 1 or 2 – if so, which? | **Yes/No** |
| Cancer | **Yes/No** |
| Lung condition | **Yes/No** |
| If any other conditions, please list: |  |

 **If you have had COVID-19:**

|  |  |
| --- | --- |
| Are you experiencing post Covid-19 circulatory complications (deep vein thrombosis, micro-embolisms, stroke symptoms or pulmonary embolism) | **Yes/No** |

 **Are you?**

|  |  |
| --- | --- |
| An NHS front line worker/key worker | **Yes/No** |
| A carer – home or care home | **Yes/No** |
| Shielding a vulnerable adult | **Yes/No** |
| **If YES to the above, please change out of work clothing and shower before coming for your treatment.** |  |
| Pregnant – how many weeks? | **Yes/No** |
| Aged over 70 | **Yes/No** |
| Allergic to latex gloves or specific cleaning products | **Yes/No** |

* **All clients must come alone for their treatment**
* **Jackets/Bags to be left in the car if possible**
* **Face mask to be worn before entering (can be supplied)**
* **I will call you prior to your appointment for your pre treatment consultation**
* **I will call after the treatment to give after care advice and book any follow-on treatment if necessary**
* **Please bring a drink of water along with you**

**SIGNED**

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.

If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Test & Trace I will inform you.

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* **When you have completed this document, please send back via email** – nuyu@live.com \*