COVID -19 DISCLAIMER

Please complete this Consultation Form and bring it with you to your appointment.

Have you had Covid-19?	YES	☐	NO	☐	
If so when?					
Were you taken into hospital?					
Details: Which hospital, duration and treatment given:					
At this present time have you any of the following symptoms:					

High Temperature/Fever	Yes	☐	No	☐
Consistent Cough	Yes	☐	No	☐
Loss of taste/smell	Yes	☐	No	☐
Diarrhoea and abdominal pain	Yes	☐	No	☐
Body ache/Exhaustion	Yes	☐	No	☐

Declaration

Declaration: I declare that the information I have given is correct and complete.
I have advised Hele O'Brien at Complete Health Clinic of anything concerning the COVID19 virus, that may alter my Colon Hydrotherapy or Complementary Treatment

By signing this form, I confirm and agree that any treatments are at my own risk, other than in relation to any physical or mental harm I suffer due to negligence and without limiting or affecting any statutory rights I may have.

Client Signature: ____ Date: _________________

Therapist Signature: ____ Date: _________________