Date: .....

WELLNESS REVIEW

3 QUESTIONS

1. Do you have a cold or flu like symptoms, sore throat, fever or runny nose (if so please stay at home and rebook when you no longer have symptoms)

.....

2. Have you been in contact with anyone that has had covid-19 within the past 30days.

.....

3. Have you been in contact with anyone in the past 30 day who has travelled from overseas.

.....

PERSONAL DETAILS

Name: ..... D.O.B. .....

Address: .....

Email: ..... Phone: .....

MEDICAL HISTORY

.....

.....

MEDICATIONS

.....

.....

NATURAL MEDICINE/SUPPLEMENTS

.....

.....

Signed: .....