COVID-19 Pandemic Chiropractic Treatment Consent Form

Name:____

Date:____

To the best of my knowledge and with honest good-faith, I:

1. do not have any flu-like, symptoms, including fever, shortness of breath, dry cough, runny nose or sore throat.
2. have not lost my sense of taste or smell.
3. have not been directly exposed to someone with flu symptoms or having tested positive for COVID-19 or coronavirus.
4. have not traveled within the last 14 days to a place of known significant outbreak of COVID-19 or coronavirus in or out of the United States.

I understand that the COVID-19 virus has a long incubation period of up to 14 days, during which carriers of the virus may not show symptoms, yet be highly contagious. It is impossible to determine who is a carrier. Being vaccinated is not a guarantee that you will not get COVID-19 or any of the variants (Delta or Omicron), however getting vaccinated minimizes the risk of hospitalization and severe outbreak of the virus if you catch it.

The CDC recommends social distancing of at least 6 feet when possible. My signature below indicates my understanding that this is not possible during chiropractic care, acupuncture or nutritional care visits.

I also understand that no medical facility can guarantee results of preventing catching COVID-19. I further know that Dr. Scott and Dr. Wieder are both following all known protocols to limit the transmission of COVID-19, but that transmission to me is still possible. I am willing to accept the risk.

Signed__________________________________ Date_________