



ELEONORA GAFTON, MS, CNS, LDN, CHHC

## Client Advisory and Acknowledgement

### Receiving Nutritional Consultation During COVID-19 Pandemic

Dear Client

You have come to our office today to receive nutritional consultation/follow up that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Center of Disease Control and Prevention infection control guidelines to prevent the spread of COVID-19 virus, we cannot make any guarantees.
- Our staff is symptom-free and to the best of knowledge, have not been exposed to the virus.

To reduce the risk of spreading COVID-19, we have asked you several “screening” questions below. For the safety of our staff, other clients, and yourself please be truthful and candid in your answers.

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

**Please answer YES or NO with your initials, to the following questions:**

- |   |     |    |
|---|-----|----|
| 1. Are you currently awaiting the results of a COVID-19 test?   | YES | NO |
| 2. Do you have a fever?   | YES | NO |
| 3. Do you have any shortness of breath?   | YES | NO |
| 4. Do you have a dry cough?   | YES | NO |
| 5. Do you have a runny nose?  | YES | NO |
| 6. Do you have a sore throat?   | YES | NO |
| 7. Have you experienced headache, fatigue, or weakness?   | YES | NO |
| 8. Do you have sneezing, watery eyes, and/or sinus pain/<br>pressure that is unusual and not related to seasonal allergies? | YES | NO |
| 9. Have you lost your sense of taste and/or smell?  | YES | NO |
| 10. Within the last 14 days, have you traveled to any foreign country?  | YES | NO |
| 11. Within the last 14 days, have you traveled within the US?   | YES | NO |
| 12. IF so where? _____  |     |    |

Stay Safe and Be Well