INFORMED CONSENT TO CHIROPRACTIC CARE

In order to be seen today, you must meet the following criteria:

You have not experienced symptoms of COVID-19 in the last 14 days. This would include

sore throat	fever
runny nose	new cough
breathing difficulties	

You have not been in contact with anyone in your home or place of work with these symptoms, or who has tested positive for COVID-19.

You have not travelled outside of Canada in the past 14 days.

You signature below acknowledges that all of the above criteria apply.

Patient Name_____

Patient Signature _____

Date _____