COVID SCREENING FORM

This questionnaire outlines the symptoms which have been most commonly associated with COVID-19.

First name: ______________________ Last name: ______________________

1. Have you received your final or second COVID-19 vaccination dose more than 14 days ago?

   Yes No

   If **YES**, go directly to **question 4** *(skip questions 2 and 3)*. If no, please continue on.

2. Did you travel outside of Canada in the past 14 days?

   Yes No

3. Did you have close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

   Yes No

4. Do you have any of the following symptoms):

- Fever and/or chills
- New onset of cough or worsening chronic cough
- Shortness of breath
- Decrease or loss of sense of taste or smell

If you are an adult (18 years of age and up):

- Unexplained fatigue/lethargy/malaise/muscles aches (myalgias)

If you are a child (under 18 years of age):

- Nausea/vomiting, diarrhea

Yes No

5. Have you tested positive for COVID-19 in the past 10 days or have you been told you should be isolating?

   Yes No

6. You agree to bring and wear a clean mask to (and during) your appointment?

   Yes No

If you answered YES to question 2, 3, 4 or 5 we are unable to treat you at this time. Please reschedule your appointment for 2+ weeks in the future.

By signing and submitting this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19.

I understand that all necessary precautions will be put in place, prior and during my therapy session but that a risk remains of becoming exposed to or infected by COVID-19.

Signature: ______________________________ Date: ______________________

Please type your name in the signature field in lieu of signing if submitting electronically