Date:

COVID-19 VIRUS QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part **of your treatment notes.**

Name *(Last, First, M.I.):* ☐ M ☐ F	

Have you brought with you 1 large bath towel?	☐ Yes	☐ No
Have you brought with you 1 small hand towel?	☐ Yes	☐ No
Have you arrived with a mask?	☐ Yes	☐ No
Have you been provided with hand sanitizer?	☐ Yes	☐ No
Have you or anyone you have been in close contact with had any symptoms associated with COVID-19 within the last 14 days?	☐ Yes	☐ No
COVID-19 Virus ie:		
High Temperature?	☐ Yes	☐ No
Hot to touch on back or chest?	☐ Yes	☐ No
A new or dry continuous cough which is persistent (no phlegm)?	☐ Yes	☐ No
a loss of, or change to, your sense of smell or taste?	☐ Yes	☐ No
Have you travelled or have had close contact with anyone who has travelled in the past 14 days?	☐ Yes	☐ No
Have you had close contact with anyone with respiratory illness or a confirmed or probably/suspected case of COVID-19?	☐ Yes	☐ No
Have you checked your temperature today?	☐ Yes	☐ No
Would you like me to check your temperature now?	☐ Yes	☐ No
Have you been strictly following social distancing measures as outlined by the Government?	☐ Yes	☐ No
Were you made aware of the requirements upon arrival prior to today's appointment via text/voicemail message?	☐ Yes	☐ No
Are you considered clinically extremely vulnerable as per the letter from your GP?	☐ Yes	☐ No
Have you or anyone you have been in close contact with been advised to shield or considered at high risk under government guidelines or as per the letter from your GP.	☐ Yes	☐ No
Are you pregnant? If applicable.	☐ Yes	☐ No
Please check the boxes to acknowledge and agree:		

☐ I understand that my provider is taking many precautionary measures and these have been put into place and explained an abundance of caution. This is out of concern for the health and safety for our community. I understand that there is a risk of exposure.

☐ I am aware of the risks of acquiring COVID-19 and I take full responsibility for my decision to receive in-clinic care.

☐ I hereby confirm that the information above is true to my knowledge and would like to proceed with care on this basis.

In the event that you are not able to confirm the foregoing, I am happy to work with you to re-book your appointment for a later date.

Signature:_____ Date:_____