COVID-19 Screening Form

For ALL IN-CLINIC Patients and Visitors, It is required to fill out this screening questionnaire for EACH VISIT to the clinic.

Name *_____Email*_____

Please Carefully read and answer ALL following questions:

1. Have you had close contact with anyone with acute respiratory illness or someone who has travelled outside of Canada in the past 14 days?
   YES
   NO
2. Have you had COVID 19 or come in contact with a confirmed or suspected case of COVID 19 in the past 2 weeks?
   YES
   NO
3. Do you currently have ANY of the following symptoms?
   Fever •New onset of cough •Worsening chronic cough •Shortness of breath •Difficulty breathing •Sore throat •Difficulty swallowing •Decrease or loss of sense of taste or smell •Chills •Headaches •Unexplained fatigue/malaise/muscle aches (myalgias) •Nausea/vomiting, diarrhea, abdominal pain •Pink eye (conjunctivitis) •Runny nose/nasal congestion without other known cause
   YES
   NO
4. Does anyone living in your household have ANY of the above symptoms?
   YES
   NO
5. If you are 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?
   YES
   NO

If you answer “YES” to any of above questions, we ask you to :

Call your primary care provider or Telehealth Ontario (1-866-797-0000) OR PUBLIC HEALTH oTTAWA 613 580 6744 for further clinical assessment.
Please call our clinic and cancel your in person appointment. We will be happy to provide you treatment through telerehab.

Declaration:

1. I have answered all the above questions honestly and truthfully

2. By signing below, I consent and accept the inherent risks of in-person physiotherapy treatment in light of the COVID-19 Pandemic and any potential exposure that occurs as a result.

*Signature

Submit