K-W HOMEOPATHIC MEDICINE AND WELLNESS CLINIC

COVID-19 Screening Questionnaire

Date:_____

Name:_____

Phone Number: _____

1. Have you tested positive for COVID 19 or come into close personal contact with someone who has a confirmed case of COVID-19 without wearing appropriate Personal Protective Equipment (PPE)? **(circle one) Yes No**
2. Have you travelled outside of Canada or have come in contact with someone who travelled outside of Canada in the past 14 days? **(circle one) Yes No**
3. Do you currently have any of the following symptoms? **(check mark below)**

□ Fever (temperature of 37.8 °C or greater)
□ New or worsening cough
□ Shortness of breath or difficulty breathing
□ Sore throat
□ Difficulty swallowing
□ Decrease or loss of sense of taste or smell
□ Chills
□ Headaches
□ Unexplained fatigue/malaise/muscle aches
□ Nausea/vomiting/diarrhea/abdominal pain
□ Pink eye
□ Runny nose, or nasal congestion- in absence of underlying reason for these symptoms such as seasonal allergies, post nasal drip, etc.
□ If you are over age 70, are you experiencing delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions
□ None of the above

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE PLEASE **DO NOT ENTER IN TO THE BUILDING,** BUT FIRST CONTACT YOUR HOMEOPATH TO DISCUSS ALTERNATIVE ARRANGEMENTS AT (519) 603-0505.

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I consent to KW Homeopathic Medicine & Wellness Clinic releasing this information to Public Health in the event it is needed to assist with contact tracing. I will inform to KW Homeopathic Medicine & Wellness Clinic if I develop any COVID-19 symtpoms or am diagnosed with COVID-19 within the next 14 days.

Signature: _____