COVID 19 Screening

Bay Chiropractic Clinic 222 Spadina Avenue, Unit 138, Toronto, Ontario M5T 3B3

Please complete this questionnaire. This form will be kept in your file.

1. **Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?**

   □Yes **□ No**

2. **Have you had a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?**

   □Yes □No

Does the person have any of the following symptoms:

• Fever	**□ Yes**	**□No**
• New onset of cough	**□ Yes**	**□No**
• Worsening chronic cough	**□ Yes**	**□No**
• Shortness of breath	**□ Yes**	**□No**
• Difficulty breathing	**□ Yes**	**□No**
• Sore throat	**□ Yes**	**□No**
• Difficulty swallowing	**□ Yes**	**□No**
• Decrease or loss of sense of taste or smell	**□ Yes**	**□No**
• Chills	**□ Yes**	**□No**
• Headaches	**□ Yes**	**□No**
• Unexplained fatigue/malaise/muscle aches (myalgias)	**□ Yes**	**□No**
• Nausea/vomiting, diarrhea, abdominal pain	**□ Yes**	**□No**
• Pink eye (conjunctivitis)	**□ Yes**	**□No**
• Runny nose/nasal congestion without other known cause	**□ Yes**	**□No**

If you are 70 years of age or older, are you 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 questions please call the clinic first before your appointment

I certify that I have answered the questions truthfully

Name: _____

Signed: _____

Date: _____