Femme PhysioCare

COVID-19 SCREENING FORM

Name:

DOB:

Email:

Please read the questions carefully before answering:

1. Have you, or anyone in your household travelling out of province/country in the past 14 days? ☐ Y ☐ N
2. Have you been in contact with anyone in the last 14 days that has been tested positive for COVID-19? ☐ Y ☐ N
3. Are you experiencing any of the following symptoms?
   - Fever of 100.4 F or higher ☐ Y ☐ N
   - Cough that is getting worse ☐ Y ☐ N
   - Shortness of breath ☐ Y ☐ N
   - Sore throat ☐ Y ☐ N
   - Flu like symptoms (fatigue, muscle/joint ache) ☐ Y ☐ N
4. Does anyone in your house have any of the above symptoms? ☐ Y ☐ N
5. Have you or anyone is your house tested positive for COVID-19? ☐ Y ☐ N

If you answer "Y" to any of the above question, we ask that you immediately contact the clinic at 403-990-5929

Declaration:

- I have answered all the questions truthfully
- By signing below, I consent and accept the risks of in person physiotherapy treatment considering the COVID-19 pandemic and any potential exposure that occurs as a result

_____ _____

Signature Date