Hillsburgh Chiropractic, Physiotherapy and Massage
COVID 19 Screening Form

PATIENT INFORMATION

First Name Last Name

Street Address 1

City

Postal Code

E-Mail Address Phone Number

SCREENING QUESTIONS

Q1: Have you been in close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?	YES	NO
Q2: Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19? (Close contact meaning within 2 meters for 15 min or more, or living in household)	YES	NO

Q3: Do you have one of the following symptoms:

• Fever	YES	NO
• New onset of cough	YES	NO
• Difficulty Breathing	YES	NO

OR

At least **two** of the following symptoms

• Chills	YES	NO
• Sore throat	YES	NO
• Difficulty swallowing	YES	NO
• Decrease or loss of sense of taste or smell	YES	NO
• Digestive issues (nausea/vomiting, diarrhea, stomach ache)	YES	NO
• Headaches	YES	NO
• Fatigue	YES	NO
• Runny Nose	YES	NO
• Hoarse Voice	YES	NO
• Stuffy or congestive nose	YES	NO
• For young children and infants: sluggishness or lack of appetite	YES	NO

Q4: 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 response to ANY of the screening questions is YES, please delay your visit for 14 days AND contact your health care provider, or Telehealth Ontario (1-866-797-0000).

I acknowledge that the above information is true to the best of my knowledge.

Signature: ____

Print Name: ____

Date: ________________________________