A BODY IN MOTION
REHABILITATION™

COVID-19 Patient Screening

Thank you for taking a moment to complete this screening questionnaire. We are required by the Ministry of Health to obtain the following information before each visit.

1. Do you have any of the following symptoms? **YES** **NO**

   Fever and/or chills

   New onset of cough or worsening chronic cough

   Shortness of breath

   Decrease or loss of sense of smell

   Unexplained fatigue/lethargy/malaise/muscle aches

   Nausea/vomiting/diarrhea

2. Have you tested positive for COVID -19 in the past 10 days or have you been told to self-isolate? **YES** **NO**

3. **IF you are not fully immunized:** Have you travelled outside of Canada in the past 14 days? **YES** **NO**

4. **IF you are not fully immunized:** Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? **YES** **NO**

Thank you for your cooperation and for helping us keep our patients and staff safe and healthy!

Name: ________________________ Date:______________________

Signature: _____________________