To maintain the highest levels of hygiene within the clinic and to minimise the risk of infection, we would appreciate it If you could take the time to answer some essential pre-appointment screening questions that we must go through 24 hours before you attend your upcoming appointment. If you have any queries please give us a call.

Name: ........................................................................................................................................................................

Date/Time of Appointment:……………………………………………………………………………………………………………………………………

# Are you or a member of your household experiencing any of the following symptoms, or have had any of these in the last 7 days:

 **Cough, temperature above 37.5c, shortness of breath, Chills, Sore throat, Loss of smell, Loss of**

**taste, Headache, Diarrhea, Severe vomiting?** YES/NO

 If Yes - Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you or a member of your household had any known contact with person/s confirmed as having

COVID-19 in the last 14 days? YES/NO

#  If YES, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Are you, or anyone in your household, at high risk of transmitting the virus by nature of your occupation e.g. a nurse, doctor, care worker? YES/NO

 If Yes - Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Do you or a member of your household hold a shielding letter? YES/NO

If YES who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Are you in the high-risk category for Covid-19? YES/NO

# If Yes –Details? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you understand there is still an element of risk and would like to go ahead with the face to face hands on treatment? YES/NO
2. Do you have any concerns about visiting the practise? YES/NO

If YES please give details? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:………………………………………………………………………Date…………………………………………………………………………………