**Screening form before every appointment:**

**Q1**: Are you fully vaccinated: **Y / N / N/A** Booster**: Y / N**

**Q2**: Symptoms:

- Do you have fever and/or chills? **Y / N**
- Do you have a new onset of cough or worsening chronic cough? **Y / N**
- Do you have shortness of breath? **Y / N**
- Do you have decrease or lost of taste or smell? **Y / N**
- If you are an adult over 18 years of age: do you have unexplained fatigue/lethargy/malaise/muscle aches? **Y / N**
- If you are a child under 18 years old of age: do you have nausea/vomiting/diarrhea? **Y / N**

**Q3**: Do you have tested positive for Covid-19 in the pasdt 10 days or do you have been told you should be isolated? **Y / N**

**If you didn't answer Q1 or the answer was "N":**

**Q4**: Did you travel outside of Canada in the past 14 days? **Y / N**

**Q5**: Have you been in contact with a confirm case of Covid-19 without wearing appropriate PPE? **Y / N**

If all the answers 2-3 (4-5 either if needed) are **"N",** just confirm you wash/sanitize your hands prior to enter the office.
You also aknowledge the informations are acurate and you consent to receive a treatment during the Covid-19 pandemic.

**_____ (initials)**

**PATIENT NAME (printed): _____**

**DATE: _____/_____/_____ SIGNATURE: _____**