**COVID-19 Pre-screening Questionnaire**

|  |  |
| --- | --- |
| Full Name : |  |
| Contact Number : |  |
| Email: |  |
| Date: |  |

**Pre-Access (Part A)**

**Please complete the below questions**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| 1. Have you been outside of the UK in the past 14 days? |  |  |
| 1. Have you been alerted in the past 14 days that you have been in contact with someone who has tested positive for COVID-19? |  |  |
| 1. Have you been in close contact in the past 14 days with someone with a confirmed case of COVID-19 or been in close contact with someone who has had the following symptoms: cough, runny nose, fever or sore throat but not seasonal allergies. |  |  |
| 1. Have you been in close contact with someone who has been outside of the UK in the past 14 days and returned with the following symptoms: cough, runny nose, fever or sore throat but not seasonal allergies. |  |  |
| 1. Have you experienced cold or flu symptoms(cough, runny nose, fever or sore throat, but not seasonal allergies) in the last 3 days? |  |  |
| 1. Do you **currently** have any cold or flu symptoms (cough, runny nose, fever or sore throat but not seasonal allergies)? |  |  |

**If the response is YES to any of the above questions, we will not be able to go ahead with your appointment for a minimum of 14 days.**

**On-Site Assessment (Part-B Practitioner Use Only )**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Body Temp ℃ |  |  |
| 1. Based on the confirmation of responses to the above Pre-Access questions and the individual’s body temperature, are they cleared to have a treatment ? |  |  |
| 1. Is a medical assessment required? |  |  |

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| Practitioner Comments: |

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| --- | --- |
| Practitioner Name : | |
| Signature: | Date: |