**Please fill out this questionnaire on the day of your appointment before every appointment, and send it to my email address before coming to the clinic.**

Name ----------------------------------------------- Signature, date-------------------------------------------

Please circle the answer that applies to you.

1. Do you feel sick/ do you have any cold? yes No
2. Have you ever tested positive for Covid -19? Yes No

1. Does anybody in your family circle have/had Covid -19? Yes No
2. Have you been outside Canada in the last 3 months? Yes No

If yes please explain where; and how long?----------------------------------------------------------------------

1. Have you been in contact with any person who have tested positive for Covid 19? Yes No
2. Please check if you have any of these symptoms below?

* Fever
* Cough
* Sore throat
* Headache
* Congestion
* Sneezing
* Loss of smell
* Runny nose
* Ear pain
* Muscle pain
* Diarrhea
* Loss of appetite
* Cramps
* Stomach ache
* Nausea
* Dizziness