True Life
Wellness and Physiotherapy
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Patient Screening Questionnaire

Please answer the following questions:

1. Do you have any of the following symptoms (please circle):
   a. Fever, Shortness of Breath
   b. Cough, Sore Throat
   c. Loss of Taste or Smell
   d. Chills, Runny Nose
   e. Feeling Unwell
   f. Conjunctivitis – Pink Eye
   g. Diarrhea

2. If over the age of 65 – are you experiencing delirium, falls, acute functional decline or worsening of chronic conditions. Yes No

3. Have you travelled outside of Canada within the last 2 weeks? If yes, where? Yes No

4. Have you had close contact* with a confirmed or probable case of Covid-19? * = close contact is defined as within closer than 6 feet for 10 minutes. Yes No

5. Have you been mandated to go into quarantine by your physician or Department of Health within the past 14 days? If so, please explain the date quarantine began and the reason for quarantine. Yes No

   Date: _____ Reason: _____

If you have test positive for Covid-19 please indicate which of the following statements are true, if any:

☐ **If you were symptomatic** (had symptoms), you have been in isolation for at least 14 days since symptoms first began, **and** you have not had symptoms in the past 3 days.

☐ **If you were asymptomatic** (did not have symptoms), you have been in isolation for at least 14 days beginning from the date you were tested, **and** you have not experienced any symptoms during this 14-day period.

☐ **You have NOT completed a 14-day quarantine.** If you checked this box, please note the date you were diagnosed with Covid-19 and the date you first become symptomatic (if applicable).

Date first symptomatic: _____ Diagnosed with Covid-19: _____

Answering these screening questions honestly will assist our staff with how to care for you and all involved parties. Thank you for your cooperation.

Name: _____ Signature:_____ Date:_____