WESTWIND
MASSAGE THERAPY

PLEASE FILL OUT THIS FORM AND BRING IT TO YOUR MASSAGE APPOINTMENT

Screening Questions

1. Do you have any of the following **new or worsening** symptoms or signs?

New or worsening cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Runny nose, sneezing or nasal congestion (in absence of underlying reasons for symptoms such as seasonal allergies and post nasal drip)	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
New smell or taste disorder(s)	☐ Yes	☐ No
Nausea/vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Unexplained fatigue/malaise	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

2. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days?
   ☐ Yes ☐ No
3. Do you have a fever?
   ☐ Yes ☐ No
4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?
   ☐ Yes – go to question 5 ☐ No – screening complete

CLIENT NAME: DATE:

CLIENT SIGNATURE: