COVID-19 CLIENT QUESTIONNAIRE /DECLARATION

Our priority at this time is to keep both clients and therapists as safe as possible.

In order to achieve this we have taken measures in line with the Coronavirus act of 25th March 2020 and are duty bound to ask you the following set of questions. We assure you that the information you give remains confidential unless legally bound to release it and we thank you for your support.

Surname…… First Name(s)……..

Address……

……

Contact telephone number (preferably mobile)……

Date of Birth……..

A. **Are you currently experiencing any symptoms of COVID-19? YES NO**

Are you experiencing any of the following symptoms which have suddenly become apparent (tick those that apply)

Difficulty breathing	**Headaches**
Chest Pain	**Joint or Muscle pain**
Loss of Taste and/or smell	**Severe Lethargy**
Fever	**Runny Nose**
Persistent dry cough	**Sore Throat**

Please note: if you are experiencing difficulty breathing or chest pain you should seek medical help as soon as possible.

If you are experiencing and are worried about any of the other symptoms above you should call 111, self-isolate for 7 days and book a COVID-19 test.

B. **Is anyone in your household experiencing any symptoms of COVID-19? YES NO**

If you have answered yes, you should self-isolate for 14 days.

C. **Have you been in contact with anyone else with any COVID-19 symptoms in the last 7 days? YES NO**
Have you experienced any symptoms since? YES NO

If you have answered Yes to questions B or C, you should go online and obtain a test via the NHS website or call 119.

D. **Are you or anyone in your family currently suffering from: (tick those that apply)**

COVID-19 CLIENT QUESTIONNAIRE /DECLARATION

- **Cancer**
- **Bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs**
- **Respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD)**
- **Rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell)**
- **On immunosuppression therapies sufficient to significantly increase risk of infection**

E. Have you returned from travelling abroad in the last 14 days? YES NO

If yes, when and where?.....

F. Have you ever had a test for COVID-19 YES NO

If yes, was it positive or negative? POSITIVE NEGATIVE

If positive did you self-isolate, for how long and when did you start? YES NO

Length of time isolated……

Date commenced self-isolation……..

G. Please note that we are obliged to notify NHS track and trace if circumstances require such. if I/We report any symptoms among staff or clients, or are contacted by Track and Trace, we are legally obliged to provide them with your contact details and you may be contacted.

H. Do you promise to contact your therapist immediately if you or anyone in your household develops symptoms associated with COVID-19 within 7 days of your treatment?.....

I. If anything changes between now and your appointment time, do you promise to inform your therapist before your appointment date? ……

Signature…… **Date……**

Thank you for your cooperation.

COVID-19 - CONTROL THE INFECTION

- **Wash your hands regularly for at least 20 seconds**
- **Remember social distancing**
- **Limit your contact with others**
- **Use appropriate PPE for the circumstance**