Patient Wellness Screening Checklist

Pre-Appointment

Clients name: ..... D.O.B: .....

Contact no: ..... Postcode: .....

RECENT TRAVEL

Have you travelled abroad or to an area of high infection rate in the last 14 days? (if unsure about hot spots ensure you list all recent travel in comments)	Yes ☐	No ☐
Have any of your household or anyone you have had close contact with travelled abroad or to an area of high infection rate in the last 14 days?	Yes ☐	No ☐

SYMPTOMS / WELLNESS CHECK

Have you experienced any of the following symptoms within the last 14 days:

• Fever or feeling feverish?	Yes ☐	No ☐
• New cough?	Yes ☐	No ☐
• Shortness of breath?	Yes ☐	No ☐
• New loss of taste or smell, flu like symptoms, rash, diarrhoea or vomiting?	Yes ☐	No ☐
Have you been diagnosed or suspected of having covid-19?	Yes ☐	No ☐
If yes please provide dates: / / - / /		
Have you been tested for covid-19?	Yes ☐	No ☐
Date of test: / / - / /		
What was the test result: Positive ☐ Negative ☐		
Have you been tested for covid antibodies?	Yes ☐	No ☐
Was this capillary or venous:		
Results: Positive ☐ Negative ☐		

HOUSEHOLD & CLOSE CONTACTS

Are any of your household or people you have had close contact with in the last 14 days currently unwell with, fever, new onset cough, new loss of taste of smell, shortness of breath, flu like symptoms?	Yes ☐	No ☐
Have any of your household, or people you have had close contact with in the last 14 days been diagnosed with coronavirus or covid-19?	Yes ☐	No ☐

COMMENTS

If you have answered yes to any of the previous please provide details here:

PRE-WELLNESS CHECKLIST COMPLETED BY:

Clinician Signature:

Date: / /

DAY OF TREATMENT

I confirm that non of the above details have changed since my pre-treatment wellness check was performed. I am aware if any of the details change in the next 14 days I am obliged to inform my clinician so she can take appropriate measures.

Client signature: ..... Date: .....