COVID-19 Questionnaire

Please fill out this questionnaire for any in person treatments involving Bowen Therapy, Acupuncture, Biofeedback, or IV/Injection Therapy. All other appointments are via telemedicine and require patients not to come into the clinic.

These screening questions are based on the latest COVID-19 case definitions and the Coronavirus disease (COVID-2019) situation reports published by the World Health Organization. All questions are required.

Did you have close contact with anyone with acute respiratory Illness or have you traveled outside of the province/state or the country that our clinic is located in within the past 14 days?	○ Yes ● No
Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?	○ Yes ● No
Have you been named as a possible contact and currently under self-isolation?	○ Yes ● No
Do you have any household members who are currently under self-isolation?	○ Yes ● No
Do you have any of the following symptoms? (Please check all that apply)	☐ Fever ☐ New onset of cough ☐ Worsening chronic cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Sore throat ☐ Difficulty swallowing ☐ Decrease or loss of sense of taste or smell ☐ Chills ☐ Headaches ☐ Unexplained fatigue/malaise/muscle aches (myalgias) ☐ Nausea/vomiting, diarrhea, abdominal pain ☐ Pink eye (conjunctivitis) ☐ Runny nose/nasal congestion without other known cause

If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

○ Yes ◉ No

Declaration And Consent To Treatment

- If you answered NO to all of the screening questions please proceed with your appointment.
- If you have answered YES to any of the above questions: Please DO NOT book and appointment. If you currently have an appointment booked please contact reception to cancel immediately and to reschedule after you have completed a 14 day quarantine and are symptom free.

I understand that the treatment may be cancelled at any time if the I do not meet the pre-screening criteria upon physical presentation at the clinic. I understand that although my health care provider is following all the health and safety guidelines outlined by their governing body and the Provincial Health Officer there are no guarantees that I will not come into contact with an individual who is infected with COVID-19. I consent to receiving treatment during the COVID-19 pandemic. I understand the risks associated with close contact with others and by signing this I indemnify Butterfly Naturopathic, including their staff and health care practitioners, if I contract the COVID-19 virus as a direct result of my treatment.

I acknowledge that I have been informed of, and fully understand the above: ○ Yes ◉ No

Date:

Patient Name:

Patient Email Address:

Signature

Thank you for taking the time to read and fill out this form.

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