



## COVID-19 Screening Attestation Form

Prior to your visit at Living Well Integrative Health Centre we kindly ask you to complete this document and email, if possible, to **contact@lwhc.ca**.

If you do not have an email account, please call our office at least 24 hours prior to your appointment at, **905.372.1616** and we will assist you further.

Are you currently experiencing any of the following COVID-19 symptoms? If so please check the box next to the question, if it **does not apply**, or if your symptoms are pre-existing, **leave blank**.

Patient Name: \_\_\_\_\_

Fever 37.8 or greater?

Loss of taste or smell?

Unexplained Chills?

Headache?

New Cough?

Digestive issues? (nausea/vomiting etc)

Shortness of Breath?

Extreme Fatigue?

Sore Throat or difficulty swallowing?

Bruising or blisters on extremities or toes?

Hoarse voice?

Falling down without explanation?

Runny Nose/congestion not allergies?

Sluggishness or loss of appetite?

In the last 14 days, have you traveled to a location with known COVID-19 cases or been in close physical contact with someone who has test positive for COVID-19?

**Traveled?**

**Face to face (15m) or same room (2hr)?**

**Same home or workplace?**

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_