Covid Screening Form

Full Name	
Full Address	
Post Code	
Date of Birth	
EMAIL ADDRESS	
MOBILE NUMBER	

TESTING		
Have you or anyone in your household ever been diagnosed with Covid-19?	☐ Yes	☐ No
Have you had a Covid-19 test?	☐ Yes Date:	☐ No
If it was a positive test, do you still have symptoms?	☐ Yes	☐ No
Have you or anyone in your family been advised by the government as being clinically vulnerable and to shield?	☐ Yes	☐ No
SYMPTOMS Have you experienced any of the following symptoms now, or over the past 7 days?		
A high temperature – this means you feel hot to touch on your chest or back.	☐ Yes	☐ No
A new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual).	☐ Yes	☐ No
A loss or change to your sense of smell or taste – this means you've noticed you cannot smell or taste anything, or things smell or taste different to normal.	☐ Yes	☐ No
Have you noticed any new rashes on your body or feet?	☐ Yes	☐ No
Have you experienced any pain or cramping in your legs/calves?		☐ No
Have you been in contact with anyone with Covid-19 symptoms or been living in a household with someone self-isolating? If YES to the above please cancel your appointment and self isolate for 14 days	☐ Yes	☐ No
Have you recently travelled abroad(within the last two weeks?).	☐ Yes	☐ No
CURRENT HEALTH ISSUES (Extra PPE may be required)		
Have you undergone an organ transplant ?	☐ Yes	☐ No
Have you/ are you undergoing chemotherapy or antibody treatment for cancer, including immunotherapy	☐ Yes	☐ No
Are you having an intense course of radiotherapy (radical radiotherapy) for lung cancer?	☐ Yes	☐ No

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having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors)	☐ Yes	☐ No
Have you had blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma)	☐ Yes	☐ No
Have you had a bone marrow or stem cell transplant in the past 6 months, or are still taking immunosuppressant medicine	☐ Yes	☐ No
Have you been told by a doctor they have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD)	☐ Yes	☐ No
Have you a condition that means they have a very high risk of getting infections (such as SCID or sickle cell)	☐ Yes	☐ No
Are you taking medicine that makes them much more likely to get infections (such as high doses of steroids or immunosuppressant medicine)	☐ Yes	☐ No
Are you Pregnant	☐ Yes	☐ No
Are you over 70 years of age?	☐ Yes	☐ No
PREVIOUSLY CONTRACTED CORONAVIRUS		
When did your symptoms subside?	☐ Yes	☐ No
Are you experiencing any post covid circulatory complications such as pulmonary thrombosis, embolism, DVT or stroke symptoms?	☐ Yes	☐ No
Have you had any allergic reactions post covid?	☐ Yes	☐ No
EXPOSURE TO COVID-19 (extra PPE precautions may be required)		
Are you an NHS frontline worker?	☐ Yes	☐ No
A carer, home or care home.	☐ Yes	☐ No
Are you allergic to latex gloves or specific leaning products?	☐ Yes	☐ No
DECLARATION		
If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Test & Trace I will inform you.	☐ Yes	☐ No
I promise to contact your therapist immediately if I or anyone in my household develops symptoms associated with covid-19 within 7 days of my treatment?	☐ Yes	☐ No
I understand the risks I am undertaking of having a face to face consultation and that the treatment time will be no longer than 45minutes in total.	☐ Yes	☐ No

Signature____ Date_________________________