Form Client COVID-19 Screening Questionnaire

Good Morning,

To make sure we all stay safe and healthy, we are asking everyone entering the building some questions about their health.

Some of these questions may seem personal, but they are all important and I need to ask them.

Client Name_____

1. **Are you experiencing any of the following symptoms?**
   - **a. Fever** Yes/No
   - **b. New or worsening cough** Yes/No
   - **c. Stuffy or runny nose** Yes/No
   - **d. Sore throat or painful swallowing** Yes/No
   - **e. Difficulty breathing** Yes/No
   - **f. Diarrhea** Yes/No
   - **g. Nausea and vomiting** Yes/No
   - **h. Fatigue** Yes/No
   - **i. Muscle aches** Yes/No
   - **j. Loss of appetite** Yes/No
   - **k. Chills** Yes/No
   - **l. Headache** Yes/No
   - **m. Loss of sense of smell** Yes/No

**Cough that is not due to seasonal allergies or known to pre-existing conditions.*

2. **Have you travelled outside of Canada- Including the United States within the last 14 days?** Yes/No
3. **Have you been in close contact with someone who has COVID-19 within the last 14 days?** Yes/No

4. **Have you been in close contact with someone who has COVID symptoms within the last 14 days?** (Cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and diarrhea).
   Yes/No
5. **Have you been told to self-isolate in accordance with Public Health directives?** Yes/No

How to respond:

If the client answers "**No"** to all the questions, the client may continue on with the day.

If the client answers "**Yes" to 3 or more of the symptoms and "Yes" to questions 2-5**, then please isolate the client and contact family member immediately.

Family Contact _____ #_____

***Contact Health Link BC 8-1-1 for further instructions.*

Form completed by: _____ Date;

BC Centre for Disease Control. (2020). http://covid-19.bccdc.ca/

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