NAKED ELECTROLYSİS

Covid-19 Client Self-Assessment

Please complete this self-assessment of symptoms prior to your appointment. İf you answer No to all the questions, bring your completed assessment form with you to your scheduled appointment.

İf you answer yes to any of the below, please respect our safety - do not attend your appointment and call to re-schedule your appointment. No cancellation fee will be charges.

Name: _____ Date: _____

	Yes	No
• İn the past 14 days, were you notified by AHS that your have tested positive for Covid-19 or are you awaiting results of testing?	☐	☐
• İn the past 14 days, were you notified by AHS or anyone else that you are connected to an outbreak or that you are a close contact with anyone who is a confirmed case of Covid-19?	☐	☐
• Have you been in contact with or are you living with anyone under AHS directed quarantine or is anyone advised by AHS to isolate due to a close contact?	☐	☐
How are you feeling today - Do you have any of the following symptoms?	Yes	No
• Chills/Stuffy Nose / Painful swallowing	☐	☐
• Tiredness / Fatigue / Muscle / Joint aches and pains / Headaches / Severe exhaustion	☐	☐
• Loss of sense of smell, taste or unexplained loss of appetite	☐	☐
• Diarrhea / Nausea / Pink eye	☐	☐
Are you experiencing any of the following?	Yes	No
• Severe difficulty breathing / Chest pain	☐	☐
• Difficulty waking up / lost consciousness	☐	☐
• Feeling confused	☐	☐
İn the past 10 days, have you experienced any of the following?	Yes	No
• Fever / Sore throat / Runny nose	☐	☐
• New onset or worsening shortness of breath / Difficulty breathing / Cough / Chronic cough	☐	☐
• İnability to lie down because of difficulty breathing/shortness of breath at rest	☐	☐

Signature: _____