

COVID 19 Client Screening Questionnaire

Name & Surname	
ID Number	
Telephone Number	
Physical Home Address	
Name Of Next Of Kin	
Telephone Number Of Next Of Kin	

Have you experienced any of the following symptoms in the past 14 days	Yes	No
Felt feverish?		
Have a dry cough?		
Have a sore throat?		
Have breathing difficulties?		
Have Diarrhoea?		
Have severe muscle aches?		
Have continuous chest pains?		

Please answer the following questions:	Yes	No
Have you been in contact with a known COVID-19 patient in the past 14 days?		
Have you been in hospital (either as a visitor or patient) in the past 14 days?		
Has anyone in your household had flu-like symptoms in the past 14 days?		
Do you have any advice from the Government Health Department to stay quarantined for possible exposure ? or are you on the COVID-19 surveillance list of the Health Department?		
Have you travelled domestically using public transports or outside the country in the past 14 days		

☐ I'm willing to get my body temperature checked before beginning my salon service. If my Temperature is above 37.5°C. I agree to not visit the Salon for the next 14 days and with any of the common COVID-19 symptoms including Fever, Cough, Sore throat, Running nose, Respiratory difficulties, Muscle Aches

Temperature	
Comment	

- ☐ I consent to wearing my facial mask at all times while in the salon.
- ☐ I understand all the potential risks and complications related to COVID-19, and I would like to proceed with my desired treatment.
- ☐ I understand, read and completed this questionnaire truthfully to the best of my knowledge. All of my questions have been answered to my satisfaction and I consent to the terms herein.

Date of Appointment	
Time of Appointment	
Signature	