Mirka's
Therapeutic Health & Laser Clinic

VISITOR QUESTIONNAIRE

Have you been vaccinated YES ☐ NO ☐ If YES - First shot ☐ Second shot ☐

Have you tested positive for Covid-19 in the past 10 days? YES ☐ NO ☐

Have you been told you should be isolating? YES ☐ NO ☐

Have you flown domestically or internationally in the last month? YES ☐ NO ☐

If YES then did you self-quarantine for 14 days when you returned? YES ☐ NO ☐

Have you been in contact with anyone suspected/diagnosed with Covid-19? YES ☐ NO ☐

Do you have any of the following symptoms?	YES	NO
Fever	☐	☐
Cough	☐	☐
Difficulty breathing	☐	☐
Shortness of breath	☐	☐
Unable to eat or drink	☐	☐
Feeling weak	☐	☐
Runny nose	☐	☐
Loss of taste or smell	☐	☐
Sore throat, trouble swallowing	☐	☐
Nausea, vomiting, diarrhea, abdominal pain	☐	☐

Full Name:_____

Signature :_____ Date: _____

By signing, you agree that the above information is true to THE BEST OF YOUR KNOWLEDGE. Questionnaire must be filled out in full, signed and returned to Mirka's Therapeutic Health & Laser Clinic before receiving approval to visit.