Client Screening Questionnaire

In an effort to protect all of our clients and staff members from illness we are asking all clients please answer the following questions. Thank you for your patience and understanding.

Have you or a member of your household tested positive for COVID-19 in the last 14 days?	YES ☐	NO ☐
Have you or a member of your household had prolonged contact, close contact with anyone recovering from COVID-19 in the last 14 days?	YES ☐	NO ☐
Have you traveled outside of the USA in the last 14 days?	YES ☐	NO ☐
Have you traveled to any high-risk areas in the 14 days?	YES ☐	NO ☐

Are you or any member of your household experiencing any of the following symptoms?

Fever of higher than 100.4°F	YES ☐	NO ☐
Difficulty Breathing / Shortness of Breath	YES ☐	NO ☐
Cough / Sore Throat	YES ☐	NO ☐
Severe headache	YES ☐	NO ☐
Diarrhea / Vomiting / Severe Abdominal Pain	YES ☐	NO ☐
Muscle Pain / Weakness	YES ☐	NO ☐

If you have marked yes to any of these questions, please postpone your visit for at least 14 days from the start of your symptoms and contact your healthcare provider.

Thank you for understanding.

Signature: ____ Date: ____________________