Health Screening Questionnaire Related to COVID-19

Client Name: Date:

Have you had any person-to-person contact with someone who has exhibited COVID-19 symptoms in the last 10 days?

Yes No

Have you visited an area where there has been a significant outbreak of COVID-19 activity in the last 10 days?

Yes No

Have you had a fever for at least 72 hours (that is three full days of no fever without the use medicine that reduces fevers); AND other symptoms have improved (for example, when cough or shortness of breath have improved); AND at least 10 days have passed since symptoms first appeared. (if previously diagnosed with COVID-19)?

Yes No

Are you exhibiting any symptoms related to COVID-19, i.e. fever, cough, sore throat, shortness of breath, chills, muscle pain, headache, and new loss of taste or smell?

Yes No

Do you have a new fever (100.4°F or higher), or a sense of having a fever?

Yes No

Do you have a new cough that you cannot attribute to another health condition?

Yes No

Are you experiencing new shortness of breath that you cannot attribute to another health condition?

Yes No

Do you have a new sore throat that you cannot attribute to another health condition?

Yes No

Are you experiencing new muscle aches that you cannot attribute to another health condition, or that may have been caused by a specific activity (such as physical exercise)?

Yes No

Signed ________________________________ Date ______