Covid Screening Questionnaire (Intake Form Addendum)

Client Name: _____Date: _____

Preferred phone number: _____ Best time to call: _____

Email address: _____

Preferred form of communication: _____

COVID-19 Related Questions

1. Have you been tested for COVID-19? Yes ☐ No ☐
   - 1.1. If yes, what type of test did you have? _____
   - 1.2. When was your test? _____
   - 1.3. Where were the results? _____

2. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

3. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, nasal or sinus congestion, muscle aches, fatigue, or shortness of breath)? Yes ☐ No ☐

4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

5. Have you traveled anywhere outside of the DMV area in the last two weeks? Yes ☐ No ☐

Location: _____

6. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

7. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

8. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

9. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin, especially on the feet? Yes ☐ No ☐

Do you have any question or concerns:

_____

I declare that the information provided above is true and accurate to the best of my knowledge.

_____ _____ _____

Client's Name (printed) Client Signature Date