COVID-19 Screening Questionnaire

Patient Name: _____

Within the last 14 days…

1.	Have you had a fever over 100.0?	□ YES	□ NO
2.	Have you had shortness of breath or other difficulties breathing?	□ YES	□ NO
3.	Have you had a cough?	□ YES	□ NO
4.	Have you had any other flu-like symptoms, such as sore throat, GI upset, headache or fatigue?	□ YES	□ NO
5.	Have you experienced loss of taste or smell?	□ YES	□ NO
6.	Have you been in contact with any one confirmed positive for COVID-19?	□ YES	□ NO
7.	Have you tested positive for COVID-19?	□ YES	□ NO

I agree to notify INDEPENDENT PHYSICAL THERAPY if I do become ill with COVID-19 symptoms or test positive for COVID-19. I understand if I do become ill with COVID-19 symptoms or test positive for COVID-19 my treatment will be placed on a 14 day hold to ensure all symptoms subside prior to returning. I must bring a negative COVID-19 test result if I wish to continue treatment without a 14 day hold.

Signature: _____ **Date:** _____