COVID-19 Health Screening

Name:_____ Date:_____

1. Have you had any of the following symptoms in the last 14 days? **YES** ☐ **NO** ☐
   If "yes", please circle symptom(s).

   - ☐ Persistent cough
   - ☐ Shortness of breath or difficulty breathing
   - ☐ Fever
   - ☐ Chills
   - ☐ Body aches
   - ☐ Sore throat
   - ☐ New loss of taste or smell
   - ☐ Nausea, vomiting or diarrhea

   ☐ If you answered "yes" to any of the above: Have you discussed these symptoms with your physician? **YES** ☐ **NO** ☐
   Comment:_____

2. In the last 14 days have you been in close contact with an individual who has had any of the above symptoms? **YES** ☐ **NO** ☐
   Comment:_____

3. Have you traveled outside of WA or the USA in the last 14 days? **YES** ☐ **NO** ☐
   Comment:_____

4. Have you been in close contact with an individual who has traveled outside of WA or the USA in the last 14 days? **YES** ☐ **NO** ☐
   Comment:_____

5. Have you been exposed to someone diagnosed with COVID-19 within the last 14 days?
   If "yes," since exposure, have you been tested for COVID-19? **YES** ☐ **NO** ☐
   Comment:_____

6. Have you been diagnosed with COVID-19? If "yes," have you been cleared of it since testing positive? **YES** ☐ **NO** ☐
   Comment:_____

If you answered "yes" to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability.

If you have any questions please contact Christine Nelson at 360-201-3592. Thank you for assisting us in our endeavors to minimize the exposure to COVID-19.

Temperature:_____