# COVID-19 Pre-Appointment Screening Questionnaire

** indicates a required field*

## COVID-19 Client Screening Questionnaire

*** Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever or temperature of or greater than 100 degrees Fahrenheit?**

- ◯ Yes
- ◯ No

*** Have you or a member of your household been advised to be tested for COVID-19 by government officials or health care providers?**

- ◯ Yes
- ◯ No

*** Have you or anyone in your household been tested for COVID-19?**

- ◯ Yes, and I am awaiting test results
- ◯ Yes, and I have received the results
- ◯ No

*** Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19 in the last 21 days?**

- ◯ Yes
- ◯ No

*** Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?**

- Yes
- No

*** Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the last 30 days?**

- Yes
- No

*** Have you been in close proximity to any individual who tested positive for COVID-19 in the last 21 days (i.e. workplace)?**

- Yes
- No

**Have you been fully vaccinated for COVID-19 vaccine, including a booster vaccine? If so, please bring your COVID-19 vaccination card to your first in-person appointment or upload same to the client portal.**

- Yes
- No

* **I agree that I have answered all of the above questions to the best of my knowledge and understand that my appointment may be rescheduled or conducted via telehealth based on this screening.** _____

I consent to sharing information provided here.

Source: American Medical Association