COVID-19 CLIENT PRESCREEN

Client Name: _____ Temperature:_____

Please circle **YES** or **NO** to the following questions:

Have you and/or anyone accompanying you today:

~ traveled outside or within the USA in the last 14 days?

Yes No

~ been diagnosed with COVID-19 or been in close contact with a person known to have COVID-19?

Yes No

~ recently or currently had a fever, chills or have taken medication for a fever?

Yes No

~ recently or currently had any respiratory symptoms such as a cough of shortness of breath?

Yes No

~ recently or currently experienced a headache, sore throat or muscle pain?

Yes No

~ recently or currently experienced a new onset of loss of taste or smell?

Yes No

If answered YES to the travel question above:

Dates of Travel and Location_____

Signature of person completing this questionnaire: _____Phone Number:_____

Relationship to client/minor (if applicable:)_____