COVID-19 SCREENING QUESTIONS FOR CLIENTS

1. Do you have any of the following symptoms?
    a. Cough
    b. Shortness of breath

2. Do you have any 2 of the following symptoms?
    a. Fever of 100.4 or higher
    b. Chills
    c. Muscle Pain
    d. Headache
    e. Sore Throat
    f. Loss of Taste or Smell
    g. Vomiting or Diarrhea

3. Have you tested positive for the COVID-19 virus?

4. Have you been exposed to anyone who has tested positive for the virus within the past 14 days or less?

5. Have you been exposed to anyone, within the past 14 days or less who has experienced the following symptoms?
    a. Cough
    b. Shortness of breath

6. Have you been exposed to anyone, within the past 14 days or less, who has experienced 2 of the following symptoms?
    a. Fever of 100.4 or higher
    b. Chills
    c. Muscle pain
    d. Headache
    e. Sore throat
    f. Loss of taste or smell
    g. Vomiting or diarrhea

7. Have you traveled internationally in the past 14 days or less?

**** If you have answered "YES" to any of these questions, we request that you please contact our office to reschedule your appointment.**