COVID-19 SCREENING

Printed Name (LAST, FIRST): _____

Date of Birth (MM/DD/YY): _____ **Today's Date** (MM/DD/YY): _____

Time of Form Completion: _____

1. Have you washed your hands with warm water and soap for 20 seconds or used alcohol-based hand rub upon entry to the clinic? **YES** Please initial _____

2. Have you or do you have any of the following acute respiratory symptoms? *Please Circle the symptoms you are experiencing and cross out the symptoms you are not.*
   - ❏ Cough
   - ❏ Shortness of breath
   - ❏ Chest tightness/discomfort

   OR any of these symptoms?
   - ❏ Fever
   - ❏ Chills
   - ❏ Repeated shaking with chills
   - ❏ Muscle pain
   - ❏ Headache
   - ❏ Sore throat
   - ❏ New loss of taste or smell
   - ❏ Vomiting
   - ❏ Diarrhea

3. Check temperature: Trial 1_____Trial 2_____
   Fever present if reading is > 100 degrees F.

4. Have you been present in or worked in facilities or locations with recognized COVID-19 cases? **YES / NO**

5. Do you work or live with a person(s) with possible symptoms of COVID-19 or who has/had confirmed COVID-19? **YES / NO**

6. Have you traveled outside of the state in the last 14 days? **YES / NO**

Patient Signature: _____

Does the patient meet the criteria to stay for the appointment? **YES / NO** (*Symmetry Employee ONLY*)
Symmetry PT Staff signature: _____