To protect everyone, including our patients and staff, we are asking all visitors to complete the following questionnaire.

Patients Name: ____ Date: ___________________________

1. Have you, in the past 14 days, traveled out of the state or country? YES/NO
   Details: ____
   ____

2. Have you in the past 14 days been in contact with a novel coronavirus (COVID-19) infected person? YES / NO

3. Have you in the past 14 days felt unwell or had any of the below symptoms? Yes / No
   - Fever greater than 100 degrees
   - Shortness of breath
   - Cough
   - Digestive Symptoms such as Diarrhea or Vomiting

4. Are you over 65, or have a chronic lung condition, heart disease, diabetes, high blood pressure, high cholesterol, or an auto immune suppressive medication? YES / NO
   - If YES you are at a higher risk for serious illness from COVID-19 and should consider taking extra precautions to reduce the risk of getting sick with the disease including possibly delaying your physical therapy care if appropriate.

We would be happy to answer any questions or concerns you have may have.

Patient Signature: ____ Date: __________________