Jul 7,2020

Out East Therapy COVID-19 PATIENT SCREENING QUESTIONNAIRE

OUT EAST THERAPY

*Indicate Yes or No and provide relevant comments.

Patient Name: _____ Date: _____

Screening Questions	Pre-Appointment*	In-Office*	Anywhere else therapy is taking place/and where?
Take temperature now: Have you or anyone in your home had a fever, or have felt feverish recently?			
Do you or anyone in your home have a cough?			
Are you having shortness of breath or any difficulty breathing? Anyone in your home?			
Do you have chills or repeated shaking with chills?			
Do you have any muscle pain?			
Do you have any recent onset of headache or sore throat?			
Do you have any other flu-like symptoms?			
Do you have any recent loss of taste or smell?			
Have you experienced any recent GI upset or diarrhea?			
Are you in contact with anyone who has been confirmed to be COVID-19 positive?			
Have you been in a hospital or nursing facility in the past 14 days?			
Have you been tested for COVID-19? If yes, what was the result?			
Have you been diagnosed with COVID-19? If yes, when?			
Are you over the age of 65?			
Have you been out of NYS in the past 2 weeks?			