

TODAY'S DATE: _____

The information in this questionnaire will not be shared with anyone outside of the ProBalance Clinic/Studio. It helps to ensure the safest environment for your clinical/studio experience.

<p>1. Are you FULLY VACCINATED? **</p> <ul style="list-style-type: none"> Fully vaccinated is defined as 14 days following either your second shot of a 2 shot series or 14 days after a 1 shot vaccine (J&J). <p>**If you are fully vaccinated, you may skip questions 3-5.</p>	<p>YES NO</p>												
<p>2. Have you experienced any of the following symptoms in the past 48 hours:</p> <table border="0"> <tr> <td>Fever or chills</td> <td>sore throat</td> </tr> <tr> <td>Cough</td> <td>new loss of taste or smell</td> </tr> <tr> <td>Shortness of breath or difficulty breathing.</td> <td>Congestion or runny nose</td> </tr> <tr> <td>Fatigue</td> <td>nausea or vomiting</td> </tr> <tr> <td>Muscle or body aches</td> <td>diarrhea</td> </tr> <tr> <td>headache</td> <td></td> </tr> </table>	Fever or chills	sore throat	Cough	new loss of taste or smell	Shortness of breath or difficulty breathing.	Congestion or runny nose	Fatigue	nausea or vomiting	Muscle or body aches	diarrhea	headache		<p>YES NO</p>
Fever or chills	sore throat												
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<p>3. Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?</p>	<p>YES NO</p>												
<p>4. Have you traveled outside of the area in the past 10 days? <i>Travel is defined as any trip that is overnight AND on public transportation (plane, train, bus, Uber, Lyft, cab, etc.) OR any trip that is overnight AND with people who are not in your household.</i></p>	<p>YES NO</p>												
<p>5. Are you currently awaiting the results of a COVID-19 test? <i>Answer "NO" if you are waiting on the results of a Pre-travel COVID-19 test.</i></p>	<p>YES NO</p>												

<p>6. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?</p>	<p>YES NO</p>

I have signed this document truthfully and to the best of my ability.

<p>PRINTED NAME</p>	
<p>SIGNATURE</p>	