

TODAY'S DATE: _____

PLEASE READ EACH QUESTION CAREFULLY AND CIRCLE YOUR RESPONSE

Have you traveled outside of the general area in the last 14 days?	YES	NO
Have you experienced any of the following symptoms in the past 48 hours? Fever or chills Cough Shortness of breath or Difficulty breathing Fatigue Muscle or body aches Headache	YES	NO
Sore throat New loss of taste or smell Congestion or runny nose Nausea or vomiting Diarrhea		
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?	YES	NO
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?	YES	NO
Are you currently waiting on the results of a COVID-19 test?	YES	NO

Did you answer NO to ALL QUESTIONS?	You may proceed inside our facility and with your PT session
Did you answer YES to ANY QUESTION?	Sorry we are unable to see you in our facility at this time. Please consult with your Primary Care Physician and get further medical instruction. Thank you for helping us protect you and others at this time.

PRINTED NAME	
SIGNATURE	