Patient Name:_____

Date of Birth:_____ Date:_____

Have you experienced a fever greater than 100°F in the last 24 hours? ____Yes ____No

Have you recently been tested for COVID? ____Yes ____No

Have you experienced any of the following symptoms in the last 14 days (circle)?

Fever Chills Headache

Sore Throat Muscle Pain Repeated shaking with chills

New loss of taste of smell Vomiting/Diarrhea Shortness of Breath

____Yes ____No

Have you or anyone in your home been exposed to anyone with a confirmed diagnosis of COVID-19? ____Yes ____No If YES, please explain_____

----------STAFF USE ONLY----------

Temperature:_____

Does patient have a signed COVID-19 Risk Consent? ____Yes ____No

Have you observed client wash or sanitize their hands? ____Yes ____No

Procedure(s) Performed:

Will the client be required to remove their mask for their treatment? ____Yes ____No

**If patient must remove their mask provider must wear safety glasses

Do you (staff) have proper PPE in the room for use during the treatment? ____Yes ____No

Staff Signature: _____ Date: _____