MICHELLE MANTO
Berkshire Acupuncture ⁘ Wellness

291 Main Street, #6 | Great Barrington, MA 01230 | 413-644-9488 | berkshireacupuncture.com
Helping People Heal

COVID-19 Patient Screening Questionnaire

Patient Name: _____

Call scheduled patients 18-24 hours prior to their appointment time to conduct initial verbal screening. Re-assess by restating questions to complete screening process prior to patient entering office for planned treatment.

Have you returned from a visit to China, Japan, Iran, South Korea, or Italy – or travelled to New York, Connecticut, Massachusetts, Louisiana, Illinois, Michigan, California, or Washington State after Jan 1, 2020?

Pre-screen Date:_____ No ___Yes____ F/U Date:_____No____ Yes____ F/U Date:_____No____ Yes____

Have you been in contact with a person who has tested positive to COVID-19 or has returned from one of the above countries or states in the past 14 days who also exhibits respiratory symptoms (fever, cough, difficulty breathing)?

No ___Yes____ No____ Yes____ No____ Yes____

Any serious underlying health conditions, including high blood pressure, chronic kidney disease undergoing dialysis, liver disease, heart condition, chronic lung disease, diabetes, obesity BMI 40+, asthma, and those immune-compromised, including receiving cancer treatment, chemotherapy, smoking, bone marrow/organ transplant, poorly controlled systemic viral conditions, prolonged corticosteroids or other immune weakening medications. (Circle All)

No ___Yes_____ No____ Yes____ No____ Yes____

Do you live in a nursing home, assisted living or long-term care facility?

No __Yes____ No____ Yes____ No____ Yes____

Answers "yes" to any question listed above identifies "Vulnerable Individuals (VI)." Follow Federal, State, Local guidelines (VI recommended to remain at home). Screen for existence of two (2) or more positives for co-existing risk factors (below) during the past 14 days: Patients who answer "yes" to two (2) questions above or two (2) questions below may not be treated in your office. Refer to PCP, nearest ER or Local Health Department Clinic for COVID-19 clinical evaluation. Patient will need to provide documentation/results they were screened or tested for COVID-19 before being treated in the office.

Age 65+	No_ ____Yes____	No____ Yes____	No Yes
Fever of 100°F or greater?	No ____ Yes____	No____ Yes____	No Yes
Cough?	No ____ Yes____	No____ Yes____	No Yes
Difficulty breathing?	No ____ Yes____	No____ Yes____	No___ Yes___
Chills or repeated chills?	No ____ Yes____	No____ Yes____	No___ Yes___
Muscle pain?	No ____ Yes____	No____ Yes____	No___ Yes___
Headache?	No ____ Yes____	No____ Yes____	No___ Yes___
Sore Throat	No ____ Yes____	No____ Yes____	No___ Yes___
New loss of taste of smell?	No ____ Yes____	No____ Yes____	No___ Yes___

DOS Patient Temperature: _____

*Monitor the CDC website for additional COVID-19 risk factors and symptoms. Update screening tool as needed.

Provider Name: _____

Provider Signature: _____ Date: _____

Patient Name: _____

Patient Signature: _____ Date: _____