COVID-19 Pre-Exercise Screening Questionnaire

Name:		DOB:		Date:	
Temperature Reading:			Initial/ Read By:		

Instructions: Circle YES or NO to the following questions

Yes	No	1. Have you tested for COVID-19 in the past 14 days? If tested, what results? POSITIVE NEGATIVE PENDING
Yes	No	2. Have you been exposed to anyone with suspect or confirmed COVID-19 in the past 14 days?
Yes	No	3. Have you traveled out of the area, or state by car, airplane, or train in the past 14 days? If yes, where was the travel? _____

Have you experienced the recent onset of any of the following symptoms in the past 14 days:

Yes	No	Fever or chills	Yes	No	New loss of taste or smell
Yes	No	Cough	Yes	No	Sore throat
Yes	No	Fatigue	Yes	No	Congestion or runny nose
Yes	No	Muscle or body aches	Yes	No	Nausea or vomiting
Yes	No	Headache	Yes	No	Diarrhea
Yes	No	Shortness of breath or difficulty breathing			

Seek emergency medical attention if experiencing any of the following:
(a) trouble breathing, (b) persistent pain or pressure in the chest (c) new confusion (d) inability to wake or stay awake (e) bluish lips or face.

I, the undersigned, acknowledge that while my home care provider's office is using its best effort at maintaining good environmental and personal hygiene, they cannot ensure that the office is free from potential exposure to coronavirus. I have been given the option to defer my services to a later date. However, I understand the potential risks, including but not limited to the potential short- term and long-term complications related to COVID-19, and I would like to proceed with my scheduled appointment today.

Service Recipient Signature: _____

Witness: _____ Date: _____

Provider Approval Initials (to see Service Recipient): _____ Date: _____

PLEASE RETURN FORM TO THE ADMINISTRATOR, THEN WAIT IN THE CAR. ENTER CELL PHONE NUMBER AND PLEASE ANSWER WHEN WE CALL YOU TO COME IN. If you do not have a cell phone or got dropped off, inform the front desk.

YOUR CELL PHONE NUMBER: _____ TIME:_____

** Consider the context of symptoms by each individual, medical history or chronic condition is to be considered (if other than fever, cough, loss of taste/smell) when making clinical determination of whether or not to see service recipient.