FUNCTIONAL
PHYSICAL THERAPY

COVID-19 Daily Questionnaire

To maintain a healthy and safe environment during the ongoing pandemic, Functional Physical Therapy asks that patients fill out the following questionnaire prior to each treatment session. Following health guidelines, we will also be taking your temperature and documenting it at the bottom of this form. Please check **YES** or **NO** to each of the following questions. Thank you for assisting us in our efforts to reduce the spread of COVID-19.

I. **Have you or anyone in your household experienced any of the following symptoms, not caused by another condition?:**
   - A. **Fever (greater than 100 degrees Fahrenheit) or chills**
   - B. **Cough**
   - C. **Shortness of breath or difficulty breathing**
   - D. **Fatigue**
   - E. **Muscle of body aches**
   - F. **Recent loss of taste or smell**
   - G. **Sore Throat**
   - H. **Congestion**
   - I. **Nausea or vomiting**
   - J. **Diarrhea**

YES _____ NO _____

II. **Within the past 14 days, have you or anyone in your household had contact with anyone with known COVID-19 symptoms? Contact is being within 6 feet (2 meters) or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example coughed or sneezed on)?**

YES _____ NO _____

III. **Have you had a positive COVID-19 test for an active virus within the past 10 days?**

YES _____ NO _____

IV. **Within the past 14 days, has a public health or medical professional told you to self-monitor, self isolate, or self-quarantine because of concerns about COVID-19 infection?**

YES _____ NO_____

V. **Within the past 14 days, have you traveled outside the USA, or to a state that is currently recommended by New Jersey to self quarantine following visiting?**

YES _____ NO _____

Your Signature/Guardians Signature	**Date**

Client Name:_____Guardian Name (if applicable):_____