Sexual Assault Services
COVID-19 Screening Questionnaire

1. Have you or anyone in your household experienced any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell in the last 21 days?
   □ Yes □ No

2. Have you or anyone in your household been diagnosed with Coronavirus/COVID-19?
   □ Yes □ No

   If yes, have you and/or the person in your household been cleared as non-contagious by state or local public health authorities?

   □ Yes □ No

3. Have you or anyone in your household been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19?
   □ Yes □ No

4. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?
   □ Yes □ No

   If yes explain:

   _____
   _____
   _____

5. Have you or anyone in your household traveled in the U.S or on a cruise ship in the past 21 days?
   □ Yes □ No

   If yes explain:

   _____
   _____
   _____

6. Are you or is anyone in your household a health care provider or emergency responder?
   □ Yes □ No

   If yes explain:

   _____
   _____
   _____

7. Have you been following all CDC recommended guidelines as much as possible and limiting your exposure to the Coronavirus/COVID-19?
   □ Yes □ No