COVID-19 Health Information

Name: _____ Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes □ No □

2. Do you now, or have you in the last 14 days had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, diarrhea, shortness of breath, new loss and/or distorted sense of smell or taste, or any other new symptoms)?
Yes □ No □

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19, has coronavirus-type symptoms or has been advised to quarantine because of exposure to COVID-19? Yes □ No □

4. Have you been diagnosed with COVID-19? Yes □ No □ If yes, when? _____

5. Have you traveled anywhere outside of the state in the last two weeks? Yes □ No □

Location: _____Date returned to Portland: _____

6. Have you spent an extended amount of time (15 minutes or longer) with a person / people you don't live with in an enclosed space in the past two weeks? Yes □ No □

7. Have you been diagnosed with a blood clot or blood clotting disorder? Yes □ No □

8. Are you on any blood thinning medication? Yes □ No □

9. Can you exercise to get your heart rate and respiratory rate up without any problem?
Yes □ No □

10. Have you had any onsets of new muscle aches and/or pain since the emergence of COVID 19? Yes □ No □

11. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?
Yes □ No □

12. Have you experienced any unexplained pain, swelling, redness, tingling / numbness, feeling of warmth in your arms or legs?
Yes □ No □