

# COVID-19 Health Information Daily Screening Form

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

13. I agree to inform my therapist/client as soon as possible if within 14 days of our last appointment I develop symptoms of; become diagnosed with; or exposed to COVID19.  
Yes  No