COVID-19 Health Intake

Client Name:_____ DOB:_____

1. Have you had a fever in the last 24 hours of 100 degrees or above? Y/N

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, shortness of breath? Y/N

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Y/N

4. Have you been diagnosed in the past with COVID-19? Y/N
   If yes, date of diagnosis_____

Signature:_____ Date:_____