

## COVID-19 Intake Questions

1. Have you been tested for COVID-19? If so, when? What was the result?
2. In the last 14 days:
  - a. Have you been in contact with anyone who has been diagnosed with COVID-19 or has had coronavirus-type symptoms?
  - b. Have you been asked to self-isolate or quarantine by a doctor or local public health official?
  - c. Have you been somewhere with a high infection rate?
3. Do you now, or have you recently experienced any of the following as a NEW PATTERN since the beginning of the pandemic:
  - a. Fever
  - b. Chills
  - c. Shortness of Breath
  - d. Cough
  - e. Sore Throat
  - f. Nasal, sinus congestion
  - g. Loss of sense of taste or smell
  - h. Persistent Chest Pain or Pressure
  - i. Diarrhea, digestive upset
  - j. Skin marks, lesions, or rashes (especially on the feet)
  - k. Fatigue
  - l. Sudden onset of muscle soreness (not related to a specific activity)
  - m. Discomfort with exertion or exercise
4. If you tested positive for COVID-19 or believe you may have had COVID-19 but were not tested:
  - a. Has your medical doctor cleared you to return to work or to end self-isolation?
  - d. Are you taking any drugs to manage blood clotting?

Signature: \_\_\_\_\_

Date: \_\_\_\_\_