COVID-19 PRE-SCREENING QUESTIONNAIRE

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First Name:		MI:	Last Name:
DOB:	Age:		Today's Date:

Have YOU, or ANYONE you have been around, tested POSITIVE for COVID-19 in the last 14 days?

OYes O No

If YES, please provide the date of the positive test: _____

Have you had a FEVER in the last 14 days?

O Yes O No

What is your temperature now? (REQUIRED) _____℉

O I AGREE to check my TEMPERATURE the morning of EACH SCHEDULED IN-CLINIC report it to Physical Therapy San Pedro. **I understand** this is for the protection of my health, my clinician's health, and the health of all other patients of Physical Therapy San Pedro.

Do you, or anyone you live with / care for, have a COMPROMISED IMMUNE SYSTEM?

OYes O No

Have you had a PERSISTENT, DRY COUGH in the last 14 days?

OYes O No

Have you had any SHORTNESS OF BREATH in the last 14 days?

OYes O No

Have you felt any FLU-LIKE symptoms in the last 14 days?

OYes O No

Have you experienced a loss / lack of TASTE a*nd* / or SMELL onset in the last 14 days?
OYes O No

Have you been around ANYONE with a PERSISTENT, DRY COUGH; SHORTNESS of BREATH; FLU-LIKE symptoms; or who has experienced a lack / loss of TASTE or SMELL in the last 14 days?

OYes O No

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Patient Name: **DOB:**

Have you, or anyone you have been around, traveled DOMESTICALLY or INTERNATIONALLY in the last 6 months?

O Yes - DOMESTICALLY

O Yes - INTERNATIONALLY

O Yes- DOMESTICALLY & INTERNATIONALLY

O No - Neither DOMESTICALLY or INTERNATIONALLY

If YES, when was your last date of travel? _____

If you have any other symptoms or comments you may want to add, please write below:

_____

_____

_____

Infection Control and Prevention - Standard Precautions Followed by Physical Therapy San Pedro clinicians/staff:

Hand Hygiene - wash in / wash out. Use hand sanitizer before and after the use of any equipment.

Sanitary areas will be utilized by the clinicians/staff for their: bag / shoes / other personal items.

Cleaning and Disinfection - all evaluations tools, therapy equipment, pens, electronic devices.

Respiratory Hygiene (Cough / Sneeze Etiquette) - patient, clinicians, staff: mask on during treatment. Limited touching or repositioning of outside of mask.

O I acknowledge I have been informed of the Infection Control and Prevention - Standard Precautions followed by Physical Therapy San Pedro clinicians & staff

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Patient Name: **DOB:**

O I AGREE, to wash and sanitize my hands prior to my therapy visit, upon arrival to the clinic, before leaving the clinic, and upon arriving home from my therapy visit. I also agree to have a mask or face covering on and with me during my treatment.

O I *A*GREE, to notif*y* Physical Therapy San Pedro **IMMEDIATELY** and **CANCEL** therapy services for 14 days if I have, or anyone I have been around has, a TEMPERATURE; PERSISTENT, DRY COUGH; SHORTNESS of BREATH; FLU-LIKE symptoms; or experienced a lack / loss of TASTE or SMELL.

O I AGREE, to notify Physical Therapy San Pedro **IMMEDIATELY** and **CANCEL** therapy services for 14 days if I have, or an*y*one I have been around has, tested POSITIVE for COVID-19 or is PRESUMED POSITIVE for COVID-19. LEGAL ATTESTATION

I, the patient / responsible party, declare under penalty of perjury under the laws of the State of California, and laws of the United States of America, that the foregoing is true and correct.

Patient's Name

Patient/Guardian Signature

Guardian Name/Association

Date