COVID-19 PATIENT SCREENING QUESTIONAIRE

Name: ______________________________ Date: ______________

Screening Questions	Pre-Appointment*	COMMENTS
Do you have a fever, or have you felt feverish recently?		
Do you have a cough?		
Are you having shortness of breath or any difficulty breathing?		
Do you have chills or repeated shaking with chills?		
Do you have any muscle pain?		
Do you have any recent onset of headache or sore throat?		
Do you have any other flu-like symptoms?		
Do you have any recent loss of taste or smell?		
Have you experienced any recent GI upset or diarrhea?		
Are you in contact with anyone who has been confirmed to be COVID-19 positive?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		
Have you been tested for COVID-19? If yes, what was the result?		
Have you been diagnosed with COVID-19? If yes, when?		
Are you over the age of 65?		
you have: Heart Lung disease Kidney disease Diabetes Autoimmune disorders		

I know that these are uncertain times. The risks of COVID-19 are not well understood and there is

no control or if these measureasure will prevent the spread of Covid-19.

In consideration for providing services signing I agree to accept responsibility for the risk that I may contract COVID-19. Lenore Sussman dba Microcurrent & Electrolysis Spa takes your safety very seriously by employing new safety and sanitation initiatives by the CDC, it cannot guaranteed that any of these measures will completely protect you from contracting COVID-19. I therefore RELEASE you from LIABILITY and I INDEMNIFIY HOLD HARMLESS, of any liability.

Signed **Dated**