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COVID-19 SCREENING QUESTIONNAIRE
FOR THE SAFETY OF OUR COMMUNITY

PURPOSE: Based on the U.S. Center for Disease Control Guidelines, providers are encouraged to screen all patients for signs of respiratory illness accompanied by fever.
INSTRUCTIONS: all patients arriving for a scheduled appointment must be asked the following questions below at least 24 hours before arrival. Wala'au Therapy LLC. will maintain record for 14 days from completion of this form and have this form available upon request from the Public Health Department.

☐ **By checking this box, I pledge to provide only correct and truthful information when completing this screening**.

1. Over the past 14 days, have you experienced ANY of the following symptoms?

Dry cough ____ Yes ____ No
Shortness of breath____ Yes ____ No
Muscle or body aches ____ Yes ____ No
Sore throat ____ Yes ____ No
Runny nose ____ Yes ____ No
Headache ____ Yes ____ No
Fatigue ____ Yes ____ No
Nausea or vomiting ____ Yes ____ No
Loss of smell/taste ____ Yes ____ No
Congestion ____ Yes ____ No
Diarrhea ____ Yes ____ No

2. If you are not fully vaccinated, have you had close contact with anyone who has COVID-19 (defined as <6ft for >10 minutes)? ____ Yes ____ No

3. Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test? ____ Yes ____ No

4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection? ____ Yes ____ No

If you have answered YES, to any of the above questions, please call our office and cancel your appointment immediately.

Patient's Full Name (please print):_____

Patient's Signature_____ **Date** _____