**Sports and Orthopaedic Therapy Services, LLC Health Questionnaire**

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

Please circle answer(s)

1. Do you have sx : (Cough/ Fever/Shortness of Breath/None)

2. Temperature reading:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. A. Dx of Covid-19 / Corona virus? (Yes / No)

B. Have you been exposed to anyone who has been dx with COVID-19 / Corona virus within the last 2 weeks? (Yes / No)

B. Were you quarantined? (Yes / No)

C. When were you quarantined?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D. How long where you quarantined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Facemask provided? (Yes / No ( has their own))

5. Did patient wash and / or sanitize their hands prior to treatment? (Yes / No)

Additional comments:

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