Client Screening Questionnaire

If client answers “Yes” to any of the questions, your therapist will request the client reschedule their session until these risk factors do not apply.

	Yes	No
Have you had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?	☐	☐
Has anyone in your household had any of the above symptoms in the last 21 days?	☐	☐
Have you or anyone in your household visited or received treatment in a hospital, nursing home, or long-term care facility in the past 14 days?	☐	☐
Have you or anyone in your household traveled on a plane or been on a cruise ship in the past 21 days?	☐	☐
Are you or anyone in your household an emergency room, urgent care, or specialty COVID healthcare provider?	☐	☐
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?	☐	☐
Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?	☐	☐

Client Name: _____Date:_____

Follow-up screening dates: please have client initial that answers have not changed, and they can accurately answer “no” to each question.

Date:_____Date:_____Date:_____Date:_____

Date:_____Date:_____Date:_____Date:_____