mind body
PHYSICAL THERAPY & WELLNESS CENTER. INC.

PHYSICAL THERAPY: COVID-19 REQUIRED FORM
as of:4-2021

As part of the protocol during the Covid pandemic, Mind Body Physical Therapy & Wellness Center, Inc., is requesting that all clients answer the following questions prior to the first appointment. Your response will be kept confidential and will be reviewed by a practice clinician, who will provide guidance regarding any adjustments to your scheduled appointment.

Today's Date:

First Name _____

Last Name _____

Address _____

City, State Zip _____

Email _____

Phone _____

QUESTIONS RELATED TO COVID-19

Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever greater than 100 degrees Fahrenheit.

☐ Yes
☐ No

Have you or anyone in your household been tested for COVID -19?

☐ Yes
☐ No

Have you or anyone in your household visited or received treatment in a hospital or other health care facility in the past 30 days?

☐ Yes
☐ No

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Have you or anyone in your household traveled in the U.S. in the past 21 days?

- ☐ Yes
- ☐ No

Have you or anyone in your household traveled outside U.S. in the past 21 days?

- ☐ Yes
- ☐ No

Are you or anyone in your household a healthcare provider or emergency provider?

- ☐ Yes
- ☐ No

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?

- ☐ Yes
- ☐ No

Do you have any reason to believe you or anyone in your household has been exposed to or COVID-19?

- ☐ Yes
- ☐ No

To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19?

- ☐ Yes
- ☐ No

Thank you for taking the time to complete this questionnaire. The health and safety of our clients and our community is our priority.

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Electronic Signature:

_____

Date:

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