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Physical therapy · Fitness · Movement arts

In-Person Treatment Questionnaire

Question 1:
1A. Have you been tested for COVID-19?
1B. If yes, what type of test did you have?
1C. When was your test?
1D. What were the results?

Answer 1A:
Answer 1B:
Answer 1C:
Answer 1D:

Question 2:
Are you currently experiencing symptoms related to COVID-19? Please check if you are experiencing any of the following.
These symptoms include (but not limited to, as things are being discovered as we learn more)

A) cough
B) fever
C) chills
D) shortness of breath
E) fatigue
F) unexplained muscle aches
G) headache
H) new loss of taste or smell
I) sore throat
J) congestion or runny nose
K) GI symptoms
L) chilblains of the toes

Answer 2:

Question 3:
Have you been exposed to someone who has been diagnosed with COVID-19?

Answer 3:

Question 4:
Do you have a compromised respiratory or immune system?

Answer 4: