On the Move Physical Therapy

Covid 19 Patient Screening Questionnaire

I am requesting you complete this questionnaire prior to treatment in order to keep you and others safe and healthy. Please circle Yes/No to the following questions:

1) In the past two weeks have you experienced any of the following symptoms: Difficulty breathing or shortness of breath, persistent cough, runny nose, sore throat, fever, loss of taste or smell, muscle aches, abdominal cramps, diarrhea, or vomiting? Yes No

2) If you circled yes to the above question, did you contact your health care provider regarding you symptoms? Yes No

3) In the past two weeks have you been in close contact with a person known to have the Covid 19 infection? Yes No

4) In the past two weeks have you traveled outside the state of Maine? Yes No

5) In the past two weeks have you been in close contact with anyone who has traveled outside the state of Maine? Yes No

6) In the past two weeks have you attended a gathering of more than 10 people? Yes No

7) Are you following CDC guidelines to help stop the spread of the Coronavirus to include frequent hand washing, avoiding touching your face, wearing a face covering in public places when physical distancing of 6 feet is not possible? Yes No

Temperature__________

Name__________________________ Date_______________

Thank you for completing this questionnaire! It is imperative that we take all precautions to limit exposure to the Coronavirus in order to ensure the health and safety of our clients.

If you answered yes to any of the questions you may be asked to defer your appointment for two weeks and if appropriate, contact your Health Care provider regarding any symptoms you have reported.

Policy adopted on 5/14/2020
Written and reviewed by Cheryl Rioux, PT