**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you experienced any of the following symptoms in the past 48 hours?**

* fever or chills
* cough
* shortness of breath or difficulty breathing
* fatigue
* muscle or body aches
* headache
* new loss of taste or smell
* sore throat
* congestion or runny nose
* nausea or vomiting
* diarrhea

**\*Disclosure: If you have answered yes to any of these screening questions above, we are required to review the results of this screen to you, the client, a designated POA/guardian, and resident care coordinator/staff management. In addition, as a private practice and provider of services to many clients, safeguarding our clinicians and clients, we reserve the right to hold services until a physician is notified and provides further clarification and/or testing if medically necessary. \***

**Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time of Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**