Ridgeview PT & Wellness

Patient Screening Form

Patient Name: _____ Date: _____

*Please circle *Yes* or *No* for the following questions

Do you have a fever or have felt hot or feverish recently (10-14 days)?	Yes	No
Are you having shortness of breath or other difficulties breathing?	Yes	No
Do you have a cough?	Yes	No
Any other flu-like symptoms, such as headache or fatigue?	Yes	No
Have you experienced recent loss of taste or smell?	Yes	No
Have you been in contact with any confirmed COVID-19 positive patients?	Yes	No
Have you traveled in the past 14 days?	Yes	No
Are you currently waiting on the results of COVID-19 test?	Yes	No
Are you fully vaccinated at this time?	Yes	No
Are you comfortable being treated without a mask?	Yes	No