TERRIO Therapy-Fitness, Inc. COVID Patient Screening

Date: _____

Patient: _____

1) **Temperature (actual): _____**

2) **In the past 14 days have you been exposed to someone who has tested positive for COVID-19 (Y/N)? _____**

    a. If Yes to #2, please provide date of exposure and details of exposure:

    _____

    _____

    _____

3) **Are you currently awaiting the results of a COVID-19 test (Y/N)? _____**

    a. If Yes to #3, what was the date of your test? _____

4) **Are you experiencing any of the following symptoms today?**

- Cough (Y/N): _____
- Sore Throat (Y/N): _____
- Shortness of Breath or Trouble Breathing (Y/N): _____
- Muscle/Body Aches or Chills (Y/N): _____
- New Loss of Taste or Smell (Y/N): _____
- Nausea, Vomiting, or Diarrhea (Y/N): _____
- Congestion/Runny Nose (Y/N): _____
- Fatigue (Y/N): _____
- Headache (Y/N): _____

<u>Patients must be sent home if:</u>

- Patient has a fever over 100°F or…
- The answer is "Yes" to #3, or "Yes" to one or more of the symptomatic screening questions in #4 (congestion/runny nose, fatigue, and headache must be combined with a second symptom to be sent home)