COVID-19 Screening Tool.

Honestly responsed "YES" or "NO":

1	Have you experienced any of the following symptoms in the past **48 hours**: If **YES** please circle **ALL** that apply. • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body ache • headaches • new loss of taste or smell • sore throat • congestion • runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
2	Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
3	Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
4	Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

By signing, I agree at anytime while I am a patient of In Touch Therapy any of the above questions become YES, I will call to discuss the best plan of action.

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Patient Signature Date