

# Client Screening Questionnaire

If client answers "Yes" to any of the questions, your therapist will request the client reschedule their session until these risk factors don't apply.

	Yes	No
Have you had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your household had any of the above symptoms in the last 21 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your household visited or received treatment in a hospital, nursing home, or long-term care facility in the past 21 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your household traveled outside the U.S. or been on a cruise ship in the past 21 days?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or anyone in your household an emergency room, urgent care, or specialty COVID healthcare provider?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>

Client Name: \_\_\_\_\_

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