Pre-visit Screening Form

The safety of our patients and staff is of utmost importance to Westside Dance Physical Therapy. Given the recent COVID-19 outbreak, we are requiring all patients to complete this pre screening form prior to your first visit with us since March 16th, 2020. Please scan and email this form to your treating therapist prior to your visit. Alternatively, you may bring the form with you on the day of your visit, however, please note that we reserve the right to reschedule treatment if you have answered yes to any question below. Please answer these questions truthfully and accurately so that we can ensure that you receive care at the appropriate time and setting. Please note that all of your responses will remain confidential. Thank you for your attention to this matter.

Sincerely,

The Staff at Westside Dance Physical Therapy

*NAME:*_____

QUESTION	**YES/NO**	**If YES, please provide additional information**
1. Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shorts of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees F?		
2. Have you or a member of your household been tested for COVID-19? (This includes all swab, blood and/or antibody tests).		
3. Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers?		
4. Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care or other healthcare facility in the past 30 days?		
5. Have you or a member of your household traveled outside the U.S. in the past 30 days?		
6. Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days?		
7. Have you or a member of your household traveled on a cruise ship in the past 21 days?		
8. Are you or a member of your household healthcare providers or emergency responders?		
9. Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?		
10. Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19?		
11. To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19?		

I hereby confirm that I have answered each question truthfully and to the best of my knowledge:
Name: Date: