Health Questionnaire

Every client and staff member is required to verify their health status prior to coming in.

Client's Name:_____

1. Have you been confirmed positive for COVID-19
2. Have you knowingly been in close contact with anyone who has been confirmed positive for COVID-19?
3. Are you currently experiencing, or have you recently experienced, any acute respiratory illness symptoms such as fever, cough, shortness of breath?
4. Do you have a cold, cough, difficulty breathing, chills, muscles pain, stomach ache or headache?
5. Did you have any of these symptoms in the past 14 days?
6. Did you have a fever over 98.6 F/37/C in the past 14 days?
7. Did you have a contact with anyone with these symptoms in the past 14 days?
8. Have you been in contact with anyone who is sick and under quarantine, in the past 14 days?
9. Have you traveled out of Alaska in the last 14 days?
10. Have you knowingly been in close contact with someone who has traveled out of state and has acute respiratory illness symptoms?
11. Do you practice social distance guidelines while at work or in public?
12. Do you wear a mask while in public?

I agree to notify my provider about any changes in conditions listed above.

Signature: **Date:**

Date	Temperature	Comments	Initials