Health Questionnaire

If you have been exposed to a communicable disease, you may spread the disease to the provider, staff, or other patients/parents in the clinic. We will be asking the following questions prior to each appointment in efforts to reduce the chances of transmission.

We are looking for new symptoms or those that are different from already known chronic conditions.

Do you, your child, others accompanying you today or anyone you have recently been in contact with have any of the following symptoms:

Fever (above 100.4 degrees) ☐Yes ☐No

Cough ☐Yes ☐No

Sore throat ☐Yes ☐No

Muscle aches ☐Yes ☐No

Headaches ☐Yes ☐No

Chills/Sweats ☐Yes ☐No

Change in taste ☐Yes ☐No

Change in smell ☐Yes ☐No

Nausea ☐Yes ☐No

Vomiting ☐Yes ☐No

Diarrhea ☐Yes ☐No

Trouble breathing ☐Yes ☐No

Shortness of breath ☐Yes ☐No

Persistent pain, pressure, or tightness in the chest ☐Yes ☐No

Have you received the COVID-19 vaccine? ◯ Yes No ◯

If yes, date of the last COVID-19 Vaccine? _____

Have you participated in a large gathering in the last week (gatherings larger than 10 ppl, i.e., birthdays, protests, family reunions)? ☐Yes ☐No

Have you, your child, anyone accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed with Covid-19? ☐Yes ☐No **If so, at work, home, other _____**

If yes provide date of illness _____ through _____

By signing this document, I consent to release of liability and assumption of risk. I fully understand the terms of this agreement and am signing it freely and voluntarily without any inducement. I have been informed about the purpose, procedures, possible benefits, and risks. I may receive a copy of this Informed consent at any time. I have been given the opportunity to ask questions before I sign and may ask questions at any time. By signing below, I attest that I completely indemnify CRCHC and will not hold CRCHC liable if I contract the COVID-19 virus.

If exhibiting any of these symptoms, you may be asked to return to your car and a staff member will assist you.

_____ _____

Patient Name **Date**

_____ _____

Parent/Legal Guardian signature **Date**

OFFICE USE ONLY

Current Temperature: _____ Time: _____ Staff Initials: _____