Spine and Sport Physical Therapy
Coronavirus Disease 2019 Questionnaire
This Information is Highly Confidential & Will be Securely Managed

Name: _____ Date: _____

You will be asked to complete this form at each visit or to verbally confirm that there have been no changes in your answers since the initial form completion.

Please check the **Yes** or **No** boxes; do not check both boxes. Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you traveled outside of the US in past 30 days? Yes ☐ No ☐
   If yes, please list the countries you have visited below.
   Comment: _____

2. Have you been in close contact with an individual who has traveled outside of the US in the past 30 days? Yes ☐ No ☐
   If yes, please list the countries he/she has visited below.
   Comment: _____

3. Have you been in close contact, in the past 30 days, with an individual who has had any these symptoms? Yes ☐ No ☐
   - ☐ Fever over 100.4°
   - ☐ Persistent cough
   - ☐ Shortness of breath
   - ☐ Diminished sense of smell and/or taste

   If yes, have they been diagnosed and/or seen the doctor? Yes ☐ No ☐
   Comment: _____

4. Have you had any these symptoms? Yes ☐ No ☐
   - ☐ Fever over 100.4°
   - ☐ Persistent cough
   - ☐ Shortness of breath
   - ☐ Diminished sense of smell and/or taste

   If yes, how long have you had these symptoms? _____
   If yes, have you been diagnosed and/or seen the doctor? Yes ☐ No ☐
   Comment: _____

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability.

Please contact Fred at SSPT if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.

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