Baylife & QPR Clinics Coronavirus Disease 2020 Questionnaire

Name: ____Date: __________

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 104°
   Persistent cough
   Shortness of breath
   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 104°
   Persistent cough
   Shortness of breath
   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 Ryan Christoff at (724) 223-2061 if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.

I am declining to complete this questionnaire. ___________________________

Baylife & QPR Clinics Coronavirus Disease 2020 Questionnaire

Signature