Clients Pre- Appointment Questionnaires

Name: _____

Email: _____

Phone Number: _____

In the past 24 hours, have you experienced any of the following?

1. **Fevers?**

   Yes ☐

   No ☐

2. **Fatigue?**

   Yes ☐

   No ☐

3. **Cough?**

   Yes ☐

   No ☐

4. **Sneezing?**

   Yes ☐

   No ☐

5. **Aches and Pains?**

   Yes ☐

   No ☐

6. **Runny or Stuffy Nose?**

   Yes ☐

   No ☐

7. **Sore Throat?**

   Yes ☐

   No ☐

8. **Headaches?**

   Yes ☐

   No ☐

9. **Shortness of Breath?**

   Yes ☐

   No ☐

10. **Have lost any Taste/ Smell?**

    Yes ☐

    No ☐

11. **Have you been in close contact with anyone who has exhibited symptoms?**

Yes ☐

No ☐

12. Have you been in contact with anyone who has tested positive for COVID-19?

Yes ☐

No ☐

13. Have you travel anywhere within 3 months?

Yes ☐

No ☐