# COVID-19 Screening Form

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| **1.** Regardless of vaccination status, have you experienced any of the following in the last 48 hours?<br><br>- Fever/chills<br>- Cough<br>- Difficulty breathing<br>- Shortness of breath<br>- Fatigue<br>- Muscle or body aches<br>- Headache<br>- Loss of taste<br>- Loss of smell<br>- Sore throat<br>- Congestion<br>- Nausea<br>- Vomiting<br>- Diarrhea | **YES/ NO** |
| **2.** Have you tested positive for COVID-19 in the last 10 days? | **YES/ NO** |
| **3.** Are you currently awaiting COVID-19 test results? | **YES/ NO** |
| **4.** Have you been diagnosed with COVID-19 in the last 10 days? | **YES/ NO** |

If you answered yes to any of the above questions, please contact Protherapy Concepts to reschedule your appointment and contact your primary care physician. Thank you!