Patient Questionnaire regarding COVID-19

Child's Name:_____ Date of Service:_____

- Has your child had a fever in the past 48 hours? YES NO
- Has your child had any fever reducing medication In the past 48 hours? YES NO
- Has anyone in your family had a fever in the past 48 hrs? YES NO
- Does anyone in your family have a cough? YES NO
- Has anyone in your household traveled outside the US in the past 2 weeks? YES NO
- Have you or any family member been in contact with anyone exposed to COVID-19? YES NO
- Do you have any questions for me regarding the Transmission of COVID-19? YES NO

Please check the CDC website at **cdc.gov** daily for updates on the virus and how to protect yourself and your family.

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Therapist Signature