Wampler and Associates Rehabilitation

Pre-Screening Questionnaire

Patient Name: ____________________________________ Date: ___________________

Do you have a temperature of 100 or greater	YES	NO
Does anyone in your family/household have a temperature of 100 or greater	YES	NO
Do you have a cough, sneezing, sore throat	YES	NO
Does anyone in your family/household have a cough, sneezing, sore throat	YES	NO
Do you have any Flu like symptoms	YES	NO
Have you had Flu like symptoms in the past 14 days	YES	NO
Does anyone in your family/household had Flu like symptoms in the past 14 days	YES	NO
Has anyone in your family/household had Flu like symptoms in the past 14 days	YES	NO
Have you or a family member recently (last 14 days) traveled out of the US	YES	NO
Have you had contact with someone with or is under investigation for COVID-19	YES	NO
Has anyone in your household had contact with someone with or is under investigation for COVID-19	YES	NO

If you answer "YES" to any of the above questions, please notify Therapist/Front Office