COVID-19 Self Screening Questionnaire

You must answer "NO" to all the questions in this questionnaire in order to enter our physical location. If you answer "YES" to any of the questions, please **DO NOT** come enter Katie M Wyss LMSW, LLC's office. If you experience any symptoms or answer "YES" to any of these questions, you must immediately contact your health care professional for recommended next steps.

1) Have you had any of the following symptoms in the last 24 hours? *

	Yes	No
Cough		
Shortness of breath or difficulty breathing		

OR at least TWO of the following symptoms in the last 24 hours: *

	Yes	No
Fever (100.4 or higher)		
Chills		
Repeated shaking with chills		
Muscle pain		
Headache		
Sore throat		
New loss of taste or smell		

*If you answered "Yes" to question one, your session will be cancelled, and you will be asked to go home with no charge to you. You should:

- **Self-quarantine for at least 14 days** from the date on which you first experienced any of the above symptoms; AND
- Wait until you have had **no fever for at least 3 days** (without the use of fever-reducing medication) AND
- Improved respiratory symptoms (no cough, shortness of breath)

2) In the last 14 days have you: *

	Yes	No
Been in contact with someone who was **diagnosed** with COVID-19?		
Been in close contact with someone who had COVID-19 **symptoms**?		

*If you answered "Yes" to any part of question two, your session will be cancelled, and you will be asked to go home with no charge to you. You should self-quarantine for at least 14 days.

I certify to the best of my knowledge; this information is accurate.

Katie M Wyss LMSW, LLC Precautions:

- ❑ I agree to wash my hands and/or use hand sanitizer prior to beginning my in-person therapy session.
- ❑ I agree to wear a mask when requested to do so while in the building in which I receive in-person therapy.
- ❑ I agree to have my temperature checked at the beginning of my therapy session by my provider.
    - ❑ If my temperature reads 100.4 degrees of higher, I agree that my therapy session will be cancelled, and I will be asked to leave.
- ❑ I agree to practice social distancing of at least six feet from all other parties that do not reside in my household while attending my therapy session.

Client Name: _____

Parent/ Guardian Name if applicable: _____

Signature: _____

Date Signed: _____