Coronavirus Disease (COVID-19) Revitalize Counseling Health Screening

Client Name:

Day / Time:

Current temperature– Temp 100.4 or higher

Have you been vaccinated?

Have you developed or in the in the Past 24 Hours Have You Experienced:

	YES	**NO**
Subjective fever (felt feverish)		
New or worsening cough		
Shortness of breath		
Sore throat		
Diarrhea		
Loss of taste of smell		
Were you tested for COVID-19		
If tested, results from test:		
In past 14 days had close contact with individual diagnosed with COVID -19		
Traveled via airplane internationally or domestically		

Telehealth counseling services available if you answer yes for any above questions or unable to comply to safe practices of the office.

_____ _____

Print Client's Name Date

_____

Signature