

# COVID-19 Pre-Visit Screening Survey

As essential healthcare workers, **Pala Chiropractic** has been able to continue to serve our community with necessary chiropractic care. As such, we must do everything possible to mitigate risk to our staff and other members of the community so it is vitally important to you complete this form accurate prior to each visit.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Have you been exposed to COVID-19 or do you believe that you have? Yes No

Please check any of the following symptoms you (or other members of your family that also have an appointment) are currently expressing:

- Shortness of breath     Productive Cough     Non-Productive Cough
- Bronchitis                 Respiratory infection    Sore throat
- Fever                         Nausea                       Vomiting
- Diarrhea                     Severe fatigue (not related with travel)
- None of the above

Other: \_\_\_\_\_

Have you traveled to or from a high-risk geographic area in the past 14 days?  Yes No

If you are visiting **Pala Chiropractic** with other family members, please list their names and which symptoms listed above (if any) they are currently experiencing:

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By signing here, you are attesting that everything you stated above is truthful and accurate to the best of your knowledge.

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Signed \_\_\_\_\_ Date \_\_\_\_\_