Growing Steps
Pediatric Physical Therapy

Helping each client take the next step!

COVID-19 SCREENING QUESTIONNAIRE

Growing Steps Physical Therapy LLC

1. Have you had any of the following symptoms of COVID-19 infection in the last seven (7) days:

- Cough (either new, or different than your normal cough), shortness of breath, or difficulty breathing? Yes _____ No _____
- Fever (either subjective, or measured), exceeding 100.4 degrees, or chills? Yes _____ No _____
- Sore throat? Yes _____ No _____
- Unusual muscle pain or unusual headache? Yes _____ No _____
- New loss of taste or smell? Yes _____ No _____

2. Have you tested positive for COVID-19 infection within the past fourteen (14) days?

Yes _____ No _____

3. Have you been within six (6) feet for longer than 15 minutes with someone who has a suspected or confirmed COVID-19 infection in the last fourteen (14) days?

Yes _____ No _____

4. Have you traveled over 100 miles away or traveled by air within the last fourteen (14) days? If so, to which state(s) / country(ies) did you travel?

Yes _____ No _____ _____

_____
Signature Date

Circle: Patient Parent Legal Guardian Other Relation:_____

_____
Printed Name

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