PROGRESSIVE MEDICAL FITNESS

COVID-19 Client Health-Screening Form

1. Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problems)? YES/NO

2. Have you been asked to self-isolate or quarantine by a doctor, local public health or government official in the last 14 days? YES/NO

3. Have you been in close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? YES/NO

4. Have you traveled to or from a high risk area within the last 14 days? YES/NO

I understand that, because physical therapy involves maintaining touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive physical therapy at Progressive Medical Fitness.

Client Signature: _____ Date:_____