COVID Screening Questions

Patti Ashley, PhD, LPC
6800 N. 79th Street, Suite 207 |Niwot CO 80503
720-565-3388 | www.pattiashley.com

Please read and check appropriately if you have had any of the following:

1. Fever of 100º F or above, or possible fever symptoms, like shivering and sweating? ***Yes*** ___ ***No*** ___

2. Sore throat? ***Yes*** ___ ***No*** ___

3. Dry cough? ***Yes*** ___ ***No*** ___

4. Trouble breathing, shortness of breath, wheezing? ***Yes*** ___ ***No*** ___

5. Fatigue? ***Yes*** ___ ***No*** ___

6. Muscle aches? ***Yes*** ___ ***No*** ___

7. Loss of smell, or taste? ***Yes*** ___ ***No*** ___

8. Nausea, vomiting, diarrhea? ***Yes*** ___ ***No*** ___

9. In the past 14 days, have you been in close, even though brief, contact with anyone having any of the symptoms above, or with a lab-confirmed case of COVID? ***Yes*** ___ ***No*** ___

a) If so, what date did you come into contact with this person?

Date: ____

b) If so, does this person live with you? ***Yes*** ___ ***No*** ___

10. Have you ever tested positive for COVID? ***Yes*** ___ ***No*** ___

__________________________________ __________________

Signature Date