Pinnacle Kidz
Pediatric Physical Therapy

Patient/Caregiver Health Screening Self-Assessment Questionnaire

To help protect against the spread of the novel coronavirus SARS-CoV-2, which causes COVID-19, we ask that all patients and caregivers self-evaluate their risk to the health and safety of others before visiting our clinic or participating in in-person physical therapy appointments by answering the following questions:

1. Has your child or anyone he/she is living with been in contact with someone known to have COVID-19 in the last 14 days? **Yes / No**

2. Has your child or anyone he/she lives with been diagnosed with COVID-19? **Yes / No**

3. Has your child or anyone he/she lives with been advised by a doctor, healthcare professional, or public health official that he/she may have been exposed to COVID-19 in the last 14 days and/or were advised to stay home/avoid contact with others? **Yes / No**

4. Has your child or anyone he/she lives with experienced fever, cough, shortness of breath, sore throat, loss of taste or smell, or other symptoms of COVID-19 in the last 14 days? **Yes / No**

Do you or your child have a temperature **above 100.4 degrees** Fahrenheit? **Yes / No**

If yes, temperature of child _____ temperature of caregiver _____

If you answered "yes" to any of the questions listed above, we respectfully ask that you <u>not</u> proceed with your in-office visit as scheduled. Please discuss options to reschedule to telehealth visits until all health screening questions are cleared. Thank you for you cooperation.

_____ _____
Patient Name Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date