Health Assessment Intake Form

Name: _____ Date: _____

Have you been tested for COVID-19? YES NO

If yes, what type of test did you have? _____

When was your test? _____

What was the result? _____

Have you been in places with a high infection rate within the last two weeks (e.g. state-designated "hotspots")? YES NO

If yes, please explain. _____

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever
__ Chills
__ Cough
__ Sore Throat
__ Diarrhea, digestive upset
__ Nasal, sinus congestion
__ Loss of sense of taste or smell
__ Fatigue
__ Shortness of breath
__ Sudden onset of muscle soreness (not related to a specific activity)
__ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise? YES NO

I declare that the information provided above is true and accurate to the best of my knowledge.

_____ _____ _____

(print name) *(signature)* *(date)*