Illness History Questionnaire

If any of your answers have an * next to it, PLEASE LET US KNOW IMMEDIATELY!

1. **Are you 14 days past receiving the final dose of the COVID 19 Vaccine?** **YES NO**

   If YES, please provide date of final dose _____
   Please bring a copy of your vaccine card for us to scan into your files.
   If you answered YES to #1, you only need to answer # (2), and (4) and sign at the bottom.

(2). Have ***you, a family member or other close contact experienced*** any of the following symptoms or ***been exposed to anyone*** who has had any these symptoms in the past 14 days?

   ****Fever, chills, generalized muscle aches/pains, cough, sore throat, shortness of breath, loss of smell or taste, new onset of unusual fatigue, headache that is unusual for you, diarrhea, nausea, abdominal pain, acute confusion, hives.** ***YES NO**

3. Have ***you or any close contacts*** had any known exposure to the Corona Virus in the past 14 days?

   ***YES NO**

(4). Are your currently taking any medications to suppress a fever? ***YES NO**

5. Are you wearing a mask when in public places and when socializing indoors, and practicing social distancing?

   YES *NO

I understand that it is my responsibility to immediately inform Progress Physical Therapy, LLC if I develop any of symptoms noted above, have had close contact with anyone else with these symptoms or diagnosed with Corona Virus, or if I have been advised to self-quarantine. I also understand that, if any of my answers have a * next to them, special accommodations may be made, my appointment *may* need to be re-scheduled or virtual visits will be offered, *if appropriate* to maintain the lowest possible risk of the spread of COVID at our office. I understand that Progress Physical Therapy, LLC has a strict policy that all who visit will wear a mask (no valve on mask) that covers their nose and mouth for the entire time visiting our office, even when social distanced from others. I will call 804-270-7754 and let Progress Physical Therapy, LLC know if I am unable to follow this policy before arriving at the clinic.**

Name (Print) _____ Signature _____ Date _____