Stone Massage & Wellness
Covid-19 Screening Questionnaire

1. **Do you have:**

A fever of 100.4 degrees Fahrenheit or higher	**Yes** ☐	**No** ☐
Sore throat	**Yes** ☐	**No** ☐
A cough	**Yes** ☐	**No** ☐
New loss of taste or smell	**Yes** ☐	**No** ☐
Shortness of breath or difficulty breathing	**Yes** ☐	**No** ☐
New confusion	**Yes** ☐	**No** ☐
Chills	**Yes** ☐	**No** ☐
Inability to wake or stay awake	**Yes** ☐	**No** ☐
Muscle pain or pressure in the chest	**Yes** ☐	**No** ☐
Bluish lips or face	**Yes** ☐	**No** ☐

2. **Have you traveled in the past 14 days to regions affected by COVID-19?** **Yes** ☐ **No** ☐

3. **Have you had contact with anyone with a <u>confirmed</u> COVID-19 diagnosis?** **Yes** ☐ **No** ☐

4. **Are you age 60 or older?** **Yes** ☐ **No** ☐

Client Information:

We are on a mission to provide our clients with relevant and timely information about Health and Wellness. Please provide your email address to receive our latest posts.

Add your Email Address Below

Client Signature: _____

Date: _____