COVID-19
ACTIVE SCREENING QUESTIONNAIRE

This will be updated as the CDC and MI State Health Departement's information on COVID-19 continues to change.

Your health and well-being are the upmost importance, and we are taking measures to keep the office safe. Anyone coming into the building will be asked to complete this questionnaire as part of our screening process.

Within the last 14 days, have you experienced -

1. a new cough that you cannot attribute to another health condition?

☐ YES ☑ NO

2. new shortness of breath that you cannot attribute to another health condition?

☐ YES ☑ NO

3. a new sore throat that you cannot attribute to another health condition?

☐ YES ☑ NO

4. new muscle aches that you cannot attribute to another health condition/specific activity?

☐ YES ☑ NO

5. new loss of taste/smell that you cannot attribute to another health condition?

☐ YES ☑ NO

6. Within the last 14 days, have you had a temp. of 100.4 or greater without using medicine or other signs of a fever?

☐ YES ☑ NO

7. Within the last 14 days, have you had close contact with someone who is currently sick with suspected or confirmed COVID-19?

☐ YES ☑ NO

If you answered YES to any of these questions, please do not enter our buildings.

Print Name: _____ Date: _____

Phone number: _____