

# Acupuncture and Integrative Healthcare, LLC.

## COVID-19 Patient Screening Questionnaire

Patient Name: \_\_\_\_\_

Call scheduled patients 18-24 hours prior to their appointment time to conduct initial verbal screening. Re-assess by restating questions to complete screening process prior to patient entering office for planned treatment.

**Have you returned from a visit to China, Japan, Iran, South Korea, or Italy – or travelled to New York, Connecticut, Massachusetts, Louisiana, Illinois, Michigan, California, or Washington State after Jan 1, 2020?**

Pre-screen Date: \_\_\_\_\_ No \_\_\_ Yes \_\_\_ F/U Date: \_\_\_\_\_ No \_\_\_ Yes \_\_\_

**Have you been in contact with a person who has tested positive to COVID-19 or has returned from one of the above countries or states in the past 14 days who also exhibits respiratory symptoms (fever, cough, difficulty breathing)?**

No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

**Any serious underlying health conditions, including high blood pressure, chronic kidney disease undergoing dialysis, liver disease, heart condition, chronic lung disease, diabetes, obesity BMI 40+, asthma, and those immune-compromised, including receiving cancer treatment, chemotherapy, smoking, bone marrow/organ transplant, poorly controlled systemic viral conditions, prolonged corticosteroids or other immune weakening medications. (Circle All)**

No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

**Do you live in a nursing home, assisted living or long-term care facility?**

No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

**Answers “yes” to any question listed above identifies “Vulnerable Individuals (VI).” Follow Federal, State, Local guidelines (VI recommended to remain at home). Screen for existence of two (2) or more positives for co-existing risk factors (below) during the past 14 days: Patients who answer “yes” to two (2) questions above or two (2) questions below may not be treated in your office. Refer to PCP, nearest ER or Local Health Department Clinic for COVID-19 clinical evaluation. Patient will need to provide documentation/results they were screened or tested for COVID-19 before being treated in the office.**

Age 65+ No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Fever of 100°F or greater? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Cough? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Difficulty breathing? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Chills or repeated chills? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Muscle pain? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Headache? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

Sore Throat No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

New loss of taste of smell? No \_\_\_ Yes \_\_\_ No \_\_\_ Yes \_\_\_

DOS Patient Temperature: \_\_\_\_\_ (Optional) O2 Level: \_\_\_\_\_

\*Monitor the CDC website for additional COVID-19 risk factors and symptoms. Update screening tool as needed.

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_