OCEAN
INTEGRATED WELLNESS CENTER

Patient Name: _____ Date: _____

In order to reduce the risk of spreading COVID-19, we require the "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers. We have the discretion to reschedule patients to decrease the risk of spreading illness.

Please answer "YES" or "NO" to the following questions:

- Have you or anyone in your household had any of the following symptoms in the last 14 days:
  - A. Sore throat ..... ____ YES ____ NO
  - B. Cough ..... ____ YES ____ NO
  - C. Chills ..... ____ YES ____ NO
  - D. Body aches for unknown reasons ..... ____ YES ____ NO
  - E. Shortness of breath for unknown reasons..... ____ YES ____ NO
  - F. Loss of smell ..... ____ YES ____ NO
  - G. Lose of taste ..... ____ YES ____ NO
  - H. Fever at or greater than 100 degrees Fahrenheit ..... ____ YES ____ NO
- Is anyone in your household currently sick? ____ YES ____ NO
- Are you or anyone in your household currently awaiting the results of a covid-19 test? ____ YES ____ NO
- Have you or anyone in your household been admitted to a hospital, nursing home, long-term health care facility in the past 30 days? ____ YES ____ NO
- Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19? ____ YES ____ NO
- To the best of your knowledge have you been in close proximity of any individual who tested positive for COVID-19? ____ YES ____ NO
- Have you traveled outside the state of New Jersey in the past 14 days? If so, where? _____ ____ YES ____ NO

I have truthfully answered these questions.

Signature Date

(for office use only)

Patient Temperature: _____ Time: _____ Staff Initial: _____