Healthy Back Chiropractic
1707 Lansing Ave. NE Salem, OR 97301
phone: (503) 589-0700 fax: (503) 586-0255
www.HealthyBackChiropractic.com

COVID-19 SCREENING

Patient Name _____ Date _____

Parent/Guardian Name _____

Instructions for use: Please mark YES or NO for each question below and sign the bottom of the form confirming you have answered to the best of your ability.

Do you have a fever, or have you had a fever in the last 48 hours?	☐ YES	☐ NO
Do you have a cough?	☐ YES	☐ NO
Are you having shortness of breath or any difficulty breathing?	☐ YES	☐ NO
Do you have chills or repeated shaking with chills?	☐ YES	☐ NO
Are you in contact with anyone who has been confirmed to be COVID-19 positive?	☐ YES	☐ NO
Have you traveled in the past 14 days outside of the US?	☐ YES	☐ NO
Have you been told that you may have been exposed to the virus?	☐ YES	☐ NO
Have you been diagnosed with COVID-19?	☐ YES	☐ NO

Positive responses to any of these would likely indicate a deeper discussion with the doctor before proceeding with treatment.

Patient Signature _____

****

Staff Use: ☐ Appt Kept ☐ Rescheduled Staff Signature _____

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again when they arrive for appointment.

***If patient answers "yes" to either question on shortness of breath or coughing, or answers yes to any combination of two other symptoms and the patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve or until patient can provide proof they are not infectious for COVID-19. The doctor may want to seek additional information from the patient regarding symptoms.*