INTAKE QUESTIONNAIRE: Person: __________________ Date: _______ By: ____________

Do you now or in the last 2 weeks have or have had any of the following symptoms:

- ☐ Fever
- ☐ Chills
- ☐ Body aching
- ☐ Cough or Shortness of Breath
- ☐ Nausea, vomiting or diarrhea
- ☐ Nasal Congestion/ Runny Nose/ Itchy Red Eyes (Conjunctivitis)
- ☐ Loss or change in sense of taste or smell
- ☐ Loss of appetite or unexpected weight loss
- ☐ Headaches
- ☐ Difficulty sleeping or staying awake
- ☐ Have you been tested for COVID-19? If so, give the date and the results
- ☐ Have you been exposed to anyone who is ill and/or was discovered to have tested positive for COVID-19?
- ☐ Has anyone in your family tested positive for COVID-19?

SOCIAL BUBBLE:

- ☐ Where do you live ________________? How many people are in your house ________? Has anyone shown those symptoms above? ☐ Yes / ☐ No
- ☐ Are all occupants of the house careful with distancing? ☐ Yes / ☐ No
- ☐ Do they use masks while in public? ☐ Yes / ☐ No
- ☐ Do you socialize outside of this bubble? ☐ Yes / ☐ No
- ☐ Past 2 weeks, have you "Dined In" or "Bar" location, participated in Groups greater than 5, spent any significant time around people without masks? ☐ Yes / ☐ No Describe: ________________________________
- ☐ Do you wear a mask while in a public area? ☐ Yes / ☐ No
- ☐ Have you flown commercially recently in the last 2 weeks? ☐ Yes / ☐ No

Reviewed with Dr. McCallum: ☐ Yes Date: ___________ By: __________________